NHS Forth Valley

A meeting of the **Forth Valley NHS Board** will be held on **Tuesday 30 June 2026** at **9.30am** in the **Boardroom, Carseview House, Castle Business Park, Stirling** FK9 4SW.

Neena Mahal
Chair

AGENDA

1.	**Welcome, Apologies and Confirmation of Quorum**		**09.30**
2.	**Declaration(s) of Interest(s)**		
3.	**Minute of Forth Valley NHS Board meeting held on 28 April 2026**	For Ratification **Pages 5 to 19**	
4.	**Matters Arising from the Minute / Action Log**	For Approval **Pages 20 to 23**	
5.	**Chair's Report** (a) Verbal Update by Ms Neena Mahal, Board Chair (b) NHS Forth Valley De-escalation to Stage 1 of NHS Scotland Support and Intervention Framework (c) Highlight Report on Board Seminars	For Information **Pages 24 to 35** For Assurance **Pages 36 to 37**	**9.40**
6.	**Board Executive Team Report** (Paper presented by Professor Ross McGuffie, Chief Executive)	For Discussion **Pages 38 to 43**	**9.50**
	7. COMMITTEE MINUTES AND FLASH REPORT TO HIGHLIGHT MATERIAL ISSUES TO THE BOARD	For Assurance **Pages 44 to 45**	**10.00**
	Governance Committee Minutes		
7.1	**Audit & Risk Committee – Minute of Meeting of 27 March**	**Pages 46 to 62**	
7.2	**Clinical Governance Committee – Minute of Meeting of 5 May 2026**	**Pages 63 to 78**	
7.3	**Staff Governance Committee – Minute of Meeting of 12 May 2026**	**Pages 79 to 90**	
7.4	**Strategic Planning, Performance & Resources Committee – Minute of Meeting of 26 May 2026**	**Pages 91 to 108**	
	Advisory Committee Minutes		
7.5	**Area Clinical Forum – Minutes of Meetings of 15 January and 23 April 2026**	**Pages 109 to 117**	
7.6	**Area Partnership Forum – Minute of Meeting of 14 April 2026**	**Pages 118 to 124**	
	INTEGRATION JOINT BOARDS		
7.7	**Falkirk Integration Scheme**	For Assurance **Pages 125 to 171**	**10.15**

FOR APPROVAL			
8.	**Strategic Risk Register Update – April to June 2026** (Paper presented by Miss Vicky Webb, Head of Risk Management)	Decision **Pages 172 to 198**	**10.20**
9.	**Digital Plan 2026 - 2027** (Paper presented by Ms Rachel Marshall, Deputy Director of Digital)	For Decision **Pages 199 to 233**	**10.30**
10.	**Governance** **(a) Board Appointments** **(b) NHS Forth Valley Board Development Plan:** **(i) 2025/26 – Progress Update** **(ii) Draft Board Development Plan 2026/27** (Papers presented by Mr Jack Frawley, Board Secretary)	For Decision **Pages 234 to 238** **Pages 239 to 249**	**10.45**
	BREAK 10.50 to 11.00		
	FOR DISCUSSION & ASSURANCE		
	Quality & Safety		
11.	**Acute Site Emergency Department Staffing** (Paper presented by Mr Garry Fraser, Director of Acute Services)	For Endorsement **Pages 250 to 260**	**11.00**
12.	**HIS Acute Services Follow-Up Inspection Report** (Paper presented by Prof Karen Goudie, Executive Nurse Director)	For Assurance **Pages 261 to 312**	**11.10**
13.	**Healthcare Associated Infection (HAI) Report May 2026** (Paper presented by Mr Jonathan Horwood, Infection Control Manager & Clinical Lead)	For Assurance **Pages 313 to 335**	**11.25**
14.	**Whistleblowing Standards and Activity Report including Annual Report** (Paper presented by Professor Karen Goudie, Executive Nurse Director)	For Assurance **Pages 336 to 364**	**11.30**
	Finance & Performance		
15.	**Finance Report** Paper presented by Mrs Jillian Thomson, Deputy Director of Finance)	For Assurance **Pages 365 to 371**	**11.40**
16.	**Performance Report** (Paper presented by Ms Kerry Mackenzie, Acting Director of Strategic Planning & Performance)	For Assurance **Pages 372 to 419**	**11.50**
17.	**Schedule of Business**	For Information **Pages 420 to 421**	
18. ANY OTHER COMPETENT BUSINESS			
19. RISKS AND REFLECTIONS			
20.	**Date and Time of Next Meeting** Tuesday 25 August, 9.30am	For Noting	
21.	**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 substantive item of business the business relates to the commercial interests of any person and confidentiality is required.	For Decision	**12.00**

22.	**Minutes of Forth Valley NHS Board Private Meetings held on:** **(i) 27 January 2026** **(ii) 24 February 2026** **(iii) 31 March 2026** **(iv) 16 June 2026**	For Ratification	
23.	**Matters Arising from the Private Minutes / Action Log**	For Approval	
24.	**(a) Community Pharmacy Model Hours** **(b) Community Pharmacy Model Hours - Variation** (Papers presented by Ms Laura Byrne, Director of Pharmacy and Mr Tom Cowan, Head of Strategic Planning & Transformation)	For Ratification	

Forth Valley NHS Board
Record of Attendance: 1 April 2026 to 31 March 2027

MEMBERS	28 Apr	16 June	30 June	25 Aug	27 Oct	15 Dec	23 Feb
Neena Mahal (Chair)	✓	✓					
Kirstin Cassells	✓	✓					
Jennifer Champion	✓	✓					
Fiona Collie	✓	✓					
Martin Fairbairn	✓	✓					
Scott Farmer	✓	✓					
Karen Goudie	✓	✓					
Alison Jaap	✓	✓					
Gordon Johnston	✓	✓					
Fiona Law	X	✓					
Stephen McAllister	✓	✓					
Ross McGuffie	✓	✓					
Clare McKenzie	✓	✓					
Karren Morrison	✓	X					
Andrew Murray	✓	✓					
Allan Rennie	✓	✓					
Finlay Scott	✓	✓					
John Stuart	✓	✓					
Scott Urquhart	✓	✓					

Key:

✓ In attendance
X Apologies
O Non-attendance

NHS Forth Valley

FORTH VALLEY NHS BOARD

3. Minute of the Forth Valley NHS Board Meeting held on Tuesday 28 April 2026
For: Ratification

Minute of the Forth Valley NHS Board Meeting held on Tuesday 28 April 2026 at 9.30am in the Boardroom, Carseview House.

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

In Attendance: Professor Paul Cameron (Director of AHP)
Ms Elsbeth Campbell (Head of Communications)
Mr Aaron Fraser (AHP Coordinator) item 14
Mr Garry Fraser (Director of Acute Services)
Mr Jack Frawley (Board Secretary)
Ms Jan Green (Lead Speech and Language Therapist) item 14
Mr Scott Jaffray (Director of Digital)
Ms Marie Kiers (Chief Finance Officer, Falkirk IJB)
Ms Kerry Mackenzie (Acting Director of Strategic Planning, Performance & Resources)
Ms Jackie McEwan (Corporate Business Manager)
Ms Louisa McGuire (Speech and Language Therapy Coordinator) item 14
Ms Trisha Miller (Lead Nurse Infection Control)
Mr Kevin Reith (Director of People)
Ms Katrina Robertson (Lead Nurse for Health and Care (Staffing) (Scotland) Act 2019 and NMAHP Workforce Planning) item 13
Ms Vicky Webb (Head of Risk)

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1. Welcome, Apologies for Absence and Confirmation of Quorum

An apology was intimated on behalf of Cllr Fiona Law. The Board meeting was quorate.

Dr Jennifer Borthwick, Mrs Morag Farquhar and Ms Gail Woodcock were not in attendance.

2. Declarations of Interest

There were no declarations of interest.

3. Minutes of Meeting

The minutes of the meetings held on 24 February 2026 and 31 March 2026, subject to previous electronic circulation and Board member approval, were **confirmed** as a correct record.

4. Matters Arising from the Minute / Action Log

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

Board members noted that actions 117, 120, 121, 122, 123, 124, 125, 126, 127 and 134 were marked as complete and would be removed from the Action Log.

In respect of 70 the approved Falkirk Integration Scheme would be presented to the next Board meeting for noting.
Item 116 would remain on the Board's action log until a report had been submitted to the Strategic Planning, Performance and Resources Committee.
The date against 128 would be reviewed to the Board date of 25 August 2026 with all expected dates to be reviewed before the next meeting.

The Forth Valley NHS Board approved the Action Log.

Action:

(1) Schedule the approved Falkirk Integration Scheme to be provided to the next Board meeting. Jack Frawley

5.

(a) Chair's Report - Verbal Update by Ms Neena Mahal

The Board Chair highlighted the following:

(a) The Chair highlighted her meeting with Primary Care colleagues which discussed how primary care was considered at the Board and the aim to strengthen engagement with primary care.
(b) The Chief Medical Officer had visited NHS Forth Valley to hear about Value Based Health and Care (VBHC) and commended the progress which was being made.
(c) The Board Chair had taken part on a panel at a senior leaders event on Value Based Health and Care across Scotland, to launch the TURAS learning on VBHC.
(d) The Forth Valley Leadership Event had been successful and provided Board Members with an excellent opportunity to connect with staff. Board Member attendance was encouraged for future events.
(e) There had been a national Board Chairs' Away Day looking at the Service Renewal Framework; Population Health, and Staff Wellbeing and Culture.
(f) Board Members were encouraged to attend upcoming events including the NMAHP Leadership Event and the June Audit and Risk Committee meeting to consider the annual accounts prior to Board consideration.

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

(b) Board Seminar Update

The Forth Valley NHS Board noted for information the Board Seminar Update report on the session held on 3 March 2026 on the draft Financial Plan, and Quality.

The following points were made in discussion:

(i) Discussion took place on whether Forth Valley was slightly ahead of the national position in relation to implementing Population Health and the work with the King's Fund. It was stated that the Board had undertaken a significant amount of Population Health Organisation work including on the concept and how to shift mindsets. Population Health was Forth Valley's main strategic direction and local work on strategy development and mapping had been shared. There was now collaboration with the King's Fund looking at global examples of where impacts had been made. There was an all-Board monthly forum to learn and share success and the Director of Public Health had presented at this forum on Maturity Matrix work.

(ii) Members sought confirmation of the next steps arising from the Quality Seminar including how the work would be taken forward. It was noted that the note of the Seminar including actions would be provided outwith the meeting.

Action:

(1) Circulate the Quality Seminar Action Note. Jack Frawley / Wendy Nimmo

Stephen McAllister joined the meeting during consideration of the previous item.

6. Board Executive Team Report

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

Key messages in the report included:

(i) The Haematology and Blood Transfusion Laboratory at Forth Valley Royal Hospital had achieved UKAS Accreditation for the very first time. Achieving accreditation required strengthening of quality systems, rigorous review of processes, and consistent demonstration of excellence across every stage of the testing pathway. UKAS Accreditation provides strong assurance to clinical colleagues, partners, and, most importantly, patients that the service delivered accurate, reliable, and high-quality results.

(ii) The Single Point of Contact (SPOC) service, piloted in Forth Valley is to be rolled out nationally and aimed to make life easier for patients with cancer by providing easier access to clinical teams for information and advice. The Cabinet Secretary for Health and Social Care, Neil Gray visited Forth Valley Royal Hospital on 12 March 2026 to meet with staff in the SPOC navigation team and talk to local patients who had benefited from the service.

(iii) The Da Vinci XI dual-console robotic system had been delivered to Forth Valley Royal Hospital and installed in theatre 3. The robot-assisted platform had the potential to significantly enhance the delivery of complex surgery across colorectal, gynaecology and urology services, including cancer care and represented an important step forward for patient outcomes, workforce sustainability and future surgical training.

(iv) An integrated cancer support service had been formally launched across Forth Valley, bringing together health, social care and third sector partners to provide people affected by cancer with coordinated emotional, practical and financial support. Funded by Macmillan Cancer Support and the Scottish Government, the Improving the Cancer Journey approach had now been fully embedded within the established Macmillan One to One (Mac One) service.

(v) Following the successful recovery of Freedom of Information (FOI) performance over the last six months, aiming to bring the Board out of its escalated position with the Information Commissioner, a debrief session was held at the Senior Leadership Team. Learning from the approach would be utilised to support earlier identification

of issues and recovery where performance had slipped. The methodology used for FOI was already making a strong impact within complaints handling.

(vi) Since the last Board meeting, there had been ongoing inspection activity: a follow-up unannounced inspection was undertaken by Healthcare Improvement Scotland on 16 and 17 March at Forth Valley Royal Hospital. Evidence submissions had been completed and the team would continue to work with the inspectorate through the inspection process.

(vii) Moving forward, Board members could anticipate further updates around the first draft of the West of Scotland Subnational plan which had been submitted to Scottish Government for review.

The following points were made in discussion:

(i) The Cabinet Secretary for Health & Social Care had written to congratulate NHS Forth Valley staff on their excellent work to help create a sustainable, low-carbon health service. NHS Forth Valley is making real progress in reducing emissions, which the Board's Climate Champion asked was commended in her absence.

(ii) Members commented on the fantastic progress made with Freedom of Information request compliance and recognised that it would be valuable to apply learning from this process in other areas.

(iii) There was a question on the plan and evaluation for utilisation of the surgery robot. There would be evaluation ongoing including patient outcomes, and patient experiences. The roll out would be a managed process with a small number of surgeons initially using the robot. There would be ongoing performance reporting with key metrics relating to post-op recovery and improved length of stay.

(iv) Following confirmation that the Long Covid service would transition to a Post-Acute Infection Syndromes (PAIS) service members asked how this would be communicated to ensure the public were aware of the service available to them. There would be an expansion of the service methodology with communications in plain English. The Long Covid Service had been very successful with high patient experience scores. The Head of Communications was working with the Service Coordinator to ensure that communications were clear on what conditions were included and to encourage GPs to refer into the service. The Board's website would also be updated.

(v) It was noted that the Clinical Governance Committee had considered matters in relation to the Ministerial Accountability Board and that the DIPLAR report had been received following a recent incident at HMP & YOI Polmont. The FAI route and oversight would be the same as for previous suicide incidents. A question was asked on the rate of prison suicides compared to the general population.

(vi) In terms of Sub-national Planning there was no further detail at the moment with June likely for the next steps.

The Forth Valley NHS Board noted the report.

Action:

(1) Circulate information relating to prison and general population suicide rates to Board Members. — Caroline Docherty

Committee Minutes

7.1 Audit & Risk Committee – 27 March 2026

Key items were highlighted from the March meeting, including: the internal audit plan, external audit update and that the production of the accounts was on track.

The Forth Valley NHS Board noted the verbal update on the meeting of the Audit & Risk Committee of 27 March 2026.

7.2 Clinical Governance Committee – 17 March 2026
Key items were highlighted from the March meeting, including: workplan approval, a recent suicide at HMP & YOI Polmont, HIS inspections, Skye House Bed Closures, SAERs progress, Complaints Annual Report approval.

The Forth Valley NHS Board noted the verbal update on the meeting of the Clinical Governance Committee of 17 March 2026.

7.3 Staff Governance Committee – Minute of Meeting of 20 January 2026 and verbal update from Meeting of 10 March 2026
Key items were highlighted from the March meeting, including: focus on absence management and PDPR compliance, bullying and harassment cases increase, work on culture measurements, Workforce Plan development, mandatory training compliance. The Minute of 20 January 2026 was commended to the Board for noting.

The Forth Valley NHS Board noted the minute of meeting of 20 January 2026 and the verbal updated on the meeting of 10 March 2026.

7.4 Strategic Planning, Performance & Resources Committee – Minute of Meeting of 31 March 2026
The Minute of 31 March 2026 was commended to the Board for noting with key issues highlighted including: NTC building issues, finance and performance metrics, early sight of the revised Risk Framework development.
It was noted in response to a question on the NTC that there was no further update.

The Forth Valley NHS Board noted the minute of meeting of 31 March 2026.

Action:
(1) Circulate the culture metrics work outwith the meeting. Kevin Reith

Advisory Committee Minutes:
7.5 Area Clinical Forum – 15 January 2026 and 23 April 2026
Key items were highlighted from the April meeting, including: Area Medical Committee abeyance and the Cataract referral service.

The Forth Valley NHS Board noted the verbal update on the meetings of 15 January 2026 and 31 March 2026.

7.6 Area Partnership Forum – 17 February 2026
Key items were highlighted from the February meeting, including: Reduced Working Week, excessive temperatures and reinstatement of Long Service and Staff Awards.

The Forth Valley NHS Board noted the verbal update on the meeting of 17 February 2026.

Action
(1) Circulate the dates for Long Service Awards to Board Members. Kevin Reith

7.7 Minutes of the Clackmannanshire & Stirling Integration Joint Board – 28 January 2026 and 27 February 2026 and Direction were noted for information.

7.8 The Minute of the Falkirk Integration Joint Board – 30 January 2026 was noted for information.

8. Strategic Risk Register Update – February 2026 to April 2026

The Forth Valley NHS Board considered a report for approval, presented by Ms Webb, which provided an update to the Strategic Risk Register for the period of February 2026 to April 2026.

Key messages in the report included:

(i) All current strategic risks had been reviewed during this period and remain unchanged.

(ii) One focused review had been completed in the reporting period, SRR003: Information Governance. This had been presented to the Strategic Planning, Performance & Resources Committee in March.

(iii) There was no change to the appetite profile of the Board for the reporting period. There were 0% of risks within the Boards appetite, 33% within Board tolerance and 67% outwith Board appetite and tolerance.

(iv) There were no overdue actions to note for the reporting period with 10 actions completed within the reporting period.

The following points were made in discussion:

(i) Comments were made in relation to whether it was desirable for the strategic risk profile to be treated as static. It was suggested that the Short Life Working Group could consider this point and achieve collective clarity on the stratification. The SLWG could also look at specific risks in relation to movement and whether the risks were appropriately defined. As an example of focus the Workforce Planning risk's definition might need to be recrafted. Proposals for any changes would be brought to the Audit & Risk Committee and/or the Strategic Planning, Performance & Resources Committee as appropriate.

(ii) Members considered the Primary Care Sustainability Risk noting additional Scottish Government funding, the need to review the impact on Forth Valley and with the Primary Care Programme Board having only met twice, whether there was appropriate pace with progressing issues. In response, it was noted that further discussion was scheduled at the Senior Leadership Team meetings on Primary Care.

(iii) In relation to SRR001 – a question was asked for clarity on what message the Board was sending if it signed the position off. Was a single action enough and was the Board comfortable to sit at a score of 20 and not get down to 8. Similar points were made in relation to SRR004. If the Board waited for an update once the Sub-national position was clear that would mean doing nothing over the summer period.

(iv) Members asked whether as a Board the right assurance was being provided and it was agreed that the SLWG would continue to consider this point. It was noted that the Strategic Risks were also considered in depth at Committees with recommendations made to Board and that it was appropriate for challenge and discussion to take place through Committees.

(v) In relation to SRR003 members discussed whether the target score process was robust enough and that detail was needed on mitigations. The Board needed to know how issues were being tackled.

(vi) Following discussion on how target dates changed, it was noted that the Internal Audit Follow-Up actions had to have a rationale for date changes which were agreed at Committee level. This could be introduced for risk management.

(vii) Members asked for further information on the Adults With Incapacity process as the date had been extended. It was advised that there were both local and national elements. The Scottish Government had looked at the current Act which had the best intentions behind it. A legislative change was being considered in the longer term. Locally there needed to be work to uncover impacts and challenges to assist families. One approach would be the use of 132a powers to move to care homes while guardianship was progressed. Through the Scottish Government's AWI Fund, the Falkirk HSCP had been able to recruit a Mental Health Officer to work through this specifically and this has brought improvements to the process.

The Forth Valley NHS Board:

(1) approved the changes to the Strategic Risk Register for February to April 2026;
(2) noted the progression of the mitigating actions identified;
(3) noted the update on the focused reviews conducted, and
(4) considered that further assurance was required that appropriate controls were in place to manage the identified risks, support the delivery of objectives and where improvements were needed, clear actions had been identified including work to be taken forward by the SLWG and Committees.

Jennifer Champion left the meeting during consideration of the previous item.

9. Risk Management Framework

The Forth Valley NHS Board considered a report for approval, presented by Ms Webb, which presented the revised Risk Management Framework.

The key messages in the report included:

(i) The Framework had previously been considered by the following groups as part of its development. The groups had either supported the content, or their feedback had informed the development of the Framework:
- The Risk Management Short Life Working Group, comprising of key executive and non-executives, was involved throughout the process of developing the risk appetite approach.
- Senior Leadership Team to oversee the new approach to Risk Appetite.
- Audit & Risk Committee, 27 March, to review and endorse the new risk management framework.
- Strategic Planning, Performance & Resources Committee, 31 March to review and endorse the new risk management framework.

(ii) The Risk Management Framework set out the principles and approaches to risk management which were to be followed throughout NHS Forth Valley.
(iii) The framework, and supporting guidance, applied to all staff, clinical and non-clinical, including contractors. All groups would be made aware of the contents of the Framework.

The following points were made in discussion:

(i) The Board thanked the Head of Risk Management and the SLWG for their work to produce the Framework and commended its quality. There were good IJB linkages noted.
(ii) A question was asked on how it would be clear if the indicators in appendix 1 were being met. The indicators were a review of reporting. There would be reporting on the organisation's position up to Board and also to SLT.

(iii) Members asked what would be done with the Framework going forward and if it would be a tool for training and communications. There would be a rolling training programme which was complemented by TURAS. All training provided by the team would be updated to reflect the Framework. There was a communications plan to support the roll out and mature the organisation in terms of risk approach. The Head of Organisational Development was also being linked in to assist with the management and leadership training.

(iv) In terms of the risk appetite and tolerances, members noted that these should not be viewed as set and that they would need ongoing review for specific areas.

(v) Members highlighted that the Control Section needed to be reflected in the index for the document.

The Forth Valley NHS Board:

(1) approved the Risk Management Framework;

(2) approved the risk appetite levels for the Board as noted in the Risk Management Framework;

(3) noted the communications and training and development plans, and

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

Action

(1) Re-circulate the updated document once the index was updated. — Vicky Webb

10. Communications Update for 2025/26 and Key Plans and Priorities for 2026/27

The Forth Valley NHS Board considered a report for approval, presented by Ms Campbell, which provided an update on communications activity undertaken during 2025/26 and an overview of key plans and priorities for 2026/27 to further strengthen and improve corporate communications across the organisation.

Key messages in the report included:

(i) Communications plans would be reviewed and adapted throughout the year to take account of any new local or national service developments, policies and priorities.
- Key activities in 2025/26 included:
- NHS Reform
- Population Health and Care Strategy
- Culture Change and Compassionate Leadership Programme
- Value Based Health and Care
- Equality and Inclusion

(ii) The key priorities for 2026/27 were:
- Patient Information
- Website Development
- Roll out of Patient Hub/Digital Front Door
- Media Management
- Social Media
- Culture Change & Compassionate Leadership Programme
- Value Based Health and Care
- Staff Engagement

- Digital Developments
- NHS Reform
- Training and Development

The following points were made in discussion:

(i) Members noted that there was a huge amount of work done by the small communications team.

(ii) For external communications it was suggested that work on patient information leaflets should be included, and for internal communications include work on Value Based Health & Care.

(iii) There was discussion of the value in making patient information more proactive in relation to Population Health & Care and the organisation's strategic aims.

(iv) Following a question on Care Opinion, it was confirmed that the Scottish Government and HIS were in discussions to turn the dashboard back on to give a greater level of information.

(v) In response to questions on ensuring that we were taking account of digital exclusion, it was noted that there had been Ofcom surveys which found that 95% of people in the UK had access to internet devices. Putting more information online helped bring down the number of direct service contacts that were required. Where Patient Hub had been rolled out there was an average 83% sign-up. Since September 2025 there had been 50,000 physical letters avoided. This would grow exponentially. It was confirmed that digital exclusion and mitigations were a normal part of project planning.

(vi) There was discussion in relation to how work on Shifting the Balance of Care would be captured and it was suggested that there could be piggybacking of IJB communications.

The Forth Valley NHS Board:

(1) noted the update on communications activities undertaken during 2025/26;

(2) approved outline communication plans and priorities for 2026/27, and

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

11. Code of Corporate Governance – Annual Review

The Forth Valley NHS Board considered a report for approval, presented by Mr Frawley, which provided the Code of Corporate Governance as an appendix.

Key messages in the report and presentation included:

(i) No changes were proposed to the Code at this stage recognising that there had been a Board Seminar on the topic of Governance held on 21 April 2026. Further to discussions at the Seminar and input from officers regarding technical updates, amendments may be brought to a future meeting for decision.

(ii) Changes to Committee Terms of Reference had been pulled through as agreed by the respective bodies.

The Forth Valley NHS Board:
(1) approved the Code of Corporate Governance as appended to the report;
(2) noted that proposed changes to the Code of Corporate Governance would be submitted to a future meeting if required from the April Board Seminar and consultation with officers, and
(3) considered that the report provided assurance that appropriate controls were in place to manage the identified risks, support the delivery of objectives and where improvements were needed, clear actions had been identified.

The Board adjourned at 11.30am and reconvened at 11.45am with all members present as per the attendance list with the exception of Jennifer Champion.

12. Quality and Safety
(a) Quality Assurance and Improvement Report
The Forth Valley NHS Board considered a report for assurance, presented by Professor Goudie and Mr Murray, which provided an overview of Forth Valley's current position in relation to key areas of quality and safety performance.

Key messages in the report included:
(i) Healthcare Improvement Scotland - Safe Delivery of Care Inspection Process
(ii) Feedback including complaints and Care Opinion
(iii) Safety Steering Group
(iv) Hospital Standardised Mortality Rate
(v) Significant Adverse Event Reviews
(vi) Patient Safety Indicators

The following points were made in discussion:
(i) Members discussed the improvements in complaints performance while noting that long waits for responses had an impact on families. There was an internal programme of improvements underway which was making good impact, with the most recent position being 120 open complaints. The same methodology used in relation to FOI improvements had been implemented to draw in the tail of long standing complaints while also responding to new ones.
(ii) Members stated that the narrative was helpful in relation to the length of time complaints were open. In terms of complaint themes a question was asked on how Forth Valley compared to other Boards. The current situation was that Safeguard did all complaints. This had been moved to the web based version and would soon move to Healthcare Guardian. Thematic analysis was done to a low level to identify golden threads for improvements. The current constraint was waiting for the new system. Complaints would be transferred into the right risk categories and escalated through the system allowing commissioning into SAERs where appropriate.
(iii) Following a question on the HIS Unannounced Inspection Follow-Up it was confirmed that this was a follow up to the 2024 Acute inspection. HIS had been on-site for two days with evidence sharing ongoing. The final date for receipt of the report was not yet known.
(iv) A question was asked on how the Safety Plan related to the Quality Management System (QMS) and whether there was a timeline for a new QMS. Work on the QMS was underway with significant parts of the system to be tied together. This work would closely align to the Safety Plan. It was requested that the QMS timelines were included in the Quality Board Seminar action note. This should also include whether a quality strategy was needed going forward.
(v) There was discussion on how the Sim Safety Centre could be used to improve decision making and change behaviours.

(vi) Members expressed concern in regard to SAER performance and the timeline to improve performance even with additional resource. Clarity was sought on the timeline for recruitment. It was confirmed that with the additional resource for one year this would deliver clearance of the backlog and newly commissioned SAERs being completed on time. The FOI improvement methodology was being applied. The Service was hopeful of delivery of the improvement in advance of December 2027. Members expressed concern that the pace was not quick enough to address the performance challenges.
(vii) There was discussion on being a data rich organisation but needing to be able to triangulate that and use it to inform decision making. Learning themes needed to be pulled together and there needed to be clarity on the quality ambition.

The Forth Valley NHS Board:
(1) reviewed the key areas of Quality and Safety contained within the report, noted the areas of progress and risk, and
(2) considered that the report provided assurance that appropriate controls were in place to manage the identified risks, support the delivery of objectives and where improvements were needed, clear actions had been identified.

Jennifer Champion rejoined the meeting during consideration of the previous item.

(b) Healthcare Associated Infection Report – March 2026
The Forth Valley NHS Board considered a report for assurance, presented by Trisha Miller, which provided the Healthcare Associated Infection Reporting Template for March 2026.

Key messages in the report included:
(i) Total SABS remained within control limits. There was one hospital acquired SAB in March.
(ii) Total DABs remained within control limits. There was one hospital acquired DAB in March.
(iii) Total CDIs remained within control limits. There was one hospital acquired CDI in March.
(iv) Total ECBs remained within control limits. There were four hospital acquired ECBs in March.
(v) Unverified data suggested NHSFV had met the SAB,ECB and CDI LDP targets.
(vi) There were no mandatory surgical site infections in March.
(vii) There was one outbreak reported in March.

The following points were made in discussion:
(i) Members asked if the TURAS hand hygiene module was mandatory. The module was currently mandatory and the Why Infection Control Matters module had information on hand hygiene in it.
(ii) It was noted that hand hygiene compliance had been identified as an issue in an inspection. It was suggested that there needed to be a review of communications in this regard. May was international Handy Hygiene Day, there would be information on the staff intranet and the team would be out visiting sites enhancing communication and the need to keep a focus on this.
(iii) Clarity was sought on the amber status of estates and domestic cleaning. It was confirmed that the issue related to an estates issue in terms of the age of the building.

The Forth Valley NHS Board:
(1) noted the HAIRT report;
(2) noted the performance in respect of SABs, DABs, ECBs and CDIs, and
(3) considered that the report provided assurance that appropriate controls were in place to manage the identified risks, support the delivery of objectives and where improvements were needed, clear actions had been identified.

13. Health and Care Staffing (Scotland) Act – Annual Report

The Forth Valley NHS Board considered a report for assurance, presented by Katrina Robertson, which sought approval of the Year 2 Annual Report covering the period April 2025 to March 2026.

Key messages in the report included:
(i) The report provided the statutory annual assurance required by the Act and set out how NHS Forth Valley had discharged its duties. It reflected system-wide activity across all professions and Healthcare staff in scope of the Act and demonstrated how staffing information had been used to inform workforce planning, risk management and service improvement.
(ii) The report confirmed that NHS Forth Valley had assessed its overall level of compliance with the Act as 'Reasonable Assurance', with areas of 'Substantial Assurance' identified for several individual duties, including real-time staffing assessment, risk escalation processes and application of the Common Staffing Method.
(iii) Areas of challenge and ongoing improvement were in relation to workforce availability, training compliance, system implementation consistency and medical staffing sustainability.
(iv) In line with statutory requirements, the report would be submitted to the Scottish Government and the Patient Safety Commissioner. Publication on the Board's website supported transparency, public accountability and national collation of Health Board reports for presentation to the Scottish Parliament.

The following points were made in discussion:
(i) The Chair of the Staff Governance Committee advised that the Committee had considered the report and been assured by the process. It was noted that the Workforce Governance Committee had also considered the report.
(ii) Following a question on any specific examples that needed escalated to the Board, it was advised that there was a vacancy gap for nursing where significant investment was needed. An emerging issue was in relation to physiotherapy where data would be obtained and then escalated if needed.

The Forth Valley NHS Board:
(1) approved the NHS Forth Valley Health and Care (Staffing) (Scotland) Act Annual Report 2025–26 for publication;
(2) noted the overall assurance position of Reasonable Assurance and the identified priorities for continued improvement during the next reporting period, and
(3) considered that the report provided assurance that appropriate controls were in place to manage the identified risks, support the delivery of objectives and where improvements were needed, clear actions had been identified.

14. Spotlight on Services – Allied Health Professions

The Forth Valley NHS Board considered a report for assurance, presented by Professor Cameron, which provided an overview of three Allied Health Profession-led service developments within NHS Forth Valley.

The Board had the benefit of a video story item in relation to the services. Aaron Fraser, Jan Green and Louisa McGuire were in attendance and supported the Board's consideration of the item.

Key messages in the report included:

(i) Each of the three service areas—Children's Speech and Language Therapy, Adult Weight Management, and AHP-led Frailty Care in Prisons—demonstrated how NHS Forth Valley was redesigning pathways to remove barriers, improve access, and embed early intervention across the system. The strategies underpinning all three services aligned fully with the Population Health & Care Strategy, Realistic Medicine, and Value-Based Health & Care principles.

(ii) Together, the developments showcased:
- A shift from reactive care to proactive support.
- Strengthened partnerships across education, justice, primary care, and community settings.
- Earlier identification of need, reducing escalation and long-term demand.
- Improved access to specialist interventions for traditionally underserved groups

The following points were made in discussion:

(i) Members considered how to bring staff with you when making service changes on the journey toward prevention. It was important to give staff headroom to think differently. Where staff where enabled to lead projects this helped with buy-in. There also needed to be investment in people to develop their skillsets to facilitate transformation with a continuous improvement lens. There had been open discussions with teams and time had been taken out to encourage innovation.

(ii) Members commented that the changes made and improvements for patients were inspiring. Members encouraged senior leaders to encourage the spread of the ideas and methodology. Work was being undertaken with the University of Stirling to make changes and be more sustainable.

(iii) Making changes which had benefited patients and improved outcomes had improved staff morale and assisted engagement. Learning had been shared at the national AHP Conference and there had been inputs on the transformation work at NHS Scotland events.

(iv) In terms of barriers experienced, it was noted that in a small team being able to get the time to innovate could be a challenge. With more resource there could be more outcomes. Services needed permission to be brave and deliver the best quality services to those who needed them. It was also important to measure what mattered. There would be a challenge around reporting while moving services upstream to prevention. There would need to be work to understand and explain the value of what was being done.

(v) It was noted that these three examples and the approach exemplified Value Based Health & Care in action and the Board commended the excellent work which had been undertaken.

The Forth Valley NHS Board noted the three service examples that demonstrated the impact of transforming care for the population of Forth Valley, and

15. Finance Report

The Forth Valley NHS Board considered a report for assurance, presented by Mr Urquhart, which provided a summary of the draft financial outturn position for the 12-month period ending 31st March 2026.

Key messages in the report included:

(i) The draft outturn indicated that all 3 statutory financial targets set by Scottish Government were met, as:
- A surplus of £0.245m against the revenue resource limit of £1,003.1m.
- A break-even position against the capital resource limit of £13.4m
- A break-even position against the cash requirement with a closing bank balance of less than £0.050m.

(ii) The draft outturn was consistent with the forecast year-end position previously reported to the NHS Board and was subject to change, pending the outcome of the external audit of the 2025/26 Annual Accounts, receipt of the final allocation letter from the Scottish Government and confirmation of both IJB outturns.

(iii) The NHS Forth Valley Financial Plan for 2026/27 was approved by the NHS Board and by Scottish Government in March 2026. It was important to continue to prioritise strong financial discipline and build early momentum on savings delivery in the first quarter of the new financial year.

(iv) Budget managers had been asked to focus on securing early savings, maintain tight control on budget management, and progress actions aligned to revised 15-box grid programmes.

The following points were made in discussion:

(i) The Board thanked all involved in the work that had been taking place to ensure we were aiming to deliver the breakeven position and noted that detailed discussion had also taken place at SPPRC and the Board seminar.

The Forth Valley NHS Board:

(1) noted that the draft outturn for financial year 2025/26 indicated that the NHS Board had met all 3 statutory financial targets;

(2) note that the draft outturn remained subject to External Audit review, receipt of the final Scottish Government budget allocation letter and confirmation of IJB yearend positions, and

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

16. Performance Report

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

Key messages in the report included:

(i) Performance Summary.

(ii) Area of Focus – Urgent & Unscheduled Care.

(iii) Performance Report: Priority Areas of Performance.

(iv) Performance Scorecard.

The following points were made in discussion:

(i) Learning from the Centre for Sustainable Delivery would be considered by the SPPRC at its meeting of 26 May 2026. Initial information suggested that CfSD felt the staffing shape was broadly correct for the day shift but that there was additionality needed for the back shift.

(ii) There had been a visit from Scottish Government, with Derek Grieve the Performance and Delivery Director looking at Forth Valley's Urgent & Unscheduled Care Plans. He had also attended the Executive Leadership Team meeting and visited the Emergency Department and Assessment Units. There would also be meetings with the HSCPs in the afternoon following the Board meeting and an opportunity to meet with the Board Chair and Chief Executive.

(iii) Members welcomed the updates provided and commented that it was important to ensure the right actions were being taken and that the overall data improvements would follow.

(iv) Following a question, it was confirmed that there was zero tolerance for 12 hour waits but that there were still people breaching. There was work ongoing in this regard and the number of breaches was down on the previous year. The focus was on getting patients to the right place first time and reducing impacts on patients.

The Forth Valley NHS Board:

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

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

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

17. Schedule of Business

The Forth Valley NHS Board **noted** for information the Schedule of Business.

18. Any Other Competent Business

There was no other business.

19. Risks and Reflections

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

20. Date and Time of Next Meeting: Tuesday 30 June 2026 at 9.30am.

4. Action Log
Forth Valley NHS Board – 30 June 2026

NO.	DATE OF MEETING	AGENDA TOPIC / ITEM	ACTION	LEAD	TIMESCALE	COMMENT / PROGRESS	STATUS
070	28.01.25	Integration Schemes	An update on any Ministerial feedback received.	Jillian Thomson / Ross McGuffie	25.08.26	The Falkirk Integration Scheme is provided as a report on today's agenda. The C&S Integration Scheme was approved by Board on 28 January and subsequently Stirling Council at its meeting on 6 February 2025. The dispute resolution process regarding the C&S Scheme is ongoing and making positive progress.	In progress
119	27.01.26	Quality and Assurance Report	Provide further information to Board members on the action plan for SAERs, to include resourcing information and a revised trajectory timeline for dealing with the backlog.	Andrew Murray	05.05.26	The Clinical Governance Committee report was circulated to Board Members.	Complete
128	24.02.26	HIS Unannounced Mental Health Services Safe	Staff Governance Committee to consider whether strengthened scrutiny of mandatory training and PDP	Kevin Reith	14.07.26	The Staff Governance Committee has closely considered mandatory training and PDP	Complete

NO.	DATE OF MEETING	AGENDA TOPIC / ITEM	ACTION	LEAD	TIMESCALE	COMMENT / PROGRESS	STATUS
		Delivery of Care Inspection - NHS Forth Valley	compliance was required, particularly in relation to the availability of trainers.			compliance. At its May meeting the Committee requested additional processes be implemented to increase compliance which would be reported back to Committee. The Committee also requested a report on the implementation and effectiveness of the targeted support and actions to increase assurance in relation to PDPR.	
129	24.02.26	HIS Unannounced Mental Health Services Safe Delivery of Care Inspection - NHS Forth Valley	Clinical Governance Committee to consider any gaps in relation to reporting and the continuous improvement lens on local processes.	Karen Goudie / Andrew Murray	07.07.26	The Medical Director and Executive Nurse Director are in discussions to develop a quality and safety dashboard which will report up to the Board and provide assurance across key local and national metrics. The thematics for Safer Together 2 are also being scoped to plan for continuous improvement in areas which require improvement support, which are also linked to the HIS reports.	In progress

NO.	DATE OF MEETING	AGENDA TOPIC / ITEM	ACTION	LEAD	TIMESCALE	COMMENT / PROGRESS	STATUS
130	24.02.26	Performance Report	Circulate the Public Health report submitted to a future Clinical Governance Committee with Board Members.	Jack Frawley	25.08.26	The report will be circulated to Board Members once available.	In progress
131	24.02.26	Performance Report	A progress report on the Emergency Department 12 Week Improvement Plan to be submitted to the Strategic Planning, Performance & Resources Committee.	Garry Fraser	26.05.26	Urgent & Unscheduled Care Performance was reported to SPPRC in May. The Committee also considered an Emergency Department Staffing Review which is on today's agenda for endorsement.	Complete
132	31.03.26	Whole System Urgent and Unscheduled Care Plan	Circulate a briefing note to Board Members on lessons learned from previous initiatives to shift care into the community.	Ross McGuffie / Gail Woodcock	25.08.26	Work is ongoing to review previous bed closures in Falkirk Community Hospital and lessons learned.	In progress
133	31.03.26	Whole System Urgent and Unscheduled Care Plan	Future papers on the topic to include information requested by Board including: effect on hospital flow; use of contingency beds; patient and workforce experience, and economic impact assessment.	Gail Woodcock / Garry Fraser	25.08.26	The most recent Board/SPPRC papers included new UUSC data pack which will be further expanded to include metrics such as number of contingency beds in use and patient/workforce experience data.	Complete
135	28.04.26	Action Log	Schedule the approved Falkirk Integration Scheme to be provided to the next Board meeting.	Jack Frawley / Euan Murray	30.06.26	A report providing the Scheme is included on today's agenda.	Complete

NO.	DATE OF MEETING	AGENDA TOPIC / ITEM	ACTION	LEAD	TIMESCALE	COMMENT / PROGRESS	STATUS
136	28.04.26	Board Seminar Update	Circulate the Quality Seminar Action Note	Jack Frawley / Wendy Nimmo	30.06.26	The Action Note was circulated.	Complete
137	28.04.26	Board Executive Team Report	Circulate information relating to prison and general population suicide rates to Board Members.	Caroline Docherty	25.08.26	The information is being prepared and will be provided to Board Members in due course.	In progress
138	28.04.26	SPPRC Minute – 31 March 2026	Circulate the culture metrics work outwith the meeting.	Kevin Reith	30.06.26	The culture metrics information was provided as part of the 9 June Board Seminar consideration.	Complete
139	28.04.26	Area Partnership Forum Minute – 17 February 2026	Circulate the dates for Long Service Awards to Board Members.	Kevin Reith	30.06.26	The information was circulated on 22 June 2026.	Complete
140	28.04.26	Risk Management Framework	Re-circulate the updated document once the index was updated.	Vicky Webb	30.06.26	The updated version was circulated on 29 April 2026.	Complete

STATUS:
Overdue
In progress
Complete

NHS Forth Valley

Forth Valley NHS Board

NHS Forth Valley

5(b). NHS Forth Valley De-escalation to Stage 1 of NHS Scotland Support and Intervention Framework

Purpose: This report is for Assurance

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

Author: Jack Frawley, Board Secretary

Executive Summary

This report provides an update on the escalation status of NHS Forth Valley, which has moved to Stage 1 with effect from 8 June 2026. NHS Forth Valley submitted an evidence paper to the National Planning and Performance Oversight Group (NPPOG) which provided information on progress made in relation to Culture, Leadership, and Governance, including summaries of 'what has changed' in each area.

NHS Scotland's Chief People Officer wrote to the Board on 5 June advising that there was assurance on the significant progress made and the sustained improvement, meaning that NHS Forth Valley was no longer an outlier in Leadership, Governance and Culture across the system. NPPOG also noted that the ongoing culture work had been baselined into business-as-usual governance, with the Board and its committee structure continuing to oversee the progress and impact of the work. De-escalation to Stage 1 meant that informal support was no longer required.

Action Required

The Forth Valley NHS Board is asked to:

(1) note the NPPOG evidence paper, set out at appendix 1;

(2) note the Chief People Officer's De-escalation to Stage 1 of the NHS Scotland Support and Intervention Framework letter, set out at appendix 2, and

(3) consider if the report provides assurance that appropriate controls are in place to manage the identified risks, support the delivery of objectives and where improvements are needed, clear actions have been identified.

Governance Route to the Meeting and Previous Board Consideration

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.

- Forth Valley NHS Board and SPPRC– Update reports throughout the period of escalation have been considered both at Board and its relevant Committees, most recently the SPPRC.
- Board Seminar – the most recent evidence paper to NPPOG was developed with input from Board Members at the 21 April Governance Seminar. Board Seminars have also considered the wider actions to deliver improvement in the escalation areas, including a presentation on the OPEL tool for culture at the Board Seminar of 9 June 2026.

Risk Assessment and Mitigation
There are no direct risk management implications in respect of this paper.

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 direct implications in respect of this paper.

Workforce Implications
There are no direct implications in respect of this paper.

Quality / Patient Care Implications
Improved leadership, governance and culture are well evidenced as contributing to quality patient care most recently, in the Blueprint for Good Governance1'*For NHS Scotland to be successful in delivering quality healthcare, good governance is necessary but not sufficient if NHS Boards are to meet or exceed the expectations of their principal stakeholders. To do that, the organisation must also excel at day-to-day management of operations and the implementation of change*.'

Population Health & Care Strategy
There are no direct implications in respect of this paper.

Climate Change / Sustainability Implications
There are no direct implications in respect of this paper.

Engagement and Communications
Was statutory engagement with stakeholders required? Yes ☐ No ☒

Appendices
Appendix 1 – NPPOG Evidence Paper
Appendix 2 – De-escalation Letter – 5 June 2026

NHS Forth Valley

Culture, Leadership and Governance

1. Introduction and Context

The paper draws on evidence from Board and Committee business, staff engagement, internal and external assurance, and organisational performance to demonstrate that improvements are embedded into routine operations.

Board, Committee, Seminar, Executive Leadership Team and Senior Leadership Team discussions over the year have consistently reinforced that a positive and open culture is a critical enabler of performance and improvement, particularly within the context of sustained operational pressures. While performance metrics remain essential, there is a clear recognition that metrics alone do not tell the full story about staff experience, wider engagement internally and externally with partners, or organisational maturity.

This paper focuses on how culture is being mainstreamed into all of our activities, how insight and data are being used to inform action, and how leadership and governance are supporting continuous improvement, while acknowledging issues facing the organisation, including pressures in urgent and unscheduled care and other ongoing challenges such as in sickness absence management. The Board has a clear understanding of challenges in performance and has a laser focus on actions being taken to make improvements as demonstrated through enhanced challenge and scrutiny at Committees and the Board and clear oversight of delivery.

2. Culture

What has changed

- Culture improvement has moved from discrete programmes to embedded mainstream arrangements, supported through workforce, governance and leadership systems.
- The Board has consistently recognised that metrics alone are insufficient and has strengthened use of qualitative insight and staff voice.
- The Living the Values workstream has completed a review of the Board's values, and the proposal to adopt NHS Scotland values has been supported through our APF, Staff Governance Committee and Board governance processes. The workstream is now focused on and supporting the embedding of values in all we do and how we support staff to ensure our work is values led and challenged where this is not the case.

2.1 Moving Beyond Metrics

The Board recognises that culture cannot be assessed through metrics alone, and has therefore sustained multiple, inter-connected programmes of work to understand and improve staff experience and organisational climate.

Alongside monitored indicators such as sickness absence and turnover, the organisation has focused on qualitative insight, narrative feedback and staff lived experience to inform action. This approach has been reflected consistently in Board and Committee discussions. The ongoing development of a Culture Change OPEL (Oversight of Performance, Escalation and Learning) Tool, brings together multiple sources of cultural intelligence and supports a shared view of severity, risk and urgency. This in turn will support response to cultural risks and hotspots.

The first version of the Culture OPEL was presented to the Staff Governance Committee in May and is expected to go live in testing form following further Board engagement at our next Board Seminar on 9th June and with our Area Partnership Forum. Significant engagement has been undertaken in developing the first version of the tool and its ongoing development will be done through engagement with our staff to reflect our ethos which has driven our work over the last 3 years. Our intention is to ensure this is embedded across the organisation through our performance monitoring processes.

The Board has an existing OPEL tool focused on whole system unscheduled care, hospital flow and community performance. This methodology has been developed over a number of years and is now fully embedded across the system and used every day, with escalation actions aligned to the tool score.

Culture and workforce data including sickness absence, iMatter and wellbeing indicators are routinely reviewed alongside performance, quality and risk information, enabling the Board to understand and seek assurance on actions to address systemic themes rather than isolated issues. This triangulated approach has been reinforced through Board development activity and internal audit feedback.

2.2 Targeted Programmes of Work

Specific programmes include:

- A Workforce Wellbeing Framework (2025-2029) was signed off by the Staff Governance Committee in November 2025 which was developed through staff engagement and will be overseen by a new partnership steering group.
- A refreshed Sickness Absence action plan is being implemented with Spend to Save resources invested to target our support to reduce staff absence. We are also aiming to adopt a new programme of work in 2026-27 to improve handling of employee relations cases which manages the impact on staff by 'doing less harm'. This work recognises the relationship between absence, workload, leadership behaviours and organisational culture.
- Continued investment in Staff Wellbeing, Speak Up services and whistleblowing, with visibility of themes and learning informing leadership discussion and improvement priorities. We aim to have completed a full external review of this work in Summer 2026 with any resultant improvements adopted during 2026/27.
- Ongoing work to address iMatter outcomes, with actions explicitly linked to local team feedback rather than generic organisational responses. We are exploring the way in which we can improve staff participation in team and individual level improvements, looking at the associated PDPR and development support interventions.

These programmes are now mainstreamed into normal governance and delivery arrangements, rather than running as a time-limited culture project.

2.3 Engagement and Partnership

Engagement has been a consistent theme in Board and Committee discussions and activity.

Key examples include:

- Board members have been fully engaged in the development of this paper to ensure it is fully reflective of
- Facilitated culture sessions with Board and senior leaders to reflect on staff experience, openness and civility.

- Joint working with the Area Partnership Forum, strengthening staff voice and partnership working.
- Ongoing evaluation of the effectiveness of the Area Partnership Forum, with improvements made to ways of working and follow-up.
- The recent election of a new Employee Director, with two candidates standing, demonstrating improved confidence in governance and staff representation.
- Organisational work aligned to the principle of 'doing less harm', focusing on reducing unintended negative consequences of processes, behaviours and decisions will be delivered in partnership.
- There was extensive staff and Board engagement in the development of the Board's Population Health and Care strategy, setting out an exciting direction of travel for the organisation.
- As part of our Equality Inclusion Strategic Framework approved in April 2025, one of our key Equality Outcomes priorities was completed with the approval of the Anti-Racism plan by the Board in February 2026. This was another piece of work completed through extensive partnership working and staff engagement in collaboration with our Ethnic Diversity Network. This builds on our commitment to create an organisation which ensure all staff feel valued and supports the delivery of safe, compassionate care for all. A Board seminar was also held in August with all of our staff networks to allow Board members to hear directly from the groups and set a strong future direction on participation and engagement.

These activities demonstrate a shift from engagement as an event to engagement as a continuous way of working.

"I have seen the change in partnership working. The APF is an effective and valuable forum which is a true reflection of partnership commitment from both staff side and senior leaders to deliver change" – **Karren Morrison, new Employee Director**.

2.4 Recognition, Openness and Civility

There has been increased emphasis on recognition and appreciation, including:

- Multiple NHS Forth Valley staff gaining national recognition through staff awards. For example, the Board had four winners at Scotland's Health Awards:
  - The Children and Young People's Speech and Language Therapy Team won both the Innovation and Tackling Health Inequalities awards
  - Charmaine Black, a community Learning Disability Nurse, won the prestigious Nurse Award which aims to recognise high quality and compassionate nursing care
  - The Prison Healthcare Team at HMP Stirling won the Unsung Heroes Award, chosen via a public vote to recognise teams that make a meaningful but often unrecognised difference to the life of others.
  - Jackie Rutherford, Senior Charge Midwife at Forth Valley Royal Hospital, was a finalist for the Midwife Award and NHS Forth Valley's Women and Children's Bereavement Team were finalists for the Tackling Health Inequalities Award.
- Reinstatement of long service awards, with ambitions to re-establish local staff awards to further celebrate contribution.
- Visible openness in Board-led events, Safety Collaboratives and culture sessions, where staff are actively encouraged to speak up and challenge constructively.
- The Board has encouraged a move towards face-to-face discussions and interactions, with a number of processes now back to being in person with Executive input, such as Staff Induction, Safety Collaborative and NMAHP Graduate development sessions. Non-Executive Director attendance at key events has also been praised by staff.

- The Board has continued to invest in in Staff Wellbeing, Speak Up services and whistleblowing to support staff to raise concerns and access support.

Staff feedback indicates greater confidence to raise issues, balanced with an honest acknowledgement that further work remains in some areas. Feedback from the last round of engagement around the culture change programme identified:

Strengths include strong leadership and board commitment to culture, widespread passion and appetite for change, and a noticeable shift in language and behaviours. Participants highlighted the positive energy generated through the programme, strong partnership and staff-side working, and the diversity of skills and perspectives involved. There is evidence of increased openness, collaboration and willingness to speak up, supported by a clear programme structure and organisational prioritisation of culture.

Risks include the potential for change overload, competing priorities, the need to embed culture consistently across all areas and loss of momentum as the programme transitions into its next phase. There is also a risk of reverting to previous behaviours if culture is not consistently prioritised, embedded and supported, particularly in the context of operational pressures, workforce challenges and communication gaps.

The mainstreaming plan for the culture change programme aims to mitigate these risks, by embedding key components within existing structures and creating space for culture change leaders from across the system to continue to engage proactively.

3. Leadership (Executive and Board)

What has changed

- Leadership stability has enabled a shift from improvement driven by escalation to sustained, future-focused delivery.
- NHS Forth Valley increasingly contributes to and is recognised within national leadership spaces. For example, the Board has been a driving force behind recent discussions around developing the Population Health Organisation approach, including the development of the Population Health Maturity Matrix. Within this space, the Chief Executive and Director of Public Health have supported the inclusion of the Population Health focus within Subnational Plans; the Director of Finance is chairing a group on preventative spend; and the Medical Director and Director of Public Health have been leading work around Value Based Health and Care.
- Additional Board capacity and diversity of thought through the recruitment of two additional Non-Executive Directors have supported strengthened governance and increased visibility.

3.1 Stability and Capability

There is now clear stability across the full leadership system, including the Board, Executive Leadership Team and Senior Leadership Team. This stability has enabled a shift from recovery to sustained improvement and future-focused delivery.

The Executive Team has developed a Programme of Work process that provides real clarity on the planned deliverables for the financial year, the associated implementation structures and through the Executive Objectives clear accountabilities for delivery, supported by the Board.

Board Members and the Senior Leadership Team have participated in a number of development sessions to enhance their skills and understanding, such as their role and

responsibilities as Corporate Parents; Equality, Diversity and Inclusion; active uptake of TURAS learning modules; and NXD Masterclasses with training planned for Remuneration Committee Members.

3.2 Leadership Development and Visibility

Leadership development has been prioritised through:

- A new Forth Valley Leadership Programme was launched in April 2026, with the aim of supporting leaders at all levels across the organisation.
- Strengthened corporate induction, with a move to face-to-face delivery with Executive input and Executive and Chair videos that set clear expectations around behaviours, culture and accountability.
- Increased visibility of Executives and Board members through Patient Safety walkrounds; participation in the Safety Club, where open and honest discussions take place amongst staff through Simulation with learning on improving Quality and Safety; participation in and attendance at staff events and service visits; and a programme of profile stories of Board members being shared on the intranet.

Staff quotes from our Sim Safety Summit meeting include:

"Thank you for the opportunity to attend the recent Sim Safety Summit. Through my attendance at the Sim Safety sessions ran by Julie Mardon, I had high expectations of what this day would deliver and it did not disappoint. It was well run with thought provoking and collaborative learning throughout. All topics were easily relatable to the individuals and had transferable learning opportunities. Look forward to the next event." – **David Watson Chief Nurse for Acute Services**

"The summit was inspiring – the enthusiasm of the participants and presenters was palpable and the depth of knowledge that the speakers have is awesome. On a personal level I went home buzzing and enthusiastic about how simulation can be used, not only for clinical simulation, but for lots of other things as well." – **Robert Clark, NHS Forth Valley, Employee Director.**

"I found the SIM Safety session to be exceptionally open, engaging and supportive of meaningful learning. The atmosphere encouraged honest discussion and reflection with participants feeling comfortable sharing experiences and perspectives in a constructive way. This positive and collaborative approach made the session highly informative and relevant to practice. Well done to all of the SIM team" – **John Stewart, Non Executive Director.**

These approaches have been consistently reinforced through Board discussions and feedback.

3.3 System and Partnership Leadership

Relationships with partners have matured significantly, including:

- Regular Joint Leadership meetings between the Chair, Chief Executive and Council Chief Executives and Leaders of the three Councils. A full joint session bringing all together was initiated by NHSFV and took place in May 2026, agreeing some joint priorities for collaborative action.
- Plans are in place to extent this into a wider joint Community Planning Partnership session, demonstrating shared system leadership.

- Clear Board support for shifting the Balance of Care, with whole-system working and partnership governance underpinning delivery, as demonstrated by the closure of Ward A11 and transfer of resource to the IJB for increased community capacity.
- Enhanced working with the College/University Partnership, including embedding these partners within our Strategic Workforce Planning Programme Board.
- Improved integration practice with regular meetings now in place with Council Chief Executives and Chief Officers to support ongoing support and progress. This has supported improved relationships across the system and both Chief Officers are fully embedded within the Executive Team and Board.

Board papers and Committee discussions reflect a growing confidence in system-level leadership rather than organisational isolation with the Board seeking and gaining whole system assurance.

3.4 Talent, Recruitment and National Contribution

There is evidence of a positive shift in organisational reputation:

- Increased interest externally in senior and corporate roles, including Chief Officer-level posts.
- Individuals progressing from NHS Forth Valley into senior national and system leadership roles, demonstrating talent development.
- National recognition of NHS Forth Valley's leadership in Value-Based Health and Care and as a Population Health Organisation, with active involvement of Board Members and Executives in national workstreams.

Executive Leadership Team and Board involvement in national programmes provides assurance of leadership credibility beyond the local system.

4. Governance

What has changed

- The governance system has matured from recovery to refinement, with clearer roles, improved flow of assurance, a greater emphasis on the Board's role in shaping and setting strategic direction and stronger collective ownership of risk.
- The Board now has a much stronger programme of regular facilitated Board seminars which are inclusive and value contribution of all members of the senior leadership team and Board members.
- There has been recognised benefit from supportive and knowledgeable Board administration, ensuring oversight of the programme of work across all committees and regular review/refresh of committee functions.
- Building on the strong progress in this area, the Board has continued a programme of continuous improvement.
- There is clear evidence that the culture of the Board has improved.

4.1 Board Composition, Induction and Development

The Board has managed significant Non-Executive changeover with new public and stakeholder appointees, with new members now settled and contributing effectively. Induction processes are under review to ensure learning from recent appointments is embedded ahead of further recruitment. The recent recruitment of three new Non-Executives has brought additional capacity and strengthened the value added through bringing different perspectives and contributions to Board scrutiny and discussions.

The Board has a development schedule which supports horizon scanning, strategic thinking, skills development and shared learning from other systems.

4.2 Risk and Assurance

A Short Life Working Group commissioned by the Board on the Risk Framework, with strong Non-Executive input, has strengthened clarity around risk appetite, escalation and assurance. This work aligns with Internal Audit findings and the evolving Board Assurance Framework.

4.3 Committee and Board Effectiveness

A full internal Governance and Committee Effectiveness Review has taken place, culminating in a whole day Board development session in April 26 to inform development priorities for the Board and areas for improvement in the effectiveness of governance structures. The review involved all members of the Senior Leadership Team and Board participating in a survey, with results highlighting strong consistency of opinion between Non-Executives and Executives and a genuine shared ownership of governance, the working of Committees and agendas. The review has been used explicitly to:

- Clarify roles and responsibilities.
- Reduce duplication, streamline governance and have a renewed focus on strategy rather than operational detail, seeking assurance rather than reassurance.
- Strengthen the ‘golden thread’ from strategy to delivery to assurance.
- Improve the use of data and the triangulation of information for assurance

Improvement actions have been agreed and are being embedded through an improvement lens rather than compliance. Respondents to the survey have commented explicitly on the culture of the Board.

“The Board models respectful, open and constructive behaviours in its discussions and … challenge is supportive and focused on improvement; Board behaviours are the best I have experienced …” – **Board/SLT respondent to the survey**

4.4 Remuneration, Transparency and National Engagement

- Targeted Remuneration Committee training is taking place on 10th June to further strengthen scrutiny and the upskilling of Committee members.
- The Chair’s involvement in national work (e.g. Value-Based Health and Care, national recruitment, Chairs’ development) provides additional confidence in governance maturity.
- Benchmarking with other Boards, including transparent publication of Board papers and performance data, reflects confidence and openness in governance practice.

5. Conclusion

Across leadership, engagement and governance, culture is increasingly being treated as core business, supported by stable leadership, robust partnership working and a commitment to continuous improvement. While significant challenges remain, particularly in urgent and unscheduled care pressures and workforce, the organisation continues to demonstrate maturity in acknowledging these issues, using insight intelligently and investing in the whole-system conditions required for improvement.

Internal Audit, governance reviews and Board self-assessment evidence confirm significant progress and increasing organisational maturity with Board and Committee papers demonstrating consistent, constructive challenge and clear ownership of improvement.

Improvements originally driven through escalation arrangements are now embedded into routine governance, leadership and delivery processes.

Chief People Officer, NHS Scotland
Fiona Hogg

E: Fiona.Hogg2@gov.scot

Chair, NHS Forth Valley
Chief Executive, NHS Forth Valley

By email:
Neena.Mahal@nhs.scot
Ross.McGuffie@nhs.scot

5 June 2026

Dear Neena and Ross

De-escalation to Stage 1 of NHS Scotland Support and Intervention Framework

I am writing to formally confirm that NHS Forth Valley will move to Stage 1 of the NHS Scotland Support and Intervention Framework for Governance, Leadership and Culture, with effect from 8 June 2026.

This decision follows a recommendation from the National Planning and Performance Oversight Group (NPPOG). At the most recent review meeting, officials were assured that significant progress has been made and the improvement has been sustained, across all the areas, so NHS Forth Valley is no longer an outlier in Leadership, Governance and Culture across the system. NPPOG also noted that the ongoing culture work has been baselined into business as usual governance, with the Board and it's committee structure continuing to oversee the progress and impact of this work.

De-escalation to Stage 1 means that informal support is no longer be required. In my role as Chief People Officer, I continue to be available to you and your team within the Board, and am looking forward to our session next week with the Remuneration Committee as part of my wider support which is available to all Boards.

It is important that focus and impact of the work on Leadership, Governance and Culture within NHS Forth Valley continues to be sustained, and I know that you and all of your Executive team and Board are committed to doing so.

As part of your recent submission, it was particularly positive to see the innovative work that NHS Forth Valley are leading, in relation to developing a Culture "OPEL" dashboard, and I am keen that we continue to collaborate on this and consider how this could be deployed more widely across the system.

From a difficult and challenging position, NHS Forth Valley has become a role model and exemplar to other Boards in leadership, governance and culture. It has been a pleasure to work with you all, we have all learned a lot over this time, which we have been able to utilise to support the wider system more effectively.

Finally, I would like to personally thank you both, as well as Kevin Reith and the wider Executive team and Board for the leadership, focus and commitment in sustaining the improvements that have led to this final de-escalation. My thanks also go to all of those involved in this work across NHS Forth Valley.

Yours sincerely,

Fiona Hogg
Chief People Officer
NHS Scotland

FORTH VALLEY NHS BOARD
Tuesday 30 June 2026

5(c). Highlight Report on Board Seminars
For: Information

Executive Sponsor: Kerry Mackenzie, Acting Director of Strategic Planning & Performance
Author: Jack Frawley, Board Secretary

Executive Summary
Board Seminars are held bi-monthly and provide an opportunity for members to consider issues in detail, allowing for development of understanding of strategic issues. The format of the sessions usually consists of a presentation or briefing from Executive Directors and managers leading the area of work, or staff involved in the work, followed by discussion and questions from members or a workshop focused on areas for board development.

Board Seminars are not decision-making meetings. The Seminars can, however, assist the decision-making process through in-depth exploration and analysis of a particular issue which will at some point thereafter be the subject of a formal Board decision. These sessions also provide an opportunity for updates on ongoing key issues.

Recommendation
The Forth Valley NHS Board is asked to note the report for information.

Key Issues to be Considered
Board Seminars have been held on 21 April 2026 and 9 June 2026 in person at Carseview House, Stirling and attendees included Board members and members from the Senior Leadership Team. Board Members were also invited to attend and participate in a session held at Forth Valley College, Stirling, titled: Culture Change & Compassionate Leadership Programme: What's Next.

The March Culture Change session was a key milestone in the shared journey allowing colleagues to come together to take a moment to recognise success so far, but also consider what was needed next to ensure the legacy of the Programme. Board Members participated in discussions covering:

- Programme Legacy: What Must We Protect?
- Sustaining Momentum: Risks, Enablers and Ownership, and
- Agreeing the Future Vision & Priority Actions

The April Seminar covered:

- Governance
  The Seminar's aims were to:
  - strengthen the Board's approach to governance, assurance and holding to account, with clear agreement on effective assurance and how the Board maximises its strategic impact.
  - reinforce the 'golden thread' of governance from committees to the Board, ensuring effective alignment, escalation and committee functioning in support of Board assurance.
  - strengthen shared understanding of roles, responsibilities and constructive challenge, including the value and role of the Strategic Planning, Performance and Resources Committee.

- enhance the Board's oversight of its strategic ambitions, including becoming a Population Health organisation, and to agree clear priorities for Board development.
- provide an opportunity for networking and sharing reflections.

The Seminar was facilitated by Claire Sweeney, Board Development Unit, Public Services Delivery Scotland and Jenny McCusker, Head of Organisational Development, NHS Forth Valley.
There was learning from others through a Q&A Conversation with Ally Boyle MBE, Chair – Public Health Scotland.

The June Seminar covered:

- Digital Plan
  - Electronic Patient Records
  - Digitisation
  - Supplier
  - Business Continuity
  - Benefits Realisation/Funding
  - Digital Culture
  - Prioritisation
  - New Tech - Medical Devices/Patient data

  The discussions were an important part in the shaping the Digital Plan, presented later in today's agenda for approval.

- Governance
  - Considered and Agreed the key actions forming the Governance Improvement Plan from the Board/Committee Effectiveness Review work
  - Considered progress on the Board Development Plan 25/26 and any carry over actions Considered the draft Board Development Plan 26/27 and any gaps
  - Agree Board oversight of the Population Health and Care Strategy/Population Health Organisation Implementation and Delivery

  The discussions built on the Board and Committee Effectiveness survey undertaken in February this year and the Board Seminar on Governance held in April. The Board Development Plan is presented later in today's agenda for approval. A proposal on oversight of the Population Health & Care Strategy is also included later on today's agenda.

- National Treatment Centre
  The Seminar received a briefing on the National Treatment Centre.

- OPEL Tool on Culture
  The Seminar received a presentation and demonstration of the OPEL Tool on Culture. Updates on this work had previously been provided to the Staff Governance Committee, which would continue to monitor progress on the Board's culture work.

- Community Pharmacy Model Hours
  The Seminar received a briefing from the Director of Pharmacy on Community Pharmacy Model Hours.

NHS Forth Valley
Forth Valley NHS Board

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

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

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

Action Required
The Forth Valley NHS Board is asked to:
(1) note the contents of the report

Governance Route to the Meeting and Previous Board Consideration
This Board Executive Report is a standing item at Board meetings, providing an opportunity to update the Board on key issues.

Risk Assessment and Mitigation
No risk assessment has been undertaken on this update report.

Impact Assessments

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

Financial and Infrastructure Implications
There are no financial implications within this update report.

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

Quality / Patient Care Implications
This report outlines inspection activity currently underway within the Board but has no implications around quality of care.

Population Health & Care Strategy
This report will include regular updates on key successes and developments around the population health strategy implementation.

Climate Change / Sustainability Implications
There are no sustainability implications within this update report. .

Engagement and Communications
Was statutory engagement with stakeholders required? Yes ☐ No ☒

Appendices
Appendix 1 – Main Report

Appendix 1

1. Celebrating Success

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

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

- Dr Michael Blackmore, a GP in Grangemouth, has been named winner of the Inspiring Fellow Award at this year's **Royal College of General Practitioners (RCGP) Inspire Awards.** Selected from more than 300 nominations, Dr Blackmore, who also serves as Chair of the RCGP West Scotland Faculty, was recognised for his outstanding leadership and commitment to improving GP recruitment and retention across Forth Valley and the wider West of Scotland. He is also a strong advocate for coaching and mentoring, supporting the next generation of GP students and trainees as they begin their careers.
- Colleagues from the **Forth Valley ICU team** completed the 23-mile Glasgow Kiltwalk in support of Brain Tumour Research. The team walked together in memory of their much-loved colleague, Dr Neil Stewart. The 'turbonators', a team representing **NTC, B12, A31, B32, Orthopaedics and Endoscopy**, also completed the course in honour of Claire McCormack, raising money alongside Claire's friends and gamily for Sepsis Research.
- Dave Williams, Lead Resuscitation Officer, has been appointed as a **Member of the Order of St John in the Priory of Scotland**, recognising his notable and committed voluntary service in training members of the public and local groups in bystander CPR.
- The **Specialist Rehabilitation Unit** won second place, and the **Prisoner Healthcare teams** were highly commended in the Nursing Team of the Year category at the 2026 RCN Scotland Nuse of the Year Awards, providing great recognition of the dedication, compassion and professionalism of the services.
- The **Renal team at Forth Valley Royal Hospital** was honoured at the 2026 Central FM Awards, where they received the NHS Team Award. The awards celebrate individuals and teams from across Forth Valley who make an exceptional contribution to their communities. The Renal team's award is particularly significant as nominations are made directly by members of the public and patients. This recognition reflects the real-life experiences of those who have benefited from the team's commitment to delivering high-quality, patient-centred care. Their success highlights the

professionalism, compassion and impact of the team, and the difference they make every day.

- The **Frailty Unit at Forth Valley Royal Hospital** recently celebrated its first anniversary and has provided high-quality care to 4616 local people from across the Forth Valley area over the last year. The 23-bed Unit, located within the hospital's Acute Assessment Unit, provides care for adults aged 65 years and over with a wide range of conditions and health issues linked to frailty – a recognised clinical condition, where the body's reserves and resilience diminish over time, making individuals less able to recover quickly after an illness, infection or accident. Patients admitted to the unit undergo a holistic assessment carried out by a multidisciplinary team of healthcare professionals.
- **Childsmile** celebrates its 20th anniversary in June 2026, marking two decades of transforming children's oral health across Scotland. Over the past 20 years, Childsmile has delivered impressive outcomes, demonstrating the power of prevention. Rates of dental decay among five-year-olds have fallen dramatically, from around 60% in 2006 to approximately 25% today. This progress has contributed to improved oral health, as well as wider benefits for children's health and wellbeing. The programme also represents excellent value for money, with strong evidence highlighting the benefits of early intervention. While the annual cost of the programme is around £1.8 million, it delivers estimated savings of £4.7 million, with treatment costs shown to be 2.5 times higher than prevention.
- Three staff from NHSFV have received **university appointments**, recognising their academic and clinical expertise:
    - Paul Cameron, Director of Allied Health Professions, has been appointed as an Honorary Clinical Professor within the University of Stirling's Faculty of Health Sciences and Sport
    - Dr Pamela Scott, Lead Nurse for ED, Acute and Clinical Assessment Units, has been appointed as an Honorary Clinical Associate Professor at the University of Stirling
    - Claire Hedley, AHP Practice Education Lead, has been awarded the title of Visiting Fellow in Occupational Therapy at Edinburgh Napier University's School of Health and Social Care.

2. General Updates

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

- The Board received confirmation on 5th June that it had been de-escalated back to level 1 of the NHS Scotland Support and Intervention Framework, which is the lowest level and means that national support is no longer required. The decision followed a recommendation from the National Planning and Performance Oversight Group (NPPOG), where officials

were assured that significant progress has been made and sustained across leadership, governance and culture.

- The Board received confirmation on 4th June from the Scottish Information Commissioner that the intervention around Freedom of Information compliance is now closed. The Commissioner was satisfied with the requested evidence submitted and was assured that the Board now has taken the necessary steps to sustainably resolve the non-compliance issues.
- I would like to place on record my thanks to Gail Woodcock for her time as Chief Officer within the Falkirk IJB and wish her the best of luck in her new role as Director of Strategy, Transformation and Performance in NHS Grampian.

3. Inspection Activity

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

- We have submitted updated 18wk action plans following both the Maternity and Mental Health inspections, highlighting progress against the agreed action areas. Delivery and Oversight groups continue for both areas, ensuring that all improvement actions are being progressed timeously.
- Following the unannounced Healthcare Improvement Scotland follow-up inspection at Forth Valley Royal Hospital in March 2026, the inspection report was published on 23rd June. The inspection highlighted a number of strengths, including staff commitment to delivering patient-centred and compassionate care, with teams working collaboratively in calm, well-led environments despite increased capacity pressures. Structured and transparent safety huddles supported a culture of psychological safety, with staff reporting visible and approachable senior leadership and feeling able to raise concerns. Positive feedback from patients and relatives further reinforced the quality of care, alongside observed improvements in mealtime management, environmental maintenance, and equipment cleanliness. Areas for improvement remain, particularly in strengthening compliance with paediatric immediate life support training and ensuring safe storage of cleaning products and effective waste management—issues consistent with previous findings. Overall, while progress is evident, continued focus is required to address outstanding patient safety concerns and sustain improvements following earlier escalation. A full action plan has been agreed and will be taken forward and reported via the Clinical Governance Committee.

4. Visible Leadership

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

4.2 Visits include:

- Patient Safety Conversation Visit (PSCV) to Ward 8 (FVRH)
- PSCV to Hospital @ Home Service (Falkirk)
- PSCV to Ward A31 (FVRH)
- Cowie Clinic
- Health Improvement (FCH)
- Maggie's Centre
- Clinical Assessment Unit
- Carer's Centre
- Haematology (FVRH)
- Health Records
- Loch View
- Graduate Stepping Forward event
- International Day of the Midwife Celebrations
- International Nurses Day Celebrations
- Patient Safety Leaders' Summit
- Digital Pathology Launch Event
- Peak Open Day
- Clackmannanshire Senior Leadership Group Awayday
- Sim Safety Club
- Audiology Heads of Service meeting at the Sensory Centre
- Clinical shifts
- Front Line Friday: *The purpose is to enhance understanding of frontline challenges, foster team engagement, and support clinical quality improvement through direct involvement in patient care activities*
- Step In My Shoes

5. National and Regional Developments

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

- The Board Chair, Director of Finance and Director of Public Health all presented at the national Realistic Medicine conference on 19th June, demonstrating the leading role NHSFV is taking within this area.

6. Horizon Scanning

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

- The Chief Executive attended a session on Public Service Reform, hosted by the First Minister, Deputy First Minister and Minster for Public Service Reform. Further updates will be provided to the Board as this develops.

FORTH VALLEY NHS BOARD
Tuesday 30 June 2026

7. Committee Assurance - Highlight Report
For: Assurance

Executive Sponsor: Kerry Mackenzie, Acting Director of Strategic Planning & Performance
Author: Jack Frawley, Board Secretary

Executive Summary
The Forth Valley NHS Board's governance and control environment includes a number of Committees with specific responsibilities. The Board's Assurance Committees are:

- Audit & Risk
- Clinical Governance
- Pharmacy Practices Committee
- Staff Governance
- Strategic Planning, Performance & Resources Committee

The Board's Advisory Committees are:

- Area Clinical Forum
- Area Partnership Forum

Minutes of these bodies, along with those of the Falkirk and Clackmannanshire & Stirling IJBs are presented to the Board. This report provides a summary of key matters the Board's Committees have agreed require to be highlighted at Board.

Recommendation
The Forth Valley NHS Board is asked to note the matters highlighted through its Committees and agree any actions as required in response.

Key Issues to be Considered

Audit & Risk Committee:

- Counter Fraud - additional all staff communications to be issued.

Clinical Governance Committee:

- Output from HIS Inspection follow-up & development of supporting SOP;
- Whole System Assurance Report-development work.
- Update on Significant Adverse Event Reviews including backlog position and resource challenges.
- HIS Clinical Governance Standards- self assessment audit.

Staff Governance Committee:

- PDP and Absence Management – Committee were assured on the new actions being implemented and noted the requirement for future updates to include data on this work as well as expected timescales.
- Culture – Recognised the positive start with the caveat that the use of this system for culture would differ from the use of OPEL within acute. Testing would be completed to evaluate the accuracy of the triggers in place. Consideration would be given to how this would be used at department level across the organisation.
- Workforce Plan – Commended the good start for future planning but thought should be given to how the preparations required for the organisation and the adequate changes as a result of the Population Health and Care Strategy and the Value Based Health

and Care work. The Committee requested a report back to a future meeting on progress against next steps, including: development of scenario planning aligned to the Population Health Strategy; and alignment with financial planning (taking account of the wording of the related risk that talks about the need for a costed workforce plan).

- Health & Safety – Significant concerns were raised against the lack of training compliance and about the effectiveness of actions to address the identified issues, but noted that processes to drive improvement would be implemented

SPPRC:

- An update on the delivery of the National Treatment Centre, the risks and the request that all Board members should have the opportunity for further detailed oversight and discussion on next steps at the June Board seminar which took place.
- Early sight of the proposed Digital Plan 26/27 and associated risks in delivery. This item is on today's agenda for decision.
- Feedback from the Centre for Sustainable Delivery (CfSD) review and an opportunity to question and shape the proposal to increase the staffing model in the Emergency Department. This item is on today's agenda for endorsement.

Area Clinical Forum:

- resolution of renumeration fees for independent contractors attending advisory committees - uplift agreed by finance and communicated.
- Finance presentation and members took action to disseminate through groups
- Resolution to lack of AMC still looking at options

Area Partnership Forum

- Area Partnership Forum Annual Report approved.
- APF Workplan agreed with additions of Sub-National Planning, Public Sector Reform, and Culture Tool.
- NHS Forth Valley Professional Assurance Framework, further information sought on staff consultation.

NHS Forth Valley

AUDIT & RISK COMMITTEE

3. Minute of the Audit & Risk Committee Meeting held on Friday 27 March 2026
For: Approval

Minute of the Forth Valley NHS Board Meeting held remotely on 27 March 2026

Present:	Cllr Fiona Collie (Chair) Martin Fairbairn (Non-Executive Director) Cllr Scott Farmer (Non-Executive Director) Finlay Scott (Non-Executive Director)
In Attendance:	Jim Boyle (Deloitte) Jack Frawley (Board Secretary) Jocelyn Lyall (Chief Internal Auditor) Kerry Mackenzie (Acting Director of Strategic Planning, Performance & Resources) Anne Marie Machan (Regional Audit Manager, FTF Audit Services) Sarah Smith (Corporate Services Assistant - Minute) Jillian Thomson (Deputy Director of Finance) Scott Urquhart (Director of Finance) Vicky Webb (Head of Risk Management)

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

There was an apology from Stephen McAllister.

Ross McGuffie and Neena Mahal were not in attendance.

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

3. Minute of the Audit & Risk Committee Meeting held on 23 January 2026
The minute of the meeting held on 23 January 2026 was **approved** as a correct record, subject to the following amendment;

- Item 9.5 'Orville' to be amended to 'Orwell'.

4. Matters Arising from the Minute / Action Log
The Committee noted that actions 28b, 29a, 33 and 36 were marked as complete and would be removed from the action log.

The following updates provided against in progress actions:
34 - It was confirmed the Senior Leadership Team had been briefed. The completed self-assessment would be reported back to the Committee at the June 2026 meeting.
35 - Proposed communications would focus on standards of business conduct and staff conduct. A further update would be provided to the June 2026 meeting.

The Audit & Risk Committee noted the Action Log.

5. Internal Audit Progress Report – March 2026

The Audit & Risk Committee considered a report for approval presented by Anne-Marie Machan, which provided an update on delivery of the 2025/26 Internal Audit Plan and sought assurance on progress and proposed amendments.

Key messages in the report included:

(i) The report provided an update on delivery of the 2025/26 Internal Audit Plan and wider internal audit activity as at March, noting that no risks had been identified that would prevent the Chief Internal Auditor from forming an annual opinion.

(ii) Proposed amendments to the 2025/26 audit plan were presented for Committee consideration, arising from earlier staffing challenges within the internal audit team, with the associated rationale explained.

(iii) Progress against the Internal Audit Improvement Action Plan (aligned to Global Internal Audit Standards and the recent external quality assessment) was reported as satisfactory, with the Partnership Board content with progress and the competency framework now completed.

(iv) An update was provided on completed and ongoing audits, including the finalisation of the complaints audit (A1726), which concluded with limited assurance, and the adverse events audit (A1826), for which the draft report had been issued and finalisation was underway.

(v) The Committee was asked to consider progress, approve the proposed plan amendments, and determine whether the report provided sufficient assurance regarding controls, risk management and objectives, with officers confirming readiness to take questions.

The following points were made in discussion:

(i) A query was raised around the governance route and oversight for actions arising from the complaints audit and sought clarification on the respective roles of the Audit & Risk Committee and the Clinical Governance Committee; it was confirmed that Members would receive the full audit report, actions would be monitored through the audit follow-up process, and the report would also be considered by the Clinical Governance Committee.

(ii) Clarification was sought that the proposed amendments to the 2025/26 audit plan would not compromise the Chief Internal Auditor's ability to provide an annual assurance opinion; assurance was provided that the overall programme of work would enable an opinion to be formed.

(iii) Concern was expressed that forthcoming audits, particularly complaints and adverse events, should extend beyond process performance and clearly identify underlying root causes, organisational learning and opportunities for improvement; Internal Audit confirmed that the revised report format included root-cause analysis and consideration of learning and effectiveness.

(iv) Clarity was requested on prioritisation and timing for audits shown as deferred or "to be confirmed", including the digital strategy audit. In response, it was explained that timings were dependent on officer availability and scoping, and that deferred audits would be risk-assessed and considered within the 2026/27 audit planning process, with draft plans to be shared for Member input.

(v) The Committee requested that a dedicated member session be arranged to support early engagement and input into the development of the Internal Audit Plan, prior to its formal submission for approval. Jocelyn Lyall agreed she would be happy to facilitate.

The Audit and Risk Committee:

(1) Considered progress with the delivery of the Internal Audit Plan and Internal Audit Activity

(2) Considered and approved the proposed amendments to the 2025/26 Internal Audit Plan.

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

Action:

(1) A dedicated member session would be arranged to support early engagement and input into the development of the Internal Audit Plan, prior to its formal submission for approval at the June Audit & Risk Committee. This would be facilitated by Internal Audit colleagues.

6. Audit Follow-Up Report

The Audit & Risk Committee considered a report for assurance, presented by Anne-Marie Machan, which provided an update on the status of agreed internal audit actions and sought assurance on progress.

Key messages in the report included:

(i) The report summarised the implementation status of internal audit actions up to the end of February 2026, drawing on updates from the Pentana system, officer submissions and assurance committee reports.

(ii) Of the 21 actions subject to follow-up in the period, 13 actions were fully validated, with three actions requiring further information to allow final validation.

(iii) One action (Audit A1926 – Supplementary Staffing) was reported as no longer relevant, reflecting a change in the control environment, with management advised to keep the revised control arrangements under review.

(iv) Four actions with extended target dates were noted, with Internal Audit advising that there were no concerns regarding progress at this stage.

(v) Overall, Internal Audit confirmed it was content with the implementation position and invited the Committee to consider whether the report provided sufficient assurance regarding the management of audit actions.

The following points were made in discussion:

(i) Members questioned the prolonged duration of several long-standing actions, including those relating to environmental management and sickness absence, and requested clarity on when these would be concluded. In response, management advised that both actions were substantially complete and progressing through the appropriate governance routes for final approval.

(ii) Clarification was sought on Audit A1926 (Supplementary Staffing), with Members expressing concern that the update did not clearly articulate what constituted completion of the action. It was queried whether the rationale provided sufficient assurance.

(iii) Further concern was raised regarding potential weakening of controls, with Members emphasising that operational difficulty or perceived safety risk should not be used to justify control removal without clear mitigating arrangements being demonstrated. Internal Audit advised that the matter had been highlighted for Committee consideration to determine whether further assurance was required.

(iv) It was explained that the supplementary staffing issue related to the removal of duplicate approval stages, which had the potential to delay decision-making and create safety risks. While Members acknowledged the explanation, it was

agreed that clearer articulation of the revised control environment was required.

(v) Action agreed: Officers and Internal Audit were requested to return with a further update to provide clearer assurance on the revised supplementary staffing controls (Audit A1926), including how effectiveness would be maintained following the change.

The Audit and Risk Committee

(1) Note the implementation status of management actions.

(2) Note the Internal Audit assessment for extended action by dates.

(3) Conclude on whether overall progress and any residual risk is acceptable.

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

Action:

(1) Management and Internal Audit would bring back a further report to the Committee providing additional detail and assurance on the revised supplementary staffing control arrangements (Audit A19/26).

7. External Audit Update

The Committee received a verbal External Audit Update, presented by Jim Boyle (Deloitte), which provided an update on progress with the 2025/26 external audit, key areas of focus, and assurance on the audit timetable and emerging risks.

The following key points were noted:

(i) James Boyle introduced himself and confirmed Deloitte's role, noting prior public-sector audit experience and an expectation of constructive engagement with the Board.

(ii) It was reported that the external audit was progressing as planned, with early planning meetings completed and greater interim/pre-year-end testing undertaken than in the previous year.

(iii) The audit approach had incorporated enhanced quality control processes, including a second partner review, built into the timetable from the outset to mitigate prior-year risks.

(iv) The presenter advised that, overall, progress was on track for timely reporting, with no significant concerns to alert the Committee to at that stage.

(v) The principal risk to the timetable was identified as the consolidation of IJB accounts, which was outside the auditors' full control; clear communication and escalation arrangements were in place should risks materialise.

The following points were made in discussion:

(i) Confirmation was requested that audit preparation was progressing more effectively than in the previous year, with assurance provided that post-audit improvement actions had been implemented, with earlier planning, interim testing and closer engagement with the audit team contributing to improved readiness.

(ii) Clarification was sought on whether the timetable remained achievable, given prior-year challenges; the external auditor and management advised that the position was currently on track, while acknowledging that the overall timetable remained tight and subject to emerging issues.

(iii) The Committee queried risks associated with IJB account consolidation and whether these posed a material threat to delivery; it was confirmed that consolidation remained the principal external dependency, but that early

engagement with IJB finance leads and clearer deadlines had been established to mitigate risk.

(iv) Additional clarity was requested on quality control arrangements, including the impact of second-partner review thresholds and it was confirmed that enhanced quality assurance processes had been built into the audit plan from the outset to avoid late-stage delays.

(v) Members sought assurance that any emerging risks or variances from plan would be escalated promptly, with both James Boyle and Scott Urquhart confirming there were clear escalation routes in place and that the Committee would be advised should concerns arise before the next meeting.

The Audit & Risk Committee:

(1) The Committee noted the update, took assurance on current progress with the external audit, and agreed that no further actions were required at this stage, subject to ongoing monitoring of the audit timetable and identified risks.

8. Strategic Risk Register Update – January 2026 – March 2026

The Audit & Risk Committee considered a paper presented by Vicky Webb which provided an update on the Strategic Risk Register position for the period January to March 2026, including an overview of the current risk profile, progress against actions, and assurance on the management of strategic risks.

Key messages in the report included:

(i) The presenter reported that all strategic risks had been reviewed during the period January to March 2026, with no change to the overall risk profile during that reporting period.

(ii) It was noted that no focused reviews had been conducted in the period; however, the Information Governance strategic risk had completed its focused review and would be considered by SPPRC, prior to being reported back to the Committee.

(iii) The presenter advised that, due to the timing of the Board and SPPRC cycle, the strategic risks had not yet been formally cited to SPPRC but were scheduled for consideration at its forthcoming meeting.

(iv) It was confirmed that there had been no change to risk appetite positions, with 33% of strategic risks within tolerance, 63% outwith tolerance and appetite, and none within the Board's appetite.

(v) The update highlighted that there were no overdue actions reported for the period, with ten actions completed, and the presenter confirmed that detailed information was set out within the paper for assurance.

The following points were made in discussion:

(i) Reference was made to ongoing work involving Non-Executive Members and officers to review and strengthen the organisation's approach to risk management and questioned how this work would influence the Strategic Risk Register; it was confirmed that this work was developmental in nature and would inform future refinement of risk articulation rather than result in immediate changes to the current risk profile.

(ii) Clarification was sought on whether the absence of changes in the Strategic Risk Register during the reporting period indicated a lack of progress, however colleagues were advised that the register remained static for the period, but supporting work to improve risk definition and maturity was continuing in parallel.

(iii) Assurance was sought on the alignment of future risk development work with agreed governance timelines; it was confirmed that the work was progressing in line with previously agreed schedules and outputs would be brought back to the Committee at the appropriate time.

(iv) Further clarity was requested on how outcomes from the ongoing risk review activity would be reported to the Committee; the presenter confirmed that any proposed

changes arising from this work would be formally reported back for consideration and assurance.

The Audit & Risk Committee:
(1) Noted the changes to the Strategic Risk Register for this reporting period (Jan'26-March-26).
(2) Noted the focused reviews conducted on the Strategic Risks for this period.
(3) Considered that the report provided assurance that appropriate controls were in place to manage the identified risks, supported the delivery of objectives and, where improvements were needed, clear actions had been identified.

9. Risk Management Annual Report
The Audit and Risk Committee considered a report for assurance, presented by Miss Vicky Webb, which provided assurance on the effectiveness and maturity of the organisation's risk management arrangements.

Key messages in the report included:
(i) Vicky Webb outlined that the report provided an overview of corporate risk management activity over the previous year, highlighting progress in strengthening organisational controls and the maturity of the risk management approach.
(ii) It was reported that a key focus during the year had been completion of the revised Risk Management Strategy and Risk Appetite statements, which were presented as part of the annual reporting cycle.
(iii) Ongoing work was highlighted to strengthen risk management capability across the organisation, including expanded training provision and the introduction of qualitative feedback to assess training effectiveness, with strong participation feedback reported.
(iv) It was confirmed that risk management reporting now supported 18 management and governance groups, with continued emphasis on improving the quality and consistency of risk reporting.
(v) An overview was provided of current risk data, noting the number and distribution of recorded risks, progress in action completion, movements within the strategic risk register, and confirmation that the focused review programme would continue into 2026/27 and was reflected in Committee forward plans.

The following points were made in discussion:
(i) Members commended the quality and breadth of the report, noting the wide reach of the risk management function and acknowledging the level of activity delivered by a relatively small team.
(ii) A question was raised around the ongoing requirement for an annual risk management report, querying whether it added value given other sources of assurance; in response, it was confirmed the report provided a consolidated source of assurance and fed directly into the Annual Governance Statement. Further clarification was provided that the report was used to support year-end assurance processes, with Internal Audit confirming that it was a valuable input to assurance and governance assessments.
(iv) A suggestion was made that the report could be strengthened by clearly articulating areas for improvement alongside progress made; this was acknowledged, with agreement that future reports could better consolidate learning and development needs.
(v) Discussion highlighted the importance of organisational ownership of risk, rather than risk being perceived as the responsibility of a single team; it was noted that the planned risk maturity assessment would support improved ownership and understanding across the organisation.

The Audit & Risk Committee:

1) Approved the Corporate Risk Management Annual Performance Report for 2025/2026.

(2) Endorsed the assurance provided on the management of the strategic risk register for the year 25/26.

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

10. Risk Framework

The Audit and Risk Committee considered a report for assurance, presented by Vicky Webb, which sought endorsement of the Risk Management Framework as the overarching approach to risk management.

Key messages in the report included:

(i) Colleagues were advised that the paper presented a reframed Risk Management Framework, replacing the previous strategy and was intended to set out clearly the Board's overarching approach to risk management.

(ii) It was explained that procedural detail had been separated into a supporting document, with the framework focusing on governance arrangements, principles and tools used to support risk management across the organisation.

(iii) New principles were highlighted within the framework to articulate how risk management was applied consistently, alongside the introduction of risk categories to reflect the different types of risk managed by the Board.

(iv) The framework explicitly recognised predictive, proactive and reactive risk management, to demonstrate that risk management extended beyond risk identification to ongoing anticipation, mitigation and response.

(v) It was reported that the risk appetite section had been updated, but it was acknowledged this element would be discussed in more detail under a separate agenda item (Risk Appetite Guide), rather than within this paper.

The following points were made in discussion:

(i) A query was raised around whether the framework sufficiently explained what was meant by risk management, including how controls were defined and understood across the organisation; Vicky Webb advised that detailed definitions sat within the supporting procedural documents but acknowledged that clearer articulation within the framework could be helpful.

(ii) Further clarity was sought on the definition of controls, including distinctions between 'preventive', 'detective' and 'mitigating' controls; Vicky Webb confirmed that these definitions were included in the procedural guidance and agreed that incorporating a summary within the framework would support shared understanding.

(iii) Members suggested that inclusion of key risk and control terminology within the framework would help establish consistent language and improve organisational awareness; it was confirmed this could be incorporated.

(iv) The Committee noted positively the separation of procedural detail from the framework itself and sought assurance that the two documents would operate coherently. Assurance was provided that the framework set the overarching approach, with procedures providing practical application.

(v) The Committee confirmed it was content with the framework, subject to the agreed enhancement around control definitions and endorsed the document as a suitable articulation of the Board's approach to risk management.

The Audit & Risk Committee:
(1) Endorsed the Risk Management Framework for onward approval at the FV NHS Board.
(2) Endorsed the risk appetite levels for the Board as noted in the Risk Management Framework, for onward approval at FV NHS Board.
(3) Considered that the report provided assurance that appropriate controls were in place to manage the identified risks, supported the delivery of objectives and, where improvements were needed, clear actions had been identified.

11. Risk Appetite Guide

The Audit and Risk Committee considered a report for decision, presented by Vicky Webb. The paper sought approval of the Risk Appetite Guide as a practical tool to support consistent application of risk appetite across the organisation.

Key messages in the report included:
(i) Colleagues were advised that the Risk Appetite Guide had been developed to support the Risk Management Framework, translating its principles into practical guidance for operational use.
(ii) It was explained that the Guide set out a clear definition of risk appetite and described how risk appetite should be applied consistently across the organisation when managing and escalating risks.
(iii) It was detailed that the Guide had been developed with input from a short-life working group, alongside consultation with Executive Directors and key organisational leads, to ensure it was fit for purpose.
(iv) The presenter highlighted that the Guide included risk appetite levels aligned to the refreshed national risk assessment matrix, providing clarity on how NHS Forth Valley's risk appetite had been determined.
(v) Vicky Webb drew attention to the supporting rationale included within the Guide, which explained the basis for appetite positions across different risk categories and was intended to aid understanding and consistent decision-making.

The following points were made in discussion:
(i) Members welcomed the structure and clarity of the Risk Appetite Guide, noting that the tabulated presentation and supporting narrative provided a clear and accessible articulation of the organisation's risk appetite.
(ii) A query was raised around the governance route and oversight for development of the Guide, seeking assurance that Non-Executive input had informed the approach; Vicky Webb confirmed that a short-life working group involving Non-Executive Members had supported development, alongside wider Executive consultation.
(iii) Clarification was sought on how the Guide should be used in practice at operational and committee level; it was confirmed that the Guide was intended to support consistent application of risk appetite locally, alongside the Risk Management Framework.
(iv) Members praised the inclusion of clear rationale for different appetite positions and sought assurance that alignment with the national risk assessment matrix had been maintained and it was confirmed alignment had been achieved and explicitly reflected within the Guide.
(v) The Committee confirmed it was content to approve the Guide, recognising it as a helpful tool to support consistent risk-informed decision-making across the organisation, and agreed it should be progressed through the remaining governance route.

The Audit & Risk Committee:
(1) Approved the use of the Risk Appetite Guide, subject to approval of the risk appetite levels at the FV NHS Board.
(2) Considered that the report provided assurance that appropriate controls were in place to manage the identified risks, supported the delivery of objectives and, where improvements were needed, clear actions had been identified.

12. NHS Scotland Accounting Manuals

The Audit and Risk Committee received a paper presented by Jillian Thomson which outlined the key requirements, deadlines and changes arising from the NHS Scotland Accounting Manuals for 2025/26, for information and assurance.

Key messages highlighted from the reports included:

(i) Jillian Thomson advised that the NHS Scotland Accounting Manuals for 2025/26 had been issued earlier that week and set out the key deadlines and changes applicable to Boards.
(ii) It was confirmed that Boards were required to submit draft accounts by 31 May 2026 and final audited accounts by 30 June 2026, with a draft Governance Statement required as part of the draft accounts submission.
(iii) The presenter highlighted that there was no requirement for a separate Significant Issues Letter, with relevant matters instead to be included within the Governance Statement.
(iv) Additional disclosure requirements were noted, particularly in relation to climate change and sustainability, which were expected to increase the length of the Performance Report.
(v) It was confirmed that certain accounting changes (including IFRS 17 and property valuation requirements) were not expected to have a material impact on NHS Forth Valley’s 2025/26 accounts, with any future changes to valuation methodology to be brought to the Committee separately.

The following points were noted in discussion:

(i) A query was raised around whether the updated Accounting Manuals reflected any specific lessons learned from previous years and whether these had resulted in changes to approach or requirements; with confirmation provided that no material issues affecting NHS Forth Valley had arisen and that any prior omissions were addressed through improved cross-checking against the Financial Reporting Manual.
(ii) Clarification was sought on references to “lessons learned” within the wider accounting guidance, as Members had noted difficulty identifying these explicitly in the Manuals; the presenter explained that this primarily related to national-level refinement of guidance rather than Board-specific actions.
(iii) James Boyle commented on the requirements around property revaluation, noting that moving away from annual full revaluation would be proportionate and welcomed, given the cost and effort involved; this was acknowledged with confirmation that any change in methodology would be brought back to the Committee for approval.
(iv) Members sought assurance that new accounting standards and disclosure requirements, including climate-related reporting, would not create unmanageable additional burden; the presenter confirmed that these were being planned for and were not expected to have a material financial impact.
(v) The Committee noted the update and confirmed that it was content with the approach outlined, with no further clarification or actions requested at this stage.

The Audit & Risk Committee

(1) Noted the year end deadlines and key changes to the 2025/26 NHS Scotland Annual Accounts and Capital Accounting Manuals.

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

13. Legal Claims Report

The Audit and Risk Committee considered a report presented by Jillian Thomson, which provided the Committee with an update on the current legal claims position, including financial exposure and recent activity, and to provide assurance on the management of claims and associated risks.

Key messages highlighted from the report included:

(i) It was reported that, as at the end of February 2026, there were 101 live claims against NHS Forth Valley, with an estimated total value of £55.6 million, the majority relating to clinical claims.

(ii) It was highlighted that approximately 73% of claims were clinical in nature, with the remaining 27% non-clinical, and that two high-value obstetric and paediatric claims accounted for a significant proportion of the total estimated exposure.

(iii) The presenter advised that 11 claims pre-dated 2015 and remained ongoing due to the long timescales associated with complex claims, with provisions maintained in line with advice from the Central Legal Office (CLO).

(iv) An update was provided on claims activity during the year, confirming that 24 claims had been settled and 19 claims closed in the reporting period, with three structured settlements remaining in place with no change.

(v) It was confirmed that the estimated claims contribution for 2025/26 was £2.7 million, which was lower than originally assumed. It was noted that the CLO Annual Report was not yet available but would be shared with the Committee once published.

The following points were made in discussion:

(i) The Chair sought clarification on whether the two high-value obstetric and paediatric claims formed part of the pre-2015 claims cohort; Jillian Thomson advised that, to her understanding, they did not but confirmed that this would be checked and confirmed separately.

(ii) Members noted the length of time that some historic claims had remained open and reflected on the implications for both financial exposure and claimant experience; officers confirmed that extended timescales were not uncommon for complex clinical claims and that provisions were maintained in line with CLO advice.

(iii) A potential learning opportunity was highlighted arising from claims data and queried how themes from litigation were linked to complaints and adverse events processes; it was acknowledged that further alignment across these areas would support prevention and improvement.

(iv) Vicky Webb suggested that risk management should be explicitly included alongside litigation, complaints and adverse events to strengthen prevention and assurance; Jillian Thomson confirmed that this was a valid observation and aligned with existing discussions.

(v) The Committee expressed support for continued work to integrate learning across claims, complaints, adverse events and risk management, and noted that this would provide additional assurance over time; no formal actions were agreed under this item.

The Audit & Risk Committee:
(1) Noted the contents of the report.
(2) Considered that the report provided assurance that appropriate controls were in place to manage the identified risks, supported the delivery of objectives and, where improvements were needed, clear actions had been identified.

Actions:
(1) CLO Annual Report to be circulated to colleagues once published.
(2) Confirmation required around high value obstetric and paediatric claims being included in pre-2015 cohort.

14. Audit & Risk Committee Terms of Reference

The Committee considered a paper presented by Jack Frawley which set out the Audit & Risk Committee Terms of Reference for review, highlighting minor updates for accuracy and seeking approval for onward submission to the Board.

Key messages in the report included:
(i) Colleagues were advised that a review of the Terms of Reference had been undertaken, with no significant changes proposed, reflecting that a more substantive review had been completed in the previous year.
(ii) It was highlighted that a minor amendment would be required to update the stated membership size of the Committee, to reflect the proposed appointment of two additional members.
(iii) It was noted that references within the document had been updated for accuracy, including alignment with the Risk Management Framework and Global Internal Audit Standards, replacing outdated terminology.
(iv) Attention was drawn to the upcoming Board governance seminar, with confirming that any consequential changes arising from that discussion would be brought back to the Committee through the appropriate route.
(v) The Committee were requested to recommended the updated Terms of Reference for approval and onward submission to the Board, subject to the minor amendments discussed.

The following points were made in discussion:
(i) Members raised a point of clarification regarding references to the risk Management Strategy, noting that this had now been refreshed as a Risk Management Framework; it was confirmed that the reference would be updated to ensure consistency.
(ii) Clarification was sought on the definition and scope of patients' private funds referenced within the document; it was explained that this related specifically to patients' funds held and managed by the Board, and Members requested that the wording be clarified to avoid ambiguity.
(iii) Members queried the continued reference to Public Sector Internal Audit Standards; Internal Audit advised that this terminology should be updated to reflect the Global Internal Audit Standards, and this amendment was agreed.
(iv) The Committee discussed the timing of any further changes, noting the upcoming Board governance seminar; it was agreed that any consequential amendments arising from that discussion would be brought back to the Committee for consideration.

The Audit & Risk Committee:
(1) Approve the appended Terms of Reference for onward submission to Board for approval as part of the Code of Corporate Governance, subject to the noted minor amendments detailed.

(2) Noted that a Governance Board Seminar will take place on 21 April and should any further changes be required to the Terms of Reference arising from discussions there these will be reported to the Audit & Risk Committee
(3) Considered 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.

Actions:
(1) Amendment and clarification of wording as raised during discussion, prior to submission to the NHS Board for approval.

15. Code of Corporate Governance – Annual Review

The Committee considered a paper presented by Jack Frawley outlining the outcome of the annual review of the Code of Corporate Governance, for confirmation that the Code remained appropriate and fit for purpose.

Key messages in the report included:

(i) Colleagues were advised that the annual review of the Code of Corporate Governance had been undertaken and that no changes were proposed at this stage, reflecting that the Code remained appropriate and up to date.
(ii) It was noted that a more comprehensive review had been carried out previously, and that the current review was intended to confirm continued compliance rather than introduce substantive amendments.
(iii) The Committee's attention was drawn to the forthcoming Board governance seminar, where wider governance arrangements would be discussed and could give rise to future updates to the Code.
(iv) It was confirmed that, should any changes be required following the seminar, these would be brought back to the Audit & Risk Committee for consideration before onward submission to the Board.
(v) The Committee were requested to approve the current version of the Code for the time being, on the basis that a further review would follow once the governance seminar had taken place.

The following points were made in discussion:

(i) Members sought clarity on why no amendments were being proposed as part of the annual review; in response, it was explained that a more substantive review had been undertaken previously and that the current exercise was intended to confirm continued appropriateness.
(ii) Clarification was requested on the interaction between the Code and the forthcoming Board governance seminar; it was confirmed that the seminar was expected to explore wider governance arrangements and could give rise to future changes to the Code.
(iii) Members discussed the appropriate timing of any future updates, noting that it would not be effective to amend the Code in advance of the seminar; officers confirmed that any required changes would be brought back to the Committee following that discussion.
(iv) The Committee sought assurance that it would retain appropriate oversight of any proposed revisions arising later in the year; it was confirmed that all changes would return to the Audit & Risk Committee before onward submission to the Board.
(v) The Committee confirmed that it was content to note and approve the current version of the Code for the time being, acknowledging the planned future review cycle; no actions were agreed under this item.

The Audit & Risk Committee:
(1) Approved the Code of Corporate Governance as appended to the report;
(2) Noted that proposed changes to the Code of Corporate Governance will be submitted to a future meeting if required from the April Board Seminar and consultation with officers
(3) Considered 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.

Action:
(1) Any changes from Board Governance Seminar to be returned to Committee.

16. Audit & Risk Committee – Annual Report

The Audit and Risk Committee considered the Audit & Risk Committee Annual Report, presented by Scott Urquhart, which summarised the Committee's activity and effectiveness during 2025/26 and sought approval for onward submission through the Board's governance process.

Key messages in the report included:
(i) Colleagues were advised that the report summarised the Committee's work and activity over the year.
(ii) It was explained that the report set out the range of matters considered by members, demonstrating how the Committee had discharged its responsibilities in line with its Terms of Reference.
(iii) The presenter highlighted that the report included a self-assessment checklist, completed on behalf of the Committee, to reflect good practice and support assurance on effectiveness.
(iv) Attention was drawn to the conclusion of the report, which confirmed that the Committee had met as required, fulfilled its remit, and maintained adequate and effective arrangements throughout the year.
(v) The Annual Report was commended for consideration and approval, prior to onward submission through the Board's governance process.

There were no challenges or points of clarification raised during consideration of this item.

The Audit & Risk Committee:
(1) Approved the appended Audit & Risk Committee Annual Report, subject to any updates required from this March 2026 meeting
(2) Agreed that finalisation of any further matters in the Annual Report are remitted to the Director of Finance in consultation with the Committee Chair
(3) Considered that the report provided assurance that appropriate controls were in place to manage the identified risks, supported the delivery of objectives and, where improvements were needed, clear actions had been identified.

17. Counter Fraud Update Report – March 2026

The Committee considered the Counter Fraud Update Report (March 2026), presented by Anne-Marie Machan, which provided an update on national and local counter fraud activity, emerging risks, and the effectiveness of fraud prevention and awareness arrangements.

Key messages in the report included:
(i) The report covered the period to March 2026, summarising national Counter Fraud Services activity and the current position in relation to local counter fraud arrangements.

(ii) Note was made of the launch of a new Fraud Impact Assessment service, encouraging Boards to utilise this early in the lifecycle of significant projects or, where appropriate, retrospectively, to assess fraud, bribery and corruption risks.

(iii) It was reported that fraud awareness and reporting messages continued to be promoted nationally, with emphasis on raising awareness of what constitutes fraud, how to report concerns, and the deterrent value of communicating investigation outcomes.

(iv) An update was provided on local fraud referrals, noting that referral numbers remained relatively steady overall, with some recent increase locally, largely relating to employee concerns, and that a proportion of referrals were closed at an early stage following initial fact-finding.

(v) Anne-Marie Machan advised that fraud awareness training completion rates remained strong, with training now mandatory across NHS Scotland, and noted that the annual engagement meeting with Counter Fraud Services was scheduled to take place shortly.

The following points were made in discussion:

(i) The Chair sought clarity on the recent increase in local referrals and whether this represented an emerging trend; it was explained that referral levels remained broadly consistent over time, with recent fluctuations likely linked to raised awareness and initial fact-finding concluding that many referrals required no further action.

(ii) Members discussed the nature of recent referrals, with clarification provided that these largely related to employee matters, including secondary employment and rostering concerns, rather than large-scale or high-value fraud.

(iii) The Committee sought assurance that the organisation's systems and controls remained robust, particularly in light of the Economic Crime and Corporate Transparency Act; with confirmation provided that work was progressing to ensure compliance and that risk assessment and communication activity was aligned to this requirement.

(iv) Discussion highlighted the importance of targeted communications to reinforce expectations around standards of business and staff conduct; it was confirmed that communications were being developed to address observed risk areas and support staff understanding.

(v) The Committee noted the update and confirmed that it was content with the assurance provided, with no further clarification requested and no actions agreed under this item.

The Audit & Risk Committee:

(1) Considered the updates from CFS.

(2) Considered the NHS Forth Valley position related to CFS activity.

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

18. Counter Fraud Services Quarterly Report

The Audit & Risk Committee considered the Counter Fraud Services Quarterly Report, presented by Anne-Marie Machan, which provided an overview of national counter-fraud activity, key developments during the quarter, and assurance on the effectiveness of Counter Fraud Services' arrangements supporting NHS Forth Valley.

Key messages in the report included:

(i) Colleagues were advised that the paper summarised Counter Fraud Services' Quarter 3 activity, providing national context and assurance on delivery of the agreed counter-fraud work programme.

(ii) The introduction of the Fraud Impact Assessment service was highlighted, encouraging Boards to use it to assess fraud, bribery and corruption risks for significant projects and spend, either prospectively or retrospectively.
(iii) It was reported that national messaging following International Fraud Awareness Week emphasised continued promotion of fraud awareness, reporting routes, and communication of investigation outcomes as a deterrent.
(iv) Fraud awareness training continued to be strongly emphasised nationally and was now mandatory across NHS Scotland, with completion rates expected to improve further.
(v) Annual engagement meetings between Counter Fraud Services and individual Boards formed part of routine assurance, with NHS Forth Valley's meeting scheduled shortly, and that Counter Fraud Services had previously expressed satisfaction with the Board's engagement and arrangements.

The following points were made in discussion:
(i) Members sought clarity on how national Counter Fraud Services activity translated into local assurance; it was confirmed that the quarterly report provided national oversight and context, complementing the Board's local counter-fraud arrangements.
(ii) Clarification was requested on the practical use of the Fraud Impact Assessment service; it was confirmed that the service was intended to support Boards in assessing fraud risk in significant projects and spend, either early in delivery or retrospectively where appropriate.
(iii) The Committee discussed the emphasis on fraud awareness, noting the importance of sustained messaging following International Fraud Awareness Week; it was confirmed that national and local communications aligned and reinforced consistent reporting routes.
(iv) Members sought assurance regarding training uptake, given the move to mandatory fraud awareness training; it was confirmed that this requirement was expected to improve completion rates and strengthen organisational awareness.

The Audit & Risk Committee:
(1) Noted the contents of the report.
(2) Considered that the report provided assurance that appropriate controls were in place to manage the identified risks, supported the delivery of objectives and, where improvements were needed, clear actions had been identified.

19. National Fraud Initiative Report

The Audit & Risk Committee considered a paper presented by Jillian Thomson which provided an update on NHS Forth Valley's participation in the National Fraud Initiative, including progress with match review activity and assurance on findings from the current exercise.

Key messages in the report included:
(i) Jillian Thomson advised that NHS Forth Valley continued to participate in the biennial National Fraud Initiative (NFI) exercise, with the 2024/25 cycle nearing completion.
(ii) It was reported that 1,915 creditor matches had been generated, the majority relating to routine duplicate payment matches arising from recurring inter-Board transactions, with a significant proportion already reviewed.
(iii) An update was provided on progress with creditor match reviews, confirming that no issues had been identified from the records examined to date.
(iv) Colleagues were advised that payroll matches had also been reviewed, including cases linked to employment across multiple public bodies and retire-and-return arrangements, with no concerns identified.

(v) It was acknowledged that the exercise was resource-intensive but valuable as a control and deterrent and confirmed that the national outcomes report was expected later in the year and would be brought back to the Committee for noting.

The following points were made in discussion:

(i) Members noted the volume of creditor matches generated through the exercise and sought reassurance that these largely reflected routine duplicate payment matches rather than genuine fraud risk; the presenter confirmed this was the case, particularly due to recurring inter-Board transactions.

(ii) Clarification was sought on the progress of reviewing creditor matches; it was confirmed that a substantial proportion had been reviewed to date and that no issues had been identified from the matches examined.

(iii) The Committee discussed the payroll match outcomes, seeking assurance that multiple-employment and retire-and-return cases were appropriately reviewed; the presenter confirmed that all payroll matches had now been reviewed with no concerns identified.

(iv) Members acknowledged that the exercise was resource-intensive and queried whether continued participation remained proportionate; it was confirmed that, despite the workload, participation was considered valuable as a deterrent and key control mechanism.

(v) The Committee noted the update and confirmed that it was content with the assurance provided, agreeing that the national outcomes report should be brought back to a future meeting once available, with no actions agreed under this item.

The Audit & Risk Committee:

(1) Noted the contents of the report.

(2) Considered 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.

Action:

(1) National Outcomes Report to be presented to a future meeting.

20. Schedule of Business 2025/26

The Audit & Risk Committee received an update on the 2025/26 Schedule of Business presented by Jack Frawley. This highlighted the need to ensure the record accurately reflected items considered during the year, including those approved through alternative routes.

Discussion focused on the importance of completeness and accuracy for assurance purposes, and it was noted that the Schedule would be revised accordingly.

The Committee was advised that an updated 2025/26 Schedule, alongside the draft 2026/27 Schedule of Business, would be presented at a future meeting for consideration.

The Audit & Risk Committee noted the Schedule of Business.

21. Any other competent business

There were no items raised.

22. Matters to raise at Board

There were no items identified.

23. Date and time of next meeting: Friday 12 June 2026 at 9am.

NHS Forth Valley

CLINICAL GOVERNANCE COMMITTEE

7.2 Minute of the Clinical Governance Committee Meeting held on Tuesday 5 May 2026

For: Assurance

Minute of the Clinical Governance Committee Meeting held on Tuesday 5 May 2026 at 9.00am in the Boardroom, Carseview House.

Present: Mr John Stuart (Committee Chair)
Mrs Kirstin Cassells (Non-Executive Director)
Mr Gordon Johnston (Non-Executive Director)
Ms Clare McKenzie (Non-Executive Director)

Mrs Neena Mahal (Board Chair)

In Attendance: Ms Laura Byrne (Director of Pharmacy)
Mr Ashley Calvert (Head of Clinical Governance)
Mr Jack Frawley (Board Secretary)
Mr Ronan Ging (Chief Nurse, Acute) Item 9a only
Mrs Karen Goudie (Executive Nurse Director)
Mr Jonathan Horwood (Infection Control Manager)
Ms June McGill (Observer)
Mr Andrew Murray (Medical Director)
Mr Finlay Scott (Observer)
Miss Vicky Webb (Head of Risk Management)
Ms Katy Williams (Observer)
Ms Nicola Wood (Chief Nurse, Falkirk HSCP) Item 9b only

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1. Welcome, Apologies for Absence and Confirmation of Quorum

The Chair welcomed everyone to the meeting. Apologies were noted from Stephen McAllister and Wendy Nimmo. Fiona Law and Julie McIlwaine were not present. It was confirmed the meeting was quorate.

2. Declarations of Interest

There were no declarations of interest.

3. Minute of Clinical Governance Committee held on 17 March 2026

The minute of the meeting held on 17 March 2026 was confirmed as an accurate record, however it was noted that, during the previous meeting, some members departed part-way through proceedings. It was agreed that this should be explicitly recorded within the minutes to ensure accuracy of attendance and governance.

4. Matters Arising from the Minute/ Action Log

The Clinical Governance Committee reviewed the action log, noting that there were 10 actions carried forward.

The following key updates were provided.

110 Process for DIPLAR (Death in Priosn Learning Audit and Review) updated with presentation to Clinical Governance Working Group. Escalation of significant cases only. Timeline of 12 weeks confirmed.

111 Centred Care / Parkinson's Medication – Discussion highlighted that learning from the Parkinson's case had been captured and supporting materials developed; it was agreed that the Person-Centred Care report should be strengthened to explicitly evidence how this learning is being applied and scaled across acute wards.

113 Medical Appraisal Data – Data alignment issue resolved; single data source agreed with consistent reporting across committees.

114 Recognised the uniqueness of Public-Health as no other area provided an Annual Report. On Agenda.

The Clinical Governance Committee noted the Action Log

5. Clinical Governance Committee Planner

The Clinical Governance Committee considered the Clinical Governance Committee Planner, presented by Mr Ashley Calvert, Head of Clinical Governance, which outlined the forward programme of work, ensuring all required reports and assurance activities were scheduled and delivered across the year.

Key messages in the report included:

i) The updated Clinical Governance Committee Planner for 2026/27 was presented, reflecting previously agreed amendments.
ii) Alignment between the planner and the current agenda was confirmed, providing assurance that scheduled items were being delivered as intended.
iii) The planner remained subject to finalisation, with some elements—particularly Public Health reporting—requiring further clarification.
iv) January and March meeting dates were yet to be confirmed and will be progressed through the Board approval process.
v) Further development was anticipated to incorporate an updated system assurance reporting approach.

The following points were made in discussion

(i) Concern was noted in relation to outstanding meeting dates, highlighting the importance of timely confirmation to support forward planning.
(ii) Members highlighted the need to reflect the evolving system assurance reporting model within the planner.
(iii) It was clarified that all DIPLAR reviews would be considered through the Clinical Governance Working Group, with relevant cases escalated to the Committee via the whole system assurance reporting process.
(iv) Discussion emphasised the importance of a clear and proportionate escalation threshold, ensuring focus on matters of significant learning or relevance.

The Clinical Governance Committee thereafter noted the Committee planner as presented.

6. Clinical Governance Committee Terms of Reference

The Clinical Governance Committee considered the Clinical Governance Terms of Reference, presented by Mr Ashley Calvert, Head of Clinical Governance.

Key messages in the report included:

(i) An updated version of the Clinical Governance Committee Terms of Reference was presented, incorporating a refreshed purpose statement and amendments based on member feedback.

ii) Track changes had been retained within the document to support transparency of proposed revisions.

iii) Additional feedback had been received in advance, including comments relating to specific sections and governance processes.

iv) It was proposed that, subject to final amendments, the Terms of Reference could be progressed for approval outwith the meeting to support timescales.

The Following Points Were Made in Discussion

(i) Members raised queries regarding sections 8.2 and 8.3, including references to programme boards and the process for minute ratification. Clarification was sought on current arrangements for approval and circulation of minutes, with it noted that electronic approval prior to Board submission should be in place but was not consistently followed. Members agreed that any proposed changes to governance processes should be reviewed and refined to ensure alignment with wider Committee Terms of Reference prior to final approval.

(ii) A minor amendment was identified to ensure consistent terminology, specifically updating references from “risk management strategy” to “risk management framework.”

The Clinical Governance Committee:

1. **Agreed that the Terms of Reference were not approved at this stage and would be updated to reflect comments raised.**

Actions:

1.	**Sections 8.2 and 8.3, including minute ratification wording, were to be reviewed offline with relevant members.**	Ash Calvert
2.	**Proposed changes to governance processes were to be considered against wider Board committee arrangements to ensure consistency.**	Ash Calvert
3.	**Terminology was to be updated from “risk management strategy” to “risk management framework”.**	Ash Calvert
4.	**The revised Terms of Reference were to be circulated for virtual approval following incorporation of amendments.**	Ash Calvert

7. Active Governance & Emergent Issues

The Clinical Governance Committee received the ‘Active Governance and Emergent Issues’ paper presented by Mr Andrew Murray, which provided assurance on active governance and any emerging issues, including inspection activity and escalation where required.

Key messages in the report included:

(i) An update on active governance and emergent issues was provided, confirming that **no** significant new risks or concerns had arisen since the previous meeting.

(ii) The paper provided an overview of current inspection activity, including follow-up engagement with Healthcare Improvement Scotland (HIS). It was noted that evidence submissions had been provided to HIS, with further feedback and a virtual session awaited.

(iii) A draft Standard Operating Procedure (SOP) had been developed to support a consistent approach to inspections, including escalation and communication processes.

(iv) The Committee was assured that no issues had required formal escalation during the inspection process.

The following points were made in discussion:

(i) Clarification was sought regarding communication and awareness of inspection activity, particularly ensuring that Board members were appropriately informed.
(ii) Members highlighted the need for clear and consistent communication processes, including how information was cascaded following inspection visits.
(iii) Queries were raised regarding the absence of escalations during inspection, with confirmation provided that this was a positive position and indicative of no immediate concerns.
(iv) Discussion noted the importance of ensuring Board-level visibility prior to publication of inspection reports, to avoid members becoming aware through external sources.
(v) Members referenced wider national discussions regarding HIS inspection methodology, including concerns around process, timelines, and use of evidence.

The Clinical Governance Committee:

1. **Noted position of the HIS inspection process for the Acute site**
2. **Considered 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.**
3. **Noted the further information would be provided to the Committee following feedback from HIS at the virtual session.**

8. Quality & Safety Report

The Clinical Governance Committee received the 'Quality & Safety Report' presented by Mr Andrew Murray, Medical Director. The purpose of the paper was to provide the Committee with an opportunity to review the report following Board consideration, assess the content, presentation and clarity of the data, and determine whether it provided appropriate assurance on quality, safety and associated risks.

Key messages in the report included:

i) The Quality & Safety Report had previously been considered by the Board and was presented to the Committee for further reflection and assurance.
ii) The report contained extensive data and performance information, with the focus of discussion being on interpretation, clarity, and usefulness rather than detailed review of all content.
iii) It was noted that the report was primarily designed for Board-level discussion, with an opportunity for the Committee to provide further scrutiny and feedback.
iv) Feedback highlighted the need for improved narrative and explanation, particularly in relation to key indicators and data presentation.
v) Longer-term development of a dashboard approach (Healthcare Guardian) was noted as the direction of travel to support more accessible and meaningful reporting.

The following points were made in discussion:

(i) Members raised concerns regarding the clarity of data presentation, particularly tables and indicators, noting that additional narrative was required to support interpretation.
(ii) Queries were raised regarding specific indicators showing zero or unusual values, with clarification provided that some measures were in development or not yet applicable.
(iii) It was noted that the inclusion of new or complex data at Board level without prior Committee discussion could lead to confusion and extended debate.
(iv) Members highlighted the need for clear explanation of acronyms, metrics and expected performance levels, to ensure accessibility for all Board members.
(v) Discussion emphasised the importance of aligning Committee and Board reporting timelines, to allow appropriate scrutiny prior to Board consideration.

The Clinical Governance Committee:

1. **Reviewed the key areas of Quality and Safety contained within the report, noting the areas of progress and risk.**
2. **Considered 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.**

Action:

1. **Future quality and safety reports to include additional narrative to support interpretation of data and explanations of acronyms.** Andrew Murray

9. System Assurance Reports

a) Acute Directorate

The Clinical Governance Committee received the 'Acute Directorate System Assurance Report' presented by Mr Ronan Ging, Chief Nurse, Acute, which provided assurance on the quality, safety and performance of acute services, including key risks, pressures and improvement activity.

Key messages within the report included:

(i) An Acute Directorate Assurance Report was presented, highlighting overall performance improvements across a number of clinical indicators, including mortality, cardiac arrest rates, stroke care, pressure damage, and falls.
(ii) It was noted that operational pressures remained sustained, with continued high demand and reliance on additional bed capacity across the site.
(iii) Ongoing challenges were identified in relation to resuscitation training capacity, with demand exceeding available training provision and compliance levels below expected standards in some areas.
(iv) Progress was reported in relation to Healthcare Improvement Scotland (HIS) inspection activity, with evidence submitted and assurance feedback received, pending further engagement.
(v) Risks relating to delays in implementation of electronic observation systems (EOBS) and outstanding adverse event actions were highlighted, with improvement activity underway.

The following points were made in discussion:

(i) Queries were raised regarding resuscitation training compliance, including the level of organisational risk and the need for clearer data on staff training coverage and trajectory.
(ii) Members highlighted the importance of trend monitoring and assurance over time, particularly in relation to training compliance and risk mitigation.
(iii) Concerns were noted regarding the visibility and clarity of learning from adverse events, with a request to strengthen how learning is evidenced and shared.
(iv) Discussion explored the impact of sustained system pressure, including additional bed usage and its effect on patient flow, staff capacity, and overall service delivery.
v) Clarification was sought on data presentation within the report, including interpretation of metrics (e.g. additional beds, governance group meetings), with acknowledgement that some elements required clearer explanation.

The Clinical Governance Committee:

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

b) Falkirk Health & Social Care Partnership

The Clinical Governance Committee received the 'Falkirk Health & Social Care Partnership System Assurance Report' presented by Ms Nicola Wood, Chief Nurse, Falkirk HSCP, providing assurance on the quality, safety and performance of services within the Falkirk Health and Social Care Partnership, including risks, incidents and service developments.

Key messages within the report included:

(i) A Falkirk Health and Social Care Partnership Assurance Report was presented, outlining adverse events, complaints performance, and service developments.
(ii) It was noted that 15 adverse events had been reviewed at the Community Adverse Event Review Group, with the majority relating to community-acquired pressure ulcers, and further focused improvement work planned.
(iii) Assurance was provided that care assurance visits were largely positive, with one limited assurance outcome in prison healthcare relating to a cultural issue, for which organisational development support was in place.
(iv) An increase in code blue incidents within prison healthcare settings was reported, linked to illicit substance use, with all individuals recovering without long-term harm.
(v) Strong performance was reported in relation to complaints handling, with high compliance against response times across both prison healthcare and the wider partnership.

The following points were made in discussion:

(i) Positive feedback was provided on the report, with particular recognition of the work on transitions of care and its potential to improve patient experience and service delivery.
(ii) Members highlighted the need for greater clarity on risk mitigation, including clearer articulation of actions, timelines, and assurance around identified risks.
(iii) Queries were raised regarding workforce and service risks, including community nursing capacity, training, and out-of-hours GP provision, with a request for clearer distinction between operational issues and strategic risks.
(iv) Discussion explored the complexity and volume of clinical pathways, noting the opportunity to rationalise pathways and improve patient flow and system efficiency.
(v) Clarification was sought on the governance and reporting route for external reports, including prison healthcare reports, to ensure visibility and learning across the system.

The Clinical Governance Committee

1. **Noted the agenda items discussed and presented at the Directorate Clinical Governance meetings.**
2. **Noted the data sources.**
3. **Considered 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.**

The Committee adjourned at 10.55 am and reconvened at 11:05 am with all members present as per the attendance list.

9.1 Healthcare Associated Infection (HAI) Quarterly Report (March 2026)

The Clinical Governance Committee received the 'Healthcare Associated Infection (HAI) Report March 2026 presented by Mr Jonathan Horwood. The report provided an oversight of the HAI targets, Staph aureus bacteraemias (SABs), Clostridioides difficile infections (CDIs), Device associated bacteraemias (DABs), Escherichia coli

bacteraemias (ECBs) incidents, outbreagks and all other HAI activities across NHS Forth Valley.

Key messages in the report included:

(i) The HAI Quarterly Report for March 2026 was presented, highlighting positive performance against key infection control indicators.
(ii) It was reported that Local Delivery Plan (LDP) targets for key infections (including Staphylococcus aureus bacteraemia, E. coli bacteraemia and Clostridioides difficile infection) were expected to be met, subject to formal validation.
(iii) Surveillance data indicated that infection rates remained low, with single-figure cases reported across key measures during the period.
(iv) The Board's performance was noted to be in line with or around the national average, providing assurance on relative performance.
(v) Improvements were noted in outbreak management and infection prevention activity, with a low number of outbreaks reported over the winter period.

The following points were made in discussion:

(i) Members noted the overall positive performance position, with acknowledgement of sustained improvement across key indicators.
(ii) Discussion highlighted a reduction in hand hygiene compliance in recent months, with assurance provided that this had been identified and was being addressed through an agreed action plan.
(iii) It was noted that training and awareness initiatives, including a "train the trainer" approach, were being progressed to support improvement in compliance.
(iv) Members reflected on the importance of maintaining visibility of infection prevention messaging, including consideration of wider communication approaches.
(v) Assurance was provided that infection control performance continued to be closely monitored through governance structures, including the Infection Control Committee.

The Clinical Governance Committee:

1. **Noted the report.**
2. **Noted the performance in respect for SABs, DABs, ECBs & CDIs.**
3. **Considered that the report provided assurance that appropriate controls were in place to manage the identified risks, support the delivery of objectives and where improvements were needed, clear actions had been identified.**

10. Public Health Update

It was noted that the Public Health update was not presented. There was a discussion that focussed on the status of the Public Health Annual Report, acknowledging it was historically produced and not a standard requirement, with agreement that further consideration was required to determine the future approach to reporting.

Action:

1. **Clarity to be sought around requirements for future Public Health Annual reports and on future Public Health updates to the Clinical Governance Committee/Forth Valley Board.** — Andrew Murray

10.1 Strategic Risk Register: Risks aligned to Committee

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

Key messages in the report included:

(i) During the reporting period, all current strategic risks had been reviewed, and all remained static.

(ii) There had been no change to the Board's appetite and tolerance levels at the time of this report. It remained that 67% of the strategic risks were outside the Board's appetite and tolerance, with 33% of risks within the Board's tolerance level.
(iii) There were no overdue actions during the reporting period.

The following points were made in discussion:
(i) It was noted that there had been limited movement across several risks, prompting discussion on how to manage risks that were difficult to influence.
(ii) Members emphasised the need for continued evaluation of mitigating actions, despite challenges in progressing some risks.
(iii) It was acknowledged that organisational risks were inherently complex and more difficult to mitigate than those at Directorate level.
(iv) The wider context of approximately 400 risks within Pentana was noted, with those escalated to organisational level representing the most complex and priority risks.
(v) It was confirmed that steps were being taken to escalate key clinical governance risks, including those relating to adverse event management and SCR processes, to organisational level to strengthen oversight.
(vi) There was discussion on whether there was value in having a Quality & Safety Strategic Risk for the Board. Members commented that if there were not appropriate processes around safety and quality there would be impact on patient harm.

The Clinical Governance Committee:
1. **Endorsed the Clinical Governance Strategic Risks for the period March'26-May'26 for onward reporting to the NHS Forth Valley Board.**
2. **Considered if the report provided 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.**

Action:
1. **SRR004 further narrative required to clearly articulate the rationale for the risk score and mitigating actions prior to Board submission.** — Vicky Webb
2. **Take forward action to evaluate whether a Quality & Safety Strategic Risk was appropriate.**

11. Complaints & Feedback Report including Care Opinion

The Clinical Governance Committee received the 'Complaints & Feedback Report including Care Opinion' presented by Mrs Pauline Easson-Donnelly, Person Centred Manager, which provided an overview of complaints performance and feedback activity, including Care Opinion, to support assurance on trends, learning and controls.

Key messages in the report included:
(i) It was reported that complaints performance had improved, with ongoing work to strengthen learning, thematic analysis and consistency of responses across services.
(ii) A high proportion of complaints had been managed at stage one, supporting timely local resolution.
(iii) The main complaint themes remained consistent, relating to treatment, access, medication, waiting times and nursing care.
(iv) A reduction in live complaint cases was noted, reflecting sustained improvement in backlog management.
Care Opinion activity had continued to increase year on year, with further work planned to enhance engagement and demonstrate learning and improvement from feedback.

The following points were made in discussion:

(i) It was noted that performance improvements reflected significant effort from the complaints team and wider organisation.

(ii) Members highlighted the importance of demonstrating the "so what" from feedback, particularly evidencing improvements arising from Care Opinion stories.

(iii) Discussion took place on the development of enhanced Care Opinion reporting, including use of dashboards and PREMs data to strengthen assurance and thematic analysis.

(iv) It was acknowledged that further work was required to improve visibility and consistency of responses to Care Opinion stories, particularly at senior leadership level.

(v) It was recognised that direct engagement with service users through Care Opinion provided a more immediate and authentic feedback mechanism compared to formal complaints processes.

The Clinical Governance Committee:

1. **Noted the current position of the patient relations performance within the organisation.**
2. **Note the feedback activity across the organisation.**
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.**

Action:

1. **Consideration to be given to evidencing improvements arising from Care Opinion and in response to complaints and this to be shared with CGC.** — Karen Goudie

11.1 Audit Report A17/26 Complaints

The Clinical Governance Committee received the 'Audit Report A17/26 Complaints' presented by Professor Karen Goudie, Executive Nurse Director, which presented the internal audit findings on complaints and feedback processes, highlight areas for improvement, and provide assurance that an action plan was in place to address identified risks.

Key messages in the report included:

(i) The audit report was presented, identifying a number of findings relating to complaints handling, including areas of significant, moderate and minor concern.

(ii) An improvement plan had been developed in response to the audit findings, with actions in place to address identified weaknesses.

(iii) Progress had been made in implementing the improvement plan, including strengthening processes and increasing staffing within the Patient Relations Team.

(iv) The audit highlighted the importance of consistency, timeliness and quality in complaint responses, alongside the need for clearer processes.

(v) Ongoing monitoring arrangements had been established to track delivery of improvement actions through relevant governance groups.

The following points were made in discussion:

(i) It was noted that complaints performance had improved despite the audit findings, reflecting the impact of improvement actions already underway.

(ii) Members discussed the variation between prison and acute complaints performance, noting the influence of dedicated resources and differing complaint complexity.

(iii) The importance of ensuring robust monitoring of audit actions through governance structures was emphasised.

(iv) It was highlighted that thematic analysis and learning from complaints required continued strengthening.

(v) Assurance was sought that sufficient resource and oversight were in place to sustain improvements and address audit recommendations.

The Clinical Governance Committee:

1. **The Committee noted the audit findings and accepted the level of assurance provided.**
2. **It was agreed that actions arising from the audit would be progressed through an improvement plan.**
3. **The Committee agreed that ongoing monitoring of actions would be undertaken through established governance routes, including updates to the Clinical Governance Committee and working group.**

Action:

1. **Consideration to be given to evidencing improvements arising from Care Opinion and in response to complaints and this to be shared with Clinical Governance Committee.** Karen Goudie

Mrs Neena Mahal and Professor Ross McGuffie left the meeting at 12:20 pm.

12. Significant Adverse Event Report

The Clinical Governance Committee received the 'Significant Adverse Event Report' presented by Mr Ashley Calvert, Head of Clinical Governance, to provide the Committee with an update around the number of open SAERs, associated backlog and capacity challenges, alongside ongoing work to improve processes, resource allocation and learning dissemination.

Key messages in the report included:

(i) It was reported that there were 33 open Significant Adverse Event Reviews (SAERs), with a number unable to progress due to limited facilitation resource.
(ii) Performance against key timescales remained poor, with delays in both commissioning and completion of reports, significantly exceeding required standards.
(iii) Despite delays, the quality of completed reports was noted to be high, with strong application of human factors and clear recommendations supporting improvement plans.
(iv) Patient and family engagement within the SAER process was highlighted as a strength, with positive feedback received on the approach taken.
(v) Work was ongoing to address backlog and capacity issues, including seeking additional resource and exploring alternative delivery models.

The following points were raised during discussion:

(i) It was acknowledged that delays in SAER completion impacted timely organisational learning, with concern regarding the length of time taken to provide resolution for patients and families.
(ii) Members discussed the need for greater organisational ownership, noting that responsibility for progressing SAERs could not sit solely with the central team.
(iii) The availability of facilitation resource was identified as a key constraint, alongside challenges in securing clinical input and review panel capacity.
(iv) Consideration was given to adopting a more pragmatic approach, including testing models where experienced leads could progress reviews with reduced facilitation input.
(v) It was emphasised that SAERs were a critical component of the organisation's learning system, requiring appropriate prioritisation alongside clinical duties.

The Clinical Governance Committee:

1. **Considered NHS FV's position on current SAERs with specific regard to compliance of the commissioning, completion, acceptance of SAERs and development of an improvement plan, within the timescales of the national framework.**
2. **Considered 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**

Action:

1. **Ongoing work required to address the SAERs backlog including confirmation to the CGC of progress regarding the additional resource requested to support this work.** Ashley Calvert

12.1 Clinical Policy & Guidelines Governance – deferred till September

12.2 Clinical Governance Annual Report

The Clinical Governance Committee received the 'Significant Adverse Event Report' presented by Mr Ashley Calvert, Head of Clinical Governance, to present the draft Clinical Governance Committee Annual Report for approval and seek authorisation for onward submission to the Audit and Risk Committee.

Key messages in the report included:

(i) The report provided a summary of the Committee's activity over the reporting year, aligned to the Terms of Reference.
(ii) It outlined Committee membership, including any changes during the year.
(iii) It confirmed that the Committee met six times and was quorate on each occasion.
(iv) It detailed the key issues considered by the Committee, including regular reports and programme of work.
(v) It identified the strategic risks overseen by the Committee and highlighted matters of concern discussed during the year.

The following points were raised during discussion:

(i) It was noted that the report provided comprehensive coverage of Committee activity over the reporting period.
(ii) Members highlighted the importance of ensuring accuracy of attendance records and terminology prior to submission.
(iii) Discussion confirmed that all required governance business had been addressed during the year.
(iv) Consideration was given to future reporting improvements, including how information could be presented more effectively.
(v) It was agreed that ongoing monitoring of actions and outputs should continue to be reflected in future annual reporting.

The Clinical Governance Committee:

1. **Approved the draft Clinical Governance Committee Annual Report.**
2. **Authorised the Committee Chair and Lead Executive to submit a finalised annual report to the Audit & Risk Committee in June 2026, taking account of any comments received at this meeting.**
3. **Considered 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**

12.3 Clinical Governance working Group Annual Report

The Clinical Governance Committee received the 'Clinical Governance Working Group Annual Report' presented by Mr Ashley Calvert, Head of Clinical Governance. The report aimed to provide assurance that the Clinical Governance Working Group had fulfilled its responsibilities over the year by outlining the business undertaken and confirming delivery against its planned programme of work.

Key messages in the report included:

(i) The Clinical Governance Working Group Annual Report was presented for consideration.
(ii) It was confirmed that the report demonstrated that all required business had been completed over the reporting period.
(iii) Minor amendments were identified within the report, including corrections to wording and content accuracy.
(iv) The report provided assurance on the activity and effectiveness of the Working Group in supporting Committee oversight.

The following points were raised during discussion:

(i) It was noted that the report provided a comprehensive overview of Working Group activity.
(ii) Members emphasised the importance of ensuring accuracy and clarity of content prior to finalisation.
(iii) Discussion confirmed that the Working Group had fulfilled its governance role in supporting the Committee.
(iv) It was highlighted that monitoring of outstanding actions remained an important element of ongoing assurance.
(v) Consideration was given to how future reports could further strengthen visibility of outputs and impact.

The Clinical Governance Committee:

1. **Reviewed the content of the CGWG annual report and consider if the report provides an appropriate level of assurance that the CGWG is fulfilling its remit to provide assurance to the Clinical Governance Committee.**
2. **Considered 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.**

12.4 Clinical Governance Working Group Update

The Clinical Governance Committee received the 'Clinical Governance Working Group update' presented by Mr Ashley Calvert, Head of Clinical Governance, to provide an update from the Clinical Governance Working Group, highlighting key issues, decisions and areas of assurance for the Committee to note and consider.

Key messages in the report included:

(i) An update was provided on the work of the Clinical Governance Working Group, including ongoing development of reporting and assurance processes.
(ii) It was noted that work was underway to refine the content and structure of updates provided to the Committee, ensuring focus on key risks and priorities.
(iii) Development of dashboard-style reporting was highlighted, intended to support clearer visibility of key domains and performance indicators.
(iv) The update confirmed that the Working Group continued to play a key role in filtering and escalating relevant issues to the Committee.
(v) Ongoing collaboration between senior leads was noted to strengthen the quality and focus of reporting.

The following points were raised during discussion:

(i) It was noted that further work was required to ensure reports are concise and focused on key areas of risk and assurance.
(ii) Members highlighted the importance of effective filtering of information to avoid unnecessary detail at Committee level.
(iii) The development of dashboards was recognised as a positive step towards improving clarity and accessibility of information.
(iv) It was acknowledged that the Working Group plays a critical role in supporting assurance by identifying and escalating priority issues.
(v) Ongoing refinement of reporting processes was supported to ensure alignment with Committee expectations and governance requirements.

The Clinical Governance Committee:

1. **Noted the paper and the key issues arising from the CGWG.**
2. **Considered 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**

12.5 Public Protection Report

The Clinical Governance Committee received the 'Public Protection Report' presented by Professor Karen Goudie, Executive Nurse Director, which provided an update on the Public Protection Report, including progress to improve report quality, governance arrangements, and reporting structures, and to seek assurance on actions being taken to address identified deficiencies prior to resubmission.

Key messages in the report included:

(i) The Committee noted that the Public Protection Annual Report required further development.
(ii) It was highlighted that additional work was underway to strengthen the quality, structure and level of detail within the report.
(iii) Support is being sought from external best practice, including engagement with NHS Tayside, to enhance reporting arrangements.
(iv) Work was ongoing to review governance arrangements and strengthen multi-agency input and oversight.
(v) A revised and improved report will be developed and brought forward, with interim oversight through SLT and governance structures.

The following points were raised during discussion:

(i) It was acknowledged that the initial report required further refinement to align with expected standards.
(ii) Members noted the importance of robust governance and clear reporting structures within public protection arrangements.
(iii) The need for stronger multi-agency engagement was highlighted to support comprehensive oversight.
(iv) Discussion emphasised the importance of embedding learning from reviews within the reporting framework.
(v) Assurance was if work was ongoing to address identified gaps and bring forward an improved report.

The Clinical Governance Committee:

1. **Noted that the management response and updates on actions to findings will be reviewed by this through the Internal Audit Follow Up report.**
2. **Noted the current progression of identified actions.**

3. **Considered 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**

Action:

1. **Provide the Clinical Governance Committee with a revised and improved Pul Protection Report after next meeting.** Karen Goudie

12.6 Internal Audit Update A15/25

The Clinical Governance Committee received the 'Internal Audit Update A15/25' presented by Mr Ashley Calvert, Head of Clinical Governance, to provide an update on progress against internal audit actions, including outstanding items, timelines for completion, and assurance on the effectiveness of improvement activity and governance arrangements.

Key messages in the report included:

(i) An update was provided on outstanding internal audit actions, with only a small number of actions remaining open.
(ii) It was noted that most actions were progressing within agreed timescales, with delays limited to specific areas.
(iii) One action, relating to improvement plan development, was expected to extend slightly beyond its original deadline.
(iv) Significant progress had been made in learning dissemination and improvement activity, particularly within Women and Children's services.
(v) It was anticipated that all remaining actions would be completed ahead of final deadlines, providing assurance on overall progress.

The following points were raised during discussion:

(i) It was noted that progress against internal audit actions was largely on track, with only minor delays.
(ii) Members acknowledged the importance of maintaining momentum to ensure timely closure of all actions.
(iii) Discussion highlighted improvements in sharing learning and embedding audit outcomes across services.
(iv) Assurance was provided that outstanding actions were being actively managed and monitored.
(v) It was recognised that continued oversight would be required to ensure full completion within agreed timelines.

The Clinical Governance Committee:

1. **Note that the management response and updates on actions to findings will be reviewed by this through the Internal Audit Follow Up report.**
2. **(2) Note the current progression of identified actions.**
3. **(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.**

12.7 HIS: New Clinical Governance Standards Draft Plan

The Clinical Governance Committee received the 'HIS: New Clinical Governance Standards Draft Plan' presented by Mr Ashley Calvert, Head of Clinical Governance, to outline the proposed approach and timeline for completing the HIS clinical governance standards self-assessment and seek Committee endorsement of the plan and reporting arrangements.

Key messages in the report included:
(i) A draft plan was presented outlining the approach to implementing the new Clinical Governance Standards.
(ii) It was confirmed that a self-assessment process would be undertaken using an agreed assessment tool.
(iii) The approach would involve a multi-stakeholder review, including input from key services such as digital, eHealth and complaints.
(iv) The self-assessment process was expected to be completed by October, with findings to be reported thereafter.
(v) It was noted that outcomes from the process would be reported back to the Committee to support oversight and assurance.

The following points were raised during discussion:
(i) It was noted that a structured and collaborative approach to self-assessment was required to ensure comprehensive coverage.
(ii) Members highlighted the importance of engaging a wide range of stakeholders to support an accurate assessment.
(iii) It was acknowledged that the process would provide an opportunity to identify areas for improvement against the new standards.
(iv) Discussion confirmed the need to ensure clear coordination and governance of the assessment process.
(v) It was agreed that the Committee would receive a future update on progress and outcomes.

The Clinical Governance Committee:
1. **Endorsed the approval of the Clinical Governance Working Group to support the whole system review of the Clinical Governance Standards using the HIS self assessment tool (SAT).**
2. **Endorsed the timescales contained with the report including reporting arrangements through the Clinical Governance Working Group.**
3. **Considered 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**

Action:
1. **Prepare report for the Clinical Governance Committee on the output and actions to be taken following completion of the self-assessment process.** Ashley Calvert

13. Reports from Associated Clinical Governance Groups
a) Clinical Governance Working Group Minute 19/02/26
b) Organ & Tissue Donation Committee Minute 06/01/26
c) Infection Control Committee Minute

Reports from associated Clinical Governance Groups were presented for noting, providing assurance on activity across relevant sub-groups, with no significant issues or additional concerns raised by the Committee.

14. Any Other Competent Business
The Chair summarised a recent review of governance arrangements noting a questionnaire completed. Feedback highlighted generally positive progress but identifying areas for improvement; it was agreed that a written report would be brought back to a future meeting as a substantive item, alongside proposed actions to support further development of committee effectiveness.

15. Matters to Raise at Board

The Clinical Governance Committee agreed the below items should be escalated to the forthcoming NHS Board meeting.

1. Update on HIS Inspection follow-up including development of the supporting SOP.
2. Progress on the Safety Plan/Strategy and associated development work
3. Ongoing development of the Whole System Assurance Report.
4. Continued focus on learning summaries and organisational learning
5. Further work to refine the risk strategy and approach o strategic risks.
6. Update on Significant Adverse event Reviews including backlog position and resource challenges
7. Confirmation that the Clinical Governance committee Annual Report had been approved.

16. Date and Time of Next Meeting

Tuesday 7 July 2026 at 9:00am, in the Boardroom, Carseview House.

The Chair closed the meeting at 12:30 hours.

STAFF GOVERNANCE COMMITTEE

NHS Forth Valley

7.3 Minute of the Staff Governance Committee Meeting held on Tuesday 12 May 2026

For: Assurance

Minute of the Staff Governance Committee Meeting held on Tuesday 12 May 2026 at 9.00am in the Boardroom, Carseview House and via MS Teams.

Present: Mr Martin Fairbairn (Committee Chair)
Mr Nicholas Hill (GMB Representative)
Mr Gordon Johnston (Non- Executive Director)
Mr Charlie McCarthy (Unison Representative)
Mrs Karren Morrison (Non- Executive Director)
Mr John Stuart (Non-Executive Director)

Mrs Neena Mahal (Board Chair)

In Attendance: Mrs Karen Beveridge (Corporate Services Assistant/PA)
Mrs Morag Farquhar (Director of Facilities)
Mr Jack Frawley (Board Secretary)
Prof Karen Goudie (Executive Nurse Director)
Mrs Aileen Love (Head of Occupational Health)
Mrs Jenny McCusker (Head of Organisational Development)
Mrs Linda McGovern (Deputy Director of Workforce)
Prof Ross McGuffie (Chief Executive)
Mr Cameron Raeburn (Head of Health & Safety) (Item 16)
Mrs Becky McGrath (Corporate Services Assistant/PA) (Minute)
Mr Kevin Reith (Director of People)
Ms Nicola Riddell (Workforce Manager)
Ms Katrina Robertson (Lead Nurse for Health and Care (Staffing) (Scotland) Act 2019 and NMAHP Workforce Planning)
Mrs Linda Robertson (HR Service Manager – Staff Governance)
Miss Vicky Webb (Head of Risk Management)

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1. Welcome, Apologies for Absence and Confirmation of Quorum

The Chair welcomed all present to the meeting. Apologies were received from Alison Jaap, Emma Small and Janett Sneddon.

Ross Cheape, Tom Cowan and Scott Urquhart were not in attendance.

2. Declarations of Interest

There were no declarations of interest.

3. Draft Minute of Staff Governance Committee Meeting held on Tuesday 10 March 2026.

The minute of the meeting held on Tuesday 10 March 2026 was confirmed as a correct record.

4. Matters Arising from the Minute / Action Log

The action log was reviewed. Actions 66, 67, 70, 71, 73, 74 and 70 were complete and would be removed from the action log. The following updates were provided:

(i) Action 22 would be updated to complete, recognising that an update following the next round of training would be shared with the committee.
(ii) Actions 63, 68, 69, 72,75,76, 77 and 78 were all extended for 14 July 2026.

5. Draft Staff Governance Workplan 2026/27

The Staff Governance Committee received the 'Draft Staff Governance Committee Workplan 2026/27' presented by Mrs Linda Robertson to outline the topics to be considered by the committee within 2026/27.

Key messages in the report included: -

(i) The forward planner was structured to allow the Committee to review routine and specific items and to allow appropriate scrutiny of workforce challenges, risks and activity to deliver Forth Valley's strategic ambitions.
(ii) The Professional Assurance Framework would be presented at the July meeting following presentation to the Area Partnership Forum.
(iii) A job evaluation update would be presented to the committee as appropriate.
(iv) Staff Governance Monitoring Return would be presented if there was a request from Scottish Government.
(v) The Staff Governance Standard Action Plans by Directorate/HSCP would be presented at the July meeting.
(vi) The Remuneration Committee Terms of Reference was removed from the workplan for May due to a review being carried out in January 2025 and being endorsed by the Board in April 2026.

The following points were raised in discussion: -

(i) Confirmation was provided that the Safe Staffing Report presented at this meeting incorporated the data that was submitted to Scottish Government.

The Staff Governance Committee:
(1) approved the draft 2026/27 workplan.

6. Staff Governance Report – Including Workforce Performance Reporting

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

Key messages in the report included: -

(i) The sickness absence position was showing improvement with a reduction to 6.99% in March, an improvement from the previous month. However, it was emphasised that this reflected a typical seasonal trend, and the key challenge remained sustaining long-term reductions.
(ii) To assist with maintaining the reduction of sickness absence rates additional spend to save money was available. Doug High had been appointed Deputy Chief Nurse and would conduct a comprehensive analysis of the workforce patterns across nursing and midwifery. Jayne-Marie McIntyre had been appointed as Head of Workforce Relations and would be focusing on workstreams to maintain the reduction in sickness absence.
(iii) PDPR compliance across the organisation was noted as 40%, significantly below the trajectory to achieve the anticipated target by March 2027. A project plan had been shared with the committee outlining the work to in place to drive improvement.
(iv) A comprehensive programme of work was in place, including revised guidance, system improvements, training programmes, and targeted leadership

engagement. Monthly monitoring through the Senior Leadership Team would support greater accountability and prioritisation of appraisal completion.

(v) Conversations ongoing to investigate the timescales of completion of Employee Relations cases, it was recognised that the Once for Scotland policy could create a lengthy process for cases to be completed and this can be to the detriment to staff as a result of the time taken to conclude a case. Disicussions remained underway with NHS Wales regarding their 'Do Less Harm' approach to determine whether a similar approach could be adopted within NHS Forth Valley.

The following points were raised in discussion: -

(i) PDPR figures presented to the committee did not include medical staffing or Senior Leaders. Although medical staffing falls within the remit of the Clinical Governance Committee it was thought to be beneficial that a whole picture data set be shared with this committee for assurance.

(ii) Concerns were raised on the length of time taken to conclude bullying & harassment and grievance cases with consideration of the impact this could cause to all staff and individuals involved. Due to the complexity of some cases this impacted on the information required to conclude a case. Although the Once for Scotland policy set the process that should be followed, there were no clear timelines that should be complied with. This often led to a delay with initial conversations taking place which could impact staff wellbeing.

(iii) There was a risk that staff could feel discouraged from raising concerns due to a lack of confidence in the process producing an acceptable outcome in an appropriate timeframe.

(iv) As an organisation it was noted that a proactive approach was required to ensure managers felt confident to have the early resolution conversations.

(v) In light of the concerns raised regarding confidence in existing processes for managing staff concerns, it was agreed that further discussion should take place at the Area Partnership Forum (APF) to identify and implement the necessary interventions to strengthen these processes and ensure staff were appropriately supported and heard.

The Staff Governance Committee:

(1) considered the report and appreciated the level of detail provided, highlighting the actions being taken across the organisation to increase PDPR compliance and sickness absence.

(2) requested that an update be provided on the implementation and effectiveness of the targeted support and actions outlined to increase their assurance in relation to PDPR and sickness absence.

(3) noted the concerns raised regarding the processes for Employee Relations cases and that an update would be provided on the necessary interventions following consideration by the Area Partnership Forum.

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

Action:

• **The Area Partnership Forum to consider the concerns raised relating to Employee Relations cases and any appropriate interventions required.**	K Reith/K Morrison
• **a report to be provided at the next meeting on the implementation and effectiveness of the targeted support and actions outlined to increase their assurance in relation to PDPR and sickness absence.**	Jayne-Marie/Jenny

- **future reports to include 'whole picture' data on all PDPR-type processes (recognising that the Clinical Governance Committee is responsible for overseeing the process for medical staff).** Jenny McCusker

7. Staff Governance Committee Annual Report

The Staff Governance Committee received the 'Staff Governance Annual Report' presented by Ms Linda Robertson to provide an overview of the work of the committee during the financial year 2025/26.

Key messages in the report included: -

(i) The annual report presented included the activities of the Staff Governance Committee 2025/26.
(ii) There was a recommendation that the attendance list was amended to reflect the members only.
(iii) The final Annual Report would be signed off by the committee Chair and the Executive Lead.

The following points were raised in discussion: -

(i) Reflected within the annual report was the areas of focus that were flagged as a concern by the committee, it was important to note that work would remain ongoing in these particular areas to ensure the committee received full assurance of progress.
(ii) The committee agreed for the attendance to be updated to reflect members only.

The Staff Governance Committee:

(1) Approved the Staff Governance Committee Annual Report caveat to the amendments to reflect that work in targeted areas would remain being monitored and the attendance list being updated.
(2) Agreed to delegate final sign of to the Committee Chair and Executive Lead.

8. Remuneration Committee Annual Report

The Staff Governance Committee received the 'Remuneration Committee Annual Report' presented by Mr Kevin Reith to provide oversight of the work carried out by the committee during the financial year 2025/26.

Key messaged in the report included: -

(i) Due to the Remuneration Committee being a subcommittee to Staff Governance their annual report was shared for oversight.
(ii) Following final approval by the Committee Chair and Executive Lead this would be presented to the Audit and Risk Committee.

The Staff Governance Committee:

(1) Approved the Remuneration Committee Annual Report.
(2) Agreed for final sign off to be completed by the Committee Chair and Executive Lead.

9. iMatter Update

The Staff Governance Committee received an 'iMatter Update' presented by Mrs Jenny McCusker to provide oversight of the 2026/27 iMatter timeframe and key stages.

Key messages in the report included: -

(i) The previous year's employee engagement index (EEI) was reported as 77 which was the highest recorded score since 2009, indicating a gradual improvement of uptake. When benchmarked against other Health boards across Scotland NHS Forth Valley was broadly in line with the average response rates.
(ii) A key focus for the OD team had been improving the system accuracy and governance, this included a comprehensive team confirmation exercise to ensure questionnaires would be issued to the correct staff groups. Around 70% of managers confirmed their teams.
(iii) The iMatter questionnaire for 2026 was being circulated later in the week.
(iv) To clearly demonstrate the impact of the iMatter survey to the organisation, once the deadline was passed a 'You Said, We Did' approach would be taken, highlighting to staff the actions being taken in response to the answers received. This would also provide an opportunity to celebrate the areas that done well and highlight the areas that require focused work.

The following points were raised in discussion:
(i) It was confirmed that there was often a correlation between the completion of action plans with areas that were compliant with PDPR and good attendance management demonstrated good practice by managers.
(ii) Clarity would be provided on whether there was a completion threshold in place that could lead to the prevention of managers receiving a response report.
(iii) Staff side colleagues offered their support to Jenny and her team to encourage staff to fill in their iMatter questionnaire.
(iv) Previous questionnaires included questions on the visibility of Board members, following national conversations and the varied interpretation of this question, this year's had been updated to question the visibility of senior managers.
(v) It was noted that while organisational performance against iMatter indicators was broadly in line with national benchmarks, the key issue for the Committee was the extent to which iMatter results were being meaningfully reflected upon at team and departmental level.

The Staff Governance Committee:
(1) was assured on the processes being implemented to enhance the use of the iMatter questionnaire in 2026/27.
(2) considered that the report provided assurance that appropriate controls were in place to manage the identified risks, support the delivery of objectives and where improvements were needed, clear actions had been identified.

Action:

- **Provide a report to a future meeting setting out how iMatter results are reviewed and acted upon at team and departmental level, including:** K Reith/J McCusker
  - **the approach to action planning;**
  - **the consistency of implementation across the organisation; and**
  - **how assurance on the effectiveness of this process is obtained and reported**

10. Internal Audit Action update

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

Key messages in the report included: -

(i) The 2 recommendations from the Internal Control Evaluation report 2025/26 had been delivered and marked as complete, these were:
  a. Remuneration Committee Cohort
  b. Focused Risk Review paper

(ii) There was one outstanding action, A21/25 Management of Sickness Absence Ref 2, the follow up of attendance management audits which was anticipated to be complete by the July committee meeting.

(iii) No new audit recommendations had been received since the previous Staff Governance Committee Meeting on 10 March 2026.

The following points were raised in discussion:

(i) Clarity was provided that the outstanding actions against the management of sickness absence would be completed by June, but this would not be reported back to committee until the July meeting.

The Staff Governance Committee:

(1) noted the status of the current audit follow up actions aligned to the Staff Governance Committee and agreed the closure of the complete items.

(2) took assurance on the overdue action and the progress update provided.

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

11. Culture Programme Update

The Staff Governance Committee considered the ‘Culture Programme Update’ presented by Julie Mardon to demonstrate the OPEL scoring dashboard which would be adapted to measure the ongoing work against culture as this is embedded into business as usual.

Key messages in the report and presentation included: -

(i) Since presentation of the work on a Cultural Indicator Score work at the January Committee, this work has progressed using the methodology and lessons learned from our OPEL scoring tool which has been successfully introduced, tested and refined to assess service delivery challenges and support meaningful engagement and decision-making.

(ii) Following the successful implementation of the OPEL scoring tool within the acute site this methodology had been adapted to measure an initial suite of triggers that would identify the correct status assessment which would be combined to produce an overall culture score.

(iii) The Committee was asked to note that this early presentation did not yet reflect a conclusive assessment and will be subject to further organisational engagement with functional experts.

(iv) Several additional data points would be triangulated to be incorporated within the scoring matrix to ensure an accurate culture measurement score was reflected.

The following points were raised in discussion: -

(i) The committee welcomed the in-depth update and noted the benefits of the live presentation to allow for an accurate view of the culture position across the organisation.

(ii) It was emphasised that the value would lie in trends, variation and understanding the underlying causes, rather than individual scores. The methodology was recognised as involving judgement and requiring further validation.

(iii) It was acknowledged that the application of this scoring tool within the culture programme differed from its use within the Emergency Department setting,

recognising that certain elements of the culture work would remain static due to the nature and timescales of the interventions being implemented.

(iv) Confirmation was provided that the OPEL scoring tool would not only provide a score for the organisation as whole but could be broken down further to identify challenging areas and project where focus work would be required. This tool could be built into directorate performance review discussions to ensure teams were taking stewardship of their own data and carrying out targeted work where necessary.

(v) Given the breadth of tools available across the organisation, the importance of triangulation and cohesive working to ensure alignment of approaches and minimise duplication was emphasised.

The Staff Governance Committee:

(1) was content with the intention of implementing OPEL as a measurement tool for culture.

(2) noted that testing and validation of triggers was still to be completed.

(3) noted that consideration should be given to the use of this tool at team level.

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

Action:

- **Present proposals for how the Culture dashboard will be used at Board, directorate and team level, especially alignment with existing processes.** K Reith
- **Provide a further update on validation of indicators and how data reliability will be assured.** K Reith

12. Reduced Working Week Update

The Staff Governance Committee received a ‘Reduced Working Week Update’ presented by Linda McGovern to provide an update and assurances on the implementation and continued oversight of the Reduced Working Week.

Key messages in the report included: -

(i) The reduced working week (RWW) had been implemented on 1st April 2026 and full-time pro rata staff were now working to a 36 hour week.

(ii) An Implementation Group and an Oversight Group was established to monitor progress and ensure updated support and guidance was in place.

(iii) It had been agreed that part time staff could retain their hours if this was their preferred choice. Work was underway to ensure all managers were aware of this agreement and that it was being implemented correctly.

(iv) There were two mailboxes in operation for individuals to contact should they have any queries relating to the RWW.

(v) Due to the submissions for backfill requirement being lower than anticipated work was underway to ensure accuracy in this regard.

The following points were raised in discussion: -

(i) Confirmation was provided that the Area Partnership Forum was assured on the process in place to mitigate any outstanding issues, but concerns were noted on the percentage of backfill being lower than anticipated.

(ii) Conversations were taking place at the senior leadership team meeting to validate the backfill requirements that had been submitted and this was still under review.

The Staff Governance Committee: -

(1) considered that the report provided assurance on the process in place to monitor the implementation of the reduced working week.

13. Workforce Plan

The Staff Governance Committee received an update on the 'Workforce Plan' presented by Mrs Nicola Riddell to provide an update on the development of NHS Forth Valley Workforce Planning governance and infrastructure.

Key messages in the report included: -

(i) The initial workforce plan for 2026/27 was now completed and had been shared with the committee.

(ii) This plan was created based on 6 specific questions that were shared across all staff and Partnership colleagues and aligns with the 5 pillars of workforce planning.

(iii) In order to ensure this plan was an accurate representation of the organisation this work was linked with the safe staffing annual report.

(iv) Ownership of the workforce plan would sit with the Strategic Workforce Programme Board.

The following points were raised in discussion: -

(i) The workforce plan would be maintained at a local level as there was no requirement for a report to be submitted to Scottish Government for approval.

(ii) Committee recognised that this was the beginning stages of extensive work that would be carried out setting the baseline for the future workforce. Given the evolving nature of the workforce and the populations requirements as it continues to grow the detail within the plan creates a positive foundation for moving forward.

(iii) In particular, it was noted that the plan would require to be translated into clear actions and aligned with financial planning, including further work to establish affordability.

(iv) Alignment to the Population Health and Care Strategy and Value Base Health and Care work was an essential part of the process to ensure the full anticipated needs of the future workforce was encapsulated.

(v) To ensure oversight of this work as it progressed and that risks were being mitigated appropriately an action plan would be developed and monitored by the Strategic Workforce Programme Board. An update of the initial next steps and an outline of the expected actions would be shared with the committee through the programme board.

(vi) Requested was the circulation of this document to the Board Members to ensure full visibility whilst outlining the next steps for the organisation.

The Staff Governance Committee: -

(1) was assured on the initial baselines demonstrated within the workforce plan recognising the essential alignment to the Population Health and Carse Strategy and Value Based Health and Care.

(2) agreed that the next steps would be shared with the committee through the Strategic Workforce Planning Group.

Action:

- **Report back to a future meeting of the Committee on progress against next steps, including: development of scenario planning aligned to the Population Health Strategy; and alignment with financial planning (taking account of the wording of the related risk that talks about the need for a costed workforce plan).** K Reith/N Riddell

14. Safe Staffing Annual Report

The Staff Governance Committee received the 'Safe Staffing Annual Report' presented by Professor Karen Goudie to provide an update the Staff Governance Committee that NHS Forth Valley's Year 2 Annual Report under the Health and Care (Staffing) (Scotland) Act 2019 (HCSSA), covering the period April 2025 to March 2026 has been published by the deadline of 30th April.

Key messages in the report included: -

(i) In line with statutory requirements, the report had been submitted following Board approval to the Scottish Government and the Patient Safety Commissioner. It had also been published on the NHS Forth Valley website.

The following points were raised in discussion: -

(i) To provide adequate opportunity for the committee to provide feedback, the reporting cycle for the Safe Staffing Annual Report required to be adjusted due to the submission deadline to Scottish Government.
(ii) Conversations would take place offline to map the review cycle and ensure all necessary committees had oversight prior to publication.

The Staff Governance Committee:
(1) noted the content of the annual report.
(2) would receive clarification on the appropriate route of oversight.

Due to the interrelation of items 15 and 19a, the Chair determined to take these items in conjunction.

15. Speak Up/Whistleblowing Quarterly Activity Report, and
19(a) Whistleblowing annual report

The Staff Governance Committee received the 'Speak Up/Whistleblowing Quarterly Activity Report' and the 'Whistleblowing Annual Report' presented by Professor Karen Goudie which provided an update on Whistleblowing activity during Q4 2026 and outlined the 2025/26 activity across NHS Forth Valley.

Key messages in the report included: -

(i) There had been no activity reported during Q4 and work was underway to create a communications piece reminding staff of the service and encourage them to raise concerns where necessary.
(ii) To date, NHS Forth Valley had received a total of 26 whistleblowing complaints, 10 had been managed under stage 1 and 16 under stage 2. A total of 6 cases relating to NHS Forth Valley had been escalated to INWO.
(iii) The case figures noted for NHS Forth Valley were in line with national figures.
(iv) The Whistleblowing annual report outlined the key performance indicators and NHS Forth Valley's performance against each of these.
(v) NHS Forth Valley were compliant against the national Whistleblowing Standards but the low activity was thought to be in relation to the extensive culture work that had been carried out across the organisation.
(vi) Work in preparation of Speak Up week was underway although a date was yet to be confirmed this was expected to take place around October 2026.

The Staff Governance Committee: -

(1) was assured by the Whistleblowing performance outlined within the report.

(2) endorsed the Whistleblowing Annual Report.

16. Strategic Risk Register

The Staff Governance Committee received an update on the 'Strategic Risk Register' presented by Miss Vicky Webb to provide an update of the position as of May 2026, focusing on the risks aligned to the Staff Governance Committee.

Key messages in the report included: -

(i) During this reporting period, all current strategic risks were reviewed and remained static.

(ii) A focused review of SRR009 Workforce Plans was scheduled for presentation to the committee at the 14 July 2026 meeting and SRR019 Culture & Leadership was scheduled for 17 November 2026.

(iii) All actions had been updated, 5 were completed within this cycle and 8 were ongoing.

The following points were raised in discussion: -

(i) Recognised was the requirement to review the risk descriptors and the detail within the actions to ensure that this information was appropriate and valuable.

(ii) Consideration should be given to the inclusion of detail on the effectiveness of internal controls against the mitigating actions when the above review was taking place.

The Staff Governance Committee:

(1) endorsed the Staff Governance Strategic Risks for the period March-May 2026 for onward reporting to the NHS Forth Valley Board.

(2) was assured on the controls in place recognising the in depth review on the content and descriptors of both these risks was due to be carried out.

17. Health & Safety Quarterly Report

The Staff Governance Committee received the 'Health & Safety Quarterly Report' presented by Mr Camerson Raeburn to provide an update on the Health & Safety issues for NHS Forth Valley during the period of January to March 2026.

Key messages in the report included: -

(i) 90% of adverse events were reported within 3 days of them occurring, equal to Q3 with 78% of adverse events being reviewed within the 9-day target, 10% higher than Q3. Although this was a positive increase the compliance rate was still significantly below the anticipated 90% target.

(ii) Actions had been identified to target poor performing areas but following a review it was evident that the actions did not align to the reported barriers for not achieving the expected target. Discussions between Cameron Raeburn and Fiona Murray had been organised to discuss a target approach to improve compliance across the acute site.

(iii) Internal Audit recently reviewed the adverse event processes identifying nine findings, with four specifically relating to the timeliness and quality of event reviews and a number of actions had been identified in response to the findings.

(iv) Training compliance across the organisation for Manual Handling and Violence & Aggression remained significantly below the anticipated national target. In the current position it was deemed unlikely that this target would be achieved by the deadline of June 2027. Due to continuous low compliance and a high number of areas remaining below the trajectory, the suggestion was put forward for these areas to escalate compliance rates to their local risk register.

The following points were raised in discussion: -

(i) Noted was the Senior Leadership Team's involvement and efforts to support individual areas and create the necessary action plans, but this had not generated the expected outcome. Extensive work had been carried out to improve both FOI and complaint backlogs and it was recognised that a similar methodology could be implemented to drive training compliance.

(ii) Training compliance would become a regular item at the Whole System Leadership Team meetings as all directorates would be in attendance and this would allow space for an appropriate plan moving forward to be created and each area to be held accountable.

(iii) Despite the Health & Safety Committee reaching out to specific areas requesting detail on the resolution to the identified barriers it was recognised that teams were not accepting responsibility to submit the required information.

(iv) There was a request that additional processes being put in place were outlined at the next committee meeting.

(v) Following a query as to why bullying & harassment was not considered an adverse event it was noted this would require to be investigated offline.

The Staff Governance Committee:

(1) noted the report and appendices;

(2) was assured 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

(3) but was not assured regarding performance in key areas of health and safety, in particular training compliance and the effectiveness of actions to address identified issues but noted that processes to drive improvement would be implemented.

Actions:

(i)	**additional processes being implemented to increase compliance would be outlined at the next committee.**	C Raeburn

18. Health & Safety Annual Report

The Staff Governance Committee received the 'Health & Safety Annual Report' to provide an overview of the work carried out during the financial year of 2025/26.

The Staff Governance Committee:

(1) endorsed the Health & Safety Annual Report.

19b. Acute Services Partnership Form Minute 12.02.2026

The Staff Governance Committee **noted** the Acute Services Partnership Forum Minute.

19c. Area Partnership Forum Minute 17.02.2026

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

19d. Health & Safety Committee Minute 10.02.2026

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

20. Any Other Competent Business

Following a question on the Long Service Awards it was confirmed that this was in hand and dates had been arranged for later in the year with invitations expected to be sent in the near future.

Valedictory
The Chair led the Committee in noting Janett Sneddon's retirement from the organisation and thanked her for her positive contributions to the Staff Governance Committee over many years.

21. Matters to Raise at Board and Reflections
The Chair confirmed that the below matters would be raised at Board:

- PDP and Absence Management – Committee were assured on the new actions being implemented and noted the requirement for future updated to include data on this work as well as expected timescales.
- Culture – Recognised the positive start with the caveat that the use of this system for culture would differ from the use of OPEL within acute. Testing would be completed to evaluate the accuracy of the triggers in place. Consideration would be given to how this would be used at department level across the organisation.
- Workforce Plan – Commended the good start for future planning but through should be given to how the preparations required for the organisation and the adequate changes as a result of the Population Health and Care Strategy and the Value Base Health and Care work.
- Health & Safety – Significant concerns were raised against the lack of training compliance.

22. Date of Next Meeting
Tuesday 14 July 2026 at 9:00am, Boardroom, Carseview House, Stirling

NHS Forth Valley

STRATEGIC PLANNING, PERFORMANCE & RESOURCES COMMITTEE
Tuesday 30 June 2026

7.4 Minute of the Strategic Planning, Performance & Resources Committee Meeting held on Tuesday 26 May 2026

For: Assurance

Minute of the Strategic Planning, Performance & Resources Committee Meeting held on Tuesday 26 May 2026 at 9.30am in the Boardroom, Carseview House.

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

In Attendance: Mrs Karen Beveridge (Corporate Services Assistant)
Dr Jennifer Borthwick (Interim Chief Officer, Clackmannanshire & Stirling IJB)
Mrs Elsbeth Campbell (Head of Communications)
Mrs Morag Farquhar (Director of Facilities)
Mr Garry Fraser (Director of Acute Services)
Mr Jack Frawley (Board Secretary)
Professor Karen Goudie (Executive Nurse Director)
Mrs Sarah Hughes-Jones (Head of Information Governance) item 12
Mr Scott Jaffray (Director of Digital)
Ms Kerry Mackenzie (Acting Director of Strategic Planning and Performance)
Ms Louise McCallum (Primary Care Lead) item 11
Ms Jackie McEwan (Corporate Business Manager)
Professor Ross McGuffie (Chief Executive)
Mr Andrew Murray (Medical Director)
Ms Susie Porteous (Interim Director of Psychological Services) item 7
Ms Lorraine Robertson (Chief Nurse) item 7
Mr Scott Urquhart (Director of Finance)
Miss Vicky Webb (Head of Risk Management)
Mrs Gail Woodcock (Chief Officer, Falkirk IJB)

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1. Welcome, Apologies for Absence and Confirmation of Quorum

There were no apologies. The meeting was quorate.

Paul Cameron, Jennifer Champion Tom Cowan and Kevin Reith were not in attendance.

2. Declarations of Interest

There were no declarations of interest.

3. Minute of Strategic Planning, Performance & Resources Committee held on 31 March 2026

The minute of the meeting held on 31 March 2026, subject to previous electronic circulation and committee member approval, was confirmed as an accurate record.

4. Matters Arising from the Minute / Action Log

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

The Committee noted that actions 177, 179, 181, 183, 184, 185 and 186 were marked as complete and would be removed from the Action Log.

Following discussion, it was agreed that item 178 could be closed on the basis of the update provided and that any further clarity regarding capital refurbishment would be made available as and when it emerged.

The Committee sought clarity on the progress required to close action 173. Work was ongoing to determine what the future model could look like which would then be shared back. The wording of the action progress would be updated.

A question was raised on item 181. It was agreed that this would be addressed during item 6(c) National Treatment Centre.

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

5. Chief Executive Update

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

(i) **National Performance and Planning Oversight Group (NPPOG)Paper:** Members were thanked for their input and feedback which had shaped the paper which was being submitted to NPPOG for their consideration around further de-escalation from Stage 2. In terms of Culture there had been an ask to include more information on the HSCPs and development of the OPEL tool. Updates had also been made to include Whistleblowing / Speak-Up, the wide engagement on the Population Health & Care Strategy and involvement of Staff Networks in Board Seminars. For Governance there was information on strengthened Seminars and board administration along with the oversight of the Programme of Work. Information had been included on the work to strengthen integration. Any update from NPPOG's consideration would be brought to the Board when available.

(ii) **HIS Acute Inspection Follow-Up Report:** The HIS Acute Follow-Up Inspection report was scheduled for publication on 23June and would be shared as soon as it was available to the Board. An action plan had been submitted on 25 May. There would be updates provided to the Scottish Government on the work to progress the action plans in place following the inspections of Maternity and Mental Health Services.

(iii) **Meningitis Vaccination Roll Out:** The MenC (Meningococcal C) Vaccine; Vaccination programme was planned to be rolled out to students across the UK. There were two doses required, administered four weeks apart, with a short period before the vaccine became fully effective. Vaccinations were

expected to be delivered in students' home areas rather than where they attend University. While vaccine costs were likely to be covered, workforce costs were expected to be met by the Board. The eligible age range had yet to be confirmed. There was an aim for a consistent rollout across the UK. Work was ongoing in the background, and further details would be shared via a formal briefing once available.

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

Action

(1)	**Circulate a briefing on the MenC Student Vaccination Programme once detail is clear.**	Ross McGuffie

Cllr Fiona Law left the meeting during consideration of the previous item.

6(a). Finance Report

The Strategic Planning, Performance & Resources Committee received the Finance Report presented by Mr Scott Urquhart, which provided assurance on the organisation's financial position, sustainability and key financial risks.

Key messages in the report included:

(i) The draft Annual Accounts for 2025/26 were submitted to the External Auditor on 1 May 2026, and the audit process was proceeding broadly as planned, with good progress across the NHS Board elements. The timing of information received for the Integration Joint Boards (IJBs) accounts had not aligned with the original timetable, which had impacted certain aspects of the consolidation process.

(ii) For 2026/27, a net funding gap of £38.0m was identified through the financial planning process. A programme of cost improvement plans and efficiency initiatives had been developed to address the shortfall, with an aim of achieving a breakeven position. However, the initial review of Month 1 results indicated continuing financial pressure, with a £1.9m overspend reported as at 30 April 2026.

(iii) Targeted communications had been issued to budget managers setting out key priorities for the early part of 2026/27, including the need to secure early savings and maintain tight budgetary control.

(iv) The *Making the Most of our Resources* toolkit – a practical resource providing guidance, prompts and examples to support effective stewardship – had been launched via the staff intranet to support budget managers and leaders in delivering these actions. In addition, a staff wide initiative to generate savings ideas and proposals had been introduced, with positive responses to date.

(v) Further communications were planned over the coming weeks, including whole-system engagement to share examples of effective stewardship and local best practice.

The following points were made in discussion:

(i) A question was asked on the external audit timescale and whether this would be adhered to. Lessons had been learned from the previous year and a lot of work had been undertaken at the planning stage. The additional layer of

checks had been built into the planning for this year with assurance that the audit was on track.

(ii) Information was sought on the national position in relation to overspending Boards. There were a number of Boards in a deficit position with significant challenges. Two Boards had been escalated to Stage 4 of the finance intervention framework. This meant that in those Boards there was support in place from Scottish Government improvement teams. Sub-nationally there was an expectation of collaboration, however, there was no brokerage available for overspending Boards.

(iii) Members asked how concerning it was to have a £1.9m overspend in month one and how the challenges related to Acute Services were being addressed. Although it was a concern, a more balanced view could be taken once the month 3 position was known. £38m of savings were required to be delivered by year-end to achieve breakeven. There had been a lot of work done in Acute which had resulted in a significant improvement in recent years. This was the highest area of budget and workforce. Further adjustments would be made to budgets which could reduce the reported UUSC overspend. There was a clear grasp on the areas of pressure which were being tackled in a staged way.

(iv) A question was asked as to whether the National Prevention Spending Advisory Board provided advice and targets. There was a focus on prevention through the Population Health & Care Strategy. An budget tagging process was underway to identify how much was currently being spent on prevention. A wider group comprising Directors of Finance, Directors of Public Health and Public Health Scotland were considering where the most impactful areas of spend could be made to shift spend long term.

(v) Members sought clarity on the evaluation process in terms of the Financial Stewardship Toolkit. There had been a good response to the Toolkit from staff with a number of staff suggestions received. The Toolkit was being actively promoted through and by the Whole System Leadership Team and its impact would be monitored.

The Strategic Planning, Performance & Resources Committee:

(1) Noted delivery of the 2025/26 financial targets, subject to audit, with progress broadly on track for completion of the 2025/26 annual accounts external audit process in accordance with the required timescales.

(2) Noted the level of financial risk and challenge for 2026/27, with prompt corrective action required during the first quarter to set a path towards financial balance.

(3) Noted an in-depth review of the overall financial position, including initial forecast outturn projections, would be undertaken following receipt of the Quarter 1 financial results in July.

(4) Noted the forward-look items highlighted in the report.

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

6(b). Financial Sustainability Oversight

The Strategic Planning, Performance & Resources Committee received the Financial Sustainability Report presented by Mr Scott Urquhart, which provided assurance on longer-term financial sustainability risks and the effectiveness of mitigating actions.

Key messages in the report included:

(i) Savings of £26.8m had been delivered during 2025/26 against a total target of £38.1m, of which £19.4m were recurring.

(ii) A further £38.0m of savings were required to achieve breakeven in 2026/27. The updated Financial Sustainability Action Plan outlined a portfolio of schemes across six workstreams, aligned to the to the refreshed national "15-point framework" and the Scottish Government's 3% recurring savings requirement.

(iii) The 3% recurring savings target applied to baseline budgets including those delegated to IJBs) and equated to £24.6m in 2026/27. Of this, £18.4m related to the Board, with the remaining £6.2m attributable to IJBs.

The following points were made in discussion:

(i) A key concern was the Resident Doctor Rota Compliance and it was noted that actions had been taken to address this.

(ii) Members sought information on transport arrangements and the role of the third sector. There was a financial pressure in relation to transport, particularly in Renal. There was high spend on non-emergency ambulance costs. Options were being considered as part of the national spend to save initiative to pump prime something which would deliver improvements locally for long term savings. Where possible a collaborative solution was sought taking the chances to maximise opportunities with the third sector.

(iii) A question was asked on sickness absence and the costs related to this. There had been small improvements through a number of actions including investment in psychological services and a new Senior Nuse post focused on sickness absence. There would be a Whole System Leadership Team discussion on what further work could be done to improve the position and target support where it was most needed. There had been a lot of focus on this by the Staff Governance Committee.

(iv) It was stated that it would be helpful to see a trajectory of savings delivery in the report.

(v) Members asked how work had progressed to realign overspending budgets to be more realistic and whether lessons had been learned from the £7m miss in relation to service redesign and reform. The level of savings delivered had not been as planned for. Value Based Health & Care work was at too early a stage for cash releasing savings, the initial projections had been overly ambitious. Going forward projections would be more structured and realistic.

(vi) Sub-national impacts were queried alongside the 15 box-grid descriptors such as productive theatres. Theatre efficiency was a main strand of review and benchmarking nationally. Information on this could be brought in future reports. In terms of sub-national work an SLA tightening process was underway. It was important that the rates charged for mutual aid reflected the actual cost to the treating Board, particularly as Forth Valley had done a lot of work for other Boards.

The Strategic Planning, Performance & Resources Committee:

(1) Noted the contents of the report.

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

6(c). National Treatment Centre Ward Update

The Strategic Planning, Performance & Resources Committee considered a presentation by Mr Scott Urquhart, which provided an update on activity regarding the National Treatment Centre inpatient ward facility, outlined the background, current position, proposed risk position and next steps including review of governance arrangements and decision-making milestones ahead of the next Committee meeting in June 2026.

Key messages included:

(i) A final determination had been expected by end of April 2026 on the building design proposal put forward by the contractor to address fire safety compliance issues. This remained outstanding.

(ii) There continued to be focused engagement and dialogue between key stakeholders including Falkirk Council, Forth Health, Scottish Government and NHS Assure.

(iii) Ongoing fortnightly Programme Oversight Group meetings with Forth Health as the body responsible for managing and delivering the contract, chaired by the NHS Forth Valley SRO continued during April and May 2026.

(iv) If the current option was accepted, by all relevant parties, a detailed workplan would be developed to take forward any required changes to the ward building along with a timetable for completion of the work. If the current option was rejected, the contractor would have to submit options which were likely to have considerable resource and timescale implications beyond the current proposal.

(v) A review of the NTC risk position progressed during April and May 2026, with options presented to the Senior Leadership Team recommending an approach to stratify the NTC risk descriptor across three separate and discrete themes:
- Delivery of the NTC model
- Orthopaedics waiting times delivery
- NTC inpatient ward building delay

The following points were made in discussion:

(i) Clarification of the Board’s role within the NTC, including understanding the background and timeline of events was sought. The SRO provided information and noted that further consideration would take place at the June Board Seminar.

(ii) Discussion on governance arrangements and Board members being assured that the Board was doing all it could. The Chief Executive and Director of Finance were continuing to do everything possible to expedite the process to achieve a solution on the way forward between all relevant stakeholders. It was agreed that the Chair and Chief Executive would have further discussions with the SRO to consider any further actions to expedite the issues.

(iii) Members sought clarity on the risk consideration process. The SRO had worked with the Head of Risk Management to identify the best way to describe, stratify and quantify the risk and mitigation strategies. The building risk was assessed as organisational rather than strategic and clear information would continue to be reported on this.
(iv) There were comments that the stratification of the risk was helpful but that there were reputational elements too. It was important to consider who bore the risk and who was responsible for what. There would be further discussion at the June 2026 Board Seminar on the roles and accountabilities of the key stakeholders
(v) There continued to be media interest in the development of NTCs across Scotland. Communications have sought to explain the current position and highlight that an interim NTC ward is in place in Forth Valley Royal Hospital which is treating a significant number of patients while work continues to agree a solution between all relevant stakeholders.

The Strategic Planning, Performance & Resources Committee:
(1) Noted the status of the National Treatment Centre ward programme.
(2) Noted that the timeline for ward completion and associated Key Stage Assurance Review processes was not confirmed and would require resolution of outstanding compliance issues by all relevant stakeholders as advised by NHS Scotland Assure.
(3) Noted that further information regarding programme risk and governance arrangements would be presented to the SPPRC meeting in June 2026.
(4) Considered that the report provided assurance that appropriate controls were in place as far as possible to manage the identified risks, support the delivery of objectives and where improvements were needed, clear actions had been identified. It was recognised that external issues remained.

Actions:

(1) A clear timeline of events to date and clarity on roles and responsibilities to be provided at the June 2026 Board Seminar.	Scott Urquhart

The Committee adjourned at 10.55am and reconvened at 11.05am with all members present as per the sederunt with the exception of Cllr Law.

Items 7(a) and 7(b) were considered jointly.

7(a). Urgent & Unscheduled Care Performance

The Strategic Planning, Performance & Resources Committee considered a report presented by Mr Garry Fraser, which provided an update on performance in relation to Urgent & Unscheduled Care.

Key messages in the report included:
(i) April 2026 demonstrated continued recovery following peak winter pressures, with improvement across whole-system flow measures. The 4-hour performance improved to 61.3% but remained below the required standard due to sustained high demand, ED capacity constraints and whole-system flow challenges.
(ii) Average length of stay reduced to 6.9 days (meeting the ≤7-day target), acute occupancy improved to 107.3% (though above target), and delayed discharges reduced by 20% from baseline. However, pressure persisted, particularly at the front door, with increased ED attendances and early-day occupancy impacting flow.

(iii) Delivery was supported through established U&UC governance and workstreams (ED flow, FNC, Hospital at Home, Discharge Without Delay, Frailty), with a clear focus on discharge reliability, early flow, workforce stabilisation and improved digital visibility.
(iv) Key constraints remained workforce gaps (particularly in ED), downstream capacity (D2A/step-down), and persistent long-stay patients impacting bed availability.

7(b). Acute Site Emergency Department Staffing

The Strategic Planning, Performance & Resources Committee considered a report presented by Mr Garry Fraser, which highlighted the acute site emergency department staffing and proposals to increase staffing, after receiving a review by CFSD.

Key messages in the report included:
(i) The Emergency Department at Forth Valley Royal Hospital was operating under sustained and increasing pressure due to a significant mismatch between patient demand and available workforce capacity, particularly within Senior Decision Maker (SDM) roles.
(ii) Demand patterns demonstrated:
- Peak activity concentrated between late afternoon and midnight
- Persistent overcrowding extending into overnight periods
- Regular exceedance of safe operational capacity

(iii) The data showed that current staffing levels were insufficient to provide consistent senior clinical decision-making across the full 24-hour period, resulting in; delays to assessment and treatment, compromised flow and overcrowding in the ED, adverse impact on patient safety and experience, workforce fatigue and retention challenges.
(iv) A detailed review of demand, CFSD benchmarking against national standards, acuity of patients attending at ED over 2025/26 period and workforce modelling had identified a clear requirement to expand staffing. The outcome from the evidence was a required mixture of medical staff to meet the demand attending the FVRH site.

The following points were made in discussion:
(i) Members requested that future reports provided clearer assessments on progress with the agreed strategies. It was confirmed that this would be actioned going forward to ensure a consistent focus of reporting.
(ii) A question was asked on an increase in front door presentations despite a number of initiatives already in place and whether this was also seen nationally. There had been a rise through NHS24 nationally who were referring more people to ED. The Scottish Government were looking at the referral process and how it was operating. NHS Tayside re-triaged all NHS24 calls through a consultant. Demand was up everywhere as people got older and had co-morbidities. More general medical patients took longer to work through the system.
(iii) Members asked who attended ED and whether there could be re-direction to the GP Walk-in Centre once operational. It was too early to say in terms of the impact of GP Walk-in Centres but there was an ambition to divert some attendances from ED. Community Frailty Pathways workstream was developing.
(iv) In terms of recruitment to Hospital at Home, a question was asked on whether there was multi-Board competition through concurrent recruitment

and any financial implications. There was a positive feeling around Hospital at Home and that recruitment would proceed successfully. Through slippage in Hospital at Home expenditure, it had been possible to use some of the funding elsewhere, such as to support more care packages.

(v) Members suggested that better communications could be used to direct people to the right place for the right care.

(vi) There were comments that while there had been good progress to reduce the use of contingency beds there was a danger their use became normalised. Other comments highlighted that the use of contingency beds was bad for staff morale and impacted on sickness absence, PDPR compliance and training. There was an ongoing focus to reduce the use of contingency beds. Where the length of stay could be reduced and flow increased there would be less need for contingency beds.

(vii) Following clarification on performance figures, it was confirmed that the data missed out Minor Injuries performance which was why there could be discrepancies in the position members saw reported.

(viii) In discussion on the proposal to recruit staff to ED and an opportunity for Members to get early sight of the proposal, assurance was sought that Phase one of the ED Staffing proposal was fully funded by Scottish Government so there was no ask of the Board this year. However, a report would still be brought to the Board for awareness and endorsement as this could have ongoing revenue implication, if the evaluation of the additional staff demonstrated positive impacts.

(ix) £900k had been provided to test the model and further years would be considered as part of a business case process. Members were assured that it had been made clear to staff that there needed to be an evidenced impact on the four-hour standard performance if additional resource was provided.

(x) Supportive comments were made with end-to-end flow improvements needed. There were also comments about the need to ensure that prevention remained a focus to support older people in communities.

(xi) Variable grades of staff were being sought, and the market would be tested to identify what was available. The Director of Acute had met with physicians and there had been discussion on the need to have 7 day a week discharge.

(xii) Members asked that the evaluation measures of the pilot were strengthened, that there was a clear exit strategy and that the risks were considered and clearly articulated.

(xiii) Following a question on how long it would take to get the staff in place, Committee was advised that the 12-month pilot would run from when staff were in place.

The Strategic Planning, Performance & Resources Committee:

(1) Noted the areas where further improvement actions were required, particularly in relation to workforce, discharge conversion and downstream capacity.

(1) Noted the recommendations of increasing the workforce in ED.

(2) Supported phase one implementation of the increased staff model costing £900k and noted that the proposal to increase ED staffing would be taken to the NHS Board for endorsement.

(3) Noted that the ELT would continue to review the recommendations and workforce plan, monitor the benefits realisation, and report back to SPPRC.

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

Actions:

(1)	**The ED Staffing Report to be considered by the NHS Board on 30 June including further information on evaluation measures, the exit strategy and risks.**	Garry Fraser

Cllr Fiona Law rejoined the meeting during consideration of the previous item.

7(c). Performance Report

The Strategic Planning, Performance & Resources Committee considered a report presented by Ms Kerry Mackenzie, which provided assurance on current organisational performance and enabled scrutiny of key risks and trends. The Area of Focus was Mental Health & Learning Disability, Dr Jennifer Borthwick provided an overview of this area.

Key messages in the report included:

(i) The report provided detailed information, through appendices, on:
- Performance Summary
- Area of Focus Mental Health & Learning Disability
- Performance Report
- Performance Scorecard
- Directorate Assurance Review Summary

(ii) NHS Forth Valley reported performance against a range of non-financial performance metrics. The Performance Report was presented to update the Committee in respect of NHS Forth Valley's performance against a range of national and local measures with information provided to support effective monitoring and management of system-wide performance.

(iii) The overall approach to performance within NHS Forth Valley underlined the principle that performance management was integral to the delivery of quality improvement and core to sound management, governance, and accountability.

(iv) The scorecard provided an 'at a glance' view of measures with work on-going to ensure accuracy of data, and that all the definitions and reporting periods remain appropriate and meaningful. The scorecard was continually reviewed to ensure appropriate revisions or amendments are included in a responsive and timely manner.

The following points were made in discussion:

(i) Members sought an update on the anti-ligature work programme and the risk consideration. There had been lots of work done on the anti-ligature programme. It was recognised that there was a need for clear oversight and this was monitored by SLT. Some of the challenges included the work being multi-partner and having substantial costs associated. The highest risks had been identified and prioritised. The window replacement programme in Ward 3 had commenced.

(ii) A follow up question was asked on how the SPPRC and Board could get assurance on progress. There was reporting to the Clinical Governance Committee and the Health & Safety Committee, but further consideration would be given as to how well sighted the Board was and whether the work should be reported more fully at the Board.

(iii) In relation to the focus on Mental Health and Learning Disabilities and waiting times in mental health, by sex a question was asked on whether there was a breakdown of the data by sex and whether there was any evidence of the impact of menopause being an issue. In response, it was noted that the information could be broken down by sex by an Information Analyst and further consideration would be given to the value add of doing this.

(iv) Members requested a briefing on the work of the ADP in relation to substance misuse. A report was being prepared for the June C&S IJB which could be shared with Members.

(v) Following a question on 12 week waits in Scheduled Care, it was noted that the focus was generally on the 52-week performance as it was a national priority.

The Strategic Planning, Performance & Resources Committee:

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

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

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

Actions:

(1) SPPRC to be provided with clarity on the reporting of the governance oversight for anti-ligature works. Jennifer Borthwick

(2) The June C&S IJB paper on ADP to be shared with SPPRC Members.

8. Population Health Organisation – Delivery & Programme of Work

The Strategic Planning, Performance & Resources Committee considered a report presented by Professor Ross McGuffie, which provided an update on the 2026/27 Programme of Work which set out the key deliverables that would be taken forward in year against the commitments in the NHS Forth Valley Population Health & Care Strategy.

Key messages from the report

(i) The Corporate Objectives 2026/27 were approved by Board in March 2026 and the Executive Team had been developing a corresponding Programme of Work for 2026/27, with the aim of creating clarity on deliverables, roles and responsibilities for the year ahead.

(ii) The aim in 2026/27 was to build on the work commenced in 2025/26 in the creation of a 'delivery organisation', which involved:

- Creating a clear and shared understanding of key deliverables, supported by a well-defined delivery structure
- Assigning specific roles, responsibilities and accountabilities to ensure ownership and efficiency
- Developing robust governance mechanisms to monitor progress, manage risks, and ensure alignment with strategic goals
- Ensuring success was clearly defined and measurable, enabling the organisation to track performance and continuously improve.

(iii) Executive leads were assigned for each area through a delivery structure of nine programme boards each chaired by an Executive Director.
(iv) The themed priorities provided a coherent, system-wide programme of work to deliver the ambitions set out in the Population Health and Care Strategy.
(v) Through a robust programme board structure, clear executive accountability, and strong alignment to partners and governance arrangements, the programme would support:
- Improved population health outcomes
- Reduction in health inequalities
- Sustainable and high-quality health and care services
- Delivery of NHS Forth Valley's corporate objectives

(vi) The phased approach ensured both immediate progress and long-term transformation, with ongoing monitoring and review to inform future strategic direction.

The following points were made in discussion:
(i) Members noted that the governance arrangements for population health needed to be discussed and an agreement reached at the 9 June Board Seminar.
(ii) Further to previous discussion, members commented that a diagram of groups reporting into the Board's governance structure would be useful.
(iii) Members cautioned to not get too focused on the granularity if that meant forgetting the big picture and outcomes.
(iv) As the Strategy covered a 10-year period there needed to be consideration of a diarised annual stocktake to understand progress.
(v) It was noted that the Whole System Leadership Team (WSLT) will consider a new Programme Board structure to bring these elements together, with a view to reporting back into the Board.
(vi) Members supported the approach and were complimentary about how the programme of work provided a comprehensive overview of delivery of objectives.

The Strategic Planning Performance & Resources Committee:
(1) Endorsed the Programme of Work.
(2) Noted that an annual stocktake session would be held with Board Members to review progress against the Population Health & Care Strategy.
(3) Noted the Remuneration Committee would ensure alignment through the 2026/27 Executive and Senior Manager Objective process.
(4) Considered that the report provided 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.

9(a). Digital Plan 2026/27

The Strategic Planning, Performance & Resources Committee considered a report presented by Mr Scott Jaffray, which set out NHS Forth Valley's programme of digital investments to deliver both local service priorities and national digital projects. It continued with the progress made in 2025/26 as well as working to the increasing demand, system interdependencies, and resource pressures. It was noted that Digital would also be a focus at the June Board Seminar.

Key messages from the report:
(i) The Plan set out NHS Forth Valley's Digital portfolio for 2026 / 2027. It detailed all projects set out in the following categories:
- Major Changes
- Core Infrastructure
- Information Services
- Health Records
- Medical Physics

(ii) The Information contained within the Plan had been developed in conjunction with all departments within the Digital Directorate, which included Medical Physics, Information Services and Health Records. As the Quality and Innovation projects had a reliance on digital resource, projects taken on within that directorate were also detailed in the Delivery Plan.
(iii) Consultation work had been undertaken with key clinical areas so as the work captured within the plan reflected the requirements of all Directorates.
(iv) All programmes, projects and deliverables were assessed to ensure they aligned and supported both the local and national strategies.

The following points were made in discussion:
(i) A question was asked on whether lessons were being learned from the rollout of the GP IT system. There had been learning from others before the local rollout of the programme even commenced and now learning was taken as moving from practice to practice. The project governance was strong.
(ii) Following a question on benefits realisation, it was noted that this was built in at the planning stage.
(iii) Requests were made that a better understanding of the implications of eObs, patient safety, multiplicities of systems and a single patient record were considered at the upcoming Board Seminar.
(iv) In terms of resource and a question on whether that was sufficient, there was a limit to what the Directorate could deliver while expectations were only increasing.

The Strategic Planning, Performance & Resources Committee:
(1) Considered the draft Digital Plan 2026/27 and recommended it to the Forth Valley NHS Board for approval.
(2) Considered that the report provided assurance that appropriate controls were in place to manage the identified risks, support the delivery of objectives and where improvements were needed, clear actions had been identified.

Alison Jaap left the meeting prior to consideration of the following item. Cllr Fiona Collie left the meeting during consideration of the following item.

9(b). Digital and eHealth Infrastructure Strategic Risk Review
The Strategic Planning, Performance & Resources Committee considered a report presented by Mr Scott Jaffray and Ms Vicky Webb, which provided an update on the focused risk review of SRR011: Digital and eHealth Infrastructure.

Key messages from the report:
(i) A review of the control environment was presented and an overview of the effectiveness of the controls given. Due to the number of controls RAG rated as red, it was felt that the paper presented limited assurance.

(ii) The risk was currently outwith the Board's appetite for this risk and steps needed to be taken to improve the exposure from the risk. It was likely that the review of the Digital Directorate Review would propose resource and staffing requirements to mitigate this risk.

The following points were made in discussion:
(i) The Short Life Working Group (SLWG) on Risk was in place and having discussion on whether conversations were sharp enough in terms of risk definition, mitigations and controls. Each committee needed to take ownership of its own risks.
(ii) There were comments that the risk definition and bowtie did not link well in that the second theme of staffing did not look like an explosion of the first. There was work ongoing in regard to the Strategic Risks.
(iii) When the Digital Plan report was presented to the Board it was requested that the risk position was explicitly considered.

The Strategic Planning, Performance & Resources Committee:
(1) Endorsed the evaluation of assurance provided for SRR011: Digital & eHealth Infrastructure.
(2) Considered that the report provided assurance that appropriate controls were in place to manage the identified risks, support the delivery of objectives and where improvements were needed, clear actions had been identified.

Action
(1) Report to Board to reflect the discussion and responses from SPPRC consideration including the request to tighten up risk definitions and to make sure all controls and mitigations were directly relevant. — Scott Jaffray

10. Strategic Planning, Performance & Resources Committee – Annual Report
The Strategic Planning, Performance & Resources Committee considered a report presented by Mr Frawley, which provided the draft Annual Report 25/26 for approval.

The following points were made in discussion:
(i) Section 4 of the Annual Report required to be updated to reflect the start dates in-year of Board Members.

The Strategic Planning, Performance & Resources Committee:
(1) Approved the Strategic Planning, Performance & Resources Committee Annual report.
(2) Considered that the report provided assurance that appropriate controls were in place to manage the identified risks, support the delivery of objectives and where improvements were needed, clear actions had been identified.

Action — Jack Frawley
(1) Section 4 to be updated.

11(a). Strategic Risk Register Update – March to May 2026
The Strategic Planning, Performance & Resources Committee considered a report presented by Ms Vicky Webb which provided Committee with an update on the status of the Strategic Risk Register and support assurance that key strategic risks are being appropriately monitored and managed.

Key messages from the report included:
(i) The eight risks aligned to the Strategic Planning, Performance and Resources Committee (SPPRC) had been reviewed for May 2026 and all eight risks had remained static.
(ii) There was a change to the appetite profile of the Board for this reporting period. There were 0% of risks within the Board's appetite, 25% within the Boards tolerance and 75% outwith the Board's appetite and tolerance. This was due to changes in the Risk Management Framework.
(iii) There were no overdue actions to note for the reporting period with 6 actions completed within the reporting period.
(iv) Work was being conducted on the review of the Strategic Risk process based on previous developments points raised at Assurance Committees and the FV NHS Board. Key developments that would be introduced were:
- Action Criticality introduced into reporting.
- Updates to the SRR based on the Risk Management Framework
- Approval process for action extension.

The following points were made in discussion:
(i) Members suggested that the report should explicitly reference delivery within current financial constraints.

The Strategic Planning, Performance & Resources Committee:
(1) Endorsed the Strategic Planning, Performance & Resources Strategic Risks presented in the report.
(2) Considered that the report provided 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.

11(b). SRR018: Primary Care Sustainability Focused Review
The Strategic Planning, Performance & Resources Committee considered a report presented by Ms Louise McCallum which provided an update on the focused risk review of SRR018: Primary Care Sustainability.

Key messages from the report included:
(i) The paper provided an in-depth review of the Primary Care Sustainability Strategic Risk.
(ii) The control environment was presented with an overview of the effectiveness of the controls. Due to the number of controls RAG rated as red, it was felt that the paper presented limited assurance.
(iii) The risk was currently outwith the Board's appetite.
(iv) The introduction of the walk-in centre and the additional funding received from Scottish Government were initiatives which may reduce the risk exposure in time. As these are still new, it was unclear how they would impact on the risk position.

The following points were made in discussion:
(i) It was acknowledged that there are elements out with organisational control and that further consideration should be given to how the risk was articulated.

(ii) It was suggested that, going forward, where risks were influenced by external factors, this should be clearly distinguished from internal risks factors.
(iii) Planning for the GP walk-in model was discussed, with work undertaken alongside local GP practices to understand requirements.
(iv) It was noted that demand was difficult to quantify at this stage; however, ongoing collaboration with clinical leads and GPs would support further assessment and planning.
(v) Sustainability funding via loans was awaited from the Scottish Government. There was discussion on the use of developer contributions in relation to refurbishment of primary care buildings.

The Strategic Planning, Performance & Resources Committee:
(1) Endorsed the evaluation of assurance provided for SRR018: Primary Care Sustainability.
(2) Considered that the report provided 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.

Kirsten Cassells and Stephen McAllister left the meeting during consideration of the previous item.

12. Information Governance
(a) Learning from the FOI Intervention - Update
The Strategic Planning, Performance & Resources Committee considered a report presented by Mrs Sarah Hughes-Jones, which provided an update on the learning and process of sharing this arising from the recent FOI intervention.

Key messages from the report included:
(i) NHS Forth Valley developed and delivered an FOI Improvement Action Plan which achieved all of the requirements set out by the Commissioner. The paper set out the organisational learning which had been gained from the experience of Intervention and was presented to the SLT in February 2026.
(ii) Weekly FOI Position meetings & SLT Reporting was implemented. FOI became the focus for senior leaders through the provision of weekly update reports to SLT. In addition to the SLT report, the Medical Director held weekly meetings with nominated Directorate and Service reps on a Monday morning (in advance of SLT) to review the SLT report.
(iii) The following key lessons were reflected to SLT and were brought to SPPRC for consideration:
- Visibility of the problem
- Curiosity
- The ‘right’ resource
- Communication

The following points were made in discussion:
(i) It was commended that the learning from FOI improvements was being taken and applied to complaints, SAERs, mandatory training and PDPRs. It was noted that the implementation of Healthcare Guardian would give enhanced oversight.

(ii) Discussion also took place on whether there was sufficient assurance that escalation processes when performance is off track, is dynamic enough. This would be considered further by the Chief Executive.

The Strategic Planning, Performance & Resources Committee:

(1) Noted the learning which had been shared around improving FOI performance.

(2) Considered that the report provided 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.

(b) Network & Information Systems Regulations Update

The Strategic Planning, Performance & Resources Committee considered a report presented by Mrs Sarah Hughes-Jones, which provided an update on the 2025/26 Network and Information Systems Regulations progress review and the revised national cyber assurance approach being applied by the Scottish Health Competent Authority.

Key messages from the report

(i) The final NIS Audit Programme 2025/26 Progress Review reported a strong assurance position for NHS Forth Valley. Overall compliance was 93%.

(ii) This reflected substantial work delivered across Cyber, Digital and wider corporate teams, and provided a solid platform as national expectations shifted.

(iii) A separate national assessment of cyber incident readiness had also been completed for NHS Forth Valley. This looked specifically at how prepared the organisation was to manage a significant cyber incident, including detection, escalation, communications, supplier coordination, technical response and exercising. The assessment confirmed there were areas of good practice, while also identifying areas where further improvement was required, particularly around detection consistency, communications and escalation, supplier integration, and testing.

The following points were made in discussion:

(i) Member commended all those who had contributed in achieving the 93% compliance rate and commented on the positive meeting they had attended to discuss the Audit.

The Strategic Planning, Performance & Resources Committee:

(1) Noted the final NIS Audit Programme 2025/26 Progress Review and the overall compliance position of 93%.

(2) Noted the move from PSCRF v2.0 to NCSC CAF v4.0 from April 2026 and the associated national assurance expectations for NHS Forth Valley.

(3) Noted the key next steps and planned actions in relation to CAF gap analysis, Cyber Action Plan refresh, privileged user management, BC/DR testing and supply chain assurance.

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

13. Internal Audit Actions Follow Up

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

Key messages from the report included:

(i) The one remaining action aligned to the Strategic Planning, Performance & Resources Committee was due for completion throughout 2026 with monitoring of progress through the SPPRC and the Audit and Risk Committee.

(ii) Five actions had been closed since the last meeting of the Committee.

The Strategic Planning, Performance & Resources Committee:

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

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

14. Emergency Planning & Resilience Group Minute

The Strategic Planning, Performance & Resources Committee received the 'Emergency Planning & Resilience Group Minute' of the meeting held on 26 March 2026.

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

15. Strategic Planning, Performance & Resources Committee Planner

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

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

16. Any Other Competent Business - Valedictory

The Chair led the Committee in expressing thanks to Gail Woodcock who was leaving the post of Chief Officer Falkirk IJB. The Chair thanked Gail for her dedication and contribution over many years of service and wished her well in her new role.

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

There were no matters to highlight to the NHS Forth Valley Board.

18. Date and Time of Next Meeting

Tuesday 30 June 2026 at 9:30am, in the Boardroom, Carseview House.

The Chair closed the meeting at 1.40pm.

NHS Forth Valley

Minute of the **Area Clinical Forum** meeting held on 15 January 2026 at 6.15 pm via MS Teams.

Present: Kirstin Cassells (Chair), Andrew Baird, Fiona Struthers, Gillian Lennox, Lucie Risk, Marissa Parker, Oliver Harding

In attendance: Rachel Tardito - Equality, Diversity and Wellbeing Lead (for Item 6.1)

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1. Apologies for Absence/Confirmation of Quorum

The Chair welcomed everyone to the meeting and apologies for absence were noted on behalf of Liz Kilgour.

2. Declaration(s) of Interest(s)

No declarations of interest were made by any members.

3. Draft minute of Area Clinical Forum meeting held 13 November 2025

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

4. Action Log

1. **Reimbursement for Professional Committees**: Kirstin Cassells reported ongoing difficulty benchmarking reimbursement fees for attending professional committees across boards, with limited responses from other boards. The next step is to write to Jillian and Scott for a final attempt to gather information, and if unsuccessful, request a local review of fees.
2. **Workforce Development**: This remained a potential future agenda item to monitor developments in workforce planning.]
3. **Future documents for Forum:** The financial plan update was postponed as Scott was unable to attend; it will be picked up at the next meeting.
4. **Hospital Doctors sub-Group**: Oliver confirmed plans to reform the Area Medical Committee, proposing a timeframe to complete this by the end of March.
5. **ACF 2026 dates:** Dates for future ACF meetings have been issued and item could be marked as complete

5. Matters Arising

There were no matters arising.

6. FOR DISCUSSION

6.1 Anti-Racism Plan

The Committee received a presentation from Rachel Tardito, Equality, Diversity and Wellbeing Lead, on the NHS Forth Valley Anti-Racism Plan. Rachel outlined that the plan had been developed in response to a Directive from the Scottish Government requiring all

territorial boards to have an anti-racism plan in place. NHS Forth Valley had already been considering such a plan, and it was subsequently established as one of the Board's equality objectives within the Equality and Inclusion Strategic Framework. The plan was intended to be a living document, not a static or "tick box" exercise, and aims to drive meaningful change for both staff and patients.

The Anti-Racism Plan covered the period 2026–2029 and set out a series of actions, with a strong emphasis on ongoing engagement and collaborative working with workforce, patient service users, third sector partners, and community groups. Rachel highlighted that the plan had undergone several iterations, incorporating feedback from a wide range of stakeholders, and had been through the necessary governance routes. The plan was scheduled for final Board approval at the end of January, with a soft launch to follow, and a formal launch planned for March.

A key focus of the plan is the use of data and evidence to inform actions, recognising this was an area for development. The plan included a delivery tool that would outline key actions for each year, as well as a communications and engagement strategy to ensure the plan was widely disseminated and embedded. Rachel emphasised the importance of creating safe spaces for staff to share experiences and raise concerns and noted that the plan would be supported by senior leadership buy-in and appropriate resourcing.

During discussion, members commended the comprehensive nature of the plan and the extensive engagement undertaken. It was noted that the inclusion of clear priority actions and measurement criteria in the appendices would support effective implementation and monitoring. The Committee also discussed the importance of workforce development, education, and the creation of psychologically safe environments, particularly in the current societal context.

In response to a query, Rachel confirmed that the plan was intended to be inclusive of contractors and community partners, with opportunities for joint actions and shared education initiatives. The Committee agreed that ongoing feedback would be valuable, particularly as the delivery tool and communications plan are rolled out.

6.2 ACF requirements from Board

The Forum considered the requirements of the Area Clinical Forum (ACF) from the Board. This discussion followed previous engagement with the Board Chair and Chief Executive, during which it was agreed that the ACF should reflect on any specific needs or requests it may have of the Board going forward.

Members noted that the relationship with the Board had improved and that both the Chair and Chief Executive had expressed willingness to attend ACF meetings or engage with advisory committees as required.

It was agreed that, at present, there were no additional specific requirements to escalate to the Board, but it was recognised that the situation should remain under review.

The Chair reminded colleagues that if any issues arose within their advisory committees that would benefit from Board input or support, these should be brought forward for consideration.
It was also agreed that the current arrangement, whereby Board representatives attend as needed and information is shared with advisory committees, should continue, with the option to revisit this approach should circumstances change.

6.3 Board Agenda items

The Area Clinical Forum reviewed the forthcoming Board agenda and noted several key items for discussion. The Anti-Racism Plan was identified as a significant agenda item, with members having received a comprehensive presentation from Rachel Tardito. Members acknowledged the importance of the plan's approval and subsequent launch.

The Robotic Surgery Business Case was also discussed, noting NHS Forth Valley does not currently offer robotic surgery, and concerns were raised regarding the Board's position relative to other Boards, potential recruitment challenges, and the efficiency of surgical procedures.

Recent unannounced inspections in Mental Health and Maternity services were outlined, recognising that action plans were pending and that these inspections may result in actions for multiple professional groups.

7. FOR APPROVAL

7.1 Flash Report Layout

The Area Clinical Forum considered the proposed Flash Report template for advisory committee updates. Members agreed that the template was generally fit for purpose but suggested several amendments to enhance its utility.

- Add a section for "Risks and Issues" or "Key Achievements and Challenges" to highlight barriers and escalation points.
- Increase space for narrative updates, especially for committees reporting on multiple professions.
- Condense "Next Meeting Date" and "Agenda/Minutes" sections to allow more room for substantive content.
- Separate "Key Achievements" and "Actions" into distinct boxes and consider reordering for logical flow.

The template would be revised and circulated for piloting at the next meeting. **Action: Admin**

8. FOR NOTING

8.1 ToR check in prior to April deadline

The Area Clinical Forum undertook a review of progress regarding the update of Terms of Reference (ToR) for each advisory group, in line with the agreed April deadline. Members provided verbal updates on the status of their respective ToRs.

It was noted that several groups had completed their reviews and submitted revised documents to the Board Secretary, with only minor amendments outstanding in some cases. Other groups reported that their ToRs were in draft form, pending final discussion and ratification at upcoming committee meetings.

The importance of aligning ToRs with the current Board governance template was reiterated, and members were reminded to ensure that frequency of meetings and election processes for chairs and deputies were clearly specified. The Committee agreed to continue monitoring progress, with all groups expected to finalise and submit their updated ToRs in advance of the April deadline.

8.2 Area Pharmaceutical Committee - 06/08/25 Ratified & 01/10/25 Draft

Kirstin Cassells provided an update on the Area Pharmaceutical Committee (APC) minutes. She reported that the Committee met in December, during which elections were held and she was re-elected as Chair for a further three-year term. Note was made of the Committee's plans to introduce leadership and spotlight sessions, noting that the Director of Pharmacy had presented an overview of the pharmacy vision, with further presentations by associate directors planned for future meetings.

Ongoing pharmacy projects were noted, including Sunday pharmacy openings over the festive period and the associated learnings. Kirstin also advised that the Committee was exploring ways to broaden participation and development opportunities and noted the re-establishment of the APC Chairs group across boards, with the first meeting scheduled for March.

It was confirmed that the APC's Terms of Reference have been updated, reviewed by the Board Secretary and ratified by the Committee.

8.3 Area Optical Committee Flash Report

Andrew Baird reported that the Area Optical Committee's Terms of Reference have been updated and are pending final approval, with minor changes including reduced meeting frequency and updated terminology. He raised concerns about low attendance at meetings and highlighted the imminent rollout of new specialist supplementary services, which will allow referrals to prescribing optometrists and aim to reduce hospital visits. Andrew noted delays in launching the community glaucoma service due to data upload issues, with a government-mandated start date approaching. He also reported ongoing challenges in securing clinical portal access for optometrists, which was increasingly important as prescribing expands. Finally, he mentioned the upcoming one-stop cataract service, which was expected to boost meeting attendance through generating significant interest and increased engagement.

8.4 Allied Health Professionals Flash Report

The Forum received an update from Fiona Struthers, who noted The Allied Health Professionals (AHP) Clinical Advisory Group had submitted its Terms of Reference to Jack for review. Only minor formatting amendments have been requested, and the document was expected to be finalized shortly.

It was agreed that the group will meet four times per year, taking into account current capacity constraints. The next meeting is scheduled for March.

There have been no recent meetings of the AHP Clinical Advisory Group since the last Area Clinical Forum and no items were escalated from the AHP Leadership Group at the most recent session.

8.5 Psychology Advisory Committee - 20/11/25

Lucie Risk provided the Forum with an update and noted The Psychology Advisory Committee had agreed to move to bimonthly remote meetings to improve attendance and would finalise its updated Terms of Reference.

The Committee had raised serious concerns about ongoing vacancies in Children and Young People's Psychological Services, noting that most posts have been on hold for

eighteen months due to funding issues. This had led to a significant drop in referral-to-treatment performance, from 98% to 61%, and is impacting service delivery. The matter has been escalated for further workforce planning and action.

8.6 Area Nursing & Midwifery Advisory Committee

An update on the The Area Nursing & Midwifery Advisory Committee was provided by Marissa Parker. She reported increased membership and engagement, with ongoing efforts to expand participation, especially among healthcare support workers. The Committee was developing a web page for staff support and will continue remote meetings to maintain inclusivity. The Terms of Reference were under review, with plans to retain executive appointment for Chair and introduce elected Deputy Chairs. Upcoming events and board engagement were noted, with no urgent items escalated.

Area Dental Committee
An update was provided by Gillian Lennox. New secretarial support has been secured, improving committee administration, and work was underway to update the Terms of Reference. Recruitment remained a key challenge, with a Forth Valley Dental Job Shop planned to attract dentists from outside the area. A major national development was highlighted: dentistry was moving from a financial prior-approval system to a clinical governance model. This change is expected to reduce delays to patient care, particularly for Public Dental Service and sedation services. The new approach will introduce tiered oversight, with closer scrutiny for dentists new to Scotland. Overall, the update was framed as positive and likely to improve both patient experience and service delivery.

8.7 Healthcare Sciences

No update was provided to the meeting.

8.8 Area Medical Committee

Earlier in the meeting, Oliver had provided an update regarding the Area Medical Committee. He reported that the Committee had not convened for some time and that he was currently undertaking efforts to reform and re-establish its activities. As part of these efforts, there were plans to create a hospital doctor subgroup, with a proposed target to make progress by the end of the current financial year.

9. AOCB

9.1 Items for escalation to Chair/Chief Executive

The Forum identified several items for escalation to the Chair and Chief Executive. This included concerns around long-standing psychology vacancies impacting children and young people's service. Also, there was an identified need for clarity and transparency regarding the allocation of funding for the reduced working week.

Forthcoming changes in Dental Service Regulations were highlighted, noting this involved a transition from a financial model to a clinical governance model for prior approval of treatments. The change was anticipated to improve patient care and reduce delays and it was agreed the Executive Team should be notified of this positive development.

There were no other AOCB items raised.

NHS Forth Valley

Minute of the **Area Clinical Forum** meeting held on 23 April 2026 at 6.15 pm via MS Teams.

Present: Kirstin Cassells (Chair), Oliver Harding, Andrew Baird, Fiona Struthers, Emma Butchard-MacDonald

In Attendance: Sarah Smith (minute)

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1. Apologies for Absence/Confirmation of Quorum

The Chair welcomed everyone to the meeting and apologies for absence were noted from Liz Kilgour, Gillian Lennox and Lucie Risk. It was confirmed the meeting was quorate.

2. Declaration(s) of Interest(s)

No declarations of interest were made by any members.

3. Draft minute of Area Clinical Forum meeting held 15 January 2026

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

4. Action Log

1. **Professional Committee Reimbursement review** – progress was continuing with a proposal in development pending finance approval.
2. **Workforce Development** – ongoing work linked to strategic developments.
3. **Sustainability/AHP engagement action** – this item was complete.]
4. **Programme Board Structure (Intranet)** – It was agreed Admin would follow up on availability.

5. Matters Arising

There were no matters arising.

6. FOR DISCUSSION

6.1 Finance Update

This item had been deferred to the next meeting.

6.2 Fees

The Area Clinical Forum received an update around the ongoing review of reimbursement arrangements for professional committees, specifically for members who were independent contractors.

The Chair advised that discussions had taken place with finance colleagues, including Jillian Thomson, to review the current reimbursement rate, which was applied as a standard hourly fee.

It was noted that the existing rate had not been reviewed for a considerable period and concerns had been raised that it may no longer be reflective of current costs, including locum cover required to support attendance at meetings.

A proposal was being] developed to address this, with consideration given to applying an annual uplift to the existing fee in line with Board-wide percentage increases applied in other areas. Benchmarking with other Boards had been attempted; however, it was acknowledged that there was no consistent national approach to reimbursement arrangements.

As at the time of the meeting, a formal paper outlining the proposed approach had not yet been finalised. This was due to the requirement for review and approval by the Director of Finance prior to submission to the Forum.

It was agreed that, once finalised, the paper would either be circulated to members for comment outside of the meeting or presented at a future meeting for consideration.

6.3 Board Agenda items

The Committee reviewed the forthcoming NHS Board agenda and considered whether any items required specific commentary or input from the Area Clinical Forum.

Members were advised that the agenda included a range of standing items and reports, including strategic risk, governance updates, quality assurance, and service spotlight reports. No specific concerns were raised in relation to the content.

Discussion focused on the broader topic of risk management, with the Chair highlighting ongoing work within the organisation to strengthen approaches to risk identification, scoring, and governance mapping. Members reflected that, while risk management formed part of core roles for many, the complexity of organisational and corporate risk structures can make this area challenging to navigate. It was proposed that Vicky Webb, Head of Risk Management could be invited to a future meeting to present on risk management arrangements and recent developments. **Action: Chair/Admin**

The Committee also noted that work was underway to support governance mapping for the Board Assurance Framework. A Microsoft Form had been developed to capture information on committee structures and reporting relationships. It was agreed this would be circulated to members. **Action: Chair**

6.4 Update on Area Medical Committee

An update was provided on proposals to revise the structure for medical representation within the Area Clinical Forum.

It was noted that the current Area Medical Committee arrangements have been in abeyance for a period, primarily due to challenges in achieving quorum and sustaining engagement. As a result, alternative structural arrangements were being explored.

The proposed model would involve the GP Sub-Committee feeding directly into the Area Clinical Forum, alongside the establishment of a separate group representing hospital medical staff. This approach was considered to better reflect the size and complexity of the medical workforce while ensuring appropriate representation.

Work had been undertaken in collaboration with Corporate Services to develop draft terms of reference and supporting documentation. It was agreed that a period of consultation with

medical staff across Forth Valley would be required to inform the development of the revised structure.

Options for consultation were discussed, including the use of a Microsoft Form to gather structured feedback, with a proposed response period of approximately two weeks.

Discussion also highlighted the potential benefit of enhanced GP representation within ACF, particularly in supporting communication and alignment between community and secondary care services.

7. FOR APPROVAL

7.1 Amended Flash Report Layout

The revised Flash Report template was presented for approval. The template was designed to provide a concise and consistent summary of key achievements, risks, and actions across advisory groups.

Members confirmed that they were content with the proposed format, and the template was formally approved.

7.2 ACF Annual Report 2025/26

The Draft Annual Report for 2025/26 was presented to the Committee.

The report summarised the role and activity of the Area Clinical Forum over the preceding year, including key issues considered, progress overseen, and areas of concern. It was confirmed that the report followed the standard Board template.

Members were broadly content with the content of the report; however, it was agreed that additional reference should be included to the work on culture change and compassionate leadership, reflecting its significance within the organisation. **Action: Admin**

8. FOR NOTING

8.1 Board Agenda 28/04/26

This had been covered under Item 6.3

8.2 Area Pharmaceutical Committee 06/08/25 & 01/10/25

The Area Pharmaceutical Committee reported progress in developing a new pharmacy vision, supported by staff engagement activity and ongoing communication with teams.

8.3 Area Optical Committee Flash Report

The Area Optical Committee provided a positive update on the implementation of a new cataract referral pathway and the rollout of community glaucoma services. These developments were noted as improving patient pathways, reducing hospital attendances, and enhancing access to care.

8.4 Allied Health Professionals Flash Report

The Allied Health Professional Advisory Group highlighted a range of workforce pressures, including safe staffing concerns and challenges associated with maternity leave backfill.

Alongside these risks, positive developments were noted, including student placement expansion and strengthened links with the University of Stirling.

Concern was raised regarding the potential withdrawal of Speech and Language Therapy (SLT) input within the Bairns Hoose model, which had been introduced as a test of change.

It was noted that children accessing the service often presented with complex communication needs and removal of SLT support was considered to present a clinical risk to this vulnerable group.

The issue had been escalated through appropriate channels, with further consideration required as to whether it should also be raised for wider organisational awareness.

The Chair advised that, subject to confirmation from the relevant service lead, the issue could be raised for awareness with senior leadership, not as a request for direct intervention but to ensure visibility of the potential risk. **Action: Chair**

8.5 Psychology Advisory Committee

The Psychology Advisory Committee reported no significant issues for escalation, although administrative support challenges were noted following recent changes.

8.6 Area Nursing & Midwifery Advisory Committee
8.7 Healthcare Sciences
8.8 Area Dental Committee

No updates or discussion were presented at this meeting.

9. AOCB

9.1 Items for escalation to Chair/Chief Executive

The Committee identified the following matters for escalation or awareness:

- Potential clinical risk associated with proposed changes to Speech and Language Therapy provision within the Bairns Unit, subject to further clarification.
- Ongoing lack of access to clinical portal systems for optometry, presenting a risk to safe and effective delivery of enhanced clinical services.

NHS Forth Valley

Item 7.6 Minute of the Area Partnership Forum meeting held on Tuesday 14 April 2026 at 2 pm, via MS Teams.

Present:
Kevin Reith, Director of People (Chair)
Karren Morrison (Joint Chair)
Emma Small, RCN
Janet Sneddon, RCM
Jenny McCusker, Head of Organisational Development
Jennifer Borthwick, Interim Chief Officer, Falkirk HSCP
Karen Goudie, Executive Nurse Director
Laura Byrne, Director o]f Pharmacy
Linda Robertson, HR Manager Staff Governance
Lynsey Walker, British Dietetics Association
Michael Brown, Head of Workforce and Resourcing
Morag Farquhar, Director of Facilities
Nicholas Hill, GMB

In Attendance:
Jillian Thomson, Deputy Director of Finance (for Scott Urquhart)
Claire Champman, Home First Lead, Falkirk HSCP
Caroline Doherty, Head of Community Services, Falkirk HSCP
David Watson, Director of Nursing, Corporate & Acute
Kerry Mackenzie
Sarah Smith, Corporate Services (Note)

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1. Apologies for Absence/Confirmation of Quorum

Apologies for absence were noted on behalf of: Greig Kelbie, Scott Urquhart, Elaine Macdonald, Garry Fraser, Karen Leonard, Kevin Bye, Pamela Bowman, Tom Cowan, Linda McGovern.

2. Declaration(s) of Interest(s)

There were no declarations of interest made.

3. Draft minute of meeting held on 17 February 2026

The note of the meeting held on 17 February 2026 was approved as an accurate record.

4. Matters arising

There were no matters arising.

5. Action Log

The action log was reviewed and would be updated to reflect discussions.

Action 63 – Partnership working intranet page
- Linda Robertson and Karren Morrison to review and finalise required amendments, with a further update to be progressed to enable launch.

Action 73 – Absence management reporting
- A workplan will be developed to ensure regular, scheduled updates to APF rather than ad hoc reporting.
- Linda Robertson and Admin to develop a reporting schedule to improve visibility and forward planning.

Action 85 – Temperature issues (FVRH / mental health unit)

- A cost proposal (~£50k+) is under review; clarification is being sought on whether the Board should fund this. Agreed to prioritise both short-term mitigations and longer-term solution, with additional discussion required on staff communications.

Action 90a – Job evaluation (health records posts)

- Initial work ongoing; limited cases have reached pre-panel stage. Agreed to gather further information and arrange follow-up discussion with relevant managers, with a date to be set for progress reporting.

Action 95 - Workforce Policies (Phase 3)

- Policies largely complete and available online; supporting materials (e.g. PowerPoint) being finalised. Aim to close this action at next APF meeting once dissemination is complete.

Action 97 Circulars

- To be reissued and action complete.

During discussion, the Forum emphasised the need for timely updates, clearer timelines, and proactive handling of operational risks before the next meeting.

6. Items for approval

6.1 Interim Care Team Proposal

The Area Partnership Forum considered a paper 'Interim Care Team Proposal' presented by Caroline Doherty Head of Community Services and Claire Chapman, Home First Lead, Falkirk HSCP.

The paper outlined a proposal to withdraw the Interim Care Team, noting this had been established during COVID-19 as a short-term bridging service. The review found the service was now low volume (c.50 hours per week) with a high cost compared to other provision and presented governance risks as a non-regulated service. It was noted that improved care at home capacity and discharge pathways could meet demand. The proposal highlighted potential savings of approximately £538k over two years and confirmed that 13 staff would be subject to redeployment.

During discussion, members sought assurance on the robustness of consultation and learning from previous Ombudsman findings. It was confirmed that staff engagement had included surveys, briefings and one-to-one discussions, although patient engagement was more limited due to the short-term nature of the service. Concerns were raised regarding workforce implications, particularly availability of suitable roles and whether posts could be ring-fenced. It was noted that HR and trade unions were engaged, and that system-wide vacancies -particularly for healthcare support workers - should support redeployment.

Members emphasised the need for clear communication and support for staff throughout the change process. It was also noted that final approval would sit with the Integration Joint Board, providing additional time to refine workforce and communication arrangements.

The Forum acknowledged the review findings and supported the direction of travel, subject to governance approval. A minor amendment was requested within the paper to clarify that the service related to Falkirk residents only. The need for continued focus on staff support and communication was reinforced as the proposal progressed.

6.2 Interim Discharge Service

The Area Partnership Forum considered a paper and presentation on a proposed 'Interim Discharge Service', led by Caroline Doherty, Head of Community Services and Claire Champman, Home First Lead, Falkirk HSCP.

The paper described a strategic model intended to address fragmented discharge arrangements across Forth Valley and to improve patient flow, reduce delayed discharges and support alignment with Home First and discharge without delay principles.
The proposed model involved a coordinated multidisciplinary discharge planning service, hosted by Falkirk Health and Social Care Partnership and operating across all partnership areas, with a single

point of contact, greater consistency of approach and clearer pathways through admission to discharge. It was noted that further work was required to develop the detailed service design, workforce model, financial position and governance arrangements.

During discussion, members supported the strategic direction of travel but raised significant concerns regarding the lack of detail on workforce implications and the cumulative impact of repeated service redesign on staff. Members emphasised the need for greater clarity on the impact on existing teams, how change would be managed, and how benefits would be demonstrated. It was noted that previous service changes had affected staff, and members stressed that the proposal should not proceed without clear evidence of improvement and appropriate consideration of staff impact.

Members also raised concerns regarding governance, accountability and operational complexity across the four organisations. It was noted that further development was required to clarify governance arrangements, delegated responsibilities and accountability for quality, safety and performance. Assurance was sought that the proposed pathway model would not create additional silos or complexity. Members further emphasised the need for meaningful engagement with service users, carers and staff, including learning from lived experience.

However, assurance was provided to the Forum, noting the paper represented a strategic vision, with further work to be undertaken to develop the detailed workforce, financial and operational model. It was also confirmed that engagement would continue with staff, trade unions and service users, and that a more detailed proposal, including implementation planning and performance measures, would be brought back to a future APF.

7. Better Workforce
7.1 Corporate Governance Directorate Structure

The Area Partnership Forum received a paper ‘Corporate Governance Directorate Structure, presented by Kerry Mackenzie, Acting Director of Strategic Planning and Performance.

The paper set out a proposal to integrate the Corporate Governance Directorate with Forth Valley Quality, reflecting increasing alignment between the two functions through programmes such as Value-Based Health and Care and the Population Health and Care Strategy. It was noted that formal integration would strengthen collaborative working and strategic alignment. The proposal did not involve any change to functions, terms and conditions, with the exception of a minor line management adjustment. Engagement with senior teams and wider staff had been positive, highlighting the benefits of closer working and shared purpose.

During discussion, members welcomed assurance that there would be no substantive impact on staff roles and emphasised the importance of ongoing communication to provide clarity and reassurance. The need to maintain clear links to clinical governance oversight was highlighted, with confirmation that appropriate executive oversight and matrix working arrangements would continue.

The Forum supported the proposal, recognising the rationale and benefits of integration. It was noted that continued engagement with staff would be essential as implementation progressed to address any emerging concerns and ensure staff remained informed and supported.

7.2 Reduced Working Week

The Area Partnership Forum received a paper on the ‘Reduced Working Week’ update on the implementation of the Reduced Working Week, presented by Michael Brown, Head of Workforce and HR Resourcing, with financial input from Jillian Thomson, Deputy Director of Finance.
The report confirmed that revised arrangements had gone live from 30 March and that oversight and implementation structures remained in place to provide assurance, respond to operational issues and support ongoing communication. The paper outlined system readiness, supporting guidance, dedicated inboxes for queries, and ongoing work on backfill, recruitment and service validation.
During discussion, members acknowledged the progress made since earlier meetings but raised significant concerns regarding the consistency of communication and understanding of the

arrangements across services. In particular, concerns were raised around staff awareness of the ability to request retention of part-time hours, consistency in how managers were applying guidance, and lack of clarity regarding the interaction with flexible working arrangements. Members observed that confusion remained among both staff and managers and emphasised the need for further, clearer communication, which it was agreed would be progressed.

Concern was also expressed regarding the current assessment of backfill requirements, with members questioning whether submitted figures adequately reflected operational need. It was noted that assumptions had not consistently taken account of part-time staff retaining hours, and members emphasised the importance of reconciling this position to avoid double counting and ensure recruitment decisions were based on an accurate position. Members stated that retention of part-time hours should be prioritised within existing establishments before progressing to recruitment, and that further validation of workforce requirements would be undertaken.

Further discussion focused on rostering arrangements, with members seeking clarity on the use of roster periods beyond the four-week standard and the rationale for variation in some clinical areas. Members highlighted the need for a clear audit trail where deviations were required for clinical safety reasons. In response, it was confirmed that additional communications would be issued regarding part-time retention, a centralised data collection exercise would be implemented, and a consolidated record of Reduced Working Week implementation across services, including rationale for any variation, would be developed and reported back through the oversight group and APF.

7.3 In person induction

The Area Partnership Forum received a paper outlining 'In Person Induction' presented by Jenny McCusker, Head of Organisational Development.

The paper proposed the introduction of a pilot in-person induction programme to improve the experience of new staff joining the organisation. The proposal was informed by feedback from the culture programme and evaluation of recent new starters, which indicated that the current induction process was not consistently positive. The proposed model involved a monthly welcome event at the Forth Valley Learning Centre, designed to provide a structured introduction to the organisation, promote values and behaviours, and support early connections across teams. The pilot would be evaluated over a 12-month period, with feedback used to inform further development.

During discussion, members were supportive of the proposal, recognising the benefits of a more consistent and welcoming induction experience, including opportunities for staff to build connections and engage with senior leaders. It was emphasised that senior leaders should maintain a visible presence at these events to reinforce organisational commitment. It was also highlighted that the induction content should reflect a whole-system approach, and it was suggested that information on Health and Social Care Partnerships should be incorporated. This was accepted and agreed to be included in the programme design.

The Forum supported the pilot approach and noted that engagement with staff and partners had been positive to date. It was agreed that the programme would be progressed and refined based on feedback, with updates to be brought back to a future APF meeting to demonstrate impact and inform further development.

8. Better Value
8.1 Finance Report

The Area Partnership Forum received a Finance Report presented by Jillian Thomson, Deputy Director of Finance.

The paper provided an update on the Board's financial position, based on the Month 11 report, indicating a small in-year overspend but a forecast breakeven position for year end. This position was sustained despite ongoing financial pressures, particularly within acute services, including staffing costs, prescribing, drugs and devices, and service level agreements.

It was noted that there had been positive progress in delivering savings, particularly in nurse bank and agency usage and prescribing efficiencies, although some areas remained behind plan, including estates and facilities. Recurring savings performance had improved compared to the previous year.

The discussion was limited, with members acknowledging the update and the overall breakeven position, noting both the ongoing financial pressures and the positive progress made in delivering savings.

8.2 15 Box Grid

The Area Partnership Forum received a paper outlining the refreshed Scottish Government 15 Box Grid, presented by Jillian Thomson, Deputy Director of Finance.

The 15 Box Grid set out priority areas for efficiency, productivity and savings, with ongoing quarterly reporting requirements. It was noted that a significant proportion of the Board's savings plan aligned to these workstreams.

Members recognised that the Grid reflected national priorities and that some progress had already been made against previous actions. It was suggested that stronger communication to staff would be beneficial to increase awareness of the workstreams and the progress achieved. However, it was also emphasised that any communication should be carefully managed to avoid creating concern, particularly where areas such as administrative functions were referenced.

It was therefore agreed that consideration should be given to how the 15 Box Grid could be communicated in a clear and balanced way, ensuring transparency while providing appropriate context for staff.

8.3 Sub National West Plan

The Area Partnership Forum received an update on the Sub-National West Plan led by Kevin Reith, Director of People.

The paper outlined the requirement for NHS Boards to participate in regional collaborative planning in response to ministerial direction, and referred to a number of specified priority areas, including elective care, urgent care, digital services and aligned financial planning. It was noted that the work remained at an early stage, had been developed within a compressed timescale, and would continue to evolve as further detail was developed. NHS Forth Valley had been aligned to the West region for the purposes of this work.

During discussion, staff-side representatives expressed significant concern regarding the lack of meaningful partnership engagement at national level in the development of the proposals. Members advised that the national position remained unresolved and that relationships between staff side, government and employers had deteriorated considerably in relation to this work. Concern was expressed that, unless these issues were addressed, there was a risk that unresolved national disagreement could translate into local tensions and disputes as the work progressed. It was made clear that, while the item was presented for noting, this should not be interpreted as endorsement of the approach taken to date.

Members also highlighted concerns regarding the absence of engagement with Integration Joint Boards and chief officers, particularly given that some of the services potentially affected by sub-national planning were delegated through partnership arrangements. It was noted that failure to involve these partners could create governance, accountability and implementation risks, and that wider partnership structures required to be recognised if planning was to be effective. In response, it was reaffirmed that local partnership working would continue to be protected and that the APF would continue to receive updates as the position developed. It was also recognised that the wider national and political context remained fluid and that further clarity would be required before any settled position could be reached.

8.4 Professional Principles Development NM Taskforce

The Area Partnership Forum received a paper presented by David Watson, Corporate & Acute Director of Nursing, outlining a draft framework of professional principles to support consistent decision-making in relation to the temporary redeployment of nursing and midwifery staff.

It was noted that the work had been developed at a national level, informed by taskforce activity and engagement and aimed to establish a clear, consistent approach to support safe practice, staff experience, and accountability. The document outlined high-level principles intended to guide local application.

During discussion, members acknowledged the importance of the work, noting ongoing challenges and concerns raised by staff regarding redeployment practices. It was recognised that a clear and consistent framework was required to support both staff and service delivery. However, staff-side representatives advised that the document had not been agreed through national partnership routes and therefore could not be supported locally at this stage. It was agreed that further clarification would be sought regarding the national position. **Action: David Watson**

In response, it was emphasised that the paper was presented for discussion rather than approval, and members were encouraged to provide feedback to inform further development. It was agreed that staff-side organisations would review the document collectively and provide consolidated feedback, and that the presenter would also seek clarification at national level on the partnership position.

The Forum noted the paper and supported the approach of gathering further feedback prior to progression, recognising the need to achieve alignment through agreed partnership processes.

9. For Noting

9.1 Circulars and Policies

The Area Partnership Forum received an update on recent circulars and policy changes presented by Linda Robertson, including confirmation of an additional public holiday granted by NHS Forth Valley. It was noted that this had not been adopted by local authority partners, creating potential operational challenges where NHS and council staff worked together.

Updates to workforce policies were also highlighted, reflecting changes in employment legislation, including removal of the requirement to publish trade union facility time annually and updates to areas such as parental leave and sexual harassment guidance.

During discussion, concerns were raised regarding the impact of the additional public holiday, particularly the potential for inequity between NHS and local authority staff working within integrated teams. It was recognised that this could create operational and workforce challenges, including maintaining safe staffing levels and consistency across services.

In response, it was acknowledged that these challenges would need to be managed operationally, with services required to balance workforce arrangements while maintaining service delivery. It was also reaffirmed that, despite national changes to reporting requirements, the organisation would continue to prioritise improvement of local arrangements for monitoring and managing facility time, with further work to strengthen this approach ongoing.

The update was noted by the Forum.

9.2 People Strategy

The Area Partnership Forum received a paper outlining the ‘People Strategy’ presented by Kevin Reith, Director of People.

The paper outlined the initial development of the Strategy, commissioned by the Staff Governance Committee following approval of the Population Health and Care Strategy. It was noted that the intent was to produce a high-level strategic document, focused on key workforce priorities and levers to support organisational transformation, rather than a detailed operational plan. Engagement activity was planned across leadership teams, staff, and governance groups to inform its development.

During discussion, it was emphasised that the strategy would be shaped through ongoing engagement and consultation, with opportunities for staff side and wider stakeholders to contribute to its development. It was confirmed that this engagement would be taken forward over the coming months, including attendance at relevant forums to gather feedback and refine the content.

The Forum noted the approach and supported progression of the strategy, with agreement that further updates would be brought back as engagement progressed and the strategy was developed.

10. Any other competent business

The meeting formally recognised the retirement of Janet Sneddon, acknowledging her long-standing contribution to partnership working within NHS Forth Valley. Members highlighted her significant involvement in the Area Partnership Forum and wider governance arrangements over many years, noting her role in supporting staff-side engagement and partnership development.

The discussion reflected appreciation for her commitment and recognised the impact of her work over an extended period of service. Members conveyed their thanks and best wishes for her retirement.

The next meeting would be held on Tuesday 23 June 2026 at 2 pm

NHS Forth Valley

Forth Valley NHS Board

7.7 Falkirk Integration Scheme
Purpose: This report is for Assurance

Executive Sponsor: Ross McGuffie, Chief Executive
Author: Ewan C. Murray, Business and Governance Lead, Falkirk HSCP

Executive Summary
The revised Falkirk Integration Scheme (hereafter referred to as the Falkirk Integration Scheme) was approved by Scottish Ministers on 9 April 2026 and supersedes the previous Integration Scheme from this date as the legal partnership agreement between NHS Forth Valley and Falkirk Council which sets out the key arrangements for how integrated health and social care services are to be planned, delivered and monitored.

Action Required
The Forth Valley NHS Board is asked to:
(1) note that the Falkirk Integration Scheme was approved by Scottish Ministers on 9 April 2026.
(2) note that the Falkirk Integration Scheme extends the functions delegated by Falkirk Council to include Children's and Justice Social Work services and incorporates details of services to be integrated and delivered on a pan-Forth Valley basis (commonly referred to as Hosted Service and/or Lead Partner arrangements)
(3) note the Falkirk Integration Scheme incorporates an increase in the numbers of voting Integration Joint Board members from both NHS Forth Valley and Falkirk Council from 3 to 4.
(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
The Falkirk Integration Scheme was considered and approved by the Board of NHS Forth Valley on 28 January 2025 and by Falkirk Council on 30 January 2025 along with a paper endorsing the proposed integration of Children's and Justice Social Work Services into the Falkirk Health and Social Care Partnership (HSCP). A paper was also considered by the Falkirk Integration Joint Board (IJB) on 31 January 2025 which endorsed the proposed integration of Children's and Justice Social Work Services into the Falkirk Health and Social Care Partnership.

Risk Assessment and Mitigation
Approval of the Falkirk Integration Scheme reduces the risk that the integration of Children's and Justice Social Work Services into Falkirk HSCP without delegation of the associated functions to the IJB complicates the governance and monitoring arrangements makes accountability less clear than it should be. It also gives a clear approved position for the development and approval of the next iteration of the strategic plan for health and social care in Falkirk which is due to be completed and approved during 2026/27 and will agree priorities within a strategic framework for the next 10 years.

Impact Assessments

Equality & Diversity and Fairer Scotland Duty
Does this report require an EQIA or Fairer Scotland Duty Assessment? Choose an item.
If yes, please confirm this is attached. Attached☐ Not required ☒

Financial, Digital and Infrastructure Implications
There are no direct financial, digital and infrastructure implications arising as a result of this paper. Any implications will be managed through the strategic planning and annual business case processes for the IJB.

Workforce Implications
There are no direct workforce implications as a result of this paper. Any workforce implications will be managed through the annual business case process for the IJB.

Quality / Patient Care Implications
There are no direct quality and patient care implication arising as a result of this paper.

Population Health & Care Strategy
The Falkirk Integration Scheme aims to create arrangements which support the delivery of better outcomes for the population of Falkirk and, as such, is congruent with the aims of the Population Health & Care Strategy including Realistic Medicine and Value Based Health & Care.

Climate Change / Sustainability Implications
There are no direct climate change or sustainability implications arising as a result of this paper. The annual IJB Business Case process will continue to detail sustainability implications based on the methodology set out in the Integration Scheme and relevant national guidance.

Engagement and Communications
Was statutory engagement with stakeholders required? Yes ☐ No ☒

- If yes, please provide details.

Describe any engagement activity or communication which has been undertaken or is planned.

Appendices
Appendix 1 – Main Report
Appendix 2 – Falkirk Integration Scheme

APPENDIX 1

Falkirk Integration Scheme

Background

The Public Bodies (Joint Working) (Scotland) Act 2014 requires Local Authorities and Health Boards to jointly prepare an integration scheme. The integration scheme is a legal document, subject to Ministerial approval, which sets out the key arrangements for how integrated health and social care services are to be planned, delivered and monitored in the local area. Each integration scheme should be reviewed every 5 years meaning the next review should take place by April 2031.

The Falkirk Integration Scheme was initially prepared and agreed in 2016 and revised in 2018 to take account of the Carers Act. The pandemic delayed review of many integration schemes however a working group met during 2024 to prepare a revised integration scheme.

The Falkirk Integration Scheme was submitted to Scottish Ministers post approval by Falkirk Council and NHS Forth Valley in January 2025. Although the process of gaining approval from Scottish Ministers took longer than envisaged the changes made were more of clarity and definition in nature rather than material changes in substance from the version approved by the NHS Board and Council.

Main Considerations

The key changes within the Falkirk Integration Scheme in comparison to the previous integration scheme are:

- Delegation of Children's and Justice Social Work from Falkirk Council
- An additional voting member on the IJB from NHS Forth Valley and Falkirk Council increasing the number of voting members from each organisation from 3 to 4.
- Incorporation of provisions within the Integration Scheme in relation to services to be integrated and delivered on a pan-Forth Valley basis per the table below.

Falkirk	***Clackmannanshire and Stirling***	***Health Board***
• Primary care including out of hours. • Prisoner Healthcare • Forth Valley wide health improvement where these fall out with the arrangements for each HSCP	• Specialist mental health and learning disability (including adult Mental health inpatients)	**Operational management only** in relation to: • Large hospital services including Accident and Emergency and wards associated with unplanned admissions.

These provisions are mirrored within the draft Clackmannanshire and Stirling Integration Scheme. These arrangements may be subject to change by agreement of the NHS Board and the three Forth Valley Local Authorities.

- Clear financial risk sharing arrangements including in relation to the set aside budget for large hospital services.

Conclusion

Given the Falkirk Integration Scheme is one of the NHS Boards most significant legal agreements NHS Board members should be fully aware of its content, implications and responsibilities placed upon the NHS Board both corporately and through the voting members of the IJB.

NHS Board members should also note that as a consequence of a Scottish Statutory Instrument (SSI) there are changes to the IJB order which will result in 3 lived experienced members of Falkirk IJB gaining voting rights from September 2026. This is not directly related to the Integration Scheme itself and will not require further amendment to the Integration Scheme.

Falkirk
Health and Social Care
Integration Scheme
2026

This integration scheme is to be used in conjunction with the Public Bodies (Joint Working) (Integration Scheme) (Scotland) Regulations 2014

These regulations can be found at http://www.scotland.gov.uk

The Preamble

Our shared Vision for Integration

NHS Forth Valley and Falkirk Council are the partners in this Integration Scheme. As partners we recognise that the main purpose of integration is:

- To improve the wellbeing of people who use health and social care services, in particular those whose needs are complex, and which require support from health and social care at the same time;
- To improve the wellbeing of those for whom it is necessary to provide timely and appropriate support in order to keep them well;
- To promote informed self-management and preventative support to avoid crisis or ill health; and
- To jointly deliver on the national health and wellbeing outcomes.

Our shared vision for integration between NHS Forth Valley and Clackmannanshire, Stirling and Falkirk Councils is for confident and ambitious Integration Joint Boards which support people to achieve better outcomes and experience fewer inequalities, where voices are heard, and people are supported to enjoy full and positive lives in the community.

We aim to deliver success in integration where:

- People experience improved health and wellbeing;
- Integrated services provide holistic care focused on outcomes;
- Pathways between health, social work and social care services become seamless;
- Inequalities are reduced;
- Shared resources are deployed using best value principles to achieve better outcomes, maximise efficiencies from integrated care allowing public funds to go further to meet demand; and
- Good clinical, care and professional governance improves the quality of service delivery.

To achieve this, we will:

- Build on the Integration delivery principles set out in the Public Bodies (Joint Working) (Scotland) Act 2014;
- Respect the principles of human rights, equalities, and independent living, treating people fairly;
- Work collaboratively to embed this shared vision within staff teams, supporting and developing staff from all organisations to respond appropriately, putting people first;
- Recognise that our people are our greatest asset, and it is through their talents and ambitions that real improvement will continue to be made and

- Support staff to learn from and build on best practice.
- Support the Integration Joint Board to deliver on its strategic plan, progressing the national health and wellbeing outcomes.
- Provide sufficient funds to meet needs in the Local Authority area,
- Work together on human resources, finance, integrating IT and other areas that will promote integrated working by our staff.
- Support the unique role of the Chief Officer by avoiding unnecessary duplication and parallel systems, the creation of integrated or single systems that support patient/ service user/ supported people in an integrated manner. Equally, support the Chief Officer operationally to achieve single finance functions, performance management, assurance, risk and staff governance approaches.

Integration Scheme

Between

Falkirk Council, established under the Local Government etc. (Scotland) Act 1994 and having its principal offices at The Foundry, 4 Central Boulevard, Central Park, Larbert ("**the Council**");

and

Forth Valley Health Board, established under section 2(1) of the National Health Service (Scotland) Act 1978 (operating as "NHS Forth Valley") and having its principal offices at Carseview House, Castle Business Park, Stirling, FK9 4SW hereinafter referred to as **"the Health Board"**

Together referred to as "the Parties".

DEFINITIONS AND INTERPRETATIONS

"Act" means the Public Bodies (Joint Working) (Scotland) Act 2014;

"**Agreed Purposes**" means:- to manage and plan services, including, but not restricted to, the delivery of certain health and social services; to improve and support service delivery, resulting in better outcomes for individuals in contact with services; to preserve community and personal safety; to safeguard the well-being of individuals who may be in need of care or protection; to streamline data collection so that individuals are not asked the same questions by a range of different organisations; and to assess need at an individual and community level.

Care governance means a robust system for assuring high standards in the delivery of safe, personalised and effective health and social care services ; and clinical governance means a framework though which the Health Board is accountable for continuously improving the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish (together, "**Clinical and Care Governance**").

"Chief Finance Officer" means the Chief Finance Officer appointed by the Integration Joint Board in terms of section 95 of the Local Government (Scotland) Act 1973.

"Chief Officer" means the individual appointed to the Integration Joint Board by virtue of Section 10 of the Act;

"**Chief Social Work Officer**" means the chief social work officer appointed by the Council pursuant to section 3 of the Social Work (Scotland) Act 1968;

"Clackmannanshire" means the local government area for Clackmannanshire as defined in the Local Government etc. (Scotland) Act 1994

"**Community Planning Partnership**" means all those services that come together to take part in community planning as set out in the Community Empowerment (Scotland) Act 2015

"Data Protection Legislation" means data protection legislation as defined in section 3 of the Data Protection Act 2018.

"Delegated Functions" means the functions referred to in section 60 of the Act and listed in Annex 1 and 2 of this Scheme that are delegated to the Integration Joint Board.

"**Direction**" means the formal instruction to the Parties by the Integration Joint Board that is to be undertaken by each party on behalf of the Integration Joint Board and the financial resources that are being made available to each party in undertaking these services in accordance with section 26 of the Act.

“Falkirk” means the local government area for Falkirk as defined in the Local Government etc. (Scotland) Act 1994;

“**Health and Social Care Partnership**” means the single integrated operational arrangement established by the Parties in order to implement the Directions of the Integration Joint Board

“**Host**” means the designated Chief Officer operationally responsible for a service managed within the Health Board;

"Integration Authority" is the Integration Joint Board established in pursuance of this Integration Scheme

"Integrated Budget" means the budget for the delegated resources for the Integrated Functions comprising:

i. The payment made to the Integration Joint Board by the Local Authority for delegated adult social care services; and

ii. The payment made to the Integration Joint Board by the Health Board for primary and community healthcare services and for those delegated hospital services which will be managed by the Chief Officer.

“**Integration Functions”** means the functions that are to be delegated to the Integration Joint Board under section 1 or 2 of the Act

“**Integration Joint Board** means the Falkirk Integration Joint Board established by order under section 9(2) of the Act

"Integration Joint Board Order" means the Public Bodies (Joint Working) (Integration Joint Boards) (Scotland) Order 2014(SSI 285/2014)

"Integration Planning Principles" are as defined in section 4 of the Act;

"Integration Scheme Regulations" means the Public Bodies (Joint Working) (Integration Scheme) (Scotland) Regulations 2014;

“Integrated Services” means the services that are delivered by the Parties as Directed by the Integration Joint Board

"Large hospital" means a hospital serving two or more local authority areas.

"Large Hospital Services" means services that are provided in exercise of Integration Functions delegated by the Health Board to the Integration Joint Board which (a) are carried out in a hospital in the area of the Health Board and (b) are provided for the population of two or more local authorities (unless the Health Board deems that they do not require to be treated as such). These services are managed by the Director of Acute Services. Services provided in a community hospital do not ordinarily fall within this definition unless a material proportion of the care is provided for the population of two or more local authorities.

“Local Authorities” means Falkirk Council or either or both of Clackmannanshire Council and Stirling Council as the context admits.

“**National Health and Wellbeing Outcomes**” means the outcomes prescribed under section 5 of the Act

“**NHS Nursing Director**” means the individual appointed by the Health Board to provide professional leadership for nursing and midwifery services and appointed by the Scottish Ministers as an Executive Board Member of the Health Board.

“**NHS Medical Director**” means the individual appointed by the Health Board to provide the professional leadership for medical services and appointed by the Scottish Ministers as an Executive Board Member of the Health Board.

“**Operational Management**” means all the day-to-day functions required to control the delivery of delegated health and social care services including clinical, care and professional standards and governance, financial management, operational risk management and staff governance, the configuration of those services and all functions associated with ensuring the implementation of Directions issued by the Integration Joint Board.

“**Operational Risk**” means the risk of incurring detriment due to inadequate or failed internal processes, people, controls or from external events.

“**Oversigh**t” means the requirement to be assured that functions are being delivered as directed, that the Strategic Plan is being delivered and that Integrated Services operate safely and to the quality expected (i.e clinical care and professional governance). This might include receiving reports about shifts in service delivery that demonstrate the implementation of Directions and the Strategic Plan. Oversight is not about day-to-day Operational Management

"Outcomes" means the National Health and Wellbeing Outcomes prescribed by the Scottish Ministers

“Parties” means the Falkirk Council and the Health Board;

“**Partners**” means communities, staff, third sector, service users and carers and independent sector.

“**Planning Period**” means the 3-year term of the Integration Joint Board Strategic Plan

"Payment" means the contribution made by the Parties to the Integration Joint Board in respect of the Integration Functions or similarly the amount directed by the Integration Joint Board to the Parties for the operational discharge of the Integration Functions. Payment does not mean an actual cash transaction but a representative allocation for the delivery of the Integration Functions in accordance with the Strategic Plan.

“Scheme” means this Integration Scheme.

“Set Aside” means the activity-based budget for commissioned hospital services used by the Integration Authority population as set out in the Strategic Plan. This is the amount required to be set aside by the Health Board for use by the Integration Authority.

"Service Users" means persons to whom or in relation to whom services in respect of the Integration Functions are provided;

“Standing Orders” means the written rules which regulate the proceedings of the Integration Joint Board.

"Strategic Plan" means the plan with the Integration Joint Board is required to prepare and implement in relation to the delegated provision of health and social care services to adults in accordance with Section 29 of the Act;

"Strategic Planning Group" means the group established under Section 32 of the Act;

"Third and Independent Sector " includes commercial and non-commercial providers of health and social care, representative groups, interest groups, social enterprises and community organisations.

1 CHOICE OF INTEGRATION MODEL

1.1 In accordance with section 2(3) of the Act, the Parties have agreed that the integration model set out in section 1(4)(a) of the Act will be put in place in Falkirk namely the delegation of functions by the Parties to a body corporate established by Order under section 9 of the Act. This Scheme comes into effect on the date approved by Scottish Ministers.

1.2 As the Parties intend to delegate functions 'to a body corporate' there will be no wholesale transfer of staff either between the Council and the Health Board, or vice versa, or from both organisations.

2 DELEGATION OF FUNCTIONS

2.1 The functions that are to be delegated by the Health Board to the Integration Joint Board are set out in Part 1 of Annex 1 annexed as relative hereto. The description of the services to which these functions relate are set out in Part 1 of Annex 1 of the Scheme. Unless otherwise stated, health functions are delegated only in relation to persons over the age of 18 years. The description of the services to which these functions relate are set out in Parts 2 and 3 of Annex 2.

2.2 The functions that are delegated by the Council to the Integration Joint Board are set out in Parts 1,2 and 3 of Annex 2 annexed as relative hereto. The description of the services to which these functions relate are set out in Part 4 of Annex 2.

3 MEMBERSHIP

3.1 Membership of the Integration Joint Board will be determined in accordance with the Integration Joint Board Order.

3.2 The Council will nominate four of its councillors to the Integration Joint Board and the Heath Board will nominate four Board members to the Integration Joint Board, to be voting members.

4 LOCAL GOVERNANCE ARRANGEMENTS

4.1 The term of office of a member of the Integration Joint Board is a maximum of the term of office as a Non-Executive Board member of the Health Board or in respect of Elected Members the term of the Council. Integration Joint Board members may be reappointed for a further term(s) of office. Board members appointed by the Parties will cease to be members of the Integration Joint Board in the event that they cease to be a non-executive board member of the Health Board or an elected member of the Council. The Chief Social Work Officer, Chief Officer and Chief Finance Officer remain members of the Integration Joint Board for as long as they hold the office in respect of which they are appointed.

4.2 The Chairperson and Vice Chairperson will be drawn from the Health Board and the Council voting Members of the Integration Joint Board. If a Council Member is to serve as Chairperson, then the Vice Chairperson will be a member nominated by the Health Board and vice versa. The appointment to Chairperson and Vice Chairperson is time limited to a period not exceeding two years from the date of appointment and carried

out on a rotational basis between the Council and Health Board appointed Chairpersons. The Council or the Health Board may change their appointee as Chairperson or Vice Chairperson during an appointing period.

5 LOCAL OPERATIONAL MANAGEMENT ARRANGEMENTS

5.1 The Integration Joint Board has the responsibility for the planning of services in relation to the Delegated Functions and is required by section 29 of the Act to prepare a Strategic Plan. The Strategic Plan must set out the arrangements for carrying out the integration and how these arrangements are intended to achieve or contribute to achieving the National Health and Wellbeing Outcomes.

5.2 The Integration Joint Board is responsible for the planning of Delegated Functions as specified in Annex 1 and Annex 2 of this Scheme. For the avoidance of doubt this includes strategic planning responsibility for those Delegated Functions for which another manager of the Health Board retains Operational Management responsibility as set out in paragraph 5.12 below.

5.3 The Integration Joint Board shall be responsible for carrying out the Integration Functions but shall do so by way of Direction to one or both Parties to carry out each Integration Function having regard to the Strategic Plan.

5.4 The Parties agree to integrate Delegated Functions at an operational level through the Chief Officer who will manage a Health and Social Care Partnership where the integration of services for the benefit of people who use services can happen. This will allow the Parties to have arrangements in place to carry out the integration planning principles as set out in section 4 of the Act.

Corporate support

5.5 It will be the responsibility of the Parties to work collaboratively to provide the Integration Joint Board with support services which will allow the Integration Joint Board to carry out its functions and requirements. The Parties agree to make available to the Integration Joint Board such professional, technical, or administrative resources as are required to support the development of the Strategic Plan and the carrying out of Delegated Functions. The workforce to support some of these functions may work within the Health and Social Care Partnership. These arrangements will be reviewed through regular reports from the Chief Officer of the Integration Joint Board.

5.6 The Parties agree to ensure sufficient corporate support is available within the operating parameters of the Parties to ensure the delivery of operational services through the Health and Social Care Partnership and to support the workforce.

Support for Strategic Planning

5.7 The Integration Joint Board will participate as a partner in the Community Planning Partnership in line with local arrangements.

5.8 The Health Board will provide the necessary activity and financial data for services, facilities or resources that relate to the planned use of services, provided by other Health Boards, by people who live within Falkirk.

5.9 The Council will provide the necessary activity and financial data for services, facilities or resources that relate to the planned use of services within other local authority areas by people who live within Falkirk.

5.10 The Parties agree to use all reasonable endeavours to ensure that the Clackmannanshire and Stirling Integration Joint Board and any other relevant integration authority will share the necessary activity and financial data for services, facilities and resources that relate to the planned use of resources by residents in their integration authority area.

Operational management

5.11 The Health Board are responsible for the Operational Management of all health services where Operational Management is through the Chief Officer, Health and Social Care Partnership and the Director of Acute Services.

5.12 Large Hospital Services will be operationally managed by the Director of Acute services who will act on Directions from the Integration Joint Board in relation to Delegated Functions and provide all required information on performance, finance and Clinical and Care governance as required by the Integration Joint Board.

5.13 The Integration Joint Board will have Oversight of integrated services delivered through the Health and Social Care Partnership and integrated Large Hospital Services to ensure compliance with the Strategic Plan of the Integration Joint Board.

5.14 The Health Board will through the Chief Officer and Director of Acute Services provide information on a regular basis to the Integration Joint Board on the performance and governance of these services and compliance with Directions.

5.15 The Council is responsible for the Operational Management of all social work and social care services through the Chief Officer.

5.16 Certain delegated housing functions will be operationally managed by the Head of Housing and Communities or equivalent who will act on Directions from the Integration Joint Board and provide all required information on performance, finance and Clinical and Care governance as required by the Integration Joint Board.

5.17 The Council will through the Chief Officer provide information on a regular basis to the Integration Joint Board on the performance and governance of those services and compliance with Directions.

5.18 The Parties, with Clackmannanshire and Stirling Councils recognise that certain Integrated Services require Operational Management best delivered on a Forth Valley wide basis. It is proposed that a Hosting approach to these services is adopted (known as Hosted Services). The role of the Host Chief Officer is set out in paragraph 6.7 below.

5.19 The arrangements for Hosted services are set out in Annex 1 Part 3 with one Chief Officer acting as Host in most circumstances. The Host may be subject to change in agreement between the Falkirk, Clackmannanshire, and Stirling Councils, the Health Board and the Falkirk, and Clackmannanshire and Stirling Integration Joint Boards.

5.20 The Integration Joint Board is responsible for Oversight of all Delegated Functions through the Chief Officer.

5.21 The Parties will advise the Integration Joint Board where they intend to change operational service provision in any area of provision including support services that may have a resultant impact on the Strategic Plan.

Performance Management

5.22 The Integration Joint Board has a performance framework which contains the lists of targets and measures that relate to the Delegated Functions, and which show progress against their Strategic Plan. The reporting cycle is set out in the Performance Framework but will be no less than annually in order that the Integration Joint Board can prepare its annual report in accordance with section 42 of the Act.

5.23 The Parties will provide the relevant information, including activity and financial information, to the Integration Joint Board to meet the requirements of the performance framework and to enable the Integration Joint Board to prepare a report as required by section 42 of the Act and in accordance with The Public Bodies (Joint Working) (Content of Performance Reports) (Scotland) Regulations 2014. This report will be shared with the Council's Scrutiny Committee (or any other committee which may replace its scrutiny obligations) and the equivalent committee in the Health Board.

5.24 The Parties will also provide information on the non-integrated functions of the Parties that will have to be taken into account by the Integration Joint Board in relation to the preparation of their Strategic Plan.

Directions

5.25 The Integration Joint Board will routinely receive from the Chief Officer and Chief Finance Officer, for agreement and approval, reports as relevant. The Integration Joint Board upon consideration of such reports may issue, amend, or withdraw a Direction to the relevant party in line with their Directions Policy.

5.26 A Direction is the end point in a planning or change process that includes appropriate and sufficient engagement with the Parties involved as detailed in the Directions Policy.

5.27 Information will be provided by the Parties, to the Integration Joint Board setting out the arrangements they have made to ensure that a Direction has been delivered and that the objectives of the Strategic Plan will be achieved. If it is considered by the Integration Joint Board that any of the arrangements made by either of the parties are not sufficient, the Chief Officer will bring this to the attention of the party in question, in writing, with details of any further action which the Integration Joint Board considers should be taken.

6 Chief Officer

6.1 The Integration Joint Board shall appoint a Chief Officer in accordance with section 10 of the Act. The arrangements in relation to the Chief Officer agreed by the Parties are:

6.2 The Chief Officer will be employed by one of the Parties on behalf of the Integration Joint Board, to which they will be accountable. The Chief Officer will be a substantive member of the senior management teams of both the Council and the Health Board. The Parties agree to a single integrated model for Operational Management for Integrated Services by the Chief Officer through a single integrated operating unit known as the Health and Social Care Partnership.

6.3 The Chief Officer shall not also hold the office of Chief Social Work Officer, NHS Medical Director, or NHS Nursing Director.

6.4 The Chief Officer will report to the Chief Executives of both Parties on Operational Management. Joint performance review meetings, involving the Parties Chief Executives will take place regularly and at a minimum of quarterly. A key element

of the Chief Officer's role will be to develop close working relationships with elected members of the Council and Non-Executive and Executive Health Board members.

6.5 The Chief Officer will be responsible for the operational management and performance of Integrated Services, including hosted services as set out in Annex 1 and 2. Large Hospital Services with the exception of Mental Health Inpatients will be operationally managed by the Director of Acute Services.

6.6 The operational role of the Chief Officer is detailed in a job description agreed by the Integration Joint Boardand Parties.

6.7 Appropriate communication and liaison will be in place between the Chief Officer and the Director of Acute Services in order that the strategy, resourcing and performance of Large Hospital Services and inpatient mental health services can be agreed by the Integration Joint Board and any required Directions can be issued.

6.8 Where a Chief Officer is the Host in relation to a hosted service set out in in Annex 1 part 3 the Parties agree that the Host will:

- Have Operational Management responsibility for those services across Forth Valley.
- Co-ordinate the Strategic Planning of those hosted services with the chief Officer of the other Integration Joint Board and have regard to all localities across Forth Valley.
- Will seek approval from both Integration Joint Boards on proposed strategy for those services as required in section 29 of the Act and having regard to all localities in the Forth Valley area.
- Will ensure that the service complies with agreed Clinical and Care governance standards and participate in the respective Integration Joint Board clinical, care and professional governance processes, and
- Will provide reports on those services to the other Integration Joint Board at least in every Planning Period, ensuring consultation where significant service change is planned at any point or where efficiency savings or other financial targets are to be applied to the service. Reports will include both performance and financial information in respect of the service.

6.9 The Chief Officer will have in place management structures and a Senior team of direct reports that ensure adequate and effective oversight and assurance to the Integration Joint Board in relation to performance, professional and Clinical and Care governance.

6.10 The Chief Officer shall establish and maintain effective working relationships with a range of key stakeholders across the Health Board, the Council, the Third and Independent Sector, Service Users and carers, Scottish Government, trade unions and relevant professional organisations. The Chief Officer will be a partner in the Community Planning Partnership.

6.11 Where the Chief Officer is absent or otherwise unable to carry out their responsibilities, a member of the team of directly managed staff who is an employee of either the Council or the Health Board will be designated as Depute Chief Officer. If the Chief Officer's absence is expected to be more than three months, an interim recruitment process will be put in place by the Parties, unless the Parties' Chief Executives agree that such a step is not necessary in the circumstances.

7. CLINICAL AND PROFESSIONAL CARE GOVERNANCE

7.1 The Parties are accountable for ensuring appropriate professional Clinical and I Care Governance arrangements in respect of their duties under the Act. The Parties will have regard to the principles of the Scottish Government's Clinical and Care Governance Framework (or its successor document), including the focus on localities and service user and carer feedback. The parties will agree an integrated framework for the delivery for integrated clinical, care and professional governance arrangements. Professional and service user networks or groups will inform an agreed Integrated Clinical, Care and Professional Governance Framework directing the focus towards a quality approach, continuous improvement, and the integration of Delegated Functions and services.

7.2 To provide assurance to the Integration Joint Board and the Parties on the effectiveness of these arrangements the Parties will have in place explicit lines of professional and operational accountability. These arrangements underpin the delivery of safe, effective, and person-centred care by employees of the Council, the Health Board, and the Third and Independent Sector in all care settings delivered.

7.3 In relation to Delegated Functions, the Health Board is accountable for the Clinical and Care Governance of health services, and the Council is accountable for governance of social work and social care services.

7.4 It will remain the responsibility of the Parties to assure the quality and safety of services commissioned from the Third and Independent sectors in line with the requirements set out in the Strategic Plan.

7.5 The structure of the Clinical and Care Governance arrangements as it relates to the Delegated Functions and the provision of assurance to the Integration Joint Board and the Parties is set out in the Clinical and Professional Care Governance framework. The framework will be reviewed at a frequency of no less than 3 years.

7.6 Professional governance responsibilities will continue to be carried out by the professional leads through to the health, social work, and social care professional regulatory bodies.

7.7 Principles of Clinical and Care Governance will be embedded at service user/clinical care/professional interface using the Clinical and Professional Care Governance framework. The Parties will ensure that explicit arrangements are made for professional supervision, learning, support, and continuous improvement for all staff.

7.8 The Parties will provide, by way of assurance to the Integration Joint Board, evidence of effective performance management and professional Clinical and Care Governance systems in relation to the operational delivery of the Integrated Services.

7.9 Both Parties will retain separate duty of candour policies. The Parties agree to work towards an integrated duty of candour process to be included in the Clinical and Professional Care Governance Framework.

7.10 In respect of clinical, care and professional governance for delegated health functions where the Integrated Services are managed by the Director of Acute Services, the Health Board will establish a Clinical Governance Committee. The Clinical Governance Committee (or its successor) will provide oversight, advice, guidance, and assurance to the Integration Joint Board in relation to those Delegated Functions. These arrangements will be set out in the Clinical and Professional Care Governance Framework.

7.11 The Chief Social Work Officer, the Medical Director, Director of Nursing and Midwifery, Director of Pharmacy, Director of Allied Health Professions or their representatives and

a Medical Practitioner whose name is included in the list of primary medical services performers (the executive professional leads), will provide professional advice to the Chief Officer and the Integration Joint Board in respect of the overview, consistency of service quality and assurance and, application of the Clinical and Care Governance Framework.

7.12 The executive professional leads will provide advice to the Strategic Planning Group and localities for the purposes of locality planning in respect of inpatient (acute, mental health drug and alcohol and learning disability) and community services respectively.

7.13 The Director of Acute Services will have in place management structures that ensure accountability and responsibility for professional, clinical and care standards and governance for Integrated Services which they have Operational Management responsibility.

8. WORKFORCE

8.1 The Parties are committed to ensuring staff possess the necessary skills and knowledge to provide Service Users with the highest quality services. Any future changes in staff arrangements will be planned and co-ordinated and will involve the full engagement of those affected by the changes in accordance with established practices and procedures.

8.2 The Parties will deliver an Integrated Workforce Plan for Integrated Functions. In doing so the plan will consider the needs of the integrated health and social care workforce, including the impact of Third and Independent Sector care provision as part of the overall planning process. The Plan will set out how support and development will be provided for and to the workforce and how the workforce will be developed to meet the requirements of the Integration Joint Board's Strategic Plan. Reviews of the Workforce Plan will be undertaken in conjunction with a review of the Integration Joint Board's Strategic Plan and in consultation with the Integration Joint Board.

8.3 The Parties will provide human resource services and workforce planning information as required by the Chief Officer from the appropriate corporate human resource functions within the Council and the Health Board.

8.4 The Parties will ensure that professional/clinical supervision arrangements are in place.

9. FINANCE

9.1 References to the Integration Joint Board's Chief Officer and Chief Finance Officer in this section are references to those persons acting on behalf of the Integration Joint Board and are without prejudice to the Integration Joint Board adopting a scheme of delegation delegating such powers as it thinks appropriate to the Chief Officer and the Chief Finance Officer.

Financial Governance arrangements

Appointment of a Chief Finance Officer

9.2.1 The Integration Joint Board shall appoint a Chief Finance Officer to oversee the proper administration of its financial affairs in accordance with section 95 of the Local Government Scotland Act 1973.

9.2.2 The Chief Finance Officer will be employed by one of the Parties.

9.2.3 In the event that the Chief Finance Officer position is vacant, the Chief Officer shall secure, through agreement with both the Council's Section 95 officer and Health Board's Director of Finance, an appropriate interim resource to discharge the role until such time as the post is permanently appointed to.

9.2.4 With respect to the provision of corporate support functions, the Parties shall identify appropriate operational finance personnel to support the Chief Finance Officer.

Published Accounts and Audit requirements.

9.3.1 As a public body defined under section 106 of the Local Government (Scotland) Act 1973 (Section 13), the Integration Joint Board is required to produce audited annual accounts in accordance with the Local Authority Accounts (Scotland) Regulations 2014 and the Chartered Institute of Public Finance and Accountancy Code of Practice on Local Authority Accounting in the United Kingdom. The Integration Joint Board must also publish an Annual Performance Report which incorporates financial performance and best value.

9.3.2 The Accounts Commission shall appoint the external auditors to the Integration Joint Board.

9.3.3 The nature of the relationship between the Parties is considered to be a joint venture and will be reported as such in the accounts of the Council and the Health Board as appropriate. Corresponding disclosures will be included in the Integration Joint Board accounts.

Budget setting process

9.4.1 The Parties agree to the establishment of an Integration Joint Board budget comprised of an Integrated Budget and a Set Aside Budget.

Integrated budget

9.5.1 The Parties recognise that the establishment of an Integrated Budget to meet commitments in the Strategic Plan depends on their co-operation between each other and with the Integration Joint Board and that all Parties must approach such discussions in good faith, recognising the pressures and constraints on their respective budgets and services. The Integrated Budget will be funded by payments from all Parties in respect of all relevant Delegated Functions specified in Annex 1 and Annex 2 of the Scheme. The funding contribution and amounts to be paid by the Parties shall be determined based on the following:

- An annual Business Case prepared by the Chief Finance Officer which summarises the Integration Joint Board's funding requirements and financial planning assumptions including savings and efficiencies for the forthcoming financial year to deliver against the Strategic Plan and the national health and wellbeing outcomes. The Business Case will be presented to the Parties in November/December of each year in order to inform their respective financial planning processes and to enable payments to be negotiated and agreed in advance of the financial year to which they relate.
- Where anticipated resources to deliver the strategic plan priorities are assumed to be insufficient, the business case should set out the anticipated impact on performance as far as possible and identify any strategic or operational risks.

- The Business Case will align with the Integration Joint Board's strategic plan and will reflect all known national policy commitments and local service developments, including the impact of service redesign and efficiency initiatives arising from Integration Joint Board Directions and Scottish Government sustainability and value targets.
- Where resources allocated to either of the parties are ring fenced, the same ring fencing shall apply when resources are delegated to the Integration Joint Board (the Integration Joint Board is not permitted to use such ring-fenced resources for any other purpose other than that originally intended).
- The annual payment from each Party will be indicatively shared with the Integration Joint Board by 28 February and formally notified to the Integration Joint Board no later than 31 March each year, subject to Scottish Government confirmation of NHS and Local Authority funding levels.
- Once funding contributions from the Parties are formally agreed, the Integration Joint Board will draft and issue Directions to all Parties to confirm the agreed Integrated Budget for all relevant Delegated Functions as specified in Annex 1 and Annex 2 of the Scheme in the first reporting cycle of the financial year. The Directions will remain in force until they are varied, revoked, or superseded as a consequence of specific Integration Joint Board decisions or in response to changes in strategic priorities and financial planning assumptions. Directions will be developed and issued in line with the Integration Joint Board's Directions Policy.
- With respect to subsequent financial years, as part of medium-term financial planning arrangements, the Parties shall provide indicative future year funding contributions to the Integration Joint Board to inform the Integration Joint Board's Strategic Plan and accompanying medium term financial plan.

9.5.2 The Parties will ensure that the Chief Officer and Chief Finance Officer are actively engaged in both the NHS and Local Authority strategic financial planning processes.

9.5.3 The Parties may increase the payment to the Integration Joint Board in year for supplementary allocations related to Integrated Functions which could not have been reasonably foreseen at the time the Integrated Budget was agreed or due to decisions made by them which have an impact on the Integrated Budget.

Set Aside Budget

9.6.1 The Set Aside budget should reflect the consumption of hospital services. Where the Integration Joint Board's Strategic Plan identifies a change or there is a change in hospital consumption over time, the impact of the anticipated shift in the balance of care, including resource implications for the Set Aside budget, will be agreed via a detailed business case from the Chief Officer and Chief Finance Officer to be approved by the Integration Joint Board and the Health Board.

9.6.2 Any significant change to set aside arrangements may require a review of the Set Aside budget and consumption of hospital services by the Integration Joint Board and the Health Board. Any review of the Set Aside budget will also involve the Clackmannanshire and Stirling Integration Joint Board.

Financial Management Arrangements

Financial Reporting

9.7.1 The Parties shall maintain detailed records of all financial transactions in respect of both integrated and set aside services and will provide accurate and timeous financial analysis, reports, budget statements, forecasts, and briefings to the Chief Finance Officer as appropriate.

9.7.2 The Chief Finance Officer will reconcile and consolidate the information received from the Parties to prepare the Integration Joint Board's annual financial statements, medium term financial plan, annual business case, Integration Joint Board finance reports provided at a minimum of quarterly, Scottish Government returns and other routine budgetary control statements.

9.7.3 The Parties will ensure that appropriate and sustainable finance support is provided to the Chief Finance Officer in respect of financial reporting arrangements in line with section 8.4.2 above.

Reserves

9.8.1 The Public Bodies (Joint Working) (Scotland) Act 2014 empowers the I Integration Joint Board to hold reserves. Reserves are typically held for 2 key purposes; the first as a contingency to offset the financial impact of unforeseen events and/or emergency situations and the second to fund specific projects or earmarked future commitments as part of the Integration Joint Board's Strategic Plan.

9.8.2 The Integration Joint Board shall develop and maintain a transparent and prudent reserves policy. The Integration Joint Board shall ensure that all reserve balances are both adequate and necessary in line with its strategic plan and accompanying the medium-term financial plan.

9.8.3 The Parties may take into account the levels of reserves held by the Integration Joint Board as part of the annual budget setting process and in the context of both the Strategic Plan and the Integration Joint Board's reserve policy, subject to Scottish Government direction.

Virement and management of budget variances

Virements

9.9.1 The Integration Joint Board will provide a Direction instructing how the Integrated Budget is to be used to deliver the agreed outcomes and priorities contained within its Strategic Plan. The allocation of payments from the Parties to each Delegated Function is therefore a matter for the Integration Joint Board to determine. As such, the Chief Officer may vire resources between the Health and the Social Care arms of the Integrated Budget as appropriate and with an appropriate audit trail.

9.9.2 Budget virement between the different arms of the Integrated Budget will require in-year balancing adjustments to the Directions issued to each Party in respect of payments from the Integration Joint Board (i.e. to confirm a reduction in the payment from the Integration Joint Board to one Party and a corresponding increase in the payment to another Party as appropriate).

9.9.3 The Chief Officer will not be able to vire between the Integrated Budget and any other budgets managed by the Chief Officer which are outside of the scope of the Integration Joint Board or within the Set Aside, unless explicitly agreed by the Parties.

9.9.4 The Integration Joint Board's financial regulations provide further details of arrangements for the virement of budgets.

Management of budget variances

9.10.1 The Chief Officer will manage the Integrated Budget so as to deliver the agreed outcomes within the Strategic Plan.

9.10.2 The Chief Officer will manage in year budget variances to deliver a breakeven position against the Integrated Budget.

9.10.3 The Director of Acute Services will be responsible in respect of the management of variations within the Set Aside budget and will manage in year budget variances to deliver a break-even position against the Set Aside budget.

Underspends

9.11.1 In the event of a favorable variance against the Integrated Budget, the underspend will be retained by the Integration Joint Board and carried forward through reserves unless subject to exception detailed in 9.11.2 below. The Chief Finance Officer will consider if the underspend will be carried forward as a general or earmarked reserve dependent on the nature of the underspend and seek approval from the Integration Joint Board where required.

9.11.2 In the majority of circumstances, any underspend will be retained by the Integration Joint Board, subject to some exceptions:

- Where funding is provisionally identified for a new service which is not then approved/implemented; or
- Housing Revenue Account funding.

9.11.3 For the exceptions above, discussions will take place between the relevant parties to agree the outcome.

9.11.4 In the event of a projected in-year under spend in respect of the Set Aside budget, the Health Board may agree to make additional contributions to the Integration Joint Board. This type of funding is likely to be non-recurring. This will require discussion and agreement between the relevant parties.

Overspends

9.12.1 To effectively manage overspends it is essential for the Chief Officer, Chief Finance Officer, and Director of Acute services to work together to effectively manage the whole pathway.

9.12.2 The Chief Officer and the Director of Acute Services will be responsible for the management of in-year pressures within the Integrated Budget and Set Aside Budget respectively and will be expected to take remedial action to mitigate any net variances and remain within the budget envelope.

9.12.3 In the event of an adverse variance against the Integrated Budget and/or Set Aside Budget, the Chief Officer and Director of Acute Services respectively shall take immediate and appropriate corrective action to address the overspend in conjunction with the Chief Finance Officer. This may require a formal recovery plan which may include remedial actions to return to balance. Where remedial actions can't be identified, the plan may include a decision by the Integration Joint Board to increase the payment

to the affected Party, by utilising an underspend on another arm of the budget and/or reviewing existing reserves or adjusting the Strategic Plan. The review of reserves will include both general fund reserves and those earmarked reserves which are not statutory or subject to Scottish Government policy direction. The recovery plan will be developed in collaboration with both Parties and subject to approval by the Integration Joint Board.

Risk sharing

9.13.1 In the event that there are insufficient reserves to offset a projected overspend or the Strategic Plan cannot be adjusted, then the Parties have the option to:

- make an additional one-off payment to the Integration Joint Board, taking into account the nature and circumstances of the overspend to be agreed by all parties; or
- provide additional resources to the Integration Joint Board which are recovered in future years, subject to scrutiny of the reasons for the overspend and discussion between the parties on a realistic medium to long term recovery plan.

9.13.2 Financial risk shall be managed through the financial management process noted above (recovery plan) and the use of reserves or additional contributions as previously outlined.

9.13.3 Where overspends remain unresolved following the development of the recovery plan, review of reserves and discussion as at 9.13.1, each Party retains ultimate responsibility for resolving the net overspend pressure within the functions that they have delegated.

9.13.4 Recurring overspends will be considered as part of the following year's budget process. If a solution to the overspend cannot be agreed by the Parties, or is not agreed by the Integration Joint Board, then the dispute resolution mechanism in this Scheme may require to be implemented.

9.13.5 With regard to setting aside services risk share arrangements will not apply. Instead, the Health Board will continue to manage overspend pressures out with these risk share arrangements until such time as baseline activity metrics and on-going activity tracking can be agreed and implemented, to allow the consequences of business decisions to be understood and associated variances to be attributed to relevant parties.

Capital and Asset Management

9.14.1 The Integration Joint Board, in conjunction with the Parties, shall identify all asset requirements necessary to deliver its Strategic Plan.

9.14.2 The Integration Joint Board will not hold a capital budget and does not have the power to borrow to fund capital expenditure. Rather capital investment, together with property and asset management, remains the responsibility of the Parties.

9.14.3 The Integration Joint Board shall be an integral part of the capital planning process of both Parties in order to secure capital investment and the effective use of property and assets to support health and social care integration.

9.14.4 Where the Chief Officer identifies as part of the Strategic Plan, new capital investment requirements, a business case should be developed for the Parties to consider. Options may include one or both of the Parties approving the project from its capital budget or where appropriate, other funding mechanisms.

9.14.5 In general, the Integrated Budget does not include payments from the Parties to cover the revenue costs of assets (rents, repairs, cleaning etc). Any change to this position

will be agreed as part of the budget negotiations. There may be some exceptions, for example the Joint Loan Equipment Store and Primary Care functions but these areas will be discussed and agreed by all relevant parties.

10. PARTICIPATION AND ENGAGEMENT

10.1 A proportionate joint consultation on this Scheme took place during September to December 2024. The following principles were agreed by the Parties and followed in respect of the consultation process:

- The views of all participants were valued;
- It was transparent;
- The results of the consultation exercise were published;
- It was an accessible consultation;
- The material for consultation was provided in a variety of formats;
- The draft scheme was published, and comments invited from members of the public; and
- It was the start of an on-going dialogue about integration.

10.2 The stakeholders consulted are identified in Annex 3 to this Integration Scheme.

10.3 A range of engagement methods were used to consult on the Scheme:

- A questionnaire made available by email to a range of partners, carers and the wider public;
- Electronic distribution of the Scheme with information available on the home pages of the Council and the Health Board and the Falkirk Health and Social Care Partnership;
- Information shared through social media;
- A joint press release which informed the public
- Electronic team briefings for staff; and
- Briefings with members of the Health Board, Elected Members of the Council and with the Integration Joint Board.

10.4 The Parties will support the Integration Joint Board to prepare and review an Involvement and Engagement Plan by providing appropriate resources and support. The Involvement and Engagement Plan shall ensure significant engagement with, and participation by, members of the public, representative groups, and other organisations in relation to decisions about the carrying out of integration functions. Feedback will be encouraged with internal and external stakeholders and the range of ways in which communities, groups and individuals can comment or share ideas will be explicit in all involvement and engagement activity.

10.5 The Parties and the Integration Joint Board will carry out Equality and Socio-Economic Impact Assessments (EQSEIAs), to ensure that services and policies do not disadvantage communities and staff.

10.6 The Parties will make available communication support to allow the Integration Joint Board to engage and participate.

10.7 The Parties will continue to allocate responsibility to the Chief Officer, senior managers, and their teams to support local public and staff involvement and communication.

11. INFORMATION SHARING AND DATA HANDLING

11.1 Section 49(3) of the Act enables the Parties to disclose information to each other for the purposes of carrying out integration functions. In processing personal data, the Parties are bound by Data Protection Legislation.

11.2 In order to provide integrated services it will be necessary to share personal data between the Parties and with external agencies. The Parties, along with Clackmannanshire and Stirling Integration Joint Board, have signed an Information Sharing Protocol to support the lawful flow and joint processing of information for the delivery of integrated services (Joint Processing Protocol). Where personal data is shared with external agencies for the delivery of integrated services, the Parties will ensure that there is appropriate governance documentation (e.g. information sharing agreements and/or contracts) in place to govern information sharing and data handling arrangements.

11.3 In addition, the Parties, and other relevant stakeholders (Falkirk and Clackmannanshire and Stirling Integration Joint Boards) have signed an Information Sharing Protocol which covers guidance and procedures for staff for sharing of information amongst them, other than in relation to integrated services (Controller/Controller Protocol). Each Party to the Controller/Controller Protocol will act as an independent controller for information received or disclosed under that Protocol.

11.4 The Controller/Controller Protocol covers the sharing of information between the Parties and other relevant stakeholders in all instances of routine sharing between them as data controllers in support of the Agreed Purposes (as defined by the Controller/Controller Protocol). The Parties, alongside the other relevant stakeholders, will ensure that there is appropriate governance documentation (e.g. information sharing agreements and/or contracts) in place to govern information sharing and data handling arrangements where appropriate.

11.5 The Parties will each appoint a Data Protection Officer, as defined in the Data Protection Legislation, who will be responsible for monitoring and reviewing the effectiveness of the Protocols to ensure that the Parties comply with Data Protection Legislation.

12. COMPLAINTS

12.1 The Parties will retain separate complaints policies reflecting the distinct statutory requirements.

12.2 The Parties agree that complaints should be viewed with a positive attitude and valued as feedback on service performance leading to a culture of good service delivery. The Parties agree the principle of early frontline resolution to complaints and the Parties will efficiently direct complaints to ensure an appropriate response.

12.3 The Parties agree to work towards an integrated process for complaints handling from the earliest point of contact as far as the differing legislative requirements will allow in respect of integrated services. Where a complaint is predominately a social care complaint but includes a health complaint, this will be dealt with using the Council

complaints handing procedure. Where a complaint is predominately a health complaint but includes a social care complaint this will be dealt with using the Health Board complaints handling procedure.

12.4 There will be a single point of contact for complainants in relation to integrated services. This will be agreed between the Parties to co-ordinate complaints specific to the Delegated Functions to ensure that the requirements of existing legal/prescribed elements of health and social care complaints processes are met.

12.5 All complaints handling procedures will be clearly explained, well publicised, accessible, will allow for timely recourse and will sign-post independent advocacy services.

12.6 The person making the complaint will always be informed which Complaints Handling Procedure is being applied to their complaint.

12.7 The Parties will produce a quarterly joint report, outlining the learning from upheld complaints. This will be provided for consideration in accordance with agreed arrangements on professional Clinical and Care Governance.

12.8 This arrangement will respect the statutory and corporate complaints handling procedures currently in place for health and social care services. This arrangement will benefit carers and Service Users by making use of existing complaints procedures and will not create an additional complaint handling process.

12.9 Data sharing requirements relating to any complaint will follow the Information and Data sharing protocol set out in section 10 of this scheme.

13. CLAIMS HANDLING LIABILITY AND INDEMNITY

13.1 The Parties and the Integration Joint Board recognise that they could receive a claim arising from, or which relates to, the work undertaken as directed, and on behalf of, the Integration Joint Board.

13.2 The Parties agree to ensure that any such claims are progressed quickly and in a manner which is equitable between them in accordance with legal principles of liability.

13.3 Scots Law will apply.

13.4 The Parties will assume responsibility for progressing and determining any claim which relates to any act or omission on the part of one of their employees.

13.5 The Parties will assume responsibility for progressing and determining any claim which relates to any building which is owned or occupied by them.

13.6 In respect of any claim where it is not clear which party should assume responsibility or in the event of any claim against the Integration Joint Board, the Chief Executives of the Parties, and the Chief Officer (or their representatives) will liaise and determine which party should assume responsibility for progressing the claim.

14. RISK MANAGEMENT

14.1 The Parties and the Integration Joint Board have a shared risk management strategy for the Parties and the Integration Joint Board for the significant risks that impact on integrated service provision (“RM Strategy”).

14.2 The primary objectives of this strategy will be to:

- promote awareness of risk and define responsibility for managing risk within the Integration Joint Board;
- establish communication and sharing of risk information through all areas of the Integration Joint Board and operational provision by the Parties;
- initiate measures to reduce the exposure of the Integration Joint Board and the Parties to risk and potential loss; and
- establish standards, principles and processes for the efficient management and escalation of risk, including regular monitoring, reporting, and review.

14.3 The RM Strategy will include a risk monitoring framework ("RM Framework"). The RM Framework will be aligned with the broader governance arrangements for the Integration Joint Board and the Parties, including the framework for monitoring performance and audit.

14.4 The Parties will commit all necessary resources to support risk management by the Integration Joint Board. The Parties will support the Integration Joint Board to:

- establish risk monitoring and reporting as set out in the RM framework; and
- maintain the risk information and share with the Parties within the timescales specified.

14.5 The Parties will support the Integration Joint Board to assess its risk and develop a risk register which will list the risks to be reported under the RM Strategy ("Risk Register"). The Integration Joint Board will be responsible for managing strategic risk. The Parties will retain responsibility for managing Operational Risk.

14.6 The Chief Officer will be responsible for maintaining the Risk Register and for keeping the Integration Joint Board and the Parties informed of any significant existing or emerging risks that could seriously impact the Integration Joint Board's ability to deliver the outcomes of their Strategic Plans or the reputation of the Integration Joint Board or the Parties. The Parties will make information on Operational Risks available to the Chief Officer at a minimum of quarterly to support assessment of strategic risk by the Integration Joint Board. Where a number of Operational Risks impact across multiple service areas or, because of interdependencies, require more strategic leadership, these risks will be escalated by the Parties to the Chief Officer as having 'strategic risk' status for the attention of the Integration Joint Board. The Chief Officer will maintain a register of strategic risks for the Integration Joint Board and will share this with the Parties at least biannually to support understanding.

14.7 The Parties and the Integration Joint Board will consider these risks at least bi-annually and notify each other where they have changed.

14.9 The RM strategy will be reviewed every three years. Any changes to the RM Strategy must be agreed amongst the Parties and the Integration Joint Board in writing.

15. DISPUTE RESOLUTION MECHANISM

15.1 Where either Party fails to agree with the other on any issue related to this Scheme, then the process set out in this section will be followed.

15.2 The Chief Executives of the Parties will meet to resolve the issue within 10 working days of either Party giving written notice to the other of the issue.

15.3 If unresolved, the Parties will each prepare a written note of their position on the issue and exchange it with the other within 14 days of the meeting.

15.4 Each Party must respond to the other in writing within 14 days.

15.5 In the event that the issue remains unresolved, representatives of the Parties will proceed to mediation with a view to resolving the issue.

15.6 The mediator shall be selected within 10 days by agreement between the Parties, failing which, by the director of the Scottish Mediation Network after consultation with the Parties. The mediation shall commence no later than 42 days after the selection of the mediator.

15.7 If there is any issue about the conduct of the mediation upon which the Parties cannot agree, then the mediator selected in accordance with paragraph 14.6 shall, at the request of either Party, decide that issue after consultation with the Parties.

15.8 Unless they agree otherwise, the Parties shall share equally the fees, costs and expenses relating to the mediation and each Party shall pay its own expenses of preparation for, and participation and representation in, the mediation.

15.9 If the Parties are unable to resolve the issue within 28 days of the mediation commencing, and only if the mediator and the Parties agree, the mediator may produce for the Parties a non-binding recommendation of terms of settlement.

15.10 Any settlement agreement reached in the mediation shall not be legally binding until it has been reduced to writing and signed by, or on behalf of, the Parties.

15.11 The mediation will terminate when:

- either Party withdraws from the mediation;
- the Parties resolve the issue; or
- a written agreement is concluded.

15.12 Where the issue remains unresolved, the Parties agree to notify Scottish Ministers within 14 days of the unsuccessful mediation terminating that agreement cannot be reached and to seek a direction pursuant to section 52 of the Act.

15.13 The Parties agree to be bound by any direction of the Scottish Ministers in relation to the issue.

ANNEX 1

PART 1

Functions delegated by the Health Board to the Integration Joint Board

Set out below is the list of functions that will be delegated by the Health Board to the Integration Joint Board as set out in the Public Bodies (Joint Working) (Prescribed Health Board Functions) (Scotland) Regulations 2014. The functions in this list are being delegated only in respect of the services described in Annex 1 part 2(a) and Part 2(b)

Functions prescribed for the purposes of section 1(6) and 1(8) of the Act

Column A ***Enactments to be conferred***	**Column B** ***Limitations***
The National Health Service (Scotland) Act 1978	
All functions of Health Boards conferred by, or by virtue of, the National Health Service (Scotland) Act 1978	Except functions conferred by or by virtue of— section 2(7) (Health Boards); section 2CB (functions of Health Boards outside Scotland); section 9 (local consultative committees); section 17A (NHS contracts); section 17C (personal medical or dental services); section 17 I(b) (use of accommodation) section 17J (Health Boards' power to enter into general medical services contracts); section 28A (remuneration for Part II services); section 38 (care of mothers and young children); section 38A (breastfeeding); section 39 (medical and dental inspection supervision and treatment of pupils and young persons); section 48 (residential and practice accommodation); section 55 (hospital accommodation on part payment); section 57 (accommodation and services for private patients); section 64 (permission for use of facilities in private practice); section 75A (remission and repayment of charges and payment of travelling expenses); section 75B (reimbursement of the cost of services provided in anther EEA state); section 75BA (reimbursement of the cost of services provided in anther EEA state where expenditure is incurred on or after 25 October 2013); section 79 (purchase of land and moveable property); section82 (use and administration of certain endowments and other property held by Health Boards); section 83 (power of Health Boards and local health councils to hold property on trust); section 84A (power to raise money, etc., by appeals, collections etc.); section 86 (accounts of Health Boards and the Agency);

Column A ***Enactments to be conferred***	**Column B** ***Limitations***
	section 88 (payment of allowances and remuneration to members of certain bodies connected with the health services); section 98 (payment of allowances and remuneration to members of certain bodies connected with the health services); paragraphs 4, 5, 11A and 13 of Schedule 1 to the Act (Health Boards); **and functions conferred by—** The National Health Service (Charges to Overseas Visitors) (Scotland) Regulations 1989; The Health Boards (Membership and Procedure) (Scotland) Regulations 2001 The National Health Service(Clinical Negligence and Other Risks Indemnity Scheme)(Scotland) Regulations 2000; The National Health Services (Primary Medical Services Performers Lists) (Scotland) Regulations 2004; The National Health Service (Primary Medical Services section 17C Agreements) (Scotland) Regulations 2018; The National Health Service (Discipline Committees) (Scotland) Regulations 2006; The National Health Service (General Ophthalmic Services) (Scotland) Regulations 2006; The National Health Service (Pharmaceutical Services) (Scotland) Regulations 2009; The National Health Service (General Dental Services) (Scotland) Regulations 2010; and The National Health Service(Free Prescriptions and Charges for Drugs and Appliances)(Scotland) Regulations 2011
Disabled Persons (Services, Consultation and Representation) Act 1986	
section 7 (Persons discharged from hospital)	
Community Care and Health (Scotland) Act 2002	
All functions of Health Boards conferred by, or by virtue of, the Community Care and Health (Scotland) Act 2002.	
Mental Health (Care and Treatment) (Scotland) Act 2003	
All functions of Health Boards conferred by, or by virtue of, the Mental Health (Care and Treatment) (Scotland) Act 2003.	Except functions conferred by— section 22 (Approved medical practitioners); section 34 (inquiries under section 33:co-operation); section 38 (duties on hospital managers: examination, notification etc.); section 46 (hospital managers' duties: notifications); section 124 (transfer to other hospital); section 228 (request for assessment of needs: duty on local authorities and Health Boards);

Column A ***Enactments to be conferred***	Column B ***Limitations***
	section 230 (appointment of patient's responsible medical officer); section 260 (provision of information to patient); section 264 (detention in conditions of excessive security: state hospitals); section 267 (orders under sections 264 to 266: recall) section 281 (correspondence of certain persons detained in hospital); **and functions conferred by-** The Mental Health (Safety and Security) (Scotland) Regulations 2005 The Mental Health (Cross border transfer: patients subject to detention requirement or otherwise in hospital) (Scotland) Regulations 2005; The Mental Health (Use of Telephones) (Scotland) Regulations 2005 ; **and** The Mental Health (England and Wales Cross border transfer: patients subject to requirements other than detention) (Scotland) Regulations 2008.
Education (Additional Support for Learning) (Scotland) Act 2004	
section 23 (other agencies etc. to help in exercise of functions under this Act)	
Public Services Reform (Scotland) Act 2010	
All functions of Health Boards conferred by, or by virtue of, the Public Services Reform (Scotland) Act 2010	Except functions conferred by— section 31(Public functions: duties to provide information on certain expenditure etc.); and section 32 (Public functions: duty to provide information on exercise of functions).
Patient Rights (Scotland) Act 2011	
All functions of Health Boards conferred by, or by virtue of, the Patient Rights (Scotland) Act 2011	Except functions conferred by The Patient Rights (complaints Procedure and Consequential Provisions) (Scotland) Regulations 2012.
Carers (Scotland) Act 2016	
section 31 (duty to prepare local carer strategy)	Only in so far as it applies to adults

PART 2

Services currently provided by the Health Board which are to be integrated.

Interpretation

In this schedule:

“Allied Health Professional” means a person registered as an allied health professional with the Health Professions Council;

“general medical practitioner” means a medical practitioner whose name is included in the General Practitioner Register kept by the General Medical Council;

“general medical services contract” means a contract under section 17J of the National Health Service (Scotland) Act 1978;

“hospital” has the meaning given by section 108(1) of the National Health Service (Scotland) Act 1978;

“inpatient hospital services” means any health care service provided to a patient who has been admitted to a hospital and is required to remain in that hospital overnight, but does not include any secure forensic mental health services;

“out of hours period” has the same meaning as in regulation 2 of the National Health Service (General Medical Services Contracts) (Scotland) Regulations 2004(); and

“the public dental service” means services provided by dentists and dental staff employed by a health Board under the public dental service contract.

The functions listed in Annex 1 Part 1 are delegated only in relation to these services:

- Accident and emergency services provided in a hospital
- Inpatient hospital services relating to the following branches of medicine:
    - General medicine;
    - Geriatric medicine;
    - Rehabilitation medicine;
    - Respiratory medicine; and
    - Psychiatry of learning disability.
- Palliative care services provided in a hospital;
- Inpatient hospital services provided by general medical practitioners;
- Services provided in a hospital in relation to an addiction or dependence on any substance;
- Mental health services provided in a hospital, except secure forensic mental health services;
- District nursing services;
- Services provided out with a hospital in relation to addiction or dependence on any substance;
- Services provided by allied health professionals in an outpatient department, clinic, or out with a hospital;
- The public dental service;

- Primary medical services provided under a general medical services contract, and arrangements for the provision of services made under section 17C of the National Health Service (Scotland) Act 1978, or an arrangement made in pursuance of section 2C (2) of the National Health Service (Scotland) Act 1978;
- General dental services provided under arrangements made in pursuance of section 25 of the National Health (Scotland) Act 1978;
- Ophthalmic services provided under arrangements made in pursuance of section 17AA or section 26 of the National Health Service (Scotland) Act 1978;
- Pharmaceutical services and additional pharmaceutical services provided under arrangements made in pursuance of sections 27 and 27A of the National Health Service (Scotland) Act 1978;
- Services providing primary medical services to patients during the out-of-hours period;
- Services provided outwith a hospital in relation to geriatric medicine;
- Palliative care services provided outwith a hospital; Community learning disability services;
- Mental health services provided out with a hospital;
- Continence services provided out with a hospital;
- kidney dialysis services provided outwith a hospital; and Services provided by health professionals that aim to promote public health;
- Services provided by health professionals that aim to promote public health.

PART 3

Services provided by the Health Board which are to be integrated

The functions listed in Annex 1 Part 1 that are delegated in relation to the services that are to be integrated and delivered on a pan-Forth Valley basis are noted in the table below. The arrangements for these services are noted in paragraph 6.8 of the Integration Scheme. Whilst these arrangements may be subject to change by agreement of the Health Board and the three Forth Valley Local Authorities, the Parties recommend that they are hosted/delivered on a Lead Partner basis as follows:

Falkirk	***Clackmannanshire and Stirling***	***Health Board***
• Primary care including out of hours. • Prisoner Healthcare • Forth Valley wide health improvement where these fall out with the arrangements for each HSCP	• Specialist mental health and learning disability (including adult Mental health inpatients)	**Operational management only** in relation to: • Large hospital services including Accident and Emergency and wards associated with unplanned admissions.

PART 4

The following services from Part 2 of Annex 1 and Part 3 of Annex 1 will also be integrated in respect of people under the age of 18:

- Accident and Emergency services provided in a hospital;
- Public dental services;
- Primary medical services provided under a general medical services contract, and arrangements for the provision of services made under section 17C of the National Health Service (Scotland) Act 1978, or an arrangement made in pursuance of section 2C(2) of the National Health Service (Scotland) Act 1978;
- General dental services provided under arrangements made in pursuance of section 25 of the National Health (Scotland) Act 1978;
- Ophthalmic services provided under arrangements made in pursuance of section 17AA or section 26 of the National Health Service (Scotland) Act 1978;
- Pharmaceutical services and additional pharmaceutical services provided under arrangements made in pursuance of sections 27 and 27A of the National Health Service (Scotland) Act 1978;
- Primary medical services out-of-hours ;
- Community learning disability services;
- kidney dialysis services provided out with a hospital;
- Services provided by allied health professions.

ANNEX 2

PART 1

Functions delegated by the Council(s) to the Integration Joint Board

Set out below is the list of functions that are delegated by the Council(s) to the Integration Joint Board as set out in the Public Bodies (Joint Working) (Prescribed Local Authority Functions etc.) (Scotland) Regulations 2014.

Functions prescribed for the purposes of section 1(7) of the Public Bodies (Joint Working) (Scotland) Act 2014

Column A **Enactment conferring function**	**Column B Limitation**
National Assistance Act 1948	
section 48 (duty of councils to provide temporary protection for property of persons admitted to hospitals etc.)	
The Disabled Persons (Employment) Act 1958	
section 3 (Provision of sheltered employment by local authorities)	
The Social Work (Scotland) Act 1968	
section 1 (local authorities for the administration of the Act.)	So far as it is exercisable in relation to another integration function.
section 4 (provisions relating to performance of functions by local authorities.)	So far as it is exercisable in relation to another integration function.
section 8 (research.)	So far as it is exercisable in relation to another integration function.
section 10 (financial and other assistance to voluntary organisations etc. for social work.)	So far as it is exercisable in relation to another integration function.
section 12 (general social welfare services of local authorities.)	Except in so far as it is exercisable in relation to the provision of housing support services.
section 12A (duty of local authorities to assess needs.)	So far as it is exercisable in relation to another integration function.

Column A **Enactment conferring function**	**Column B Limitation**
section 12AZA (assessments under section 12A - assistance)	So far as it is exercisable in relation to another integration function.
section 13 (power of local authorities to assist persons in need in disposal of produce of their	
section 13ZA (provision of services to incapable adults.)	So far as it is exercisable in relation to another integration function.
section 13A (residential accommodation with nursing.)	
section 13B (provision of care or aftercare.)	
section 14 (home help and laundry facilities.)	
section 29 (power of local authority to defray expenses of parent, etc., visiting persons or attending funerals.)	
section 59 (provision of residential and other establishments by local authorities and maximum period for repayment of sums borrowed for such provision.)	So far as it is exercisable in relation to another integration function.
The Local Government and Planning (Scotland) Act 1982	
section 24(1) (The provision of gardening assistance for the disabled and the elderly.)	
Disabled Persons (Services, Consultation and Representation) Act 1986	
section 2 (rights of authorised representatives of disabled persons.)	
section 3 (assessment by local authorities of needs of disabled persons.)	
section 7 (persons discharged from hospital.)	In respect of the assessment of need for any services provided under functions contained in welfare enactments within the meaning of section 16 and which are integration functions.

Column A Enactment conferring function	Column B Limitation
section 8 (duty of local authority to take into account abilities of carer.)	In respect of the assessment of need for any services provided under functions contained in welfare enactments (within the meaning set out in section 16 of that Act) which are integration functions.
The Adults with Incapacity (Scotland) Act 2000	
section 10 (functions of local authorities.)	
section 12 (investigations.)	
section 37 (residents whose affairs may be managed.)	Only in relation to residents of establishments which are managed under integration functions.
section 39 (matters which may be managed.)	Only in relation to residents of establishments which are managed under integration functions.
section 41 (duties and functions of managers of authorised establishment.)	Only in relation to residents of establishments which are managed under integration functions
section 42 (Authorisation of named manager to withdraw from resident's account.)	Only in relation to residents of establishments which are managed under integration functions
section 43 (statement of resident's affairs.)	Only in relation to residents of establishments which are managed under integration functions
section 44 (resident ceasing to be resident of authorised establishment.)	Only in relation to residents of establishments which are managed under integration functions
section 45 (appeal, revocation etc.)	Only in relation to residents of establishments which are managed under integration functions
The Housing (Scotland) Act 2001	
section 92 (assistance for housing purposes.)	Only in so far as it relates to an aid or adaptation.
The Community Care and Health (Scotland) Act 2002	
section 5 (local authority arrangements for of residential accommodation outwith Scotland.)	

section 14 (payments by local authorities towards expenditure by NHS bodies on prescribed functions.)	

Column A Enactment conferring function	Column B Limitation
The Mental Health (Care and Treatment) (Scotland) Act 2003	
Section 17 (duties of Scottish Ministers, local authorities and others as respects Commission)	
section 25 (Care and support services etc.)	Except in so far as it is exercisable in relation to the provision of housing support services.
section 26 (services designed to promote well-being and social development.)	Except in so far as it is exercisable in relation to the provision of housing support services.
section 27 (assistance with travel.)	Except in so far as it is exercisable in relation to the provision of housing support services.
section 33 (duty to inquire.)	
section 34 (inquiries under section 33: Co-operation.)	
section 228 (request for assessment of needs: duty on local authorities and Health Boards.)	
section 259 (advocacy.)	
The Housing (Scotland) Act 2006	
section 71(1)(b) (assistance for housing purposes.)	Only in so far as it relates to an aid or adaptation.
The Adult Support and Protection (Scotland) Act 2007	
section 4 (council's duty to make inquiries.)	
section 5 (co-operation.)	
section 6 (duty to consider importance of providing advocacy and other.)	
section 11 (assessment orders.)	
section 14 (removal orders.)	

section 18 (protection of moved persons property.)	
section 22 (right to apply for a banning order.)	
section 40 (urgent cases.)	
section 42 (adult protection committees.)	
section 43 (membership.)	
Social Care (Self-directed Support) (Scotland) Act 2013	
section 5 (choice of options: adults.)	
section 6 (choice of options under section 5: assistances.)	
section 7 (choice of options: adult carers.)	
section 9 (provision of information about self-directed support.)	
section 11 (local authority functions.)	
section 12 (eligibility for direct payment: review.)	
section 13 (further choice of options on material change of circumstances.)	Only in relation to a choice under section 5 or 7 of the Social Care (Self-directed Support) (Scotland) Act 2013 .
section 16 (misuse of direct payment: recovery.)	
section 19 (promotion of options for self-directed support.)	

Column A Enactment conferring function	Column B Limitation
Carers (Scotland) Act 2016	
section 6 (duty to prepare adult carer support plan)	
section 21 (duty to set local eligibility criteria)	
section 24 (duty to provide support)	
section 25 (provision of support to carers: breaks from	
section 31 (duty to prepare local carer strategy)	
section 34 (information and advice service for users)	
section 35 (short breaks services statements)	

PART 2

Functions, conferred by virtue of enactments, prescribed for the purposes of Section 1(7) of the Public Bodies (Joint Working) (Scotland) Act 2014

Column A Enactment conferring function	Column B Limitation
The Community Care and Health (Scotland) Act 2002	
Section 4 The functions conferred by Regulation 2 of the Community Care (Additional Payments) (Scotland) Regulations 2002	

PART 3

Additional Functions to be delegated by the Council

Column A **Enactment conferring function**	**Column B Limitation**
Matrimonial Proceedings (Children) Act 1958	
Section 11 (Reports as to arrangements for future care and upbringing of children.)	
The Social Work (Scotland) Act 1968	
Section 5 (Powers of Secretary of State.) Section 6B (Local authority inquiries into matters affecting children.) Section 27 (Supervision and care of persons put on probation or released from prisons etc.) Section 27ZA (Advice, guidance and assistance to persons arrested or on whom sentence deferred.) Section 78A (Recovery of contributions) Section 80 (Enforcement of duty to make contributions.) Section 81 (Provisions as to decrees for ailment.) Section 83 (Variation of trusts.) Section 86 (Adjustment between authority providing accommodation etc., and authority of area of residence.)	
The Children Act 1975	
Section 34 (Access and maintenance.) Section 39 (Reports by local authorities and probation officers.) Section 40 (Notice of application to be given to local authority.) Section 50 (Payments towards maintenance of children.)	

Foster Children (Scotland) Act 1984	
Section 3 (local authorities to ensure well-being of and to visit foster children.) Section 5 (Notification by persons maintaining or proposing to maintain foster children.) Section 6 Notification by persons ceasing to maintain foster children.) Section 8 (Power to inspect premises.) Section 9 (Power to impose requirements as to the keeping of foster children.) Section 10 (Power to prohibit the keeping of foster children.)	
The Children (Scotland Act 1995	
Section 17 (Duty of local authority to child looked after by them.) Section19 (Local authority plans for services for children) Section 20 (Publication of information about services for children) Section 21 (Co-operation between authorities) Section 22 (Promotion of welfare of children in need) Section 23 (Children affected by disability) Section 25 (Provision of accommodation for children etc.) Section 26 (Manner of provision of accommodation to child looked after by local authority) Section 26A (Provision of continuing care: looked after children) Section 27 (Daycare for pre-school and other children) Section 29 (Aftercare) Section 30 (Financial assistance towards expenses of education or training and	

removal of power to guarantee indentures etc.) Section 31 Review of case of child looked after by local authority) Section 32 (Removal of child from residential establishment) Section 36 (Welfare of certain children in hospitals and nursing homes etc.) Section 38 (Short term refuges for children at risk of harm.) Section 76 (Exclusion orders.)	
Criminal Procedure (Scotland) Act 1995	
Section 51 (Remand and committal of children and young persons.)	
The Adults with Incapacity (Scotland) Act 2000	
Section 40 (Supervisory bodies.)	
Management of Offenders etc (Scotland) Act 2005	
Sections 10 (Arrangements for assessing and managing risks posed by certain offenders) Section 11 (Review of arrangements)	
Adoption and Children (Scotland) Act 2007	
Section 1 (Duty of local authority to provide adoption service.) Section 45 (Adoption support plans.) Section 47 (Family member's right to require review of plan) Section 48 (Other cases where authority under duty to review plan) Section 49 (Re-assessment of needs for adoption support services) Section 51 (Guidance) Section 71 (Adoption allowance schemes.) Section 80 (Permanence Orders.) Section 90 (Precedence of certain other orders)	

Section 99 (Duty of local authority to apply for variation or revocation.) Section 101 (Local authority to give notice of certain matters.)	
The Adult Support and Protection (Scotland) Act 2007	
Section 7 (Visits) Section 8 (Interviews)	
Children's Hearings (Scotland) Act 2011	
Section 35 (Child assessment orders.) Section 37 (Child protection orders.) Section 42 (Parental responsibilities and rights directions.) Section 44 (Obligations of local authority.) Section 48 (Application for variation or termination Section 49 (Notice of an application for variation or termination.) Section 60 (Local authorities duty to provide information to Principal Reporter.) Section 131 (Duty of implementation authority to require review.) Section 144 (Implementation of a compulsory supervision order; general duties of implementation authority.) Section 145 (Duty where order requires child to reside in a certain place.) Section 166 (Review of requirement imposed on local authority) Section167 (Appeal to Sheriff Principal: section 166) Section 180 (Sharing of information: panel members.) Section 183- (Mutual Assistance) Section 184 (Enforcement of obligations of health board under section 183)	

Social Care (Self-directed Support) (Scotland) Act 2013	
Section 8 (Choice of options; children and family members.)	
Carers (Scotland) Act 2016	
Section12 (Duty to prepare a Young Carer Statement)	

PART 4

Adult Services provided by the Council which are to be integrated

- Social work services for adults and older people;
- Services and support for adults with physical disabilities and learning disabilities;
- Mental health services;
- Drug and alcohol services;
- Adult protection and domestic abuse;
- Carers support services;
- Community care assessment teams;
- Care home services;
- Adult placement services;
- Health improvement services;
- Aspects of housing support, including aids and adaptions and those areas of housing support that involve an indistinguishable overlap between personal care and housing support;
- Day services;
- Local area co-ordination;
- Respite provision;
- Occupational therapy services; and
- Re-ablement services, equipment and telecare.

Social care services for children and young people that are to be integrated.

- Child Care Assessment and Care Management
- Looked After and accommodated Children
- Child Protection
- Adoption and Fostering
- Special Needs/Additional Support
- Early Intervention
- Through-care Services
- Youth Justice Services

Social Care Justice Services that are to be integrated

- Services to Courts and Parole Board
- Assessment of offenders
- Diversions from Prosecution and Fiscal Work Orders
- Supervision of offenders subject to a community-based order
- Through care and supervision of released prisoners
- Multi Agency Public Protection Arrangements

Consultees to the Integration Scheme

Participation arrangements are set out in section 9 of this Integration Scheme. The list of consultees includes: The Health Board;

The Council;

Falkirk Integration Joint Board;

Health professionals;

Users of health care;

Carers of users of health care;

Commercial providers of health care;

Non-commercial providers of health care;

Social care professionals;

Users of social care;

Carers of users of social care;

Commercial providers of social care;

Non-commercial providers of social care;

Staff of the Health Board and the Council;

Union and staff representatives;

Non-commercial providers of social housing;

Third sector bodies carrying out activities related to health or social care;

General Public;

Elected members of the Council.

NHS Forth Valley
Forth Valley NHS Board

8. Strategic Risk Register Update – April'26-June'26
Purpose: This report is for Decision

Executive Sponsor: Kerry Mackenzie, Acting Director of Strategic Planning & Performance
Author: Miss Vicky Webb, Head of Risk Management

Executive Summary

The enclosed report provides a retrospective update to the Strategic Risk Register for the period April 2026 to June 2026. It reflects a fixed point in time, as the content represents the position formally endorsed by each of the Standing Governance Committees prior to submission for final Board approval. Accordingly, the timescales referenced within the report are aligned to, and should be interpreted in the context of, the discussions and considerations at those respective committee meetings.

The Risk Management Working Group continue to meet monthly to discuss the recommendations made by the Standing Governance Committees and FV NHS Board to strengthen the Strategic Risk Management process. The group has successfully supported the review and refresh of Risk Appetite and Tolerance, introduced action criticality to reporting, and has proposed Governance Committee approval of action extension to support Committee ownership of the strategic risks. Further work is ongoing to refresh the focused review template and realign the strategic risk descriptions to the Population Health & Care Strategy. A paper the outputs of this process will be presented to the Strategic Planning, Performance & Resources Committee at a later date.

Action Required

The Forth Valley NHS Board is asked to:

(1) approve the changes to the Strategic Risk Register for this reporting period (April'26-June-26).
  a. SRR004: Scheduled Care increased in score from 20 to 25.
  b. Reframing of SRR005: Financial Sustainability to reflect the Strategic Position.
(2) note the progression of the mitigating actions identified.
(3) consider the assurance provided through the focused reviews conducted within this period.
(4) note the work of the Risk Management Working Group to strengthen the Strategic Risk Management processes.
(5) 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.

- Clinical Governance Committee, at every meeting. The committee reviewed the risks within its remit and formally endorsed the existing position to the Forth Valley NHS Board. Clarity was obtained about the increase in score of Scheduled Care, with an ask made to provide further context on the increase in score of SRR004. This is an evolving picture and following discussion it has been confirmed that this will be reviewed and updated ahead of the next CGC. Furthermore, initial points were raised around the potential of a Quality & Safety Strategic Risk, and an action was taken to discuss further with Executive Leads.

- Staff Governance Committee, at every meeting. The committee reviewed the risks within its remit and formally endorsed the existing position to the Forth Valley NHS Board. Clarity was obtained around the current position of risks, scrutiny obtained on the current actions and controls mitigating these risks. With further discussion held on reframing the Workforce Strategic Risk, in line with the Population Health & Care Strategy.
- Strategic Planning, Performance & Resources Committee at every meeting. The committee reviewed the risks within its remit and formally endorsed the existing position to the Forth Valley NHS Board. This committee discussed three focused reviews on Primary Care Sustainability, Digital & eHealth, and Information Governance, with challenge posed on the description and controls of each. Financial Sustainability was reframed in light of the Population Health & Care Strategy, to reflect the long-term strategic goal of the Board and was endorsed by the committee for approval at the Board. The remaining strategic risks received scrutiny and discussion on their position.
- Audit & Risk Committee, on the 12 June. The Committee received a quarterly update on the risk management processes for the Board. The Committee scrutinised the paper, including the Risk Management Performance Indicators. Secondly, the Committee approved the Risk Management Procedures for roll out across the organisation.

Risk Assessment and Mitigation
The report details the current Strategic Risk position for the NHS FV Board and the ongoing work to strengthen these processes.

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

Financial and Infrastructure Implications
Financial and Infrastructure implications are detailed where relevant to risk.

Workforce Implications
Workforce implications are included in the body of the paper where relevant to risk.

Quality / Patient Care Implications
Injury /Illness and Healthcare Experience implications are included in the body of the paper where relevant to risk.

Population Health & Care Strategy
Our Strategic Risks are risks that will impact on our ability to meet the overall aims of the Population Health & Care Strategy.

Climate Change / Sustainability Implications
Climate Change implications are included in the body of the paper where relevant to risk.

Engagement and Communications
Was statutory engagement with stakeholders required? Yes ☐ No ☒

- If yes, please provide details.

Appendices
Appendix 1 – Strategic Risk Register Update – April'26-June'26

Appendix 1 - Strategic Risk Review – April'26-June'26

Contents

1. Summary and Key Messages
2. Strategic Risks in Focus
    2.1 Strategic Risk Dashboard
    2.2 Strategic Risk in Focus
3. Risk Controls Progress Update
4. Risk Trend Analysis
5. Strategic Risk Focused Reviews

1.Summary and Key Messages

All current strategic risks were reviewed during this period with SRR004 increasing to a score of 25 - section two of this report provides additional details. Alongside this, SRR005 risk description has been reviewed to re-emphasise the strategic risks to the Board.

- Three focused reviews have been conducted in this time period:
    - SRR003: Information Governance
    - SRR011: Digital & eHealth Infrastructure
    - SRR018: Primary Care Sustainability

There is a change to the appetite profile of the Board for this reporting period – due to changes in the reporting requirements through the new Risk Framework. As it stands, there are currently 0% of risks within the Boards appetite, 25% are within the Boards tolerance and 75% are out with the Boards appetite and tolerance. Section 4 of the report provides further details on this.

There are 3 overdue actions to note for this reporting period, due to reporting timescales, with 12 actions completed within this reporting period.

1.1 Overview of the Risk Working Group Activity

The Risk Management Working Group (RWG) continue to meet monthly to discuss the recommendations made to strengthen the Strategic Risk Management process. The group have successfully reviewed and refreshed Risk Appetite and Tolerance and have supported the following:
- Action Criticality introduced into reporting.
- Updates to the SRR based on the Risk Management Framework
- Approval process for action extension. This will be introduced at the start of the next committee cycle.

The RWG continue to meet to further support the development of this process. Next steps include:
- Strengthening the Focused Review Template
- Review the Strategic Risk descriptions to align with the Population Health & Care Strategy.

2.Strategic Risks in Focus

2.1 Strategic Risk Dashboard

Ref	Risk Title	Untreated Score	Current Score	Date Assessed	Score History	Risk Trend	Target Score	Owned By	Governance Group	Lead Impact Category
SRR 002	Urgent & Unscheduled Care	25	25	27-Apr-2026	25; 25; 25		10	Garry Fraser	Clinical Governance Committee	Injury/ Illness
SRR 005	Financial Sustainability	25	25	14-May-2026	25; 25; 25		15	Scott Urquhart	Strategic Planning, Performance and Resources Committee	Financial
SRR 004	Scheduled Care	25	25	23-Apr-2026	20; 20; 25		10	Garry Fraser	Clinical Governance Committee	Service Delivery/Business Interruption
SRR 011	Digital & eHealth - Infrastructure & Strategy	20	20	22-May-2026	20; 20; 20		10	Scott Jaffray	Strategic Planning, Performance and Resources Committee	Service Delivery/Business Interruption
SRR 015	Cyber Resilience	25	20	19-May-2026	20; 20; 20		16	Andrew Murray	Strategic Planning, Performance and Resources Committee	Service Delivery/Business Interruption
SRR 017	Environmental Sustainability & Climate Change	25	20	19-May-2026	20; 20; 20		10	Morag Farquhar	Strategic Planning, Performance and Resources Committee	Compliance
SRR 020	Health Inequalities	25	20	08-May-2026	20; 20; 20		10	Jennifer Champion	Strategic Planning, Performance and Resources Committee	Health Inequalities
SRR 009	Workforce Plans	25	15	29-Apr-2026	15; 15; 20		10	Kevin Reith	Staff Governance Committee	Financial
SRR 018	Primary Care Sustainability	20	15	22-May-2026	15; 15; 15		10	Caroline Doherty	Strategic Planning, Performance and Resources Committee	Injury/ Illness
SRR 019	Culture & Leadership	25	15	05-May--2026	15; 15; 15		10	Kevin Reith	Staff Governance Committee	Compliance
SRR 003	Information Governance	20	12	05-June-2026	12; 12; 12		8	Andrew Murray	Strategic Planning, Performance and Resources Committee	Compliance
SRR 010	Estates & Supporting Infrastructure	25	12	19-May-2026	12; 12; 12		10	Morag Farquhar	Strategic Planning, Performance and Resources Committee	Service Delivery/Business Interruption

2.2 Strategic Risks in Focus

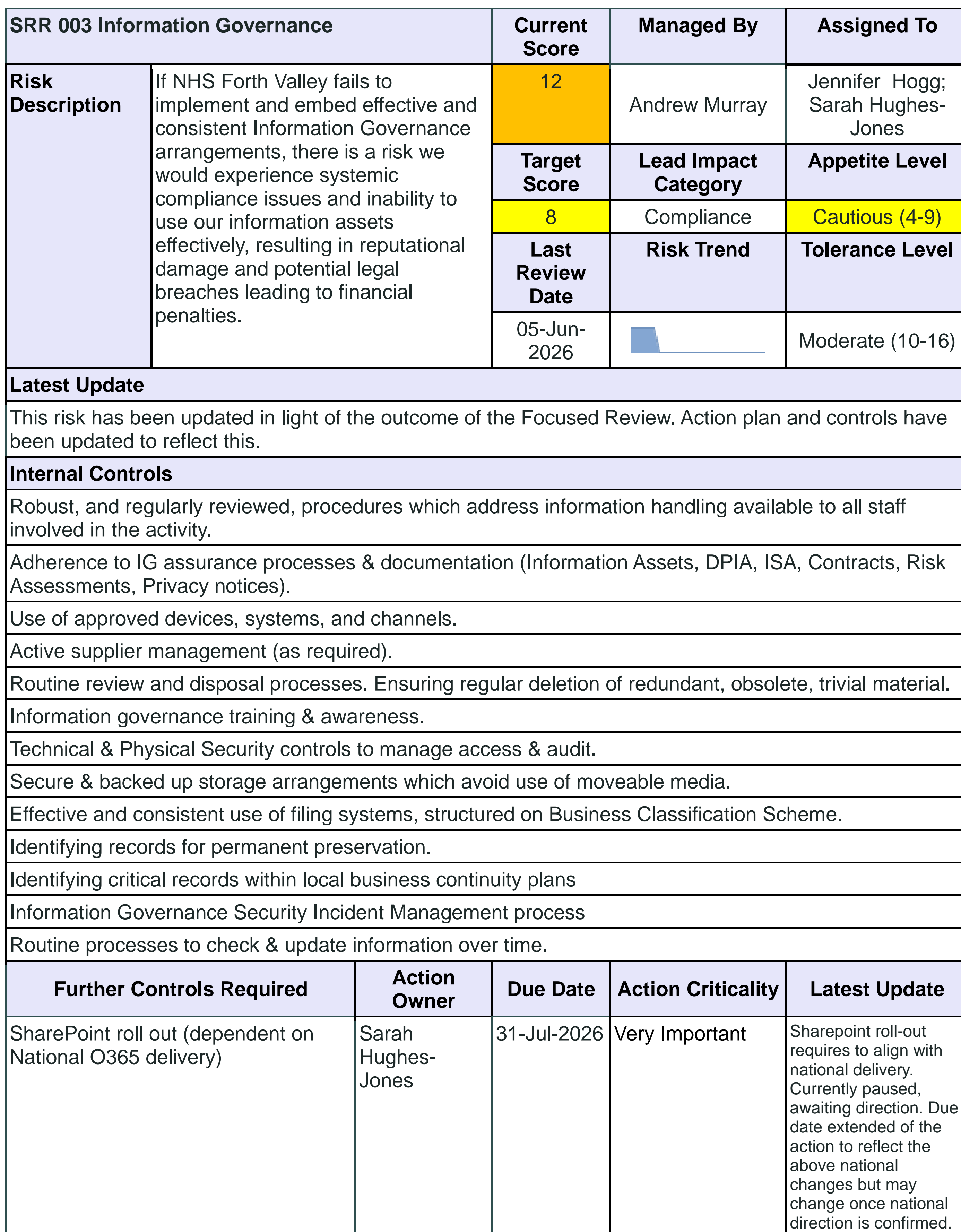
<table>
<tr><th colspan="2">SRR 002 Urgent & Unscheduled Care</th><th>Current Score</th><th>Managed By</th><th>Assigned To</th></tr>
<tr><td rowspan="6">Risk Description</td><td rowspan="6">If we do not have enough whole system capacity and flow to address key areas of improvement, there is a risk that we will be unable to deliver safe, effective, and person-centred unscheduled care resulting in a potential for patient harm, increases in length of stay, placement of patients in unsuitable places, and a negative impact on patient & staff experience.</td><td>25</td><td>Garry Fraser</td><td>Fiona Murray</td></tr>
<tr><td>Target Score</td><td>Lead Impact Category</td><td>Appetite Level</td></tr>
<tr><td>8</td><td>Injury / Illness</td><td>Cautious (4-9)</td></tr>
<tr><td>Last Review Date</td><td>Risk Trend</td><td>Tolerance Level</td></tr>
<tr><td>27-Apr-2026</td><td></td><td>Zero</td></tr>
</table>

Latest Update
This risk has been reviewed with the Head of Service for Unscheduled Care and there is no change to the scoring of this risk at this review. Progress has been made against all of the actions listed and will continue to be monitored regularly.

Internal Controls
Flow Navigation Centre Workstream
Hospital at Home Workstream
Front Door Workstream
DWD Collaborative
Whole System Frailty Workstream
Dynamically using resources to reduce and mitigate risk of patient harm.

Further Controls Required	Action Owner	Due Date	Action Criticality	Latest Update
Completion of the 12-week improvement plan and development of a robust workforce model.	Deborah Lynch	30-Jun-2026	Very Important	The 12-week plan is progressing. Workforce modelling has come through from CfSD and a local meeting has been arranged with FV teams to agree what we need to put in place, supporting the improvement team. Alongside this, mapping work has started with the ED team, including a look at ED breach analysis.
Review the Flow Navigation Centre to review movement to a Senior Decision Maker Model.	Fiona Murray	31-Mar-2027	Very Important	Discussions are still ongoing at a regional level.
Strengthen access to discharge to assess model.	Deborah Lynch	31-Mar-2027	Very Important	Action updated to remove reference to community pathways as this is the main focus of the action. Progress continues to be made on this action.

Develop Adults With Incapacity (AWI) Process.	Jennifer Borthwick; Gail Woodcock	30-Jun-2026	Important	FHSCP are looking at their local processes to support this process. Due date extended to June-26.
Embed key principles from the National DWD Collaborative.	Deborah Lynch	31-Mar-2027	Important	The national DWD Collaborative has 4 key workstreams and success has been shown in key measures around Discharge Without Delay collaborative for FV. Work continues to complete this action and show improvement within DWD.
Increase Hospital at Home Capacity, including virtual capacity, in line with SG request.	Fiona Murray	31-Dec-2026	Moderately Important	This action now covers the Hospital at Home core capacity, virtual capacity and the additional capacity required of us to deliver by Scottish Government. Progress continues to be made on this. Increased to 45 core H@H beds. 67 beds will be made up of H@H+ capacity.



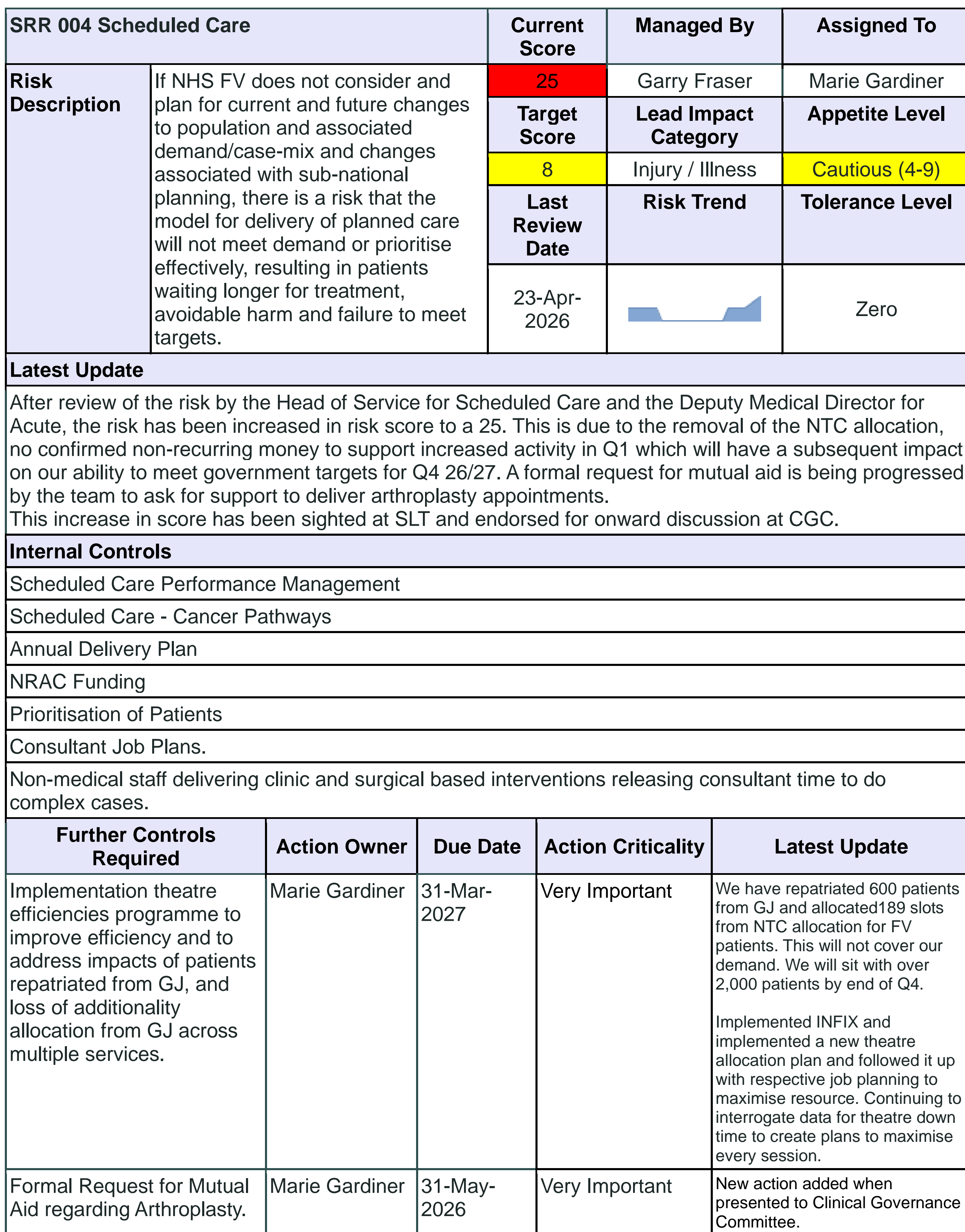
SRR 003 Information Governance		Current Score	Managed By	Assigned To
Risk Description	If NHS Forth Valley fails to implement and embed effective and consistent Information Governance arrangements, there is a risk we would experience systemic compliance issues and inability to use our information assets effectively, resulting in reputational damage and potential legal breaches leading to financial penalties.	12	Andrew Murray	Jennifer Hogg; Sarah Hughes-Jones
		Target Score	**Lead Impact Category**	**Appetite Level**
		8	Compliance	Cautious (4-9)
		Last Review Date	**Risk Trend**	**Tolerance Level**
		05-Jun-2026		Moderate (10-16)

Latest Update
This risk has been updated in light of the outcome of the Focused Review. Action plan and controls have been updated to reflect this.

Internal Controls
Robust, and regularly reviewed, procedures which address information handling available to all staff involved in the activity.
Adherence to IG assurance processes & documentation (Information Assets, DPIA, ISA, Contracts, Risk Assessments, Privacy notices).
Use of approved devices, systems, and channels.
Active supplier management (as required).
Routine review and disposal processes. Ensuring regular deletion of redundant, obsolete, trivial material.
Information governance training & awareness.
Technical & Physical Security controls to manage access & audit.
Secure & backed up storage arrangements which avoid use of moveable media.
Effective and consistent use of filing systems, structured on Business Classification Scheme.
Identifying records for permanent preservation.
Identifying critical records within local business continuity plans
Information Governance Security Incident Management process
Routine processes to check & update information over time.

Further Controls Required	Action Owner	Due Date	Action Criticality	Latest Update
SharePoint roll out (dependent on National O365 delivery)	Sarah Hughes-Jones	31-Jul-2026	Very Important	Sharepoint roll-out requires to align with national delivery. Currently paused, awaiting direction. Due date extended of the action to reflect the above national changes but may change once national direction is confirmed.

Information Governance Unit resource assessment and gap analysis to be presented to the Information Governance Group. This report will contain options and recommendations around future-proofing the services.	Sarah Hughes-Jones	31-Aug-2026	Absolutely Critical	New action added as part of focused review process.
Develop a plan to improve records management practice across NHS Forth Valley.	Jennifer Hogg	31-Oct-2026	Absolutely Critical	New action added as part of focused review process.
Strengthen policies to restrict USB usage to exceptional circumstances only. Provide role-specific training on SharePoint and OneDrive to support secure storage and collaboration.	Brian Farrell	30-Sep-2026	Absolutely Critical	New action added as part of focused review process.
Develop and implement a permanent organisation-wide model for supplier assurance.	Brian Farrell	30-Sep-2026	Absolutely Critical	New action added as part of focused review process.



SRR 004 Scheduled Care		Current Score	Managed By	Assigned To
Risk Description	If NHS FV does not consider and plan for current and future changes to population and associated demand/case-mix and changes associated with sub-national planning, there is a risk that the model for delivery of planned care will not meet demand or prioritise effectively, resulting in patients waiting longer for treatment, avoidable harm and failure to meet targets.	25	Garry Fraser	Marie Gardiner
		Target Score	**Lead Impact Category**	**Appetite Level**
		8	Injury / Illness	Cautious (4-9)
		Last Review Date	**Risk Trend**	**Tolerance Level**
		23-Apr-2026		Zero

Latest Update
After review of the risk by the Head of Service for Scheduled Care and the Deputy Medical Director for Acute, the risk has been increased in risk score to a 25. This is due to the removal of the NTC allocation, no confirmed non-recurring money to support increased activity in Q1 which will have a subsequent impact on our ability to meet government targets for Q4 26/27. A formal request for mutual aid is being progressed by the team to ask for support to deliver arthroplasty appointments. This increase in score has been sighted at SLT and endorsed for onward discussion at CGC.

Internal Controls
Scheduled Care Performance Management
Scheduled Care - Cancer Pathways
Annual Delivery Plan
NRAC Funding
Prioritisation of Patients
Consultant Job Plans.
Non-medical staff delivering clinic and surgical based interventions releasing consultant time to do complex cases.

Further Controls Required	Action Owner	Due Date	Action Criticality	Latest Update
Implementation theatre efficiencies programme to improve efficiency and to address impacts of patients repatriated from GJ, and loss of additionality allocation from GJ across multiple services.	Marie Gardiner	31-Mar-2027	Very Important	We have repatriated 600 patients from GJ and allocated189 slots from NTC allocation for FV patients. This will not cover our demand. We will sit with over 2,000 patients by end of Q4. Implemented INFIX and implemented a new theatre allocation plan and followed it up with respective job planning to maximise resource. Continuing to interrogate data for theatre down time to create plans to maximise every session.
Formal Request for Mutual Aid regarding Arthroplasty.	Marie Gardiner	31-May-2026	Very Important	New action added when presented to Clinical Governance Committee.

SRR 005 Financial Sustainability	Current Score	Managed By	Assigned To
If we do not conduct significant medium to long-term service transformation and redesign aligned to future population health and care needs, there is a risk that NHS Forth Valley will be unable to deploy its resources in a sustainable way to meet increasing demand, resulting in reduced ability to deliver high-quality, effective outcomes for the population.	25	Scott Urquhart	Jillian Thomson
	Target Score	**Lead Impact Category**	**Appetite Level**
	15	Financial	Cautious (4-9)
	Last Review Date	**Risk Trend**	**Tolerance Level**
	14-May-2026		Moderate (10-16)

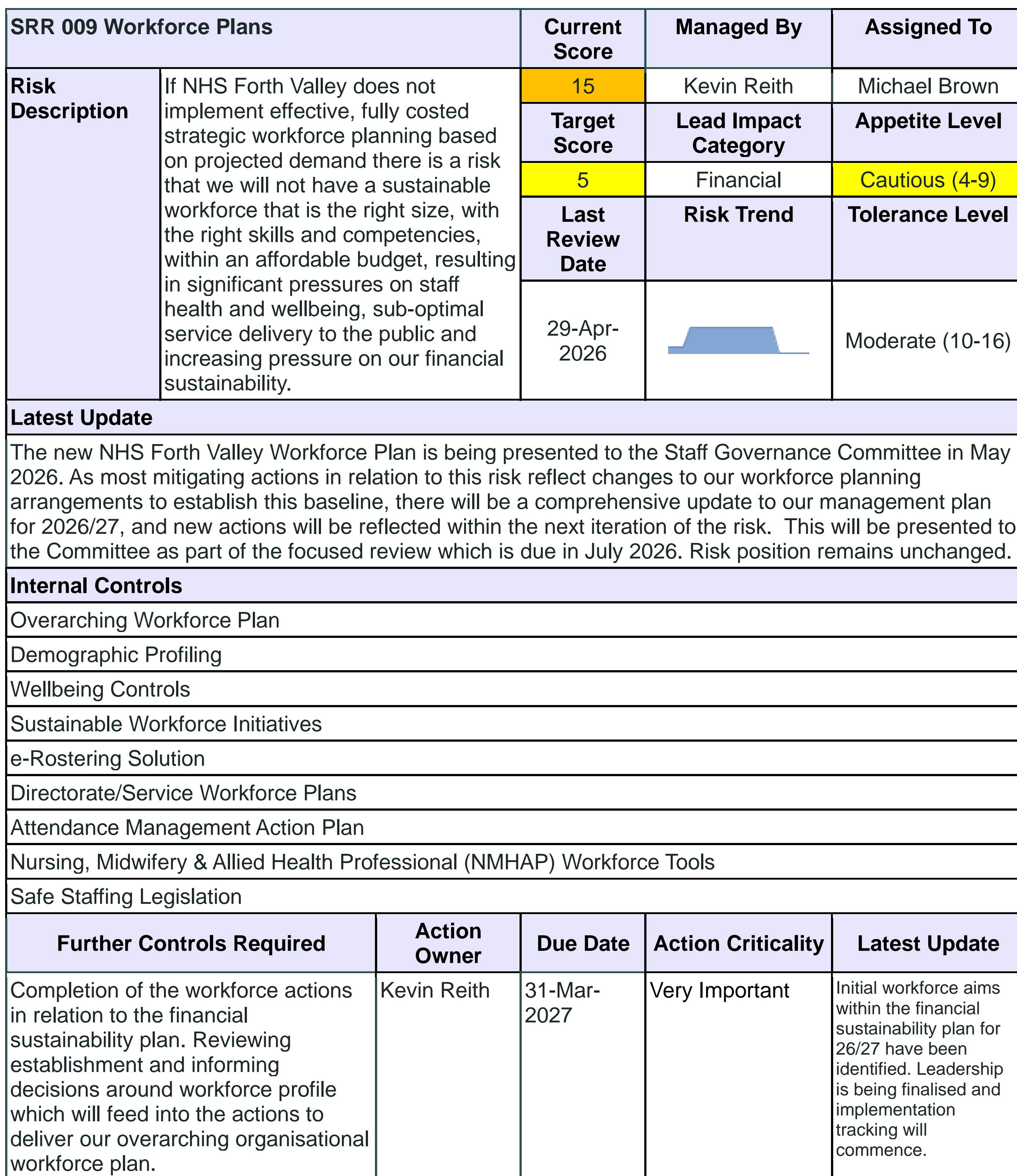
Latest Update

The risk description has had a significant review and has been reframed to look at the long-term risk of service deliverability if transformative initiatives are not conducted or not successful. To support this change of risk description and focus on the Strategic Risk, an Organisational Risk has been developed to provide insights and assurance on the mitigation of the in-year financial position of the Board.
This was presented and endorsed by SLT, prior to formal communication to the Strategic Planning Performance & Resources Committee.

Internal Controls

Financial Savings Programme

Further Controls Required	Action Owner	Due Date	Action Criticality	Latest Update
Delivery of the Population Health & Care Strategy.	Ross McGuffie	31-Dec-2035	Absolutely Critical	New action added as part of reframing of the risk.
Delivery of the Value-Based Health & Care Programme.	Andrew Murray	31-Dec-2028	Very Important	New action added as part of reframing of the risk.
Become a Population Health Organisation.	Jennifer Champion	31-Dec-2035	Absolutely Critical	New action added as part of reframing of the risk.

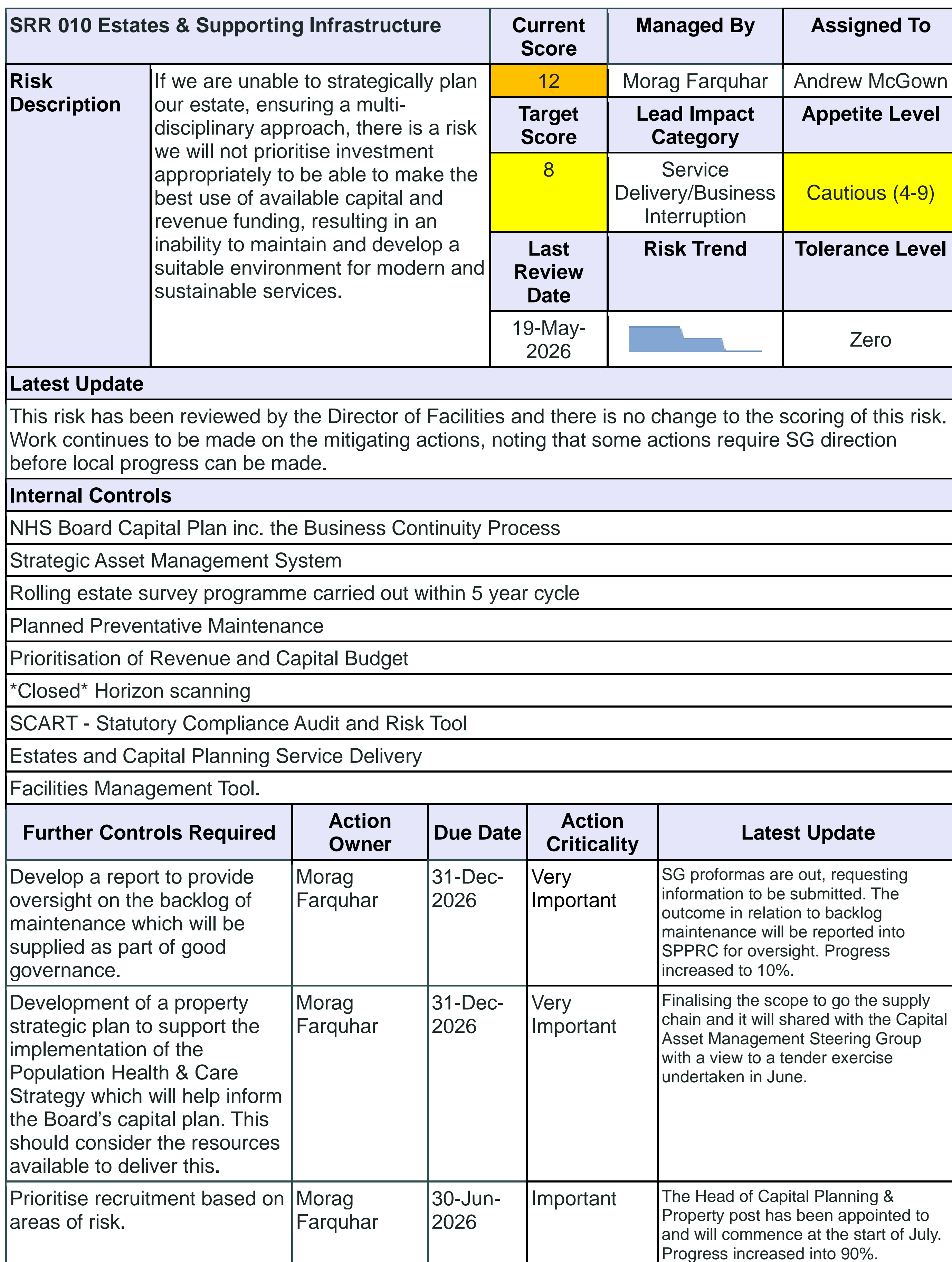


SRR 009 Workforce Plans		Current Score	Managed By	Assigned To
Risk Description	If NHS Forth Valley does not implement effective, fully costed strategic workforce planning based on projected demand there is a risk that we will not have a sustainable workforce that is the right size, with the right skills and competencies, within an affordable budget, resulting in significant pressures on staff health and wellbeing, sub-optimal service delivery to the public and increasing pressure on our financial sustainability.	15	Kevin Reith	Michael Brown
		Target Score	**Lead Impact Category**	**Appetite Level**
		5	Financial	Cautious (4-9)
		Last Review Date	**Risk Trend**	**Tolerance Level**
		29-Apr-2026		Moderate (10-16)

Latest Update
The new NHS Forth Valley Workforce Plan is being presented to the Staff Governance Committee in May 2026. As most mitigating actions in relation to this risk reflect changes to our workforce planning arrangements to establish this baseline, there will be a comprehensive update to our management plan for 2026/27, and new actions will be reflected within the next iteration of the risk. This will be presented to the Committee as part of the focused review which is due in July 2026. Risk position remains unchanged.

Internal Controls
Overarching Workforce Plan
Demographic Profiling
Wellbeing Controls
Sustainable Workforce Initiatives
e-Rostering Solution
Directorate/Service Workforce Plans
Attendance Management Action Plan
Nursing, Midwifery & Allied Health Professional (NMHAP) Workforce Tools
Safe Staffing Legislation

Further Controls Required	Action Owner	Due Date	Action Criticality	Latest Update
Completion of the workforce actions in relation to the financial sustainability plan. Reviewing establishment and informing decisions around workforce profile which will feed into the actions to deliver our overarching organisational workforce plan.	Kevin Reith	31-Mar-2027	Very Important	Initial workforce aims within the financial sustainability plan for 26/27 have been identified. Leadership is being finalised and implementation tracking will commence.



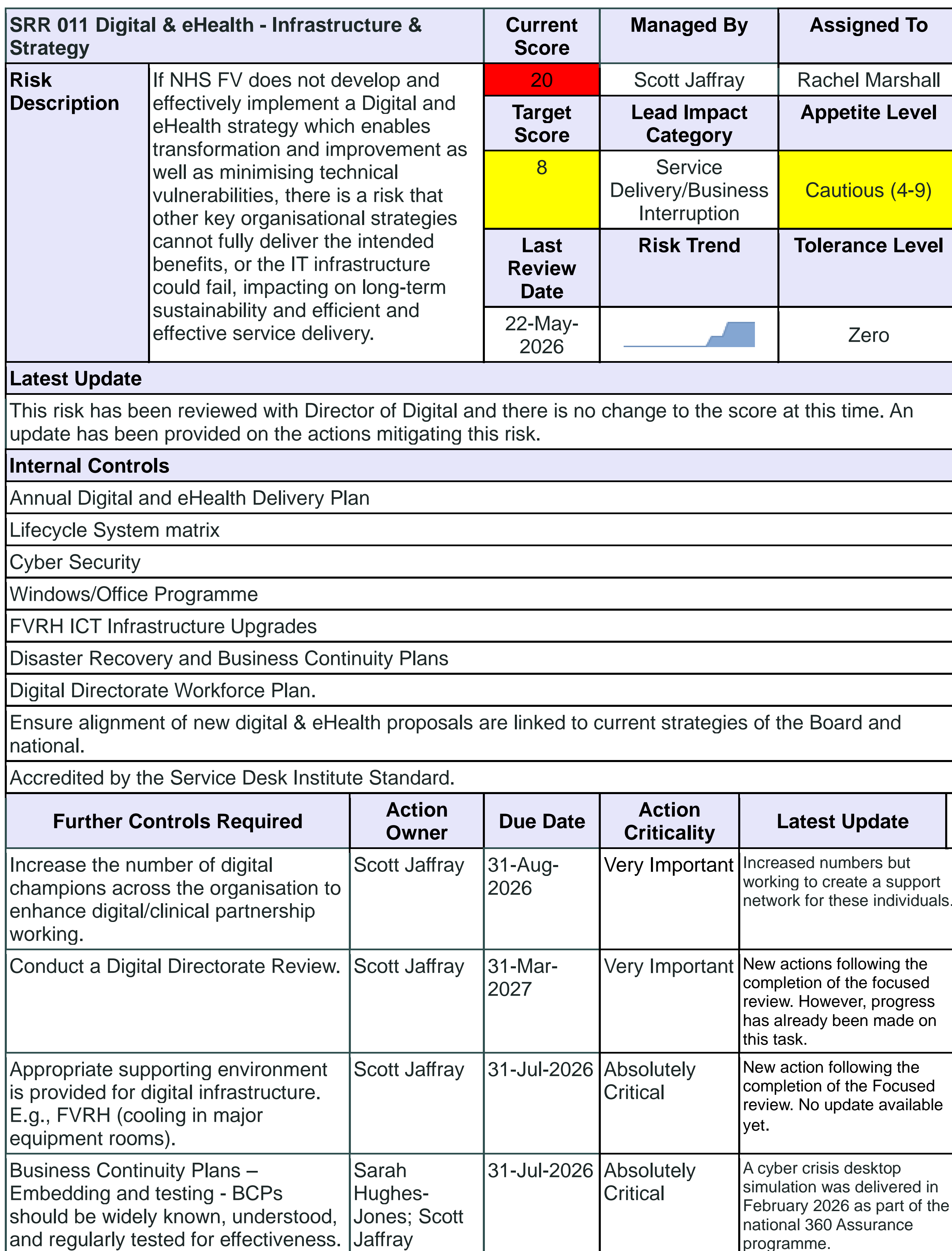
SRR 010 Estates & Supporting Infrastructure		Current Score	Managed By	Assigned To
Risk Description	If we are unable to strategically plan our estate, ensuring a multi-disciplinary approach, there is a risk we will not prioritise investment appropriately to be able to make the best use of available capital and revenue funding, resulting in an inability to maintain and develop a suitable environment for modern and sustainable services.	12	Morag Farquhar	Andrew McGown
		Target Score	**Lead Impact Category**	**Appetite Level**
		8	Service Delivery/Business Interruption	Cautious (4-9)
		Last Review Date	**Risk Trend**	**Tolerance Level**
		19-May-2026		Zero

Latest Update
This risk has been reviewed by the Director of Facilities and there is no change to the scoring of this risk. Work continues to be made on the mitigating actions, noting that some actions require SG direction before local progress can be made.

Internal Controls
NHS Board Capital Plan inc. the Business Continuity Process
Strategic Asset Management System
Rolling estate survey programme carried out within 5 year cycle
Planned Preventative Maintenance
Prioritisation of Revenue and Capital Budget
Closed Horizon scanning
SCART - Statutory Compliance Audit and Risk Tool
Estates and Capital Planning Service Delivery
Facilities Management Tool.

Further Controls Required	Action Owner	Due Date	Action Criticality	Latest Update
Develop a report to provide oversight on the backlog of maintenance which will be supplied as part of good governance.	Morag Farquhar	31-Dec-2026	Very Important	SG proformas are out, requesting information to be submitted. The outcome in relation to backlog maintenance will be reported into SPPRC for oversight. Progress increased to 10%.
Development of a property strategic plan to support the implementation of the Population Health & Care Strategy which will help inform the Board's capital plan. This should consider the resources available to deliver this.	Morag Farquhar	31-Dec-2026	Very Important	Finalising the scope to go the supply chain and it will shared with the Capital Asset Management Steering Group with a view to a tender exercise undertaken in June.
Prioritise recruitment based on areas of risk.	Morag Farquhar	30-Jun-2026	Important	The Head of Capital Planning & Property post has been appointed to and will commence at the start of July. Progress increased into 90%.

Engage with national process around primary care premises (national baseline) to inform first steps around the business case processes for primary care estate in FV.	Morag Farquhar	30-Apr-2027	Absolutely Critical	Scottish Government is planning a national Primary/Community Care Programme and has a list of pilots in mind, NHS FV is not part of this and await further from SG in relation to the implications of this. Decision making is required regarding primary care premises and whether a programme of investment can be identified and delivered using a mix of local and national capital. A new revenue funding model is not expected until at least 2030. The date has been extended to April '27 in line with the date for Strategic Assessments to be with SG - there is currently a limit of 3 per Board.



SRR 011 Digital & eHealth - Infrastructure & Strategy		Current Score	Managed By	Assigned To
Risk Description	If NHS FV does not develop and effectively implement a Digital and eHealth strategy which enables transformation and improvement as well as minimising technical vulnerabilities, there is a risk that other key organisational strategies cannot fully deliver the intended benefits, or the IT infrastructure could fail, impacting on long-term sustainability and efficient and effective service delivery.	20	Scott Jaffray	Rachel Marshall
		Target Score	**Lead Impact Category**	**Appetite Level**
		8	Service Delivery/Business Interruption	Cautious (4-9)
		Last Review Date	**Risk Trend**	**Tolerance Level**
		22-May-2026		Zero

Latest Update
This risk has been reviewed with Director of Digital and there is no change to the score at this time. An update has been provided on the actions mitigating this risk.

Internal Controls
Annual Digital and eHealth Delivery Plan
Lifecycle System matrix
Cyber Security
Windows/Office Programme
FVRH ICT Infrastructure Upgrades
Disaster Recovery and Business Continuity Plans
Digital Directorate Workforce Plan.
Ensure alignment of new digital & eHealth proposals are linked to current strategies of the Board and national.
Accredited by the Service Desk Institute Standard.

Further Controls Required	Action Owner	Due Date	Action Criticality	Latest Update
Increase the number of digital champions across the organisation to enhance digital/clinical partnership working.	Scott Jaffray	31-Aug-2026	Very Important	Increased numbers but working to create a support network for these individuals.
Conduct a Digital Directorate Review.	Scott Jaffray	31-Mar-2027	Very Important	New actions following the completion of the focused review. However, progress has already been made on this task.
Appropriate supporting environment is provided for digital infrastructure. E.g., FVRH (cooling in major equipment rooms).	Scott Jaffray	31-Jul-2026	Absolutely Critical	New action following the completion of the Focused review. No update available yet.
Business Continuity Plans – Embedding and testing - BCPs should be widely known, understood, and regularly tested for effectiveness.	Sarah Hughes-Jones; Scott Jaffray	31-Jul-2026	Absolutely Critical	A cyber crisis desktop simulation was delivered in February 2026 as part of the national 360 Assurance programme.

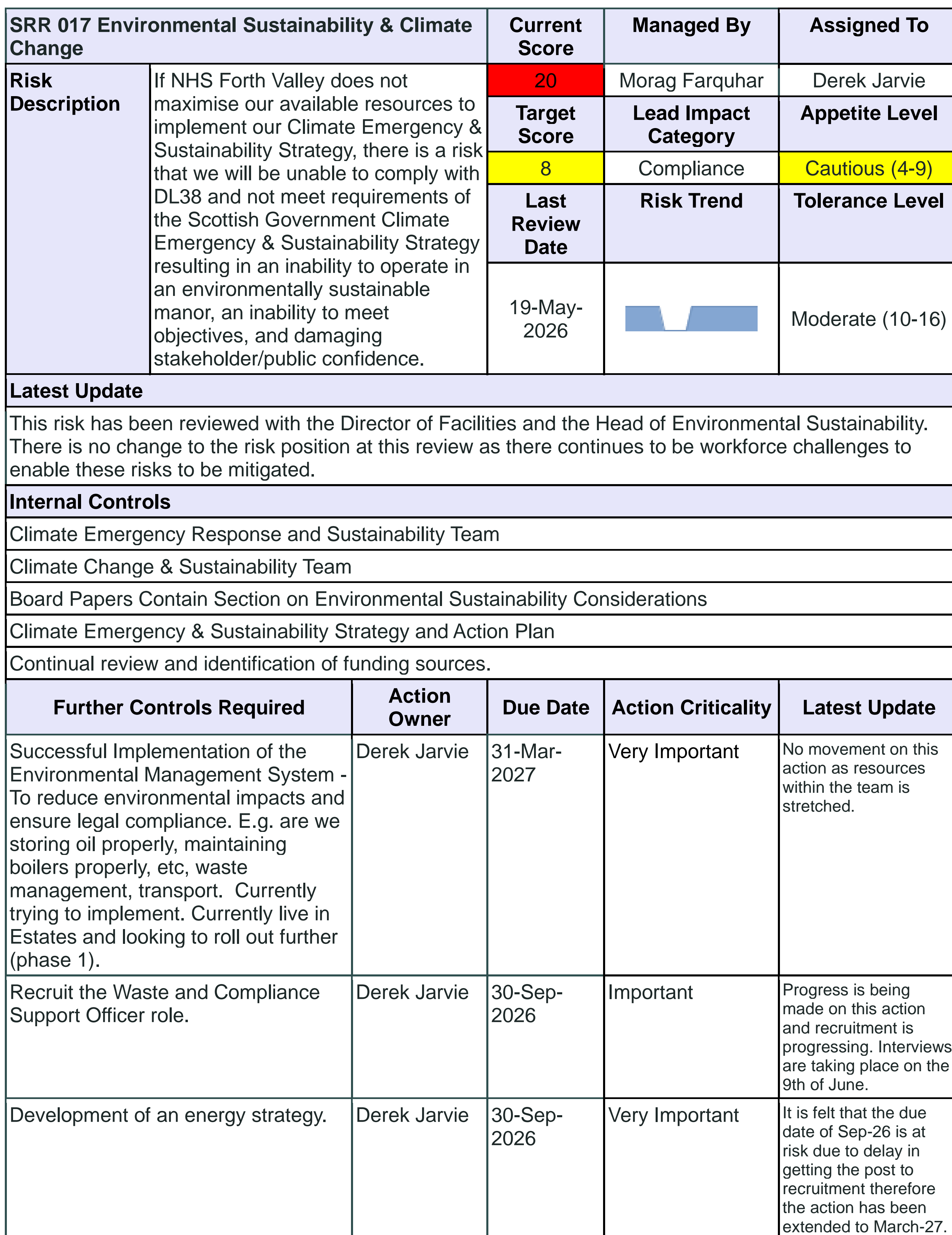
SRR 015 Cyber Resilience		Current Score	Managed By	Assigned To
Risk Description	If NHS Forth Valley do not maintain the effectiveness of current cyber security controls and implement improvements to security controls where possible. There is a risk that the cyber security of the organisation may be compromised Resulting in a significant disruption to the services delivered by the organisation and an impact to the confidentiality, integrity, and availability of systems and data.	20	Andrew Murray	Sarah Hughes-Jones; Scott Jaffray
		Target Score	**Lead Impact Category**	**Appetite Level**
		16	Service Delivery/Business Interruption	Moderate (10-16)
		Last Review Date	**Risk Trend**	**Tolerance Level**
		19-May-2026		Zero

Latest Update
This risk has been reviewed by the Cyber Security Manager and there is no change to the risk score at this review. Work continues to be made on the mitigating actions. However, it should be noted that the current Cyber Security Manager is leaving NHS FV for another post, leaving staffing gaps in the cyber team, and may impact on the deliverability of these actions.

Internal Controls
Digital and eHealth Strategy to outline funding arrangements for cyber.
Cyber Resilience Framework
Change Management processes to include cyber.
Local Policies & Procedures
Cyber Training & Simulations.
NIS Audit Recommendations
Enhanced ICT Infrastructure Business Continuity / Disaster Recovery
Cyber Security Awareness Strategy.
Digital Delivery Plan 22/23
Cyber Resilience Awareness Training
Asset Management
System Management
Threat Intelligence Processes
Vulnerability & Patch Management
Utilisation of Security Tools
Communication and awareness
Cybersecurity & Operational Staffing and Capability Development
Supplier Management
Access Control
Media Management
Operational & Network Security Management

Business Continuity & Disaster Recovery				
Privileged Access Management (PAM) & Administration account management				
Cyber Change Management Processes				
Further Controls Required	**Action Owner**	**Due Date**	**Action Criticality**	**Latest Update**
Continuous improvements and monitoring of our awareness material and training for all staff. This includes a high level of compliance with the mandatory nature of Cyber Awareness training.	Jennifer Hogg; Sarah Hughes-Jones; Scott Jaffray; Kurt McLay	31-Jul-2026	Important	A further phishing simulation is planned for June 2026. This will be targeted at staff who interacted with previous simulations, including those who submitted credentials, to help assess whether follow-up awareness activity has improved behaviour and to identify any continuing trends or areas requiring further support. The results will be reviewed alongside previous simulation outcomes to inform future targeted training, departmental engagement and wider cyber awareness activity.
Embedding and testing - BCPs should be widely known, understood, and regularly tested for effectiveness.	Sarah Hughes-Jones; Scott Jaffray; Kurt McLay	31-Jul-2026	Absolutely Critical	A cyber crisis desktop simulation was delivered in February 2026 as part of the national 360 Assurance programme. The exercise was facilitated by Core to Cloud and focused on senior decision-making, roles, communications and organisational readiness during a major cyber incident.An output report from the exercise has now been received and will be reviewed to identify any learning, gaps or follow-up actions. This will support further embedding of the Cyber Incident Response Plan, Field Manual and wider business continuity arrangements, ensuring that plans continue to be tested in a realistic incident scenario rather than remaining as standalone documents.

Gatekeeping process for third party access - Third parties (Charities, suppliers etc) have an agreed, securely managed route into our infrastructure which the Health Board controls.	Scott Jaffray; Kurt McLay	31-Jul-2026	Very Important	Work continues on the gatekeeping process for third-party access, led through Compliance within the Digital Directorate, with Cyber/IG input where required.
Conduct a review of the current cyber resources to support effective change management. This will be included by the Digital Directorate Review. Further review to also be scheduled within IGU.	Sarah Hughes-Jones; Scott Jaffray; Kurt McLay	30-Sep-2026	Absolutely Critical	Cyber capacity remains a live risk. The Cyber Security Manager is leaving the post in May 2026, which creates a short-term continuity and resilience risk for cyber leadership, escalation, governance, NIS/CAF assurance activity, incident response oversight and change-related cyber input.
Completion of actions related to Cyber Resilience Focused Review.	Brian Farrell; Kurt McLay	31-Dec-2026	Very Important	53% complete.

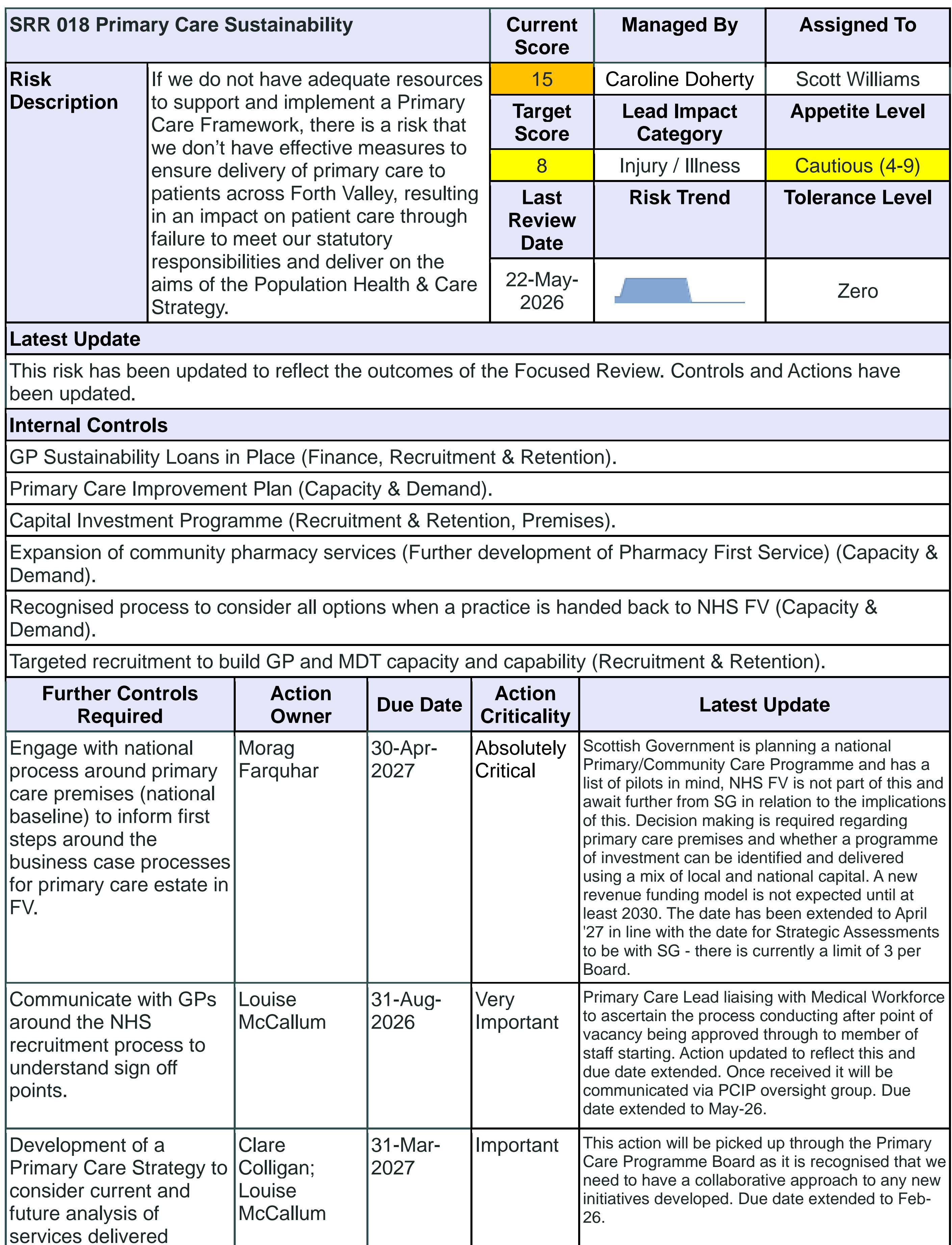


SRR 017 Environmental Sustainability & Climate Change		Current Score	Managed By	Assigned To
Risk Description	If NHS Forth Valley does not maximise our available resources to implement our Climate Emergency & Sustainability Strategy, there is a risk that we will be unable to comply with DL38 and not meet requirements of the Scottish Government Climate Emergency & Sustainability Strategy resulting in an inability to operate in an environmentally sustainable manor, an inability to meet objectives, and damaging stakeholder/public confidence.	20	Morag Farquhar	Derek Jarvie
		Target Score	**Lead Impact Category**	**Appetite Level**
		8	Compliance	Cautious (4-9)
		Last Review Date	**Risk Trend**	**Tolerance Level**
		19-May-2026		Moderate (10-16)

Latest Update
This risk has been reviewed with the Director of Facilities and the Head of Environmental Sustainability. There is no change to the risk position at this review as there continues to be workforce challenges to enable these risks to be mitigated.

Internal Controls
Climate Emergency Response and Sustainability Team
Climate Change & Sustainability Team
Board Papers Contain Section on Environmental Sustainability Considerations
Climate Emergency & Sustainability Strategy and Action Plan
Continual review and identification of funding sources.

Further Controls Required	Action Owner	Due Date	Action Criticality	Latest Update
Successful Implementation of the Environmental Management System - To reduce environmental impacts and ensure legal compliance. E.g. are we storing oil properly, maintaining boilers properly, etc, waste management, transport. Currently trying to implement. Currently live in Estates and looking to roll out further (phase 1).	Derek Jarvie	31-Mar-2027	Very Important	No movement on this action as resources within the team is stretched.
Recruit the Waste and Compliance Support Officer role.	Derek Jarvie	30-Sep-2026	Important	Progress is being made on this action and recruitment is progressing. Interviews are taking place on the 9th of June.
Development of an energy strategy.	Derek Jarvie	30-Sep-2026	Very Important	It is felt that the due date of Sep-26 is at risk due to delay in getting the post to recruitment therefore the action has been extended to March-27.



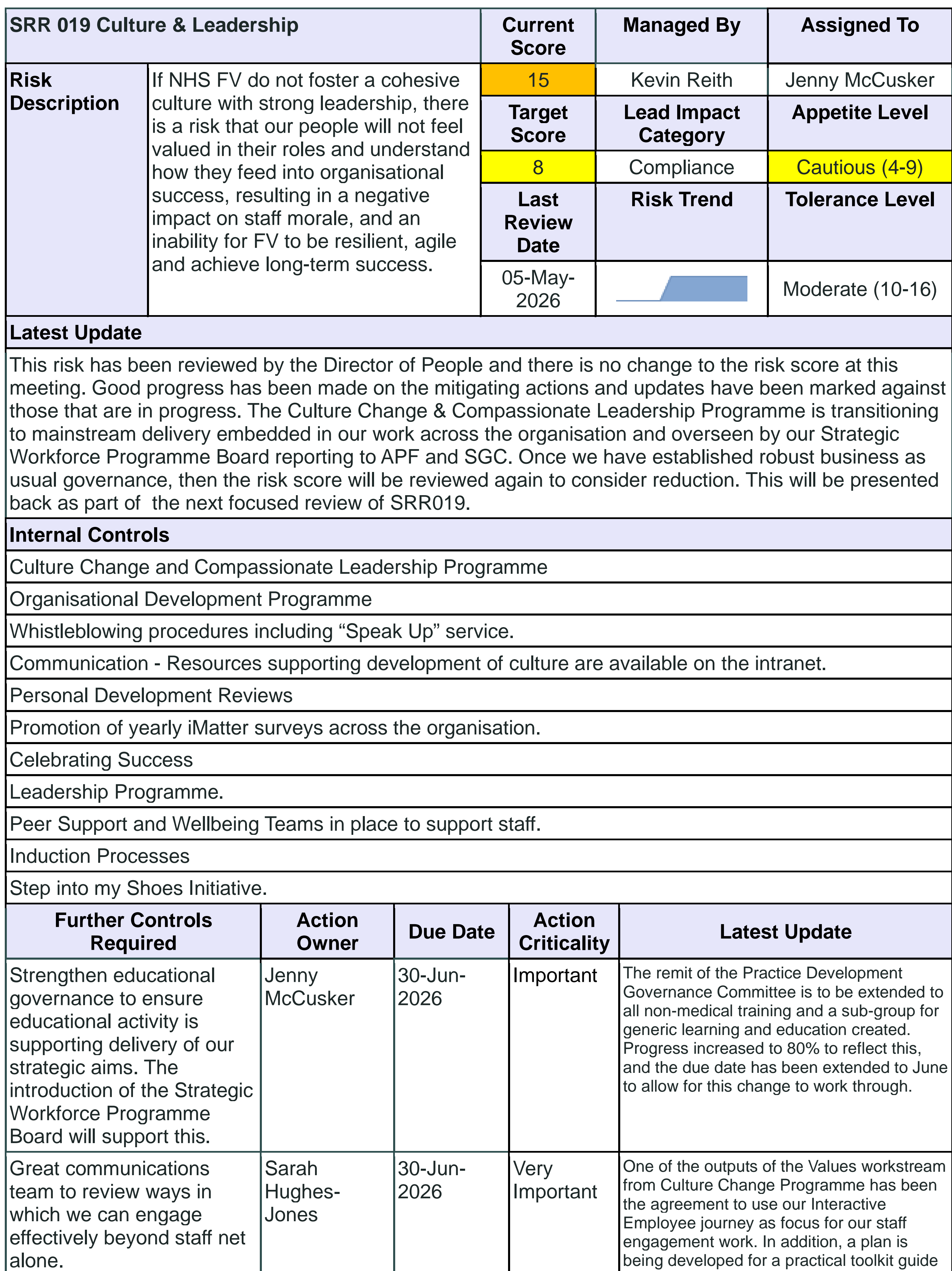
SRR 018 Primary Care Sustainability		Current Score	Managed By	Assigned To
Risk Description	If we do not have adequate resources to support and implement a Primary Care Framework, there is a risk that we don't have effective measures to ensure delivery of primary care to patients across Forth Valley, resulting in an impact on patient care through failure to meet our statutory responsibilities and deliver on the aims of the Population Health & Care Strategy.	15	Caroline Doherty	Scott Williams
		Target Score	**Lead Impact Category**	**Appetite Level**
		8	Injury / Illness	Cautious (4-9)
		Last Review Date	**Risk Trend**	**Tolerance Level**
		22-May-2026		Zero

Latest Update
This risk has been updated to reflect the outcomes of the Focused Review. Controls and Actions have been updated.

Internal Controls
GP Sustainability Loans in Place (Finance, Recruitment & Retention).
Primary Care Improvement Plan (Capacity & Demand).
Capital Investment Programme (Recruitment & Retention, Premises).
Expansion of community pharmacy services (Further development of Pharmacy First Service) (Capacity & Demand).
Recognised process to consider all options when a practice is handed back to NHS FV (Capacity & Demand).
Targeted recruitment to build GP and MDT capacity and capability (Recruitment & Retention).

Further Controls Required	Action Owner	Due Date	Action Criticality	Latest Update
Engage with national process around primary care premises (national baseline) to inform first steps around the business case processes for primary care estate in FV.	Morag Farquhar	30-Apr-2027	Absolutely Critical	Scottish Government is planning a national Primary/Community Care Programme and has a list of pilots in mind, NHS FV is not part of this and await further from SG in relation to the implications of this. Decision making is required regarding primary care premises and whether a programme of investment can be identified and delivered using a mix of local and national capital. A new revenue funding model is not expected until at least 2030. The date has been extended to April '27 in line with the date for Strategic Assessments to be with SG - there is currently a limit of 3 per Board.
Communicate with GPs around the NHS recruitment process to understand sign off points.	Louise McCallum	31-Aug-2026	Very Important	Primary Care Lead liaising with Medical Workforce to ascertain the process conducting after point of vacancy being approved through to member of staff starting. Action updated to reflect this and due date extended. Once received it will be communicated via PCIP oversight group. Due date extended to May-26.
Development of a Primary Care Strategy to consider current and future analysis of services delivered	Clare Colligan; Louise McCallum	31-Mar-2027	Important	This action will be picked up through the Primary Care Programme Board as it is recognised that we need to have a collaborative approach to any new initiatives developed. Due date extended to Feb-26.

through other community patient pathways (e.g., Community Pharmacy) with an aim to mitigate and reduce the strain on core services.				
Long term strategy and recurring resource needed to deliver on recommendations such as Golden Hello recruitment grants, coaching and mentoring, infrastructure	Louise McCallum	31-Aug-2026	Moderately Important	Another paper on GH going to the Sustainability Group in light of the additional funding. They will then decide what happens with a proposal.
Review management of vacancies within PCIP.	Nickola Jones	31-Dec-2026	Important	Action title updated to reflect management of vacancies within PCIP. This action is being tracked by the PCIP Oversight Group. Due date extended to December-26.
Successful pilot for coaching and mentoring and looking to see if there is additional resource to mainstream that.	Scott Williams	31-Aug-2026	Moderately Important	New action added as part of focused review process.
Re-establish a Primary Care Premises Group.	Tom Cowan	31-Aug-2026	Moderately Important	New action added as part of focused review process.
Await outputs of review of PCIP and the associated business case to inform next steps locally.	Nickola Jones	31-Dec-2026	Moderately Important	New action added as part of focused review process.



SRR 019 Culture & Leadership		Current Score	Managed By	Assigned To
Risk Description	If NHS FV do not foster a cohesive culture with strong leadership, there is a risk that our people will not feel valued in their roles and understand how they feed into organisational success, resulting in a negative impact on staff morale, and an inability for FV to be resilient, agile and achieve long-term success.	15	Kevin Reith	Jenny McCusker
		Target Score	**Lead Impact Category**	**Appetite Level**
		8	Compliance	Cautious (4-9)
		Last Review Date	**Risk Trend**	**Tolerance Level**
		05-May-2026		Moderate (10-16)

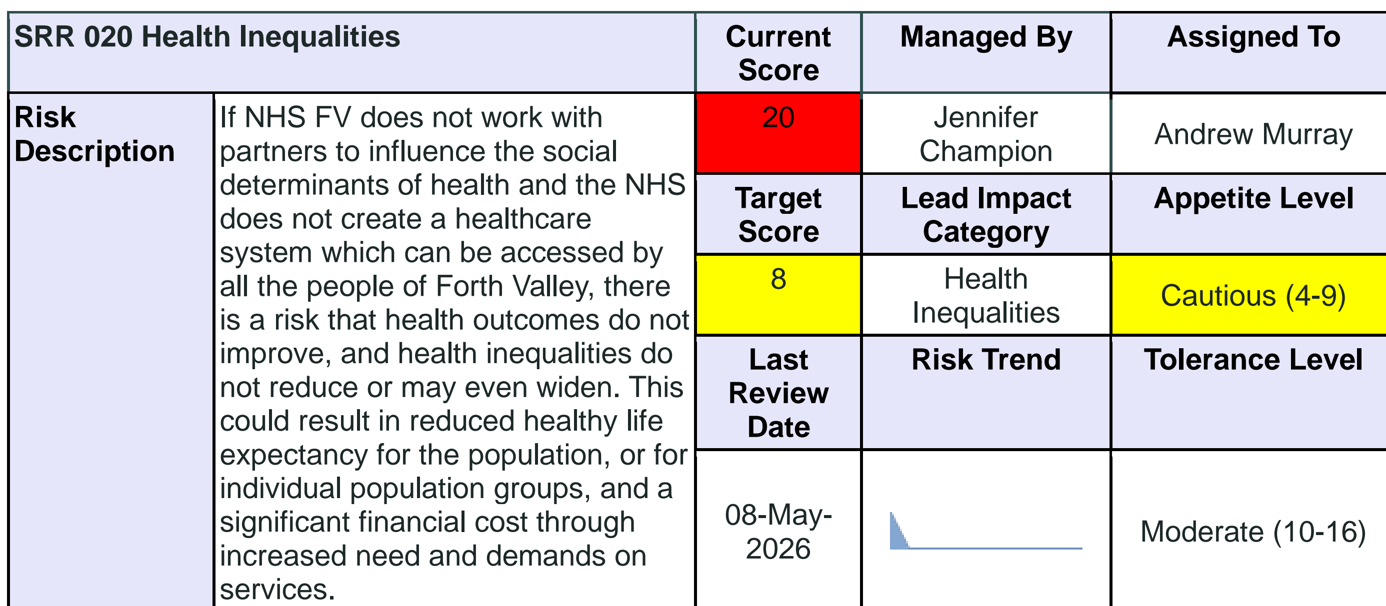
Latest Update

This risk has been reviewed by the Director of People and there is no change to the risk score at this meeting. Good progress has been made on the mitigating actions and updates have been marked against those that are in progress. The Culture Change & Compassionate Leadership Programme is transitioning to mainstream delivery embedded in our work across the organisation and overseen by our Strategic Workforce Programme Board reporting to APF and SGC. Once we have established robust business as usual governance, then the risk score will be reviewed again to consider reduction. This will be presented back as part of the next focused review of SRR019.

Internal Controls
Culture Change and Compassionate Leadership Programme
Organisational Development Programme
Whistleblowing procedures including “Speak Up” service.
Communication - Resources supporting development of culture are available on the intranet.
Personal Development Reviews
Promotion of yearly iMatter surveys across the organisation.
Celebrating Success
Leadership Programme.
Peer Support and Wellbeing Teams in place to support staff.
Induction Processes
Step into my Shoes Initiative.

Further Controls Required	Action Owner	Due Date	Action Criticality	Latest Update
Strengthen educational governance to ensure educational activity is supporting delivery of our strategic aims. The introduction of the Strategic Workforce Programme Board will support this.	Jenny McCusker	30-Jun-2026	Important	The remit of the Practice Development Governance Committee is to be extended to all non-medical training and a sub-group for generic learning and education created. Progress increased to 80% to reflect this, and the due date has been extended to June to allow for this change to work through.
Great communications team to review ways in which we can engage effectively beyond staff net alone.	Sarah Hughes-Jones	30-Jun-2026	Very Important	One of the outputs of the Values workstream from Culture Change Programme has been the agreement to use our Interactive Employee journey as focus for our staff engagement work. In addition, a plan is being developed for a practical toolkit guide

				which will sit within a new communications framework refresh. This work will be completed as part of mainstreaming activity by 30 June 2026.
Get connected team looking at improving communication between FV and partnership organisations.	Sarah Hughes-Jones	31-May-2026	Very Important	The next Step in my Shoes will go live in May 2026. Due date updated to reflect this.
Develop cultural indicators which will be used to inform assessment of progress around improving culture.	Jenny McCusker	31-May-2026	Important	Discussed at the last Staff Governance Committee and it was agreed to bring this process back to the Committee at a later date for further discussion.
Develop the process which identifies leadership talent, directs to the appropriate development activity and evaluates effectiveness.	Jenny McCusker	30-Jun-2026	Very Important	The leadership and management framework is aligned to 5 levels of leadership and supports career progression. Due date has been extended to June-26 as we are developing our process as part of the next steps in developing the leadership framework.
Review the leadership development programme and make recommendations to ensure it meets our leadership needs.	Jenny McCusker	30-Jun-2026	Important	Main review completed with initial framework agreed with pilots of the initial priority programmes (Core Management Skills pilot is live & the design stage of Transformational Change Leadership is underway. Progress remains at 75% and the due date extended to June-26, to allow for this work to finalise.
Develop a measurement framework which is built into the leadership development plan to support evaluation of effectiveness in improving organisational performance.	Jenny McCusker	30-Jun-2026	Very Important	Work on track with performance dashboard development progressing to align to the new framework.



SRR 020 Health Inequalities		Current Score	Managed By	Assigned To
Risk Description	If NHS FV does not work with partners to influence the social determinants of health and the NHS does not create a healthcare system which can be accessed by all the people of Forth Valley, there is a risk that health outcomes do not improve, and health inequalities do not reduce or may even widen. This could result in reduced healthy life expectancy for the population, or for individual population groups, and a significant financial cost through increased need and demands on services.	20	Jennifer Champion	Andrew Murray
		Target Score	**Lead Impact Category**	**Appetite Level**
		8	Health Inequalities	Cautious (4-9)
		Last Review Date	**Risk Trend**	**Tolerance Level**
		08-May-2026		Moderate (10-16)

Latest Update
Risk has been reviewed by the Director of Public Health and there is no change to the scoring of this risk. Work continues to be progressed on the implementation of the Population Health & Care Strategy, as this progresses this will inform organisational thinking and understanding of population health & health inequalities. The EQIA process has been revised to include prevention and health inequalities considerations.

Internal Controls
NHS Forth Valley is an Anchor Institution, working with other partner organisations in their role as Anchor Institutions, to improve the social determinants of health.
Director of PH work collaboratively across the local population health system with CPPs to embed tackling inequalities as a principal theme.
NHS Forth Valley senior planners and managers contribute to multiple Community Planning Partnership theme groups to plan for improved health outcomes and reduced inequalities.
Anchor NHS service design planning commenced with strategic leads and service managers to improve reach and benefit of services and programmes for diverse and disadvantaged communities.
Directors of Public Health are working with Heads of Population Health at the Scottish Government with a view to intelligence performance management around Health Inequalities activity.
Commenced work with HR re revamped EQIA with a poverty/health inequalities focus.
Healthcare PH Consultant understanding health inequalities and barriers to paediatric outpatients.

Further Controls Required	Action Owner	Due Date	Action Criticality	Latest Update
Development of a comprehensive healthcare inequalities delivery plan which supports investment in measures and embeds HI into all workstreams.	Jennifer Champion	31-Dec-2026	Absolutely Critical	This is included in the Deputy Director of Public Health's job description, and the post was interviewed for in February with no successful appointment. Therefore, a consultant in public health has been moved into this work from Health Protection from April - the Health Protection post has been backfilled from Locum. Due date to be extended to December-26 to allow for this work to progress.
Work with NES around staff accessing training to understand	Jennifer Champion	31-Dec-2026	Absolutely Critical	The delivery plan will inform this action further and an update will be provided as the plan develops. Therefore, action aligned to the due date of the delivery plan - December-26.

responsibilities around health inequalities.				
Develop a systematic way to assess and monitor health inequalities and develop performance management around outcomes on prevention and health inequalities that is embedded in Performance tables.	Jennifer Champion	30-Sep-2026	Absolutely Critical	DPH is working with PHS and SG colleagues around possible indicators for inequalities and prevention. This piece should be available in the summer. Progress increased to 40% and a due date extended to Sep-26.
Review NHS Forth Valley contribution to community planning partnerships.	Jennifer Champion	31-Oct-2026	Absolutely Critical	Progress increased to 10% due to the identification of responsible personnel for this action.

3.Risk Controls Progress Update

Picture 3.1 Summary of Strategic Risk Control Environment

In this reporting period, there are 113 current controls mitigating these risks. Supporting our control environment, there were 12 actions completed in this reporting period which further mitigate the strategic risk profile (Table 3.1 highlights these actions). At the end of this reporting period there are 3 overdue actions reported – this due to reporting timescales (as the actions were not reported as overdue when presented to the various Committees).

Table 3.1 Strategic Risk Completed Actions

Action Code	Action Title	Due Date	Status	Action Owner	Risk Owner
SRR009	Develop a joined-up approach to the whole-system plan.	31-Mar-2026	Completed	Michael Brown	Kevin Reith
SRR009.05	Increasing employability through Anchor Institution Work	31-Mar-2026	Completed	Kevin Reith	Kevin Reith
SRR009.12	Create directorate/service level workforce plans to inform the wider workforce plan.	31-Mar-2026	Completed	Michael Brown	Kevin Reith
SRR009.13	Undertake exercise to understand what capacity is needed to address and support staff regarding the implementation of attendance management controls.	31-Mar-2026	Completed	Kevin Reith	Kevin Reith
SRR002 DWD	Enhance triumvirate support model within the Acute site to support implementation of the above.	30-Apr-2026	Completed	Garry Fraser	Garry Fraser
SRR003.13	Provide Information Risk Reports to all services who have logged critical assets but which do not have a business continuity plan recorded.	30-Apr-2026	Completed	Jennifer Hogg; Sarah Hughes-Jones	Andrew Murray
SRR019.17	Engage with Head of OD regarding the communication aspect of leadership development.	30-Apr-2026	Completed	Jenny McCusker	Kevin Reith
SRR009.10	Delivery of Action Plan with definitive and quantifiable actions	31-May-2026	Completed	Michael Brown	Kevin Reith
SRR018.07	Development of Governance routes and escalation procedures	31-May-2026	Completed	Tom Cowan; Scott Williams	Gail Woodcock
SRR020.03	Health Inequalities activity to align with partnership plans.	30-Jun-2026	Completed	Jennifer Champion	Jennifer Champion
SRR015.07	Improvements to Supply Chain Security	31-Jul-2026	Complete	Sarah Hughes-Jones;	Scott Jaffray Andrew Murray

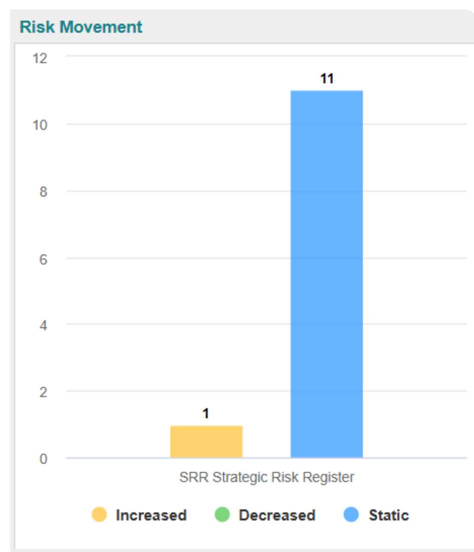
Action Code	Action Title	Due Date	Statu s	Action Owner	Risk Owner
SRR01 0.13	Seek or ring-fence other funds to fully complete the rolling Estate Survey Programme.	31-Dec-2026	Comp leted	Morag Farquhar	Morag Farquhar

Table 3.2 Overdue Actions

Action Code	Action Title	Due Date	Status	Risk Owner
SRR01 9.18	Get connected team looking at improving communication between FV and partnership organisations.	31-May-2026	Overdue	Kevin Reith
SRR01 9.19	Develop cultural indicators which will be used to inform assessment of progress around improving culture.	31-May-2026	Overdue	Kevin Reith
SRR00 4.21	Formal Request for Mutual Aid regarding Arthroplasty.	31-May-2026	Overdue	Garry Fraser

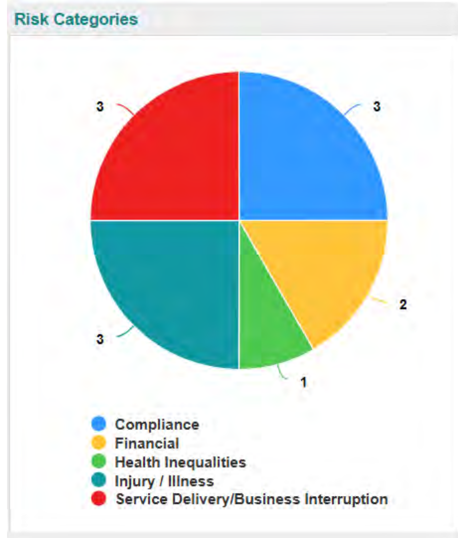
4. Strategic Risk Trend Analysis

Graph 4.1 Risk Register Activity



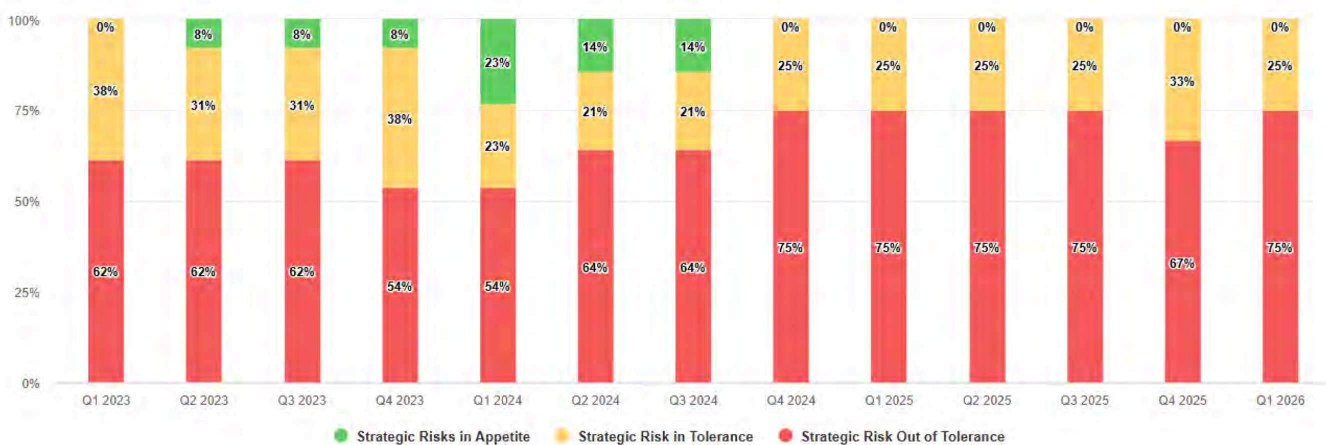
The chart to the left shows that across the Strategic Risk Register, eleven of the twelve strategic risks have remained static with SRR004 increasing in risk score.

Graph 4.2 Risk Category Breakdown



When risks are assessed, a lead impact category is selected, which sets the appetite/tolerance level for the risk. This graph has changed since the last reporting period, following the approval of the Risk Management Framework and Risk Appetite levels.

Graph 4.3 Strategic Appetite and Tolerance



A graph depicting the risk appetite profile of the strategic risks across the previous financial year:

- Quarter 1 (25/26) remained static, despite the increase in risk score for SRR011 as it was already listed as out with the Boards appetite and tolerance.
- Quarter 2 (25/26) remained static, despite the decrease in score for SRR010, as it remains outside the Boards appetite and tolerance.
- Quarter 3 (25/26) remained static.
- Quarter 4 (25/26) is on track to reduce the number of risks out with the Boards appetite and Tolerance, due to SRR009 reducing in risk score. 33% of the Boards Strategic Risks are within Tolerance levels and 67% of the Boards Strategic Risks are out with appetite and tolerance.
- Quarter 1 (26/27) is presenting a deterioration in risk appetite and tolerance levels, but this is due to the changes approved in the Risk Management Framework. SRR004 has increased in risk score as well but this does not impact on risk appetite levels.

Note that the colours in the chart represent status (In appetite, In Tolerance, Out of Tolerance) rather than score.

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Forth Valley NHS Board

9. Digital Plan 26 -27
Purpose: This report is for Decision

Executive Sponsor: Scott Jaffray, Director of Digital
Author: Rachel Marshall, Digital Programme Delivery Manager

Executive Summary

The 2026/27 Digital Delivery Plan sets out NHS Forth Valley's programme of digital investments to deliver both local service priorities and national digital projects. It continues on with the progress made in 2025/26 as well as working to the increasing demand, system interdependencies, and resource pressures.

Action Required

The Forth Valley NHS Board is asked to:

(1) approve the attached Digital plan for 2026 – 27.
(2) consider if the report provides assurance that appropriate controls are in place to manage the identified risks, support the delivery of objectives

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.

- Digital & eHealth Programme Board, 24/2/2026, the digital plan was discussed and approved at this meeting.
- Strategic Planning, Performance & Resources Committee –
- Board Seminar – group discussions included: How do we make digital the default and Prioritisation. Attendees sought updated information on clarity on:
  - the national direction and opportunities for joint working.
    - This will be done under a programme of works, namely called Digitisation of Health Records, and will include a 5 workstreams:
      - Undertake a structured review across clinical, administrative and support areas within the organisation to identify, document and assess all current paper record requirements in advance of introducing an electronic health record.
      - Review and define the retention requirements for patient electronic health records, including identifying applicable statutory, regulatory and records management obligations; assessing current arrangements and gaps; engaging key stakeholders to agree retention rules for different record types; and producing recommendations to support a compliant, consistent approach to electronic documentation retention, archiving and disposal.
      - Moving inpatient documentation from paper-based records to an electronic health record solution. It will consider the documentation set required for inpatient care, current and future workflow requirements, clinical and operational user needs, information governance and records management requirements,

integration considerations and the people, process and technology changes needed to support implementation.

        - move to a fully electronic outpatient process. While referrals are submitted electronically and clinic correspondence is digitally dictated, key parts of the outpatient pathway remain paper based. Clinic appointments are not fully managed electronically, eForms are available but not used consistently, and clinical notes are still being recorded on paper in a variety of formats including loose sheets, post-it notes and patient labels. As a result, Health Records currently receives more than 30,000 paper items each month for scanning. The project will review the current end-to-end outpatient workflow and define the changes required to replace paper-based recording, administration and scanning with a standardised electronic process that improves data quality, reduces reliance on paper and supports a complete digital patient record.
        - Structured review to identify, document and assess all paper documentation retention requirements across all services and record types. It will consider what paper documentation is currently being retained, where it is held, the purpose for retention, the applicable retention period, and the legal, operational, clinical and information governance reasons for continued storage.

- vision to reduce the number of systems
    - The current technical landscape is understood and well documented. Work is ongoing with key stakeholders, including consultants, nurses and AHP's to establish where the gaps are and help develop the digital roadmap, facilitating the move to operating from an Electronic Patient Record.
- Digital culture work.
    - Work is ongoing with the departments who don't currently use digital solutions to their full potential and understand why. It could be for any number of reasons, such as limited or no access, training needs, lack of confidence or they simply prefer the paper-based way of working. Our aim is to put the correct solutions in place so the clinical community adopt a digital first approach.

Risk Assessment and Mitigation

This programme relates to the Strategic Risk Assessment SRR011, Digital & eHealth Strategic and Infrastructure.

There are a number of programme level risks in place to capture the challenges we are currently facing in Digital

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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
This paper relates to Digital, financial and infrastructure for the organisation

Workforce Implications
The Digital plan impacts all staff across NHS FV, and specifically to all staff within the Digital Directorate.

Quality / Patient Care Implications
The digital programme plan will have a positive impact on quality of care and services.

Population Health & Care Strategy
An element of the Digital Plan will support the delivery of the population Health & Care strategy, specifically around trailing PROMS & PREMS solutions.

Climate Change / Sustainability Implications
N/A

Engagement and Communications
Was statutory engagement with stakeholders required? Yes ☐ No ☒

This Digital plan has been shared with the SLT & key stakeholders from across the organisation.

Appendices
Appendix 1 – Digital & eHealth Annual Delivery Plan 2026 -27

Digital Portfolio Delivery Plan 2026 / 2027

Version:	V01.1
Authors:	Rachel Marshall
Issue Date:	23rd February 2026
Approvals:	
Digital and eHealth Programme Board Infrastructure Board Senior Leadership Team Strategic Planning, Performance and Resource Committee Forth Valley NHS Board	24th February 2026 - 12th January 2026 - -

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Introduction

This plan set out NHS Forth Valley's Digital portfolio for 2026 / 2027. It details all projects set out in the following categories:

- Major Changes
- Core Infrastructure
- Information Services
- Health Records
- Medical Physics

The Information contained within this plan has been developed in conjunction with all departments within the Digital Directorate, which include Medical Physics, Information Services and Health Records. As the Quality and Innovation projects have a reliance on digital resource, projects taken on within this directorate are also detailed in the Delivery Plan.

Consultation work has been undertaken with key clinical areas so as the work captured within the plan reflects the requirements of all Directorates.

All programmes, projects and deliverables are assessed to ensure they align and support both the local and national strategies. As well as this, the Digital Directorate continues with the focus of other key areas, such as

- Compliance with the NIS regulations, to meet recommended actions.
- Supporting the Health & Social Care partners in digital aspirations and access to key IT and operating systems and in developing solutions to data sharing and mobile working.
- Producing Business Cases to support renewal and introduction of new systems, as well as consolidating existing systems.
- Developing further Regional and National collaboration opportunities and services.
- Work with Medical Physics to support the digitalisation of Medical Devices
- Continue with the Health Board's strategy of moving key clinical systems to national product sets.
- Continue to work with National and Regional teams to implement Microsoft 365 collaboration, software and tools, SharePoint, OneDrive & new Office Software deployment being key elements.

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Local NHS Forth Valley Digital Strategy

Health and Care in the Digital Age: A Digital Strategy for NHS Forth Valley 2023 - 2027 was published in January 2024 and sets out 3 Themes.

- Better Health
  - Improving Prison services, Alcohol and Drug Partnerships, Children and family services
- Better Care
  - Improving Primary Care and Mental Health Services while supporting Scheduled and Unscheduled hospital care
  - Transforming unscheduled care
  - Transforming Scheduled care
- Better Value
  - Improving quality and the Patient Experience
  - Improving use of Data
  - Improving communities – NHSFV as an Anchor organisation
  - Recognising Sustainability and climate change
  - Building Workforce and leadership
  - Buildings for the future

Scotland Digital Health and Care Strategy

This sets out that the health and care system as whole – and its partners in wider society – need to continue to embrace the change required. This includes but is not limited to:

- Committing to constantly improve, innovate, and evolve – and sometimes change completely.
- Making better use of the data, both that already held and data which is not routinely held at present.
- Involving people and staff in the design of tools, technologies and services that support them, noting that that those that have been designed with users are more likely to deliver meaningful and lasting change that improves outcomes.

To achieve these aims, and ultimately the vision, there will be a focus on six priority areas.

1. **Digital Access**

People have flexible digital access to information, their own data and services which support their health and wellbeing, wherever they are.

2. **Digital Services**

Digital options are increasingly available as a choice for people accessing services and staff delivering them.

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3. Digital Foundations

The infrastructure, systems, regulation, standards, and governance are in place to ensure robust and secure delivery.

4. Digital Skills and Leadership

Digital skills are seen as core skills for the workforce across the health and care sector.

5. Digital Futures

Our wellbeing and economy benefits as Scotland remains at the heart of digital innovation and development.

6. Data-Driven Services and Insight

Data is harnessed to the benefit of citizens, services, and innovation.

Prioritisation and Complexity

Each programme, project and deliverable identified within the delivery plan has been assessed and prioritised using the Digital Prioritisation and Complexity Matrix. The aim of this methodology is to provide a structured, transparent approach to scoring. Following feedback regarding an omission of a scoring around clinical priorities, a review is currently being conducted with all departments across the organisation. This review aims to ensure that clinical, digital, corporate, and interdependency priorities are all appropriately reflected and that everyone is using the same method when prioritising projects.

At the time of producing the plan, all projects within the portfolio are considered achievable within existing capacity and resource assumptions. Quarterly reviews will be carried out to monitor this and any areas requiring escalation will be raised at the Digital and eHealth Programme Board in the first instance.

Complexity Score

Each request is assessed across 6 dimensions, with each scored from 1 (low complexity) to 5 (high complexity)

- **Organisational Objectives Risk**
  - 1 = no links to objectives
  - 5 = strong link to objectives
- **Technology, Development, Production and / or Techniques**
  - 1 - no new technology involved
  - 5 = extensive use of leading-edge technology
- **Commercial and Supplier Delivery**
  - 1 = established contracts in place
  - 5 = complex commercial arrangements required
- **Financial Provision**
  - 1 = fully funded from within organisation budget
  - 5 = complex cross-organisation funding or funding not agreed.
- **Benefits**
  - 1 = relatively small benefits
  - 5 = significant benefits
- **Change and Implementation**
  - 1 = single site delivery or co-located projects
  - 5 = complex national delivery or uncertain implementation

Priority Score

- Requests are prioritised based on strategic drivers, ranked from highest to lowest:
- National Projects – driven at a national level
- Locally mandated – required to meet local priorities or directives
- Mandatory changes – compliance driven changes, for example, NIS regulations or legal obligations
- Risk Management – reducing risk associated with a system or process
- Technological Advancement – adoption of new technologies

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- Customer Request – address specific needs at a user or department level
- *Each request may align with multiple priority criteria (and often does). The overall priority score is calculated by summing all applicable scores.*

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Portfolio Overview

Major Changes

DP-001	Single Shared Device	Collaborate with Falkirk, Stirling, and Clackmannanshire Councils to develop solutions for accessing applications and shared drives using a single device.
DP-002	GP IT System Replacement	Initial migration of all GP practices to the Vision 3 product, followed by a transition to Vision Anywhere once it becomes available for rollout.
DP-003	Child Health System Replacement	Support the national implementation of a single modern cloud-based environment with capability to be migratable from the AtoS Azure cloud environment into an NHS National Services Scotland Azure cloud environment.
DP-004	Docman Upgrade	Draft Local Business Case to support the preferred option of a Commercial-Off-The-Shelf Document Management and Workflow Managed Technical Solution plus Read/Write API, purchased via the NHS England GP IT Futures framework agreement Implementation the Commercial-Off-The-Shelf Document Management and Workflow Managed Technical Solution plus Read/Write API
DP-005	Laboratory Information Management System Replacement (LIMS)	Implementation of the new National LIMS, including test, training and live environments
DP-006	Picture Archiving and Communications (PACS) System Replacement	Implement the new Sectra PACS system, including the migration of data from the current supplier, Philips.
DP-007	Microsoft 365 - SharePoint Online Rollout	Implement Microsoft SharePoint Online across all departments within NHS Forth Valley, including GP practices

DP-008	Scan for Safety	Implement solution to collect and store Unique Device Identifier (UDI) information for high risk implantable devices linked to the patient to ensure traceability.
DP-009	eOBS Implementation within TRAKCare	Implementation of TRAKCare eObs in FVRH acute settings to capture patient observations in line with NEWS2 and clinical assessments electronically.
DP-010	Master Patient Index Review	Revisit use of patient demographics for downstream systems and improve data quality
DP-011	Patient Hub Implementation	Implementation of a web-based communication system for notifying patients digitally of any outpatient appointments booked via TrakCare and view associated documentation
DP-012	Radiology Information Service (RIS) Replacement	Procurement and implementation of RIS system to replace current out of support and out of service system, provided by Philips
DP-013	Speech Recognition	Move forward with a pilot in Mental Health and Ageing in Health. Develop and finalise requirements specification, identify preferred solution and create Business Case to procure new solution
DP-014	Digital Pathology	Implementation of the new Philips IntelliSite IMS Pathology Solution and an SGS 300 Scanner.
DP-015	Order Comms Replacement	Replace DART OCM with TRAK Order Comms module. Phase 1 - deliver a like for like solution to enable the move away from incumbent provider Phase 2 - implementation of enhanced functionality
DP-017	Unified Communications	Create a business case for redesigned Unified Comms, focusing on rationalising platforms and improving resilience
DP-019	Digitisation of Health Records (Burnbank)	Create a business case to identify the preferred solution for services provided by Burnbank, covering scanning operations, infrastructure refresh, and workflow automation.

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DP-020	Open Eyes Rollout and Development	Support ongoing rollout of Open Eyes, create Support arrangements and facilitate integration work
DP-021	ICU Critical Care System	Develop a business case to replace the current paper-based ICU documentation with a Critical Care System, providing real-time, integrated digital records for critical care patients
DP-024	HEPMA Rollout in ED	Partial roll out of the HePMA system within ED for patients who are within the department for more than four hours, to support management of patient medication.
DP-025	Low Code / No Code App Opportunities	Explore the potential for rolling out M365 applications to enhance current services within NHS Forth Valley
DP-026	Digitalisation of Corporate Processes	Systematically prioritise digital projects and automation initiatives so that resources focus on what delivers the greatest organisational value, includes aligning digitalisation efforts with strategic goals, improving efficiency, and enhancing staff experience.
DP-027	Endoscopy Replacement Service	Digital and clinical upgrade project focused on replacing the legacy Unisoft Endoscopy, Cystoscopy, and Bronchoscopy systems with the nationally procured Solus Endoscopy solution from HD Clinical.
DP-028	Standardisation of Ward Data	Introduce a standardised naming and coding convention for wards and locations across all systems through an automated mechanism originating from TrakCare.
DP-029	Centralisation of EDT (Docman Connect)	National replacement for the legacy EDT Hub used across NHS Scotland for transferring patient-related documents. Enable secure, electronic document exchange across the health service, replacing outdated EDT architecture
DP-036	Digital Front Door (MyCare)	Provide a single, secure online entry point for citizens to interact with health and social care services. Delivered through the MyCare.scot application.

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DP-037	Cyber Vault Infrastructure Refresh	Develop a business case outlining the replacement of the existing infrastructure and immutable backup solution, then proceed to implement the approved approach.
DP-038	Discharge Without Delay	National programme integrating best practice and key pathways for frail patients in Scottish hospitals. Once digitally supported, it will transition to ongoing advice and support, work led by Unscheduled Care Teams.
DP-039	Immediate Discharge Letter Improvement Work	Review of current process and systems used to generate and produce IDL's. Includes a full relaunch around importance of IDL and use of systems, monitoring, oversight and accountability.
DP-040	CHI Matching / Data Sharing	Establish CHI as the shared identifier to link council social care records with NHS health records, enabling safer information sharing and automation
DP-041	Encounter Records	Replace paper case notes and certain electronic forms with a digital, standardised solution in TrakCare in a structured, consistent format. Includes a review of eForms framework
DP-042	Business Services Programme	National programme looking at replacing legacy systems with a modern, cloud-based ERP solution, simplifying how HR, Payroll, Finance, and Procurement is managed
DP-043	Value Based Health & Care Patient-Reported Outcome Measures (PROMS)	Implement a system that captures PROMS within the Heart Failure service and embed into cardiology pathways
DP-044	General Ophthalmic Service (GOS)	GOS Specialist Supplementary Service being implemented across Scotland
DP-045	InPhase	Provide the digital support in the evaluation of the use of InPhase as a replacement for Safeguard and Pentana
DP-046	Robotic Arm	Preparing for the introduction of a Robotic-Assisted Surgery (RAS) Arm

DP-047	EDMS Review	Undertake a review of EDMS to ensure it remains fit-for-purpose, supports current and emerging clinical workflows, and aligns with NHS Forth Valley's wider digital modernisation objectives.

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Core Infrastructure

CI-001	NIS Regulation Review	Ongoing work to complete follow up actions identified as part of the NIS Recommendations Report
CI-002	802.1x Implementation	Installation of 802.1x on all network points in FVRH.
CI-003	Firewall Deployment Migration	Deployment of the firewall migration tool across all sites within FCH and SCH
CI-005	Network Refresh FCH and SCH	Network refresh and Server readdress to 172.x.x.x networks
CI-006	SQL Server Refresh	Replace servers, install new licences and upgrade DB's within NHS Forth Valley estate
CI-007	Infrastructure Refresh	Replacement programme of the digital infrastructure to support the compliance of the NIS regulation
CI-009	Desktop Refresh	Continued replacement of new endpoint device hardware to refresh unsupported makes and models

CI-010	Ricoh MFD Refresh	Support eHealth process for contract renewal
CI-011	Ensemble upgrade / Data Flow Review	Upgrade to latest version, carry out review of current ensemble. Housekeeping
CI-012	Upgrade of Mortuary DB and EPL DB	Data migrated from Oracle to Microsoft SQL server. Client re-written/developed.
CI-013	Morse Upgrade	Routine system upgrade
CI-014	SCI Gateway Upgrade	Routine system upgrade
CI-015	Care Partner Upgrade	Routine system upgrade
CI-016	Digital Directorate Review	Review the roles, identify coverage needs, and clarify expectations from the Digital departments

CI-017	CHA-A upgrade	Routine system upgrade
CI-018	TRAKCare Upgrade	Routine system upgrade
CI-020	HEPMA upgrade	Routine system upgrade
CI-022	Equitrac Upgrade	Reduce to one print queue from four
CI-023	Payroll Move to NSS	Facilitate the move of staff to NSS
CI-024	Windows 11 Upgrade (GP)	Upgrade for GP Workstations
CI-025	G2 Upgrade	Upgrade G2 to version….

CI-026	UMA Implementation	Implementation of the new desk booking system in Carseview and Carronbank, followed by a review of future connections to other areas within Forth Valley
CI-027	TRAK Infrastructure Refresh	Refresh end of life hardware for the TRAK system
CI-028	Akamai Review	Contract is due for renewal. Go to marketplace for a replacement system
CI-029	Stirling Care Village Whole Infrastructure Refresh	Technology requires refresh. Linked with the Unified Comms project
CI-030	Production of an Application Heat Map	Identify the refresh / upgrade lifecycle of core infrastructure and systems
CI-031	Standardisation of the Gatekeeper process	Application of standards to all new and existing systems
CI-032	Open Eyes Upgrade	Supplier led upgrade to expand functionality and improving usability

CI-033	Moses Development	Review updated data-entry forms, a rebuilt Resus form, enhanced demographic data quality, consolidation of duplicate data processes, and new reporting developments, following confirmation that the system will remain in use within NHS Forth Valley

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Information Services

The key objectives for Information Services over 2026/27 align with the vision outlined in the NHS Information Framework 2023-2027. Over the coming years the ambition is to provide a whole system service for data and information sharing to both support integration and to fully understand the needs of the Forth Valley population. This will provide the platform to devise the best value most effective and sustainable health and care services in the years to come.

Below is a list of the projects Information Services are committed to delivering this year.

IS-002	Access to Social Care Data	Development of data sharing frameworks and governance for operational and strategic planning to inform whole system working
IS-003	Access to Care Home Data	Development of data sharing frameworks and governance for operational and strategic planning to inform whole system working
IS-004	Access to Primary Care Data	Development of data sharing frameworks and governance for operational and strategic planning to inform whole system working
IS-005	Development of Population Health Map - Phase 2	A population health map which will help us to understand our population in terms of profiling SIMD access to health and care services and population activity within those services
IS-006	Phase 2 Server Migration Decommission Server 3	Decommissioning current server move to more efficient and update software and hardware

IS-007	Phase 3 Server Migration Restructure Server 4	Restructuring databases within server 4 for more logical use that are compatible with business intelligence tools
IS-008	Scope Business Intelligence Tools	Scoping a new way forward for new BI tools to replace / work alongside SSRS
IS-009	Support Digital & eHealth Delivery Plan	Supporting the digital department in the delivery of the individual projects, where Information Services input is required
IS-010	Urgent Unscheduled Care leverages for Improvement	Working with CfSD to enhance performance within unscheduled care
IS-011	All Year Planning and BI Support	Working with Garry Fraser to craft strategic plans for sustainability and redesign of services
IS-012	Scheduled Care Services Access	Rollout of the revised national Access policy

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Health Records

Health Record Services supports NHS Forth Valley's digital delivery by collaborating on new initiatives such as electronic waiting list cards, enhanced communication through digital platforms, and implementing updated access policies. The team aims to boost efficiency, reduce paperwork, improve care continuity with secure digital records, and respond promptly to information requests while maintaining data privacy and legal compliance.

Below is a list of the projects Health Records are committed to delivering this year.

HR-001	Electronic Waiting List Cards	Transition from paper to digital cards
HR-002	Improved Comms to support Netcall and Patient Hub	Improving patient experience and reducing the waiting time a patient has in the queue whilst connecting the caller to the appropriate person
HR-004	Endoscopy Transition from OP to IP model	Waiting list management from outpatient to inpatient model
HR-005	Implementation of New National Access Policy	Write, implement and delivery training and ensure compliance
HR-006	Netcall Implementation within Radiology	Implementation of Netcall into Radiology
HR-007	Service Improvement for RIS Replacement	Service improvement at operational level for new RIS system
HR-008	Service Improvement for New Child Health System	Service improvement at operational level for new Child Health systems

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HR-010	Digitisation of Health Records moving to an Electronic Inpatient Record	Operationally leading the digitisation of health records moving forward to an electronic inpatient record
HR-011	Service Improvement for Outpatient EPR	Update and streamline processes for outpatient EPR
HR-016	Job Description Review	Review of all Health Record Services job descriptions to update and realign to working practices

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Medical Physics

The Medical Physics workplan is split into two main categories of delivery of the planned replacement programme and delivery of service developments.

The planned replacement programme for 2026/27 has been agreed in principle by the Medical Device Group. The programme is subject to change dependant on funding and changing requirements due to end of support or emergency replacements due to failures.

MP-001	AED Defibrillators x 45	Equipment has reached planned replacement date
MP-002	Endoscopes	Equipment has reached end of support date
MP-003	Ward BP Monitors x 150	Equipment has reached planned replacement date
MP-004	Theatre Stacks (endoscopy) x 2	Equipment has reached planned replacement date
MP-005	W&C Ultrasound	Equipment has reached planned replacement date
MP-006	Vascular Ultrasound	Equipment has reached planned replacement date
MP-007	Fluoroscopy Ultrasound x 2	Equipment has reached planned replacement date
MP-008	OPD Ultrasound x 1 (SCV)	Equipment has reached planned replacement date
MP-009	Radiology Ultrasound x 2 (SCV)	Equipment has reached planned replacement date

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MP-010	A and E and ITU Ultrasound x 2	Equipment has reached planned replacement date
MP-011	Topcon Scanner	Equipment has reached planned replacement date
MP-012	Labs Equipment	Equipment has reached planned replacement date
MP-013	Plinth replacement	Equipment has reached planned replacement date
MP-014	Dental chairs	Equipment has reached planned replacement date
MP-015	Bed replacement	Equipment has reached planned replacement date
MP-016	Lucas	Equipment has reached planned replacement date
MP-017	CT Scanner	Equipment has reached planned replacement date
MP-018	GS1 Data Standards	Implement the GS1 data standard for assets and locations
MP-019	Network Analyst	Introduce network analyst role into medical physics
MP-020	Medical Device Regulations	Implement new medical device regulations when they are published in summer 26
MP-021	Quality Management System	Progress the addition of a 13485 Quality management system
MP-022	RFID Tracking System	Expand use of BLE RFID tracking system

MP-023	Point of Care Ultrasound	Implementation of Ultrasound equipment to allow images to being taken at the patient bedside rather than radiology

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Digital Champions

NHS Forth Valley is developing a formal Digital Champion Network to strengthen digital confidence and promote the adoption of new tools and ways of working across clinical and corporate services. Building on early engagement through the Digital Champions Short Life Working Group and the draft Digital Champions Strategy, the programme will identify and train staff who can act as trusted, local advocates for digital transformation—providing peer-to-peer support, sharing practical insights, signposting training, and feeding frontline experience back into digital teams. This work will align with national Digital Champion initiatives and will evolve through ongoing collaboration with departments, senior leadership, and the wider Scottish Digital Champion community to ensure the network is sustainable and meets organisational needs.

Research Development and Innovation

ANIA Pathway Projects

The ANIA Pathway is the mechanism for adoption of innovation for a small number of high impact innovations. If a project is approved for implementation, it will have a completed Value Case and funding approved by the Innovation Design Authority. Once a Value Case is approved, the innovation will be added to the CfSD heat Map. This provides the basis for a joint plan with each NHS Board to incorporate this into local delivery planning. ANIA Pathway projects will be delivered in the board with local and national support. There will be requirements that will need eHealth input for delivery.

Test Bed

NHS Forth Valley has been identified as an Innovation Test Bed. This means there is the opportunity to support pre-commercial open innovation with industry, academia and health and social care staff. It is the Innovation Team ambition to scale up Test Bed projects 2026/7, working with stakeholders to build evidence, allow innovators to refine solutions, inform strategy and develop thinking, support routes to scale up and mainstreaming, seek preferential access for NHS Scotland to final products and revenue generation. The focus of industry partnership will be with the Techscaler programme, the Scottish Government's tech startup support programme. The nature of the projects is yet unknown, however projects will be aligned to local and national priorities and will require eHealth input for delivery.

Artificial Intelligence

Artificial Intelligence has become an increasing part of innovation requests in the last year, as such an AI approach has been developed. This will provide guidance for future project; it is expected further AI requests they will require digital input for delivery.

A pilot is planned for 2026/7 to use Ambient Voice Technology in primary and secondary care. The pilot will trial 3 companies and allow for completion of an options appraisal to inform a procurement process. Any procurement would need digital input for integration.

Research and Development

The scope of the R&D portfolio is increasing, with an ambition to develop commercial trials to introduce further revenue generation. Projects will follow governance processes for approval; however, some will require digital input.

Programme Level Risks and Issues

Risks

- ### Competing Projects

A high number of projects are all expected to be delivered by Q3 this year. This in itself isn't a risk but the systems that are due to be replaced, Order Comms, GP IT, RIS, PACS, LIMS, EDT and Docman, are all technically interconnected with each other and depend on each other's functionality. If one project is to be delayed, this will have a major knock-on effect to the successful implementation of the other projects.

These projects use the same resource from the Service and the Digital department so planning is key.

- ### Digital Programme Office Project Resource

There is an unprecedented demand on the Digital department this year and the Digital Project Management Office are already dealing with a high volume of projects that were due to be completed last year but have been subject to repeated delays. The delayed projects, added to the work that is required to be carried out this year will affect successful project delivery, and as such, there is a high risk of project timelines not being met.

- ### Digital Teams Resource

The high demand for technical teams within Digital, stemming from competing commitments across new and existing projects, delivery of core infrastructure enhancements and maintenance, business-as-usual (BAU) activities, and ongoing technical incident management, may lead to resource constraints, delays in delivery, and potential impacts on service continuity.

- ### Cyber Security

Ensuring the core systems and services are protected and safe from emerging cyber threats whilst competing with increased digitalisation and staff and public expectations.

The Digital department will work with Information Governance to ensure compliance with appropriate NIS regulations and regularly refresh key physical network, whilst ensuring access policies are adhered to through robust Information Governance. Acting upon intelligence sources both nationally and locally, for example, Security & Intelligence Alerts.

- ### Funding

Financial Year 2026 / 2027 continues to see an unprecedented increase in cost pressures on both core services and developments.

It is essential for the Board that Digital commence early engagement with the departments and work together throughout the year to outline the Board's priorities, creating detailed Business Cases to ensure spending is directed where it is most needed.

- ## ANIA Pathway

Planning of a scarce Digital resource is important to support the innovation work being introduced to NHS Forth Valley via the ANIA pathway.

Collaboration is key between Digital and the Innovation team to establish and understand the proposed innovation projects likely to come in via ANIA pathway during the 2026/27 year.

Manage all new ANIA pathway projects via the Digital Proposal Process to allow for the evaluation and prioritisation of each request.

- ## Digital Systems Adoption

It is important that Clinicians and managers recognise that an electronic record is as critical as a paper record, and often more so, as this is shared with other professionals.

Resistance from the clinical community to move away from paper-based processes to digital solutions could lead to data accessibility challenges, fragmented workflows, missed opportunities to improve patient care through digital innovation, resulting in inefficiencies in the delivery of healthcare to patients.

- ## Infrastructure and Resilience

Building resilience is a key strand of the Digital Strategy and financial plan for the organisation. The Core infrastructure refresh is an area of high-risk importance with reliance on systems that increases year on year which in turn requires asset base increases to support the eHealth Programme.

The Digital directorate must ensure infrastructure refresh occurs on a continual basis and at an appropriate level. Much has been done in the last 2 to 3 years and a significant focus for the Digital departments will be continuing the implementation of plans to make key systems and networks more resilient.

- ## Dealing with Ongoing Digital Demand

The Digital department is already committed to a signed off delivery programme; however, new project requests continue to arise throughout the year. Balancing these additional demands alongside planned initiatives and existing commitments places considerable strain on available resources, potentially affecting the successful delivery of planned projects.

Furthermore, the lack of long-term funding for new project requests hinders the ability to provide ongoing support for implementation and system management, limiting the long-term sustainability of these digital solutions.

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Issues

National Project Slippage

Since 2022, there have been several national projects subject to repeated delays, which is extending over multiple years, some until 2027. This is creating challenges in the planning and allocating of resources for local projects, making it difficult to be able to commit to local developments.

Insufficient Skilled Workforce

There is a shortage of skilled personnel in the Digital department to support the ongoing monitoring and administration of Ensemble, which is necessary for the projects outlined in the current Delivery Plan. Work is ongoing within the department to identify what work is required to facilitate the current projects, but this is a short-term solution. In the long-term, the management team will be reviewing and outlining potential future solutions to resolve this issue.

- ### Single point of failure

The digital department relies heavily on key individuals with specialised knowledge to manage and maintain critical clinical systems, resulting in multiple single points of failure. If one of these individuals were to take extended leave or depart from NHS Forth Valley, it could lead to operational disruption, delays in system maintenance, and significant risks to service continuity. This lack of knowledge redundancy poses a major challenge in ensuring seamless support, resilience, and long-term sustainability of essential digital infrastructure.

Digital and eHealth Programme Funding

The capital and strategic funds will support operational teams as well as Digital to deliver these projects.

The draft financial plans are outlined in Appendix II and set out how the strategic and local capital funds will be utilised to support these initiatives.

A number of resources support the implementation of these business-critical systems and developments and are outlined as follows:

- The Scottish Government supports developments through the National Strategic Fund as well as through other national funding allocations.
- Local capital funding to support Digital project and systems implementation. The current Local Delivery Plan (LDP) identifies resources for Digital within the capital element of the Financial Plan.
- Final Funding streams will be agreed with Scottish Government and Health Board finance colleagues and will be subject to final approval. The planning assumption made at this stage is in line with previous years funding levels.

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Appendix I

cost centre	Project	Sum of Capital 2	Sum of STRATEGIC	Sum of Nr uplifts
V85500	BURNBANK HLTH REC	£ 17,920.91		
V85500	CHILD HLTH REPLACE	£ 75,028.97		
V85500	DATA SHARE	£ 71,683.63		
V85500	ENDOS	£ 79,392.83		
V85500	GPIT	£ 468,075.06		
V85500	HEPMA ED	£ 8,376.51		
V85500	INFRAS	£ 143,367.25		
V85500	LABS	£ 35,548.42		
V85500	M365	£ 130,112.21		
V85500	ORDER COMM	£ 79,473.34		
V85500	PACS	£ 79,608.12		
V85500	PAT HUB	£ 51,927.52		
V85500	PATHOLOGY	£ 27,171.91		
V85500	RADIOLOGY	£ 60,235.17		
V85500	REFRESH	£ 420,809.85		
V85500	RIS	£ 19,515.15		
V85500	SCAN 4 SAFETY	£ 20,941.27		
V85590	Eh Digital Programme Mgt		£255,712.60	£119,642.00
V88568	Ehealth Strategic Management			£ 5,424.00
V88668	(blank)		£ 67,012.00	
V88668	Eh Epr		£360,650.10	
V88704	Eh Speech Recognition		£ 25,130.00	
V88713	DIGI FRONT DOOR		£ 41,882.54	
V88713	EH DIGITAL FRONT DOOR		£ 29,214.29	
V88714	EH INPHASE		£ 8,376.51	
V88715	EH VBHC		£ 12,565.00	
Grand Total		**£ 1,789,188.09**	**£800,543.03**	**£125,066.00**

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10(a) Board 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) establishment of a Short Life Task & Finish Group to provide initial oversight of the working of the Governance arrangements for the delivery of the Population Health & Care Strategy and ambitions;
(ii) establishment of a Short Life Working Group on Performance Reporting to strengthen assurance reporting;
(iii) appointment of John Stuart to the Remuneration Committee, and
(iv) changes in the Voting Members of both Integration Joint Boards.

Action Required
The Forth Valley NHS Board is asked to:
(1) agree that a Short Life Task and Finish Group is established reporting to the Strategic Planning, Performance & Resources Committee and the Board to oversee the Population Health & Care Strategy, led by the Director of Public Health and comprising: Cllr Fiona Collie, Gordon Johnston and Finlay Scott;
(2) agree that a Short Life Working Group is established to review arrangements in relation to Performance Reporting led by the Acting Director of Strategic Planning & Performance and comprising Cllr Scott Farmer, Clare McKenzie and Allan Rennie;
(3) note Alison Jaap's resignation from the Forth Valley NHS Board, effective 31 July 2026;
(4) agree to appoint John Stuart to the Remuneration Committee, effective 1 August 2026;
(5) agree to appoint Clare McKenzie as a Voting Member of the Falkirk IJB, effective 1 August 2026;
(6) agree to appoint Karen Goudie as a Voting Member of the Falkirk IJB with immediate effect;
(7) agree to appoint Finlay Scott as Chair of the Clackmannanshire & Stirling IJB, effective 1 January 2027, once the current IJB Chair, Allan Rennie's appointment as an NHS Board Member comes to an end, 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 Board most recently made appointments at its meeting of 31 March 2026. These appointments were also considered at the Board Seminar held on 9 June 2026.

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.

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. Having a full complement of Health Board Non-Voting Members on both IJBs also impacts positively on decision making which may impact on quality of care.

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 considering the balance of Board Member skillsets. There has also been engagement with Committee Chairs, Lead Executives and the Chief Executive regarding Committee appointments.

Appendices
Appendix 1 – Considerations
Appendix 2 – Population Health Governance Routes

Appendix 1

Considerations

Short Life Task & Finish Group - Population Health & Care Strategy
A 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 and the Group was stood down.

Having considered further arrangements for monitoring the implementation of the Strategy at recent Board Seminars it is recommended that a Short Life Task & Finish Group to oversee implementation of the Strategy is established, reporting to the SPPRC. The Task & Finish Group will provide initial oversight of the working of governance arrangements to oversee the delivery of the Population Health & Care Strategy and ambitions.

A detailed paper on Population Health Governance Routes which was considered at the Board seminar on 9 June is provided at appendix 2.

Ongoing monitoring relating to the Strategy includes agreement to hold an annual stocktake Board Seminar. Twice yearly reporting to the Board of the mid-year and year-end progress against the Corporate Objectives. The Board's August Seminar will include consideration of the approach to implementing the Maturity Matrix.

Remuneration Committee
As a consequence of Alison Jaap's resignation from the Board, which takes effect from 31 July 2026, it is proposed that the resultant vacancy on the Remuneration Committee is filled by John Stuart.

Falkirk IJB
As a consequence of Alison Jaap's resignation from the Board, which takes effect from 31 July 2026, it is proposed that the resultant vacancy on the Falkirk IJB is filled by Clare McKenzie.

The revised Falkirk Integration Scheme was approved by Scottish Ministers and is include in an earlier item on this agenda. This Scheme creates a fourth Voting Member position for both the Council and Health Board. Any Voting Member appointed by the Health Board must be a Board Member. Given the number of Voting Member places to be filled across the two IJBs, it is recommended that Karen Goudie, Executive Nurse Director is appointed to the fourth Voting Member position.

Clackmannanshire & Stirling IJB
NHS Forth Valley will Chair the C&S IJB for the period 1 April 2026 to 31 March 2028. Allan Rennie was appointed as Chair of the C&S IJB at the meeting of 31 March 2026. As Allan Rennie's appointment as an NHS Forth Valley Board Member will end on 31 December 2026, the Board Chair has engaged with the Board's eligible Non-Executives and recommends that Finlay Scott is appointed as C&S IJB Chair from 1 January 2027. Early determination of this appointment will allow for a smooth transition and handover.

Population Health Governance Routes

All Programme Boards reports through the Senior Leadership Team to the Board twice a year (mid-year then year-end), this would include our progress towards becoming a Population Health Organisation.

Key piece of work supported by Programme Boards may need to come through the Board Governance Committees (Clinical Governance Committee, Staff Governance Committee, Strategic Planning, Performance & Resources) and/or Board for discussion, engagement, oversight and decision e.g., Strategic developments or plans, Statutory Submissions.

1. Knowing our population	
Community mapping	• Outputs will influence the work of all Programme Boards
Population health data planning group	• Outputs will influence the work of all Programme Boards
Community Planning Data	• Strategic Planning, Performance & Resources • Statutory Partners – Local Authorities, Health Board, Police Scotland, Scottish Fire & Rescue, Scottish Enterprise
2. Embedding Prevention and tackling inequalities	
Inequality (Inequality action plan)	• Prevention Programme Board
Anchors institution	• Strategic Planning, Performance & Resources Committee - biannual or annual update (aligned to Community Planning Partnership)
Child poverty	• Children & Families Programme Board • Community Planning Partnerships
Immunisations	• Clinical Governance Committee
Screening	• Clinical Governance Committee
Sexual Health and Blood borne viruses	• Clinical Governance Committee
Alcohol & Drug Partnerships	• Integration Joint Boards • Linkage to Prevention Programme Board (where required)

Ask & Act	• Urgent & Unscheduled Care Programme Board
Population healthcare approach to planned care	• Planned Care Programme Board
Population healthcare approach to unscheduled care	• Urgent & Unscheduled Care Programme Board
3. System Focussed and Collaborative	
Increasing collaboration with HSCPs	• Mainstream activity
Community planning	• Strategic Planning, Performance & Resources Committee (aligned to Anchor)
Whole Family Support	• Children & Families Programme Board • Community Planning Partnerships
Regional Anchor Board	• Strategic Planning, Performance & Resources Committee
Collaborating with staff	• Senior Leadership Team • Staff Governance Committee
Regional Health Protection	• Clinical Governance Committee
4. Focus of Primary and Community Health • Primary Care Programme Board	
5. Value Based health and Care • Value Based Health & Care programme Board	
6. Governance for a PHO • Annual approach to engagement with NHS Board o Board Seminar o NHS Board Meeting	

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10(b). NHS Forth Valley Blueprint for Good Governance Board Development Plan:
(i) 2025/26 – Progress Update, and
(ii) Draft Board Development Plan for 2026/27

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 provides an update on the position against the Board Development Plan 2025/26 and sets out a Plan for the coming year with new actions identified for 2026/27. A Three-year Vision document is provided at appendix 1 which sets the medium term context for the Board Development Plan.

Action Required
The Forth Valley NHS Board is asked to:
(1) note the progress reported against the Board Development Plan 2025/26
(2) note that development of the 2026/27 Board Development Plan took into account the review of Board & Committee effectiveness work and recent Board Seminar;
(3) approve the Board Development Plan 2026/27, and
(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.
- Forth Valley NHS Board – 25 March 2025: approved the 2025/26 Board Development Plan
- Board Seminar – 9 June 2026: the 2025/26 Development Plan Progress report, and draft 2026/27 Board Development Plan were considered. The 2026/27 Plan has been shaped in light of the comments made at the seminar.

Risk Assessment and Mitigation
There are no direct risk management implications in respect of this paper however, to ensure good governance, it is important that actions in the 2026/27 Development Plan are delivered timeously.

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 direct implications in respect of this paper.

Workforce Implications
There are no direct implications in respect of this paper.

Quality / Patient Care Implications
All the actions set out in the Plan are intended to support improvements in service quality and patient experience. The links between good leadership, governance and culture are well evidenced most recently, in the Blueprint for Good Governance1'*For NHS Scotland to be successful in delivering quality healthcare, good governance is necessary but not sufficient if NHS Boards are to meet or exceed the expectations of their principal stakeholders. To do that, the organisation must also excel at day-to-day management of operations and the implementation of change*.'

Population Health & Care Strategy
There are no direct implications in respect of this paper.

Climate Change / Sustainability Implications
There are no direct implications in respect of this paper.

Engagement and Communications
Was statutory engagement with stakeholders required? Yes ☐ No ☒

There was review of the Board Development Plans at the June Board Seminar, with general agreement to develop a high-level Vision Document.

Appendices
Appendix 1 – Three-year Board Development Vision
Appendix 2 - Board Development Plan 2025/26
Appendix 3 – Board Development Plan 2026/27

NHS Forth Valley Board Development 3-Year Vision

1. Context and Background 2024/25 – 2026

NHS Forth Valley Board has undergone a significant period of governance strengthening, with a clear and demonstrable trajectory of improvement across leadership, oversight and organisational culture. This paper sets the context for the Board Development Plan within the wider view of the Board's vision for the next 3-years.

In 2024/25, the Board's first formalised development approach was shaped by the need to respond to national scrutiny and escalation. This included a strong focus on strengthening core governance functions, particularly in relation to assurance, risk management and performance oversight. Governance arrangements were aligned more closely with national frameworks, including the NHS Scotland Blueprint for Good Governance, and improvements identified through Internal Audit and wider governance reviews were systematically embedded.

This initial phase was characterised by the establishment of more robust committee structures and clearly defined Terms of Reference, alongside significant enhancements to risk management and assurance frameworks. The quality and consistency of Board and Committee reporting were also improved, ensuring greater clarity, transparency and effectiveness in decision-making. In parallel, governance arrangements were increasingly designed to support the delivery of financial sustainability and wider service reform objectives.

By 2025/26, the Board had built on this foundation and demonstrated further progression. The Population Health & Care Strategy 2025–2035 was approved aligned to national reform priorities. A stronger and more embedded performance management and governance cycle was also established. Importantly, the Board demonstrated sufficient maturity to be de-escalated to Stage 1 within the NHS Scotland Support and Intervention Framework, recognising sustained improvements in governance, leadership and organisational culture.

Collectively, this progress provides a strong platform for the next phase of Board development, enabling a transition from a focus on recovery and compliance towards a more high-performing, strategic and generative model of governance.

2. Key Insights from 2026 Governance Stocktake

2.1 Board and Committee Effectiveness Surveys 2026

The NHS Forth Valley Board Effectiveness Survey 2026 and Committee Effectiveness Survey 2026 were explicitly aligned to the five governance functions set out within the NHS Scotland Blueprint for Good Governance: setting direction, holding to account, managing risk, influencing culture, and engaging stakeholders. This alignment has provided a structured and consistent framework through which Board and Committee effectiveness can be assessed, supporting clearer insight into areas of strength and opportunities for further development.

The survey findings highlight a number of key strengths. There has been strong progress in strategic thinking and whole-system working, particularly in relation to the development of the Population Health approach. Performance oversight and accountability arrangements have improved, providing greater clarity and assurance. The Board has also fostered a positive organisational culture, supported through initiatives such as Board seminars and the inclusion of patient stories, which have strengthened engagement and focus on person-centred care. In addition, committee structures are now well established, with effective reporting mechanisms and robust audit oversight in place.

Alongside these strengths, the surveys have identified several areas for improvement with key themes around:.

- Strengthening Strategic Governance and Direction Setting
- Strengthening Whole System Assurance, improvements in data intelligence and delivering an Integrated Assurance Framework
- Enhancing the Board's approach to risk scrutiny, maturity and reporting
- Enhancing Engagement approaches with communities, staff and partner organisations
- Leading and Modelling an Inclusive and Positive Culture, including strengthening the Board's consideration of Equality, Diversity and Inclusion
- Optimising the operational working and effectiveness of the Board and Committees

2.2 April and June 2026 Board Governance Seminars/Discussions

A comprehensive governance stocktake was undertaken at the April 2026 Board Seminar with a clear focus on ongoing Board development, structured around a number of key themes highlighted with the Board and Committee Effectiveness Surveys.
A further discussion took place at the June 2026 Board seminar to agree priorities.

Follow through of actions from areas for improvement will now be taken forward as part of the overarching drive for continuous improvements in governance.

3. 3-Year Vision for Board Development

'NHS Forth Valley Board will operate as a high-performing, strategically focused and values-driven Board, demonstrating robust stewardship, strategic leadership and forward-looking governance, providing clear direction, robust assurance, and visible leadership in improving population health outcomes.'

This vision reflects the Board's statutory role to:

- Provide strategic leadership and direction
- Ensure effective, accountable governance
- Deliver high-quality, equitable and sustainable care

5. Delivery Approach

The 3-year plan will be delivered through:

- **Annual Board Development Plans**
  This includes findings from Board and Committee Effectiveness Surveys, insights from internal and external governance reviews, audit findings, and relevant national guidance. Collectively, this ensures that development priorities reflect both local organisational learning and wider national expectations for high standards of governance.

- **Structured Board Development Programme**
  This includes a programme of annual seminars and development sessions, complemented by targeted development activities aligned to priority governance themes, ensuring a focused and responsive approach to Board capability building.

- **NXD Masterclasses and Turas Board Development**
  Board members are encouraged to attend the NXD Masterclasses run by the Board Development Unit and to take up learning through the TURAS Board Development Modules.

- **Governance Continuous Improvement Cycle**
  A continuous improvement approach is applied through a ‘plan–review–reflect–adapt’ cycle, drawing on evidence from effectiveness surveys, audit insights and Board self-assessment to inform learning and ongoing development.

- **Alignment to National Frameworks**
  Board development is informed by established national frameworks, including the NHS Scotland Blueprint for Good Governance (second edition), alongside the wider NHS Scotland reform agenda and the Population Health approach, ensuring alignment with national priorities and expectations for modern, whole-system leadership and governance. Account will also be taken of subnational planning structures and Public Sector Reform.

6. Success Measures

Progress will be demonstrated through:

- Improved Board and Committee effectiveness survey results
- Evidence of:
  - Reduced duplication and clearer decision pathways
  - Stronger, clearer assurance reporting
  - Improved meeting effectiveness and strategic focus
- Sustained national confidence in governance, leadership and culture
- Demonstrable impact on:
  - quality, safety, and population health outcomes

7. Conclusion

NHS Forth Valley Board has transitioned from a period of governance recovery to one of stabilisation and improvement. The next three years represent an opportunity to embed this progress and evolve into a mature, high-performing Board, characterised by:

- Strategic clarity
- Integrated assurance
- Strong governance culture
- Effective system leadership

This development programme will ensure the Board is equipped to lead the organisation through continued financial, workforce and system challenges, while delivering sustainable improvements in health and care outcomes for the population of Forth Valley.

NHS Forth Valley

Progress Report: NHS Forth Valley Blueprint for Good Governance Board Development Plan 2025-26

Priority Area	Blueprint Function	High level Action	Interdependency	Lead	Timeline	Delivery Actions	Intended Good Governance Outcome	Status
Functions	**Influencing Culture**	Develop mechanisms for bringing together all aspects of Culture work for the Board to have clear oversight of performance metrics and delivery.	Staff Governance Committee / Area Partnership Forum	Director of People	By end of March 2026	• Consider metrics to provide a comprehensive and consistent approach to improving Board oversight of culture, taking account of national work also underway in this area. • Measure change by SMART metrics and incorporate into performance reporting. • Consider Board oversight, through the Staff Governance Committee, of an evaluation of the Culture & Compassionate Leadership Programme to date and any changes which are required going forward.	Staff treated fairly and consistently, with dignity and respect, in an environment where diversity is valued. A continuously improving and safe working environment, promoting the health and wellbeing of staff, patients and the wider community.	Action complete. Follow-on action for 2026/27 around the ongoing development and monitoring through the Culture OPEL Scoring Tool.

Progress to date:

- The Culture Change & Compassionate Leadership (CC&CL) Programme at NHS Forth Valley has now moved into the next phase of its lifecycle and is being embedded into routine operations.
- The Culture Indicator Score development has been progressed through dashboard development and potential incorporation into the broader Whole System Learning approach. As part of this work an initial Culture OPEL Scoring approach has been developed. The OPEL Scoring approach was demonstrated to the Staff Governance Committee at its meeting of 12 May 2026 and will be discussed at the 9 June Board Seminar before implementation.
- Work has been undertaken to build the suite of measures and there was a development list established with additional potential measures. Work on Workforce-Reported Experience Measures (WREMS) through the Values Based Health & Care programme has been considered as the approach evolved and data was triangulated for cultural measurement. The planned development was an important element of the work and reflected the approach taken throughout culture work activity.
- Board members had the opportunity to discuss the Culture work and measurements at the Culture seminar for Senior Leaders

Enablers	**Diversity, Skills and Experience**	Develop a shared understanding of equality, diversity and inclusion, building on expertise internally and externally to embed a culture of inclusion and enhance the Board's decision making	Staff Governance Committee and staff equality networks	Director of People	By end of March 2026	• Continue to build on the Board's understanding of diversity and how this should be taken account of in relation to decision making and relationships with stakeholders. • Develop the Board's EQIA processes and embed this within its decision making and development of strategies. • Create further opportunities for the Board to hear and learn from staff equality networks and diverse stakeholder views • Develop the Board's understanding of initiatives to enhance recruitment from diverse communities, both to the Board and to the organisation.	A Board that consists of a diverse group of people with the necessary skills, experience, values, behaviours and relationships. Better decision making of the Board by taking account of EDI impacts	Action complete. Follow-on action for 2026/27 is around embedding a clearer consideration of equality, diversity and inclusion in decision making and the use of Equality Impact Assessments (EQIAs)

Progress to date:

- The Board has enhanced its approach to involving stakeholders in decision making and undertook substantial engagement activities in relation to the development of the Population Health & Care Strategy. Comments received from public and stakeholder engagement were fully taken into account in finalisation of the strategy with all comments either incorporated or responded to in detail. The Board's Anti-Racism Plan was also developed in partnership with key stakeholders and was significantly shaped by engagement with the Ethnic Diversity Staff Forum.
- The Board's EQIA process has matured and is now integral to decision making. Full EQIAs are provided as part of the Board's decision making when appropriate. The EQIA process is undertaken from the commencement of strategy development and is central to the development of these.
- The Board's staff networks are well established and feed into strategy development. The Board has had direct engagement with a number of the staff networks at Board Seminars.
- This work has been embedded into BAU and will be taken account of as part of new NXD recruitment and consideration of skillsets

Delivery	**Assurance Framework**	Complete the work on the Board Assurance Framework, ensuring it is aligned to the Scottish Government NHS Blueprint for Good Governance and that it is fit for purpose.	Code of Corporate Governance, Corporate Objectives, Risk Management Strategy, Strategic Planning Framework, Performance Management Framework, Audit arrangements.	Board Secretary	By end of March 2026	• Provide further support around active governance development to enhance understanding of data, skills in challenging and triangulating information for assurance. • Undertake further development work on the use of the BAF to provide assurance. • Undertake a mapping exercise of local strategies to understand interdependencies and any gaps.	An assurance framework that aligns strategic planning and change implementation with the organisation's purpose, aims, values, corporate objectives and operational priorities.	Action complete. Follow-on actions for 2026/27 are picked up in the Board Development Plan 26/27.

Progress to date:
Progress during 2025/26 focused on establishing the core components of the Board Assurance Framework (BAF) and strengthening the wider governance architecture in which it operates.

Key achievements include:

- Improved alignment across governance frameworks, with clearer links between Corporate Objectives, the Population Health & Care Strategy, the Annual Plan and the Risk Management Framework.
- Strengthened Board and Committee oversight, with continued scrutiny of strategic risks through the Board and Audit & Risk Committee and increasing maturity in the articulation of assurance within papers.
- Enhanced assurance infrastructure, supported by the Internal Audit Plan which includes work on structures of assurance, internal control and risk management.

Collectively, these developments have strengthened the foundations of the BAF, particularly in linking strategy, risk, planning and oversight, which is essential for it to function as a meaningful source of assurance.

While the core components of the BAF are now largely in place, it is not yet fully embedded as a live, consistently applied framework across Board and Committee business.

Functions	**Managing Risk**	Review of Risk Framework and Board's Risk appetite/ tolerance and approach to Risk	Audit & Risk Committee / Code of Corporate Governance	Chief Executive	By end of March 2026	• The Board will review its Risk Framework, Risk appetite and tolerance to strengthen oversight and scrutiny in this area through a Board development session.	A more active approach to governance to make more timely, well informed and strategic decisions. A clearer understanding of the Board's risk appetite and tolerance being evident at Committee and Board level.	Action complete. Follow-on action for 2026/27 is the continued work of the SLWG

Progress to date:
The Board Seminar on Risk Management (October 2025) provided focused development time for Board members on risk appetite and tolerance and the role of risk in strategic decision-making. It supported a shared understanding of how risk should be articulated and assessed and the relationship between strategy, risk and assurance.

This seminar created the foundation for subsequent governance activity, ensuring that development and formal decision-making were aligned.

Following the seminar, a Short Life Working Group including Non-Executive Directors was established to:
- Undertake detailed review of the existing Risk Framework
- Refine the Board's approach to appetite and tolerance
- Ensure alignment with wider governance arrangements, including the Code of Corporate Governance and Committee structures

This approach supported:
- Active Non-Executive engagement and ownership
- Iterative development prior to formal Board consideration

The refreshed Risk Framework was:
- Approved by the Board on 28 April 2026
- Considered through both development and formal governance routes, including:
  - Board discussions informed by seminar outputs
  - Supporting papers setting out the proposed framework and changes

The refreshed Risk Framework provides an updated and more explicit basis for:
- Board and Committee oversight
- More timely, informed and strategic decision-making

While the formal review is complete, the next phase should focus on embedding and sustaining the revised approach, including ensuring consistent application of the risk appetite and tolerance, and consistent risk reporting formats across Committees and Board. There should also be a continued strengthening of the link between risk, assurance and performance reporting.

28 May 2026

DRAFT NHS Forth Valley Blueprint for Good Governance Board Development Plan 2026-27

Priority Area	Blueprint Function	High level Action	Interdependency	Lead	Timeline	Delivery Actions	Intended Good Governance Outcome
Functions	**Influencing Culture**	Oversee the implementation of culture metrics	Staff Governance Committee	Director of People	31 March 2027	• Monitor the development and implementation of the Culture OPEL tool and assess effectiveness of this approach. • Measure change by SMART metrics and incorporate into performance reporting.	Staff treated fairly and consistently, with dignity and respect, in an environment where diversity is valued. A continuously improving and safe working environment, promoting the health and wellbeing of staff, patients and the wider community. Successful approach to monitoring culture within the organisation.
Delivery	**Assurance**	Strengthen the Board's role in oversight and assurance	Code of Corporate Governance Board Assurance Framework Corporate Objectives Forth Valley NHS Board and its Committees	Acting Director of Strategic Planning and Performance / Board Secretary	31 March 2027	• Commence implementation of the actions from the Board and Committees Effectiveness Review and identify priorities for 26/27. • Conclude the work of the SLWG on Risk Management and review risk descriptors and controls to ensure they are clear, strategic and action focused. • Establish and support the work of a SLWG to review the Board's performance reporting and the use of data metrics and any requirement for associated Board development training • Undertake a mapping exercise of local strategies to understand interdependencies and any gaps	An effective Board operating with clear oversight and assurance in line with good governance principles as highlighted in the Blueprint for Good Governance.

Delivery	**Setting the direction**	Consider support to implement the Population Health & Care Strategy and ambitions	Task and Finish Group Assurance Committees Board Seminar	Chief Executive	31 March 2027	• Engage and work with the King's Fund and Healthcare Improvement Scotland to support work towards becoming a population health organisation including our self-assessment against the Population Health Organisation Maturity Matrix.	Determining the organisation's purpose, aims, values and corporate objectives. Setting the operational priorities and agreeing the targets for service delivery with the Scottish Government and the Executive Leadership Team Allocating the budgets and approving the capital investments required to deliver strategic and operational plans.
Enablers	**Diversity, Skills and Experience**	Develop a shared understanding of equality, diversity and inclusion, building on expertise internally and externally to embed a culture of inclusion and enhance the Board's decision making	Staff Governance Committee and staff equality networks	Director of People	31 March 2027	• Embed a clear understanding of equality, diversity and inclusion within decision-making and engagement processes, ensuring it is consistently considered and reflected in how decisions are shaped and communicated. • Establish EQIA as a core element of reporting within decision making and development of strategies.	A Board that consists of a diverse group of people with the necessary skills, experience, values, behaviours and relationships to ensure diversity of thought in governance and decision making. Better decision making of the Board by taking account of EDI impacts

NHS Forth Valley

Forth Valley NHS Board

11. Acute Site Emergency Department Staffing
Purpose: This report is for Decision

Executive Sponsor: Ross McGuffie, Chief Executive
Author: Garry Fraser, Director of Acute Services

Executive Summary
This following paper is to highlight the acute site emergency department staffing recruitment request after receiving a review by CFSD.

The Emergency Department at Forth Valley Royal Hospital is operating under sustained and increasing pressure due increased ED attendances and a mismatch between patient demand and available workforce capacity, particularly within Senior Decision Maker (SDM) roles.
Demand patterns demonstrate:

- Peak activity concentrated between late afternoon and midnight
- Persistent periods of high demand extending into overnight periods
- Regular exceedance of normal operational capacity resulting in a very busy and crowded environment
- The data shows that current staffing levels are insufficient to provide consistent senior clinical decision-making across the full 24-hour period, which can result in; delays to assessment and treatment, compromised flow and efficiency in the ED, adversely impact on patient care and experience, workforce fatigue and retention challenges.

- A detailed review of demand, CFSD benchmarking against national standards, acuity of patients attending at ED over 2025/26 period and workforce modelling has identified a clear requirement to expand staffing in the Emergency Department.

- Our consultant levels are also lower than other NHS Boards which we aim to resolve within this planned recruitment of additional staff.

Action Required
The Forth Valley NHS Board is asked to:

1. endorse the recommendations of increasing the workforce in ED;
2. support phase one implementation of the increased staff model costing £900k over the year. A decision will need to be made by the board after phase 1 is evaluated in relation to continued funding, as this may cause a cost pressure within our financial plans;
3. note that ELT will continue to review the recommendations and workforce plan, monitor the benefits realisation and measurement plan, and report back to SPPRC with an evaluation at key milestones. This is turn can be reported to the board in relation to the benefits realisation and decision making going forward;
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 paper has previously been considered by the following groups as part of its development. The groups have supported the content and their feedback has informed the development of the content presented in this report.

- Acute management team meeting, April 2026. The CFSD feedback was presented and considered by the acute team. There was agreement that the presentation was helpful to pinpoint one aspect of the complicated issues of increasing the 4-hour EAS. There was agreement to escalate to ELT as staffing resource is required.
- In May 2026 the ELT was presented an earlier draft paper to discuss the impact that additional medical staff in ED would bring. There are many component parts to increasing the 4-hour EAS however the evidence from CFSD on SDM staffing is strong. There was agreement that if funding was provided that the ELT would support an increase in medical staff in the ED and undertake a suite of measures to confirm the benefits outlined.
- SPRRC was presented this paper on 26th May 2026 and there was wide support for this paper and to progress this to the Board meeting in June 2026 given the amount of the investment being introduced.

Risk Assessment and Mitigation
There is a current strategic organisational risk SRR002 which relates to the 4-hour access standard. This staffing development will help improve flow, patient safety and improve patient and staff experience. This staffing development will contribute to mitigating this specific risk.
The financial risk is mitigated for the first 12 months as Scottish Government can provide funding to initiate the additional staffing and allow the benefits highlighted to be realised. Further detail on the financial plan is within section 8 of the paper.

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 ☐

The EQIA has not yet been undertaken for this specific paper due to the pace of the request that has come through.

Financial, Digital and Infrastructure Implications
The Scottish Government will provide funding for phase 1 of the staffing plan, outlined in the full paper, to allow a test of change to be undertaken and this is being provided within this financial year.

Workforce Implications
This is highlighted in the benefits section of the paper. There will be a massive positive impact on all the areas outlined below

Implementation will deliver:

- Improved patient safety and experience
- Reduced overcrowding and waiting times
- Enhanced staff wellbeing and retention
- Greater training and supervision capacity
- Reduce reliance on agency and locum spend
- Improve operational efficiency
- Meet national guidelines for staffing

Quality / Patient Care Implications
Describe any positive and negative impact on quality of care and services.

Implementation will deliver:

- Improved 4-hour performance
- Improved patient safety and experience
- Reduced waiting times
- Sustained Trauma Unit status
- Better meet the patient demand by acuity and hour of day
- Improve operational efficiency
- Deliver better value through improved patient flow

Population Health & Care Strategy
Describe any linkages and contributions to the Population Health & Care Strategy including consideration of Realistic Medicine and Value Based Health & Care.

Unfortunately, the current demand from the public has seen the pressure on services being high. As we work with our partners to introduce more preventative measures there is an increasing patient safety issue that is required to be addressed in the shorter term.

Climate Change / Sustainability Implications
There are no climate change implications.

Engagement and Communications
Was statutory engagement with stakeholders required? Yes ☐ No ☒

An internal comms plan to be formulated to describe the implementation of new staff and the benefits this will bring.

Appendices
Emergency Department Workforce Review

Emergency Department Workforce Review

1. Purpose

Following the Centre For Sustainable Delivery (CfSD) presentation to NHS Forth Valley acute service in April 2026, this paper was presented to the SPRCC with the Emergency Department (ED) workforce capacity recommendations to maintain and further enhance the safe, effective, and sustainable delivery of emergency care services, aligned to current demand, national standards and workforce best practice. It is now being presented to the Board for final approval.

It should be noted that this staffing model has been developed in conjunction with the Urgent and Unscheduled care strategy where optimising flow and partnership working is key to balancing and improving performance across the wider health and care system. We are working with our partners to ensure we reduce avoidable ED admissions and ensure patients can access the right care in the right place, first time.

This paper specifically outlines plans to increase the number of senior clinical decision makers within ED after CFSD undertook a detailed review of the ED data along with an external comparison of the department. Nursing levels were adequate through the period.

As previously stated in other committees, there is no single component that will increase the 4 -hour Emergency Access Standard (EAS) performance and patient experience, however ED senior decision maker staffing has been clearly shown to have a positive impact on ED efficiency, performance and processes.

2. Executive Summary

The Emergency Department at Forth Valley Royal Hospital, like many hospitals across Scotland, continues to experience sustained and increasing pressures.

Demand patterns demonstrate:

- Peak activity concentrated between late afternoon and midnight
- Persistent periods of high demand extending into overnight periods
- Regular exceedance of normal operational capacity resulting in a very busy and crowded environment

The data shows that current staffing levels are insufficient to provide consistent senior clinical decision-making across the full 24-hour period, which can result in; delays to assessment and treatment, compromised flow and overcrowding in the ED, adversely impact on patient care and experience, workforce fatigue and retention challenges.

A detailed review of demand, CFSD benchmarking against national standards, acuity of patients attending at ED over 2025/26 period and workforce modelling has identified a clear requirement to expand staffing in several areas.

Demand

The flow definitions are:

Flow 1: minor injury & minor illness who are discharged home
Flow 2: patients requiring specialist involvement who are discharged home
Flow 3: medical admissions
Flow 4: surgical admissions

For 2025/26, the volume of patients attending ED for the year was 66805 which included all patients in the analysis (planned new, unplanned new, planned return and unplanned return). Table 1 is the flow split in ED:

Table 1

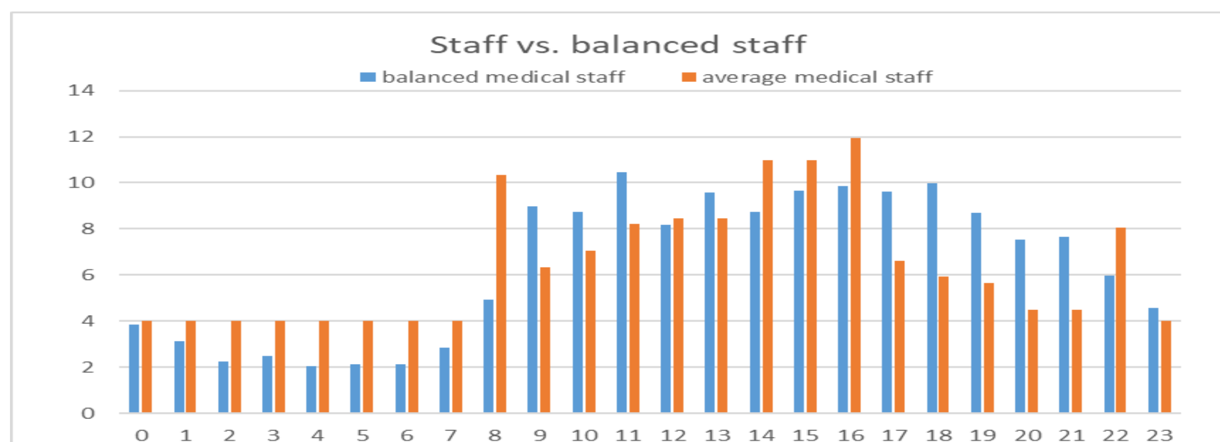
Year	2025/26

Flow	**% Attendances**
1	34.0%
2	40.9%
3	16.2%
4	8.9%
Total	**100.0%**

In table 1 we see that flow 1 are a cohort of patients that can be seen and discharged. Increasing our senior decision makers at peak attendance time will enhance our ability to affect all flow areas and possibly reduce admissions and provide a quicker outcome for the patient from ED. This is subject to a range of factors including alternative pathways of care, time of presentation and capacity within the department.

Increased staffing will provide several benefits such as ensuring appropriate staffing levels are aligned to patient demand, improve patient flow across the hospital site and performance in relation to the 4-hour EAS, reduce reliance on temporary staffing and support greater workforce sustainability.

Table 2



Within table 2, If the senior and medical staffing levels were to be balanced completely to mirror the profile of ED attendances the impact is mainly in the period from 5pm through to 9pm. This is where the medical and senior staffing levels tend to drop off before the attendances slow down.

Table 3

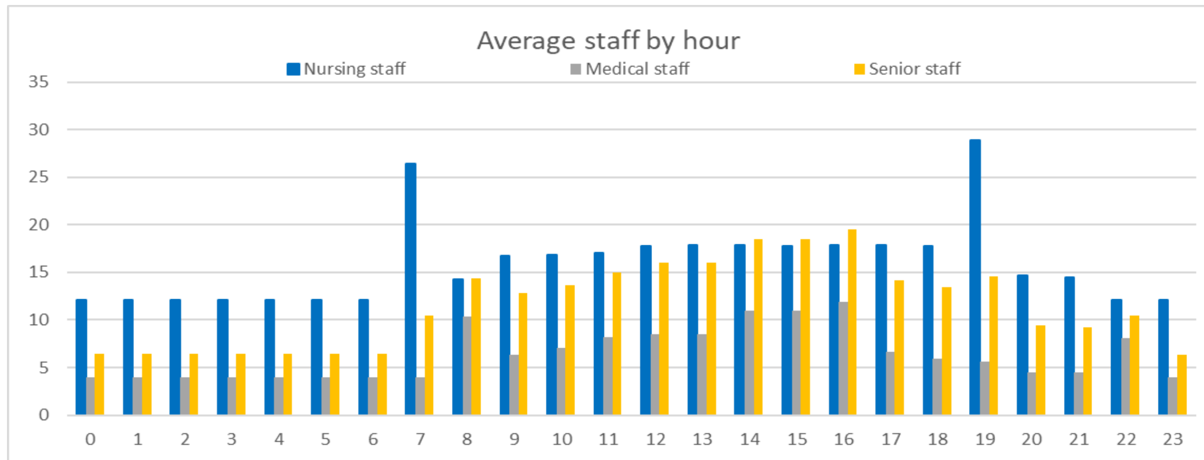
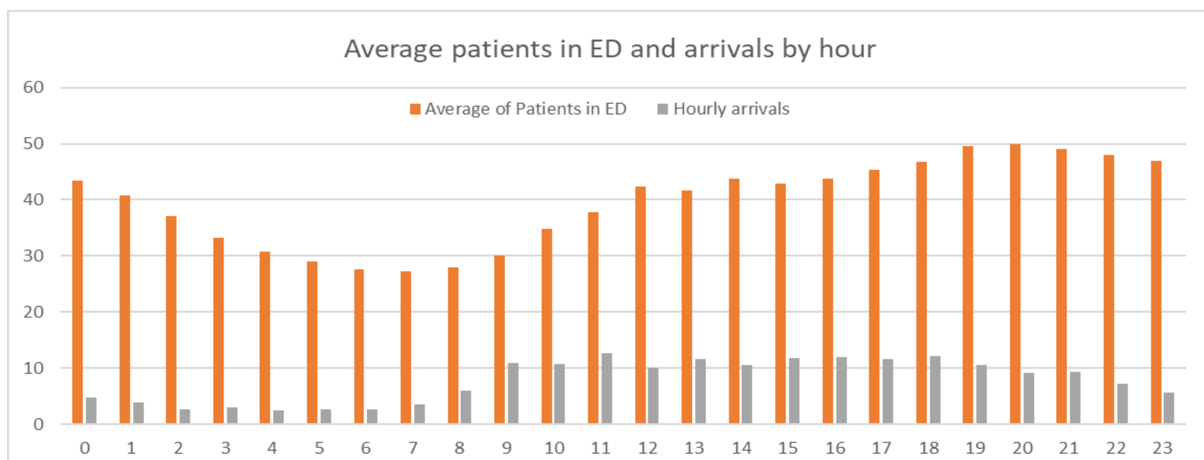


Table 4



As displayed in tables 3 and 4, the medical staffing levels look to mirror the patient arrivals and patients in department patterns during the day as does the senior staffing levels. The staffing levels, however, fall away before the arrivals drop and before the second peak of patients arrive in the department.

3. Strategic Context

This proposal aligns with several strategic priorities which are listed below:

- National Clinical Strategy for Scotland – delivering care closer to need, safely and sustainably
- Redesign of Urgent Care Programme – timely access to emergency and urgent care
- NHS Scotland Workforce Strategy 2030 – sustainable, skilled workforce
- RCEM Workforce Recommendations – appropriate senior clinical coverage

It also directly supports delivery of:

- The 4-hour Emergency Access Standard
- Safe and effective 24/7 Emergency Care
- Maintenance of Trauma Unit status

Consistent feedback via the National Centre for Sustainable Delivery demonstrates the requirement to enhance the existing workforce staffing model to deliver on improved performance and patient care. The impact of not meeting this presents both strategic and regulatory risks to the organisation.

4. Current Position

4.1 Workforce Profile

The Emergency Department currently operates with:

- 13.4 WTE Consultants
- 7.3 WTE Specialty Doctors (with contractual limitations on out-of-hours work)
- 6.0 WTE ANP

Key constraints:

- Insufficient Senior Decision Maker (SDM) presence during periods of peak demand
- Limited overnight senior coverage in the ED
- Reduced flexibility in rota design
- Limited resilience in nursing workforce

As highlighted in the review carried out by CFSD there is sufficient staff to cover the dayshift demand but not excess staff to redeploy into the back shift. Also, there are national contractual issues limiting out of hours (OOH) working for some grades of staff that would not allow for redeployment onto more OOH shifts.

4.2

The current model results in:

- Longer waiting times and reduced performance in relation to the 4-hour emergency access standard
- Increased ambulance handover delays
- Treatment in non-standard or very busy environments
- Reduced clinical efficiency

The CFSD output displays the mismatch between staff and patient demand, this is highlighted in table 5 and 6 below.

Staffing verses arrivals table 5

Hour	total staff	nursing staff	medical staff	senior staff
0	-0.12	-0.16	-0.02	0.04
1	-0.23	-0.27	-0.13	-0.07
2	-0.37	-0.41	-0.28	-0.21
3	-0.34	-0.38	-0.24	-0.17
4	-0.40	-0.44	-0.31	-0.24
5	-0.39	-0.43	-0.29	-0.22
6	-0.39	-0.43	-0.29	-0.22
7	-0.92	-1.21	-0.18	-0.46
8	-0.33	-0.13	-0.84	-0.47
9	0.37	0.35	0.42	0.29
10	0.29	0.31	0.26	0.18
11	0.50	0.56	0.35	0.34
12	0.10	0.16	-0.05	-0.11
13	0.32	0.38	0.17	0.11
14	0.07	0.24	-0.35	-0.24
15	0.22	0.39	-0.20	-0.09
16	0.20	0.42	-0.33	-0.15
17	0.41	0.38	0.47	0.27
18	0.49	0.44	0.63	0.39
19	-0.19	-0.45	0.48	0.09
20	0.32	0.26	0.48	0.36
21	0.35	0.29	0.49	0.39
22	0.03	0.17	-0.33	0.03
23	0.00	-0.04	0.09	0.16

The table on the left compares the balance of staffing compared to arrivals by hour. Where the cell is coloured red, the demand outstrips capacity and where the cells are green, the capacity levels are more suitable for the demand. The 2 points of the day where we see coloured darker green are where it looks like there are larger staff numbers, but this is falsely inflated due to the nursing shift changeover period.

It is clear that the demand is tending to outstrip capacity during the day more compared to overnight. The staffing levels are not increasing as fast as the arrivals to ED in the morning for all staff (where the colour changes to red), through to the afternoon and early evening. It looks to be more consistent throughout the day for nursing staff. For medical staff the deficit of staff compared to patients arriving is most obvious from 5pm through to 9pm (arrivals are starting to drop from the peak at 6pm). Interestingly it is during this time that we see the second peak of the number of patients in ED.

Staffing verses arrivals table 6

Hour	total staff	nursing staff	medical staff	senior staff
0	0.38	0.34	0.47	0.54
1	0.31	0.27	0.41	0.48
2	0.22	0.18	0.31	0.38
3	0.12	0.08	0.22	0.28
4	0.06	0.02	0.15	0.22
5	0.01	-0.03	0.11	0.18
6	-0.02	-0.06	0.07	0.14
7	-0.67	-0.97	0.07	-0.22
8	-0.39	-0.19	-0.90	-0.54
9	-0.27	-0.29	-0.23	-0.35
10	-0.19	-0.18	-0.22	-0.30
11	-0.17	-0.11	-0.33	-0.34
12	-0.10	-0.05	-0.25	-0.31
13	-0.12	-0.06	-0.27	-0.33
14	-0.18	-0.01	-0.60	-0.49
15	-0.20	-0.03	-0.63	-0.51
16	-0.22	-0.01	-0.75	-0.58
17	0.05	0.03	0.12	-0.08
18	0.12	0.07	0.26	0.02
19	-0.29	-0.56	0.37	-0.01
20	0.41	0.34	0.56	0.44
21	0.40	0.34	0.54	0.44
22	0.31	0.46	-0.05	0.31
23	0.47	0.43	0.56	0.63

The table on the left compares the balance of staffing compared to patients in ED by hour. Where the cell is coloured red, the demand outstrips capacity and where the cells are green, the capacity levels are more suitable for the demand. Like before the very dark green tends to indicate the extra staff in the department during shift changeover.

It is very clear that the demand is outstripping capacity in the early evening where the staff levels have dropped after 4 or 5pm but the arrivals have not dropped leading to increased numbers of patients in ED and the second peak at around 8pm.

4.3 Workforce Pressures

Working in consistently high pressured and busy environments can contribute to:

- Staff burnout and fatigue
- Increased sickness absence
- Recruitment and retention challenges
- Dependence on locum and bank staffing

4 .4 Workforce Sustainability

Progressing with the proposed new staffing model will improve and increase recruitment prospects and allow for training and development within the department. This would also

help build long term sustainability, resilience and job satisfaction. The consultant grade of additional staff will enable more supervision and training for other staff within the department.

5. Case for Change

5.1 Patient Safety and Quality of Care

Insufficient senior clinical workforce capacity matched to patient demand can result in delays in clinical decision-making, extended time to treatment, reduced supervision of junior staff and increased likelihood of errors in high-pressure environments. Overcrowding and longer waiting times are also linked to poorer outcomes.

Flow and Performance

The link to performance and effective ED flow is dependent on early senior decision-making with rapid triage (assessment)and streaming. This supports timely admission or discharge and links directly to the flow model that the UUSC strategy is working to improve. We know from CFSD that reducing the ED occupancy at 8am is a key contributor to achieving better 4-hour performance.

Current workforce gaps limit the department's ability to:

- Maintain continuous patient flow
- Meet the 4-hour standard
- Avoid crowding and backlogs

5.3 Benchmarking and Best Practice

CFSD undertook a benchmarking exercise with a comparison of two EDs and national standards. This highlighted:

- Current staffing levels fall below recommended SDM coverage
- Peak-period staffing is materially lower than comparator sites
- Gaps are most pronounced during evening periods
- A mixture of consultant grade and senior medical staff would best meet NHS Forth Valley requirements

6. Proposed Workforce Model

A fully enhanced workforce model to meet the demand has been reviewed and costed to circa £2.3m. This is described below;

- +6 WTE Consultants
- +7 WTE Specialty Doctors
- +1 WTE ANP

This model enables:

- 24/7 SDM coverage aligned to demand
- Expansion of **Senior Decision Maker triage (8am–8pm, 7 days)**
- Improved staffing during peak demand periods (especially evenings)
- Full embedding of enhanced triage model
- A mixture of consultant and senior staffing grades would best meet the needs of NHS Forth Valley within the allocated budget for the year 2026/27.

6.2 Initial phasing of ED staffing plan

Phase one of implementation with confirmed funding from Scottish Government of £900,000 for the financial year 2026/27. This would potentially comprise of the following staff model to best meet the proportion of demand. There are short term recruitment considerations and availability of medical staff to start at short notice for fixed periods of time. However, the vision of phase one would be to start recruitment and selection for the following.

- 2 consultant grades
- 4 specialty doctor grades

This will allow for the concept to be tested, measured and proven for evaluation through the remainder of the year. Although this is not the full workforce model suggested, it will greatly enhance the staffing within ED at the optimal times. In comparison with other health boards with a similar population, the addition of two permanent consultant grades would increase the ED consultant cohort to a more comparable level. The 4 specialty doctors offer a good solution to meet the demand within the financial allocation and are the type of role that can be easier to recruit to for a fixed term, in this case one year.

7. Expected Benefits

Phase one implementation will have a suite of metrics to ensure the benefits are captured and reviewed. The draft measurement plan has been produced with the ED leadership triumvirate and our QI team. In discussion with the senior leadership team and the Triumvirate for the ED, they are appreciative and excited about the prospect of the increased staffing support. They are aware of the expected outputs which include 4-hour ED performance and improving staff and patient experience. There is an MDT group being formulated to set parameters for the ED framework and monitor the impact of the incoming staffing model. CFSD have also been involved with the trajectories for the measures. Other benefits include:

- Improved 4-hour board performance to 70% in 2026/27
- Improved patient safety and experience
- Reduced overcrowding and waiting times
- Enhanced staff wellbeing and retention
- Greater training and supervision capacity

- Sustained Trauma Unit status
- Better meet the patient demand by acuity and hour of day
- Reduce reliance on agency and locum spend
- Improve operational efficiency and meet national guidelines for staffing
- Deliver better value through improved patient flow

8. Risks of not implementing the full or partial model.

No increase in staffing would result in continued underperformance with ongoing impact on patient care and experience being evident. Attraction, retention and recruitment of staff may be difficult to achieve with the current staffing model and result in reliance of locum doctors to cover shifts if recruitment to the current model is not enhanced.

The non-recurring funding will provide an opportunity to test both the data and underlying hypothesis regarding the impact on the 4-hour Emergency Access Standard (EAS), and it is expected to deliver clear patient safety benefits. If the model proves successful, a sustainable funding solution will need to be incorporated into the financial plan for the following year. Should the approach not deliver the anticipated benefits, the exit strategy would be to allow the four specialty doctor posts to conclude at the end of their fixed one-year contracts and to review the consultant workforce model thereafter, noting that NHS Forth Valley currently has fewer ED consultants compared to a number of other NHS Boards.

9. Recommendation

The Board is asked to:

1. Endorse the recommendations of increasing the SDM workforce in ED.
2. Support phase one implementation of the increased staff model costing £900k.
3. Note that the ELT will continue to review the recommendations and workforce plan, monitor the benefits realisation and measurement plan, and report back to SPPRC with an evaluation at key milestones.

NHS Forth Valley

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12. HIS Acute Services Follow-Up Inspection Report
Purpose: This report is for Assurance

Executive Sponsor: Karen Goudie, Executive Nurse Director
Author: David Watson Director of Nursing, Ronan Ging Chief Nurse Acute Services.

Executive Summary

Healthcare Improvement Scotland (HIS) undertook an unannounced follow-up inspection of Acute Services at Forth Valley Royal Hospital in March 2026, with subsequent review and oversight activity continuing through April 2026, to assess progress against previously identified patient safety concerns and the sustainability of improvements in the delivery of care. This follow-up inspection resulted in two areas of good practice, one recommendation and seven new or updated requirements. Four previous requirements were not met and have been carried forward.

Overall, HIS recognised clear and sustained progress since earlier inspections, with evidence of a more open and supportive organisational culture. Staff consistently described the hospital as a positive place to work, supported by visible and engaged senior leadership. Structured approaches such as hospital-wide safety huddles were observed to be embedded in practice, promoting transparency, shared situational awareness, and a culture of psychological safety where staff feel empowered to raise concerns. There were however several areas with opportunities for improvement.

Action Required:

The Forth Valley NHS Board is asked to:

(1) Recognise the Governance structures are in place to provide oversight of the implementation of the SDOC action plan through operational and oversight groups.

(2) Recognise the initial progress towards the completion of the individual actions.as detailed in Project Plan.

(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.

Risk Assessment and Mitigation

The principal risks to delivery of the HIS Improvement Action Plan relate to ongoing operational pressures, workforce capacity. These are mitigated through a structured governance framework, including weekly operational meetings, fortnightly oversight reviews, routine reporting, and escalation through established governance and Board structures, ensuring effective oversight, challenge, and sustained delivery of quality and patient safety improvements.

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 ☒
There are no direct equality implications arising from the report.

Financial, Digital and Infrastructure Implications
No immediate direct financial pressures are identified.

Workforce Implications
The improvement action plan strengthens expectations regarding professional practice, clinical governance, and compliance with key safety processes, whilst reinforcing the importance of visible leadership and a positive safety culture. Delivery of the action plan will support a highly skilled, competent, and engaged workforce capable of providing safe, effective, and person-centred care. Oversight through established governance arrangements will ensure workforce-related risks, training compliance, and capability requirements are monitored and addressed to support sustainable improvement and organisational assurance.

Quality / Patient Care Implications
The HIS report identifies several quality and patient safety improvement opportunities focused on enhancing the reliability and consistency of care delivery across acute services. The associated improvement action plan seeks to reduce avoidable harm, strengthen infection prevention and control, improve medicines safety, enhance workforce capability, and ensure robust risk management processes are consistently applied. Collectively, these actions will support safer, more effective and person-centred care, whilst strengthening governance, organisational learning, and Board assurance through a comprehensive programme of oversight, measurement and continuous improvement.

Population Health & Care Strategy
The HIS Improvement Action Plan supports the delivery of NHS Forth Valley's Population Health ambitions by strengthening the foundations required to deliver consistently safe, effective and person-centred care. The actions arising from the inspection focus on improving reliability of clinical processes, reducing unwarranted variation, enhancing patient safety, and strengthening governance and accountability arrangements across acute services. These improvements contribute directly to better health outcomes by ensuring patients receive safe, timely and high-quality care regardless of where they access services. The focus on infection prevention and control, medicines safety, contingency care management, workforce capability, and care documentation supports the prevention of avoidable harm and improves the overall patient experience.

Climate Change / Sustainability Implications
No significant sustainability implications have been identified. The operational decisions and mitigations described do not materially impact NHS Scotland’s climate or sustainability objectives.

Engagement and Communications
Was statutory engagement with stakeholders required? Yes ☒ No ☐

Wide representation is evident in the Operational Group membership. An information and engagement session was also held Site Wide where the HIS Report and Action plan were shared with the wider teams to support understanding, share success and promote engagement and support to achieve delivery of the key recommendations and requirements.

Appendices
Appendix 1 – HIS Acute Inspection Briefing
Appendix 2 – Unannounced Follow-up Inspection Report: Acute Hospital Safe Delivery of Care Inspection
Appendix 3 – Improvement Action Plan

Appendix 1: Acute Services Briefing June 2026.

Purpose

This report is presented for assurance regarding progress in response to the recent Healthcare Improvement Scotland (HIS) unannounced Safe Delivery of Care follow-up inspection of Acute Services at Forth Valley Royal Hospital, undertaken in March 2026 and April 2026.

Executive Summary

Healthcare Improvement Scotland undertook an unannounced follow-up inspection of Acute Services at Forth Valley Royal Hospital between 16–18 March 2026 to assess progress against previous requirements and the sustainability of improvements. A further follow up visit was also undertaken on the 7th of April 2026.

Overall, Healthcare Improvement Scotland recognised clear and sustained progress, including a more open and supportive organisational culture and visible leadership, with safety huddles embedded in practice to promote transparency and psychological safety. The inspection also highlighted areas where there was an opportunity for improvement, particularly relating to consistency of practice, compliance with key safety processes, and workforce capability.

The inspection identified:

- Two areas of good practice
- One recommendation
- Seven new or updated requirements
- Four outstanding requirements carried forward from previous inspection

Areas of good practice

- Patients were receiving assistance to carry out hand hygiene prior to mealtimes and being assisted with meals.
- Safety and capacity huddles were inclusive, with staff being observed to raise concerns regarding staffing and safety

One Recommendation

Healthcare Improvement Scotland recommended NHS Forth Valley should ensure discussion regarding patients detained under Mental Health (Care and Treatment) (Scotland) Act are discussed at hospital wide safety and capacity huddles. This will allow staff to highlight any patient or staff safety concerns, or patient care requirements and ensure management oversight. This recommendation has been fully met and monitored through site safety and capacity huddles.

Requirements

1) NHS Forth Valley must ensure all staff are aware of fire risk assessments and processes in place regarding fire safety including awareness of the evacuation process

Fire Safety training has now increased to 81% and demonstrating an upward trajectory and is being monitored through Health & Safety group. 100% of areas are now consistently identifying responsible Fire Marshall on duty and demonstrates achievement of this aspect of the requirement.

2) NHS Forth Valley must ensure staff awareness of risk assessments and of the suitability of patients to be cared for in contingency beds are recognised and ongoing review of patients is carried out.

A robust process is in place to monitor compliance with Contingency risk assessments on a weekly basis, and each usage is identified daily at site Safety huddles. Further oversight is provided through the Care Assurance visits to the clinical areas. Forth Valley continues to apply a whole system approach to reduce the utilisation of contingency beds.

3) NHS Forth Valley must ensure safe intravenous line care practices to prevent the risk of infection

A programme of improvement is underway to further strengthen intravenous (IV) line care practices across clinical services. Key prevention measures include reinforcing best practice standards through ward safety huddles, care assurance visits and targeted education sessions delivered by the Practice Development Unit.

4) NHS Forth Valley must ensure that all staff comply with the safe management and disposal of waste including sharps and linen

A range of measures are in place to support safe and effective waste management practices across clinical services. Routine environmental walk rounds are being undertaken to promote adherence to Standard Infection Control Precautions (SICPs) and reinforce good practice. This improvement work is progressing well and currently at 80% completion.

5) NHS Forth Valley must ensure all hazardous cleaning products are securely stored.

Compliance with safe storage standards is monitored through a programme of environmental walk rounds, supporting ongoing visibility of practice and reinforcing adherence to established requirements. Findings are reported through the Infection Control Committee, providing oversight and assurance through established governance arrangements. A dedicated audit tool has now been implemented and

routine data collection commenced. This will support enhanced monitoring, trend analysis and assurance over time.

6) NHS Forth Valley must ensure the safe storage of medicines at all times, always including controlled drugs

Actions to strengthen medicines management and storage are progressing across clinical services. These include enhanced staff awareness and education, strengthened assurance processes, and ongoing work to improve the clinical environment supporting medicines storage. Collectively, these measures provide additional assurance regarding compliance with medicines management standards and support the delivery of safe, effective care.

7) NHS Forth Valley must ensure patient privacy and dignity is maintained at all times

Education, leadership engagement and staff development activities continue to support a culture that prioritises patient privacy, dignity and respectful care. These measures reinforce professional standards, promote positive behaviours and provide ongoing assurance that person-centred care remains a key organisational priority.

Additional / Outstanding Requirements

1) NHS Forth Valley must ensure that nursing staff are provided with necessary paediatric training to safely carry out their roles within the emergency department and comply with the NMC Code, Professional standards of practice and behaviour for nurses, midwives and nursing associates.

The Emergency Department remains compliant with relevant RCEM guidance for paediatric life support provision. Ongoing investment in PILS training is further strengthening workforce capability, with arrangements in place to ensure appropriately trained staff are available across shifts. A continued programme of training and competency development is planned throughout 2026, with compliance monitored through established workforce and clinical governance arrangements to provide ongoing assurance regarding safe and effective care

2) NHS Forth Valley must ensure effective processes are in place to ensure the safe management and care for patients with peripheral venous cannulas within the emergency department and clinical assessment unit.

A number of measures have been implemented to strengthen the safe management of peripheral venous cannulas (PVCs). These include reinforcing the prompt removal of PVCs when no longer clinically required, embedding PVC monitoring within routine care processes, and providing targeted staff education on best practice. Ongoing audit, monitoring and awareness-raising activities are

supporting compliance with national standards and providing increased assurance regarding the safe and effective management of PVCs across clinical areas.

3) NHS Forth Valley must ensure that all patient care documentation is accurately and consistently completed and reviewed.

Completion and quality of patient care documentation continue to be supported through care assurance visits and focused audit programmes. A new audit tool has now been implemented and regular data collection commenced. This will provide enhanced monitoring, support trend analysis over time, and strengthen organisational assurance regarding compliance with documentation standards.

4) NHS Forth Valley must ensure all staff comply with hand hygiene, the use of gloves and appropriate wearing of jewellery.

A range of measures are being taken to strengthen compliance with Standard Infection Control Precautions (SICPs) and reinforce safe clinical practice across NHS Forth Valley. This includes the relaunch of the Uniform Policy, ongoing environmental monitoring and audit activity, and the delivery of targeted hand hygiene improvement initiatives to support staff awareness and adherence to best practice.

Governance and Oversight Arrangements

A structured governance framework is in place to ensure effective delivery, oversight, and assurance of the improvement plan:

- Weekly Acute Safe Delivery of Care operational meetings to monitor delivery and track progress
- Fortnightly Senior Oversight Group providing strategic scrutiny and challenge
- Reporting through local Clinical Governance structure
- Escalation through established governance routes to Board Committees and NHS Forth Valley Board.

Summary of Progress

The recent Healthcare Improvement Scotland follow-up inspection demonstrates acknowledged and sustained progress across Acute Services, with clear evidence of improvement in culture, leadership visibility, and safety processes. An improvement action plan has been developed to address the identified requirements and recommendations, with governance arrangements established to provide robust oversight, monitoring, and assurance to the Board.

- All actions are in progress and demonstrate positive progress.
- Evidence demonstrates early improvement across key areas, supported by structured monitoring and strong engagement in training and awareness initiatives. Work remains ongoing to address areas of variability and ensure consistent compliance with required standards.

Unannounced **Follow-up** Inspection Report

Acute Hospital Safe Delivery of Care Inspection

Forth Valley Royal Hospital

NHS Forth Valley

16 - 18 March 2026

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www.healthcareimprovementscotland.scot

About our inspection

Background

In November 2021 the Cabinet Secretary for Health and Social Care approved Healthcare Improvement Scotland inspections of acute hospitals across NHS Scotland to focus on the safe delivery of care. Taking account of the changing risk considerations and sustained service pressures, the methodology was adapted to minimise the impact of our inspections on staff delivering care to patients. Our inspection teams are carrying out as much of their inspection activities as possible through observation of care and virtual discussion sessions with senior hospital managers. We will keep discussion with clinical staff to a minimum and reduce the time spent looking at care records.

From August 2025 we will be undertaking a series of shorter unannounced Safe Delivery of Care follow-up inspections of all NHS Boards previously inspected. The focus of the follow-up inspections will be the NHS boards previous inspection requirements and subsequent improvement action plans. We will review progress made against the relevant actions to provide assurance that all actions were completed or where actions remain outstanding, progress has been made.

The follow-up inspections will use our existing Safe Delivery of Care inspection methodology and reporting structure to fully align to the Healthcare Improvement Scotland Quality Assurance Framework. Further information about the methodology for acute hospital safe delivery of care follow-up inspections can be found on our website.

Approach

We carried out an initial safe delivery of care inspection within Forth Valley Royal Hospital in April 2022 during which we identified a number of concerns relating to patient safety and the quality of care provided. We returned to carry out a follow-up inspection in September 2022 and remained concerned about the lack of sufficient improvement in relation to several key patient safety issues that had been escalated during the April 2022 inspection. We also identified a number of new concerns during this inspection. On both occasions Healthcare Improvement Scotland formally requested assurance from NHS Forth Valley and escalated these concerns to Scottish Government in line with our Operating Framework. Healthcare Improvement Scotland and Scottish Government: operating framework.

Our April 2022 inspection resulted in nine requirements, three of which were met during our follow-up inspection in September 2022. However, a further 11 new requirements were made to NHS Forth Valley following our September 2022 inspection.

We returned to carry out a further unannounced follow-up inspection of Forth Valley Royal Hospital in January 2024. The purpose of this follow-up inspection was to assess progress made against the actions contained within the NHS Forth Valley 2022 improvement action plans and the serious patient safety concerns raised through our formal escalation process. We observed improvements relating to patient safety and despite ongoing system pressures, areas inspected were calm, organised and well led. Staff described hospital managers as visible, accessible and supportive with staff reporting a change in culture, where they now feel safe to raise concerns.

Following the January 2024 inspection, eight of the 17 requirements from our previous safe delivery of care inspections in 2022 had been met with the remaining nine being partially met. Twelve new requirements were given to enable a new focus for improvement with the report highlighting eight areas of good practice and one recommendation

To address these requirements, and in line with our safe delivery of care methodology, NHS Forth Valley submitted an improvement action plan detailing the actions it intended to take in response to the concerns we identified.

We undertook a further unannounced follow-up inspection of Forth Valley Royal Hospital in March 2026 to assess progress made against the actions contained within the NHS Forth Valley 2024 improvement action plan and the serious patient safety concerns raised through our previous formal escalation process.

We returned to Forth Valley Royal Hospital on Tuesday 7 April 2026 to follow up on a number of potential patient safety concerns highlighted during our March 2026 inspection.

About the hospital we inspected

Forth Valley Royal Hospital, Larbert, is a 687-bedded hospital. A total of 438 beds support acute inpatient care and the other beds support women and children's services and mental health services. The hospital provides a range of outpatient, inpatient and day services such as day surgery, emergency care, critical care, women and children and mental health services.

During our **previous inspection in January 2024** we inspected the following areas:

- acute assessment unit
- children's ward
- clinical assessment unit
- emergency department
- intensive care unit
- ward A21
- ward A22
- ward A31
- ward A32
- ward B11

- urgent care centre
- ward 6
- ward 8
- ward A11
- ward A12
- ward B12
- ward B22
- ward B23
- ward B31, and
- ward B32.

During our follow-up inspection, we revisited several of the areas previously inspected to provide assurance that improvements had been made. We also included a broad range of specialties to help us to understand the extent of any wider improvements across the hospital. We inspected the following areas:

- acute assessment unit
- clinical assessment unit
- emergency department
- ward 6
- ward A12
- ward A21
- ward A31
- ward B11
- ward B12
- ward B21
- ward B22
- ward B23
- ward B31, and
- ward B32.

We reviewed progress made against the previous inspection requirements and the NHS board's subsequent improvement action plans to provide assurance that all actions were completed or where actions remain outstanding, progress has been made.

As part of our inspection, we also asked NHS Forth Valley to provide evidence of its policies and procedures relevant to the focus of this inspection. The purpose of this is to limit the time the inspection team is onsite and reduce the burden on ward staff.

On Monday 30 March 2026 we held a discussion with key members of NHS Forth Valley to discuss concerns regarding management oversight of the care of patients within the clinical assessment unit. This will be discussed further within the report.

On Tuesday 7 April 2026, we carried out an unannounced return visit to Forth Valley Royal Hospital to ensure concerns we raised had been addressed.

The findings detailed within this report relate to our areas of focus across the hospital.

We would like to thank NHS Forth Valley and in particular, all staff at Forth Valley Royal Hospital for their assistance during our inspection.

A summary of our findings

Our summary findings from the inspection, areas of good practice and any recommendations and requirements identified are highlighted as follows. Detailed findings from the inspection are included in the section 'What we found during this inspection'. Details of the previous inspection can be found here.

We observed staff working hard to deliver patient-centered care. Both the staffing and hospital wide safety huddles followed a structured format and were open and transparent and promoted a culture of psychological safety where staff felt able to raise any concerns.

Staff described a visible senior hospital management team and felt able to raise concerns. Patients and relatives were complimentary about their care and the staff providing it. Despite increased hospital capacity, the areas inspected were calm and well led with hospital teams working together to provide compassionate care

We observed improvements relating to the management of patient mealtimes, maintenance of the healthcare environment and the cleanliness of patient care equipment.

Areas for improvement identified include improved compliance with paediatric immediate life support training, the safe storage of cleaning products and management of waste. These are similar to the findings from January 2024.

Through completion of this follow-up inspection, we recognise the ongoing challenges and the further work required, alongside progress made to support NHS Forth Valley in strengthening the safe delivery of care, addressing patient safety concerns and responding to the serious patient safety concerns previously raised through our formal escalation process.

What action we expect the NHS board to take after our inspection

This follow-up inspection resulted in two areas of good practice, one recommendation and seven new or updated requirements. Four previous requirements were not met and have been carried forward.

A requirement in the inspection report means the hospital or service has not met the required standards and the inspection team are concerned about the impact this has on patients using the hospital or service. We expect all requirements to be addressed and the necessary improvements implemented.

A recommendation relates to best practice which Healthcare Improvement Scotland believe the NHS board should follow to improve standards of care.

We expect NHS Forth Valley to address the requirements. The NHS board must prioritise the requirements to meet national standards. An improvement action plan has been developed by the NHS board and is available on the Healthcare Improvement Scotland website: http://www.healthcareimprovementscotland.scot.

Area of good practice from this follow-up inspection

The unannounced follow-up inspection to Forth Valley Royal Hospital resulted in two areas of good practice.

Domain 4.1	
1	Patients were receiving assistance to carry out hand hygiene prior to mealtimes and being assisted with meals (see page 26).

Domain 4.3	
2	Safety and capacity huddles were inclusive, with staff being observed to raise concerns regarding staffing and safety (see page 28).

New recommendation from this follow-up inspection

The unannounced inspection to Forth Valley Royal Hospital resulted in one recommendation.

Domain 6	
1	NHS Forth Valley should ensure discussion regarding patients detained under Mental Health (Care and Treatment) (Scotland) Act are discussed at hospital wide safety and capacity huddles. This will allow staff to highlight any patient or staff safety concerns, or patient care requirements and ensure management oversight (see page 30).

New or updated requirements from this follow-up inspection

The unannounced inspection to Forth Valley Royal Hospital resulted in seven updated or new requirements.

Domain 1	
1	NHS Forth Valley must ensure all staff are aware of fire risk assessments and processes in place regarding fire safety, including awareness of the evacuation process (see page 13). This will support compliance with: Quality Assurance Framework (2022), Health & Social Care Standards (2017) and NHS Scotland ‘Firecode’ Scottish Health

Technical Memorandum SHTM 83 (2017) Part 2; The Fire (Scotland) Act (2005) Part 3, and Fire Safety (Scotland) Regulations (2006).

Domain 2

2 NHS Forth Valley must ensure staff awareness of risk assessments and of the suitability of patients to be cared for in contingency beds are recognised, and ongoing review of patients is carried out (see page 20).

This will support compliance with: Quality Assurance Framework (2022) Indicator 4.1 and Health and Social Care Standards (2017) Criterion 1.24.

Domain 4.1

3 NHS Forth Valley must ensure safe intravenous line care practices to prevent the risk of infection (see page 26).

This will support compliance with: Health and Social Care Standards (2017) and National Infection Prevention and Control Manual criteria 2.4 and 4.2.

4 NHS Forth Valley must ensure that all staff comply with the safe management and disposal of waste including sharps and linen (see page 27).

This will support compliance with: National Infection Prevention and Control Manual (2024), Infection Prevention and Control Standards (2022) and Healthcare Associated Infection (HAI) standards (2015) Criterion 8.1 and Control of Substances Hazardous to Health (COSHH) Regulations (2002).

5 NHS Forth Valley must ensure all hazardous cleaning products are securely stored (see page 27).

This will support compliance with: Control of Substances Hazardous to Health (COSHH) Regulations (2002).

6 NHS Forth Valley must ensure the safe storage of medicines at all times, including controlled drugs (see page 27).

This will support compliance with: Royal Pharmaceutical Society and Royal College of Nursing Professional Guidance on the Administration of Medicines in Healthcare Settings (2019) and relevant codes of practice of regulated healthcare professions.

Domain 6

7 NHS Forth Valley must ensure patient privacy and dignity is maintained at all times (see page 30).

This will support compliance with: Quality Assurance System (2022) Criteria 4.1, Care of Older People in Hospital Standards (2015) standards 15.1 - 15.4 and Health & Social Care Standards (2017) standards 4, 4.11, 4.14, 4.15, 4.17 and 4.19.

What we found during this follow-up inspection

Domain 1 – Clear vision and purpose

Quality indicator 1.5 – Key performance indicators

During our previous follow-up inspection in January 2024 we gave requirements to support improvement with paediatric life support training compliance for staff working within the emergency department, and to ensure emergency exit buttons are easily accessible to support safe fire evacuation processes.

This resulted in the following requirements.

Previous inspection (January 2024) requirements	
1	NHS Forth Valley must ensure that nursing staff are provided with necessary paediatric training to safely carry out their roles within the emergency department and comply with the NMC Code, Professional standards of practice and behaviour for nurses, midwives and nursing associates. **This has not been fully met and will be carried forward.**
2	NHS Forth Valley must ensure all emergency exit buttons are clear and easily accessible and all staff are aware of risk assessments and processes in place regarding fire safety. **To support more focused improvement, an updated requirement has been given.**

Paediatric life support training includes basic paediatric life support, paediatric immediate life support and advanced paediatric life support. The Royal College of Paediatrics and Child Health standards 'Facing the Future: Standards for children in emergency care settings' documents that every emergency department treating children must have their qualified staff trained in infant and child basic life support, with one member of staff on duty at all times who has advanced paediatric life support (or equivalent training).

During the follow-up inspection of the emergency department, we spoke with the practice education facilitator who advised that the compliance rate for staff training in relation to the care of paediatric patients had increased since the previous inspection in January 2024.

We asked NHS Forth Valley for the training compliance for registered nurses who had completed paediatric life support training or advanced paediatric life support training. Evidence provided demonstrated 68% of nursing staff within the emergency department hold a current paediatric immediate life support or advanced paediatric life support certificate. This is an improvement since our last inspection in January 2024 where only 19% of staff had completed paediatric immediate life support training. A further eight members of staff booked to complete paediatric immediate life support training, and four staff members are booked to complete advanced paediatric life support training, all due to be completed by the end of 2026. We were also provided with evidence that the majority of senior nursing staff within the emergency department are appropriately trained. This includes 80% of deputy charge nurses and 80% of senior charge nurses who are accredited in Paediatric Immediate Life Support and/or Advanced Paediatric Life Support. This ensures consistent senior clinical oversight, with advanced paediatric life support expertise available on every shift to support effective leadership and rapid emergency response.

Inspectors spoke with the emergency department clinical educator who has identified training needs within the department and has ensured regular attendance at paediatric immediate life support courses. Staff told inspectors that they felt the introduction of the clinical educator has enhanced learning opportunities within the department and confirmed that protected time was allocated to complete elearning modules.

During this follow-up inspection all emergency exit buttons were clear and easily accessible for staff and visitors. Several wards inspected operated a locked door policy. However, staff working within these wards demonstrated awareness of the policy and clear signage was in place to inform staff and visitors that the doors were locked and to provide instructions on how to how to enter and exit the ward safely.

Staff within the majority of clinical areas were unable to describe the fire evacuation process to inspectors and the majority were unaware of the individual ward specific fire risk assessment. Additionally, within several areas staff told inspectors they were not aware of who would lead the evacuation process should this be required.

Evidence submitted by NHS Forth Valley shows that the majority of wards are on the risk register in relation to fire safety. This is mainly due to staff awareness of fire safety evacuation processes and completion of training. Evidence submitted by NHS Forth Valley shows that 79% of staff have completed mandatory fire safety training.

We raised this with senior managers who provided an update that all staff undergo a fire evacuation walkround as part of their induction to the clinical area. This induction aims to orientate staff to ward specific evacuation strategies, escape routes, alarm responses and fire assembly arrangements.

NHS Forth Valley has implemented immediate actions following our feedback that some staff were unclear on evacuation procedures. These actions have been taken to strengthen local assurance through repeat briefings, plans to carry out refreshed walk rounds and improved visibility of local fire information. This will be overseen through local leadership and fire safety governance arrangements to ensure risks are mitigated and staff confidence is maintained.

We were provided with details of plans to increase mandatory fire training compliance. This includes monthly reviews of training compliance at ward level with direct follow-up by line managers. Increased visibility and promotion of available education relating to fire safety is also being implemented throughout the hospital.

Within the majority of clinical areas inspectors observed additional contingency beds. Increasing the capacity of an area can have an impact on safe access and evacuation and in some cases can lead to overcrowding. NHS Forth Valley told us that contingency beds are included in all fire safety plans and where evacuation is required additional staff would be deployed to assess from across the site. This would be coordinated by the on call manager and senior managers within the hospital at the time.

Although we acknowledge immediate actions were taken following inspection feedback to increase staff awareness in relation to fire safety, this requirement has been updated with a new focus for improvement.

Updated requirement

Domain 1	
1	NHS Forth Valley must ensure all staff are aware of fire risk assessments and processes in place regarding fire safety, including awareness of the evacuation process.

Domain 2 – Leadership and culture

Quality indicator 2.1 – Shared values

During the previous follow-up inspection we gave requirements around the triage assessment process within the emergency department and the consistent assessment of patients placed within contingency beds.

This resulted in the following requirements.

Previous inspection (January 2024) requirements	
3	NHS Forth Valley must ensure that triage assessments are provided consistently to ensure a reliable patient assessment. **This requirement has been met.**

4	NHS Forth Valley must ensure staff assessments of the suitability of patients to be cared for in contingency beds are recognised and supported. **To support more focused improvement, an updated requirement has been given.**

During our previous inspection in January 2024 we observed electronic incident reports where patients were inappropriately triaged within the emergency department and identified as fit to wait in the waiting area. However, these patients had conditions which put them at risk of sudden deterioration.

The 2024 improvement action plan from NHS Forth Valley states that the Manchester triage tool will be implemented electronically and training will be delivered to all staff within the emergency department in relation to triage. The Manchester Triage System is a clinical risk management tool used to enable staff to treat patients in order of clinical priority. Through evidence we observed that 95.8% of registered staff within the emergency department have been trained in the use of the Manchester Triage System.

During this inspection we did not observe any reported incidents relating to inappropriate triage of patients within the emergency department or the clinical assessment unit.

Inspectors observed additional contingency beds continued to be in use throughout the majority of clinical areas due to increased hospital capacity and delayed discharges. A delayed discharge occurs when a patient who is medically fit to be discharged from hospital cannot leave the hospital due to a lack of care, support or suitable accommodation, such as a nursing home placement. At the time of the follow-up inspection there were a total of 37 delayed discharges within Forth Valley Royal Hospital. The number of patients whose discharge is delayed impacts on the ability to move patients through the hospital to the right area for care and treatment. It is important to highlight that for those patients whose discharge is delayed they can experience poorer outcomes. Staff told us that where a patient's discharge is delayed they will continue to receive any input from physiotherapy and other allied health professionals such as dietetics and occupational therapy.

We observed contingency beds were placed within treatment rooms in clinical areas or an additional bed was added to a four bedded bay. On some of the wards inspected up to five additional patients were accommodated using contingency beds. This remains consistent with previous inspection findings.

Healthcare Improvement Scotland does not support the use of contingency beds and beds within non standard care areas such as treatment rooms and corridors, however, we acknowledge the need to reduce the serious pressures on services at times of increased capacity and emergency admissions. Where there is a requirement for the

use of contingency beds NHS boards must ensure that patient safety, privacy, and dignity is not compromised. Additionally, where contingency beds are being used NHS boards must ensure appropriate placement selection criteria are in place which should be fully risk assessed.

Senior managers from NHS Forth Valley told us that each patient placed within a contingency bed should have a completed Additional Bed Risk Assessment carried out and this should be stored within the patients notes.

Inspectors observed that although a contingency bed risk assessment is required for all patients placed in contingency beds, staff knowledge and use of this assessment was inconsistent. While some staff were aware of the process the majority were unaware of the risk assessment. Completion of risk assessments was variable, and in most clinical areas patients in contingency beds did not have a completed assessment. Many of these patients met the criteria for being at a higher risk for contingency bed placement, including reduced mobility, cognitive impairment, infection risk, clinical instability, or oxygen requirements. This is inconsistent with guidance, which states that patients placed in contingency beds should be medically stable with no ongoing clinical concerns.

The contingency bed risk assessment identifies that where a patient is assessed as higher risk, required actions include escalation to the senior charge nurse or nurse in charge and discussion at the site safety and capacity huddle. We attended a site safety huddle at which staff representatives from clinical areas highlighted that patients accommodated in contingency beds were assessed as higher risk. However, there was no evidence of further discussion regarding appropriate mitigation measures to reduce risk.

The guidance for the contingency bed risk assessment states that patients should be reviewed at least daily for continued suitability while accommodated in a contingency bed. Any changes to a patient's clinical condition, mobility, or cognitive status should be documented, or a 'no change' statement recorded where appropriate. Despite this, inspectors were unable to identify evidence of regular review, documentation of clinical reassessment, or clarification regarding the expected duration of placement within a contingency bed. We requested evidence of any staff or patient safety incidents directly associated with the use of contingency beds within clinical areas during March 2026. Review of this information identified a total of 17 incidents across eight wards.

Of these, four incidents related to patients being transferred to contingency beds despite being assessed as unsuitable. This included two patients with cognitive concerns, one patient with an identified infection risk, and one patient who was clinically unstable, requiring medical review and oxygen therapy. There were 11 reported falls with no injury sustained to patients placed within contingency beds. We did not identify any recurring themes or patterns across the reported incidents.

We are concerned that patients continue to be placed in non standard care areas without the necessary risk assessment and mitigations being carried out. Due to this, an updated requirement has been given to give a new focus for improvement.

During our previous inspection staff raised concerns with inspectors regarding the care of patients within contingency beds and that in some cases staff felt pressured to admit patients into these beds who were not suitable. As part of its improvement action plan, NHS Forth Valley described implementation of an action log from the safety huddles detailing actions to support staff caring for patients in contingency beds. NHS Forth valley provided us with safety huddle outputs, however there was no identified documentation of actions to support staff. During this follow-up inspection, staff did not raise concerns about feeling pressured to admit patients to contingency beds.

Inspectors spoke with several patients placed within contingency beds. All patients spoke highly of the care received and were not concerned regarding placement in a contingency bed. Patients told inspectors this had been explained to them, and they were advised this would be reviewed as alternative beds become available. Patients told inspectors they were able to obtain assistance from nursing staff in a timely manner. Inspectors did not observe buzzers ringing for prolonged periods of time.

One ward inspected was a 10-bedded contingency ward. These beds were not funded and relied on staffing support from the adjoining stroke ward.

Staff reported that this can affect the availability of a thrombolysis nurse from the stroke ward to attend the emergency department to deliver thrombolysis treatment. As a result, patients requiring thrombolysis intervention were often transferred to the intensive care unit. Thrombolysis is a time-critical emergency treatment for acute ischaemic stroke.

Evidence submitted included 10 incidents where no thrombolysis nurse was available. Although no patient harm was recorded, mitigations indicated that patients requiring thrombolysis would be admitted to the intensive care unit. We requested further information regarding stroke ward staffing and delivery of the thrombolysis service.

Stroke service staffing is managed in line with national safe staffing principles, with daily acuity-based review and escalation processes to support time-critical pathways, including thrombolysis. A review of incidents from 2025 identified no harm or delays attributed to the availability of staffing from the stroke ward.

Inspectors visited the clinical assessment unit which is situated next to the emergency department. Patients can be directed to the unit by their general practitioner, out of hours, cancer helpline and outpatient clinics. Patients are referred to the clinical assessment unit to undergo assessment, investigations, treatment and agree management plans. This may include for example patients suspected of having a deep

vein thrombosis, requiring investigation to diagnose this and treat. The clinical assessment unit has 16 cubicles, two are used for triage. However, these can be used as treatment cubicles when capacity requires it. There is also a chaired area, designed for four ambulant patients with the option to increase capacity to eight. On a patient's arrival to the clinical assessment unit, the staff member responsible for triage assesses the patient's needs and assigns the priority of treatment required. Forth Valley Royal Hospital emergency department introduced a two tier triage system in 2022 which has been replicated within the clinical assessment unit. This system is based on a 'sieve and sort' system which is a multidisciplinary approach between two registered nurses and healthcare support workers. All patients undergo the 'sieve' tier. This should be completed within 15 minutes of the patient's arrival and is a rapid simple safety triage. The sieve aims to identify patients at a higher risk of deterioration and with potential to become more unwell. Patients are prioritised in order of clinical need with those categorised as requiring immediate or requiring very urgent clinical care being taken straight to a clinical area within the clinical assessment unit, or transferred to the resuscitation area within the emergency department. All other patients will receive enhanced triage under the second tier 'sort'.

The sort process is carried out by a healthcare support worker trained in the process. The healthcare support worker will complete 'direct clinical tasks' that will help clinical decision making. This will include carrying out electrocardiogram (ECG), obtaining intravenous (IV) access, venepuncture and urine testing where clinically indicated.

A focused history and examination will then be undertaken by a senior clinical decision maker to determine the need for appropriate investigations and direction onto alternative pathways. These include admission to the hospital, redirection to other appropriate services or discharge home. Patients appropriate for review under the sort process will be reassessed if waiting longer than four hours since last clinical contact. Where there is a change in condition or a patient has been waiting longer than four hours within the clinical assessment unit, they will be reassessed by a registered nurse.

Evidence provided by NHS Forth Valley included a copy of the clinical assessment unit triage information and competency booklet for staff training, which all staff have completed. This includes a flowchart to be followed by staff, including the escalation process to report clinical concerns. Patients are assessed as red/very urgent, amber/urgent, green/non urgent and blue/ambulant depending on certain clinical criteria. For example, a reduced level of consciousness would be red. The competency booklet also includes the deteriorating patient escalation plan, admission time, triage time, national early warning score 2 (NEWS2) and if there is any clinical concern, if this has been escalated. Staff advised inspectors that triage is always undertaken by a registered nurse. NEWS2 is a tool that measures a patient's physiological measurements such as blood pressure and pulse. It identifies patients who are at risk of or have become unwell in order for medical and nursing staff to respond.

During our previous inspection in September 2022, we observed extreme overcrowding within the clinical assessment area and were not assured mitigations were in place to ensure patient and staff safety. This included concerns regarding delivery of fundamentals of care including the provision of regular medication and pain relief. These concerns were highlighted through our formal escalation process.

Within evidence submitted we observed that since December 2025, there were 20 occasions where a patient had self discharged from the clinical assessment unit against medical advice. The most common reason for self discharge cited by patients was that they were unable to wait a prolonged period on a chair and/or were unaware of the length of time they would be required to wait within the unit. Through review of evidence and incident reports we did not observe any evidence of adverse outcomes for patients as a result of self discharge from the clinical assessment unit.

During this follow-up inspection inspectors observed patients within the clinical assessment unit chaired area sitting on high backed chairs. Patients raised concerns to inspectors regarding the length of time they had been sitting on the chairs. Some patients had been there for over 23 hours. Staff told inspectors that if there were four patients within the area, they could accommodate a bed for each patient. However, if there are more than four the beds would not fit. Staff also said there were recliner chairs available for this area for use overnight. However, when the number of patients exceeds seven, and due to space, the chairs would not fit.

The clinical assessment unit care rounding chart includes National Early Warning Score 2 scores and vital signs recording frequency, pain management, fluids and nutrition and any time critical medication. Inspectors observed that the care and comfort rounding charts they were able to review had been fully completed, with no patients raising any concerns. However, this contradicted some patient feedback provided to inspectors. Patients told inspectors that they were cold, uncomfortable, in pain and one patient raised concerns that they had not received their regular cardiac medication.

We raised this as an immediate concern with senior managers who were unaware of the duration patients had been placed in this area. Immediate action was taken by the lead nurse who attended the unit, spoke with the patients, ensured regular medication was prescribed and administered and that patients were offered additional blankets if they remained cold.

Following our follow-up inspection, we met with senior managers to discuss concerns we had raised onsite in relation to management oversight of patients placed in the chaired area within the clinical assessment unit. We were told that a new template to communicate the status of the clinical assessment unit had been introduced and amendments to hospital wide safety huddles had been implemented. These include enhanced discussion regarding the number of patients waiting within the clinical assessment unit and the length of time they've been waiting. Discussions are also held

at hospital wide huddles regarding patient's specific care needs, such as pain management, and any patients waiting a prolonged period for scans or review by specialist teams.

As a result of our concerns relating to the chaired area within the clinical assessment unit we carried out a return visit to the area. During our return visit on 7 April 2026 we spoke with patients who did not raise any concerns relating to receiving fundamentals of care. Additionally, within hospital capacity outputs we observed recording of the status of the clinical assessment unit.

NHS Forth Valley is in the early stages of a review of unscheduled care services within Forth Valley Royal Hospital. This was commenced in early 2026 with oversight and leadership provided by the director of acute services. The review model is being developed through an iterative approach that uses data, operational learning and frontline feedback to continuously refine pathway design. It is informed by internal and external reviews, with learning used to improve flow, pathway effectiveness and patient experience. Strategic oversight is provided through the Urgent and Unscheduled Care Working Group, with governance oversight through the executive board.

Following our inspection in March 2026, a new escalation framework has been implemented in Forth Valley Royal Hospital to support safety within the clinical assessment unit. This is a structured, time based escalation framework to manage patient waiting times and maintain patient and staff safety. Patient flow and capacity are reviewed through scheduled capacity huddles, held five times daily. These huddles identify patients approaching or exceeding four hours, assess in line with Opel status, review downstream bed capacity, and consider surge capacity or alternative pathways such as ambulatory care.

NHS Forth Valley utilises the Operational Pressures Escalation Levels (OPEL) Framework. The aim of this is to ensure patient and staff safety and outlines the leadership and actions required during times of extremis in the hospital system. The OPEL Framework has a five level stepped response ranging from level one as the lowest response to level five as the highest level.

The escalation process is clearly defined and proportionate to risk. Early escalation occurs for patients nearing four hours, with action taken to address delays and flow barriers. Delays beyond four hours prompt escalation to senior nursing, medical staff, and on call management, with surge capacity activated where required. More prolonged delays trigger site management involvement and, where necessary, whole system escalation in line with Opel 3 or 4 arrangements.

Out of hours arrangements are explicitly described, including enhanced escalation, a formal safety huddle at 21:45, and mandatory comfort and dignity checks for patients experiencing prolonged waits. All escalation actions, decisions, and risks are

documented, with incident reporting undertaken where delays contribute to harm or near misses.

During our return visit on 7 April 2026, inspectors reviewed the clinical assessment unit template used to inform the hospital wide safety huddle. Inspectors observed that data relating to time to triage and time to first clinical assessment within the unit is now routinely captured and reported during hospital wide safety huddles.

The template also records the number of patients within the department, including those in waiting areas, cubicles and the chaired area. Additional information relating to patients in the chaired area is documented, including the longest waiting time, reason for delay, and the number of patients waiting longer than 12 hours.

Inspectors did not attend a hospital wide safety huddle during the return visit, however we reviewed completed safety huddle documentation. This demonstrated that a comprehensive overview of activity and pressures within the clinical assessment unit was being communicated through the hospital wide safety huddle process.

Senior managers have implemented daily walkrounds of the clinical assessment unit. These are being undertaken to enhance visibility and oversight of patient care. These walkrounds have been structured using a check in, check through and check out approach. Inspectors were provided with evidence of a walkround template designed to support a consistent and focused review of care delivery.

The template prompts staff to assess key aspects of patient care, including food, fluid and nutritional needs, and to identify potential safety concerns such as overcrowding and call bells ringing for prolonged periods. Consideration is also given to staff wellbeing, with prompts to identify indicators of fatigue, particularly during periods of increased activity and peak demand. In addition, the template supports clear and effective communication with patients, including providing information on waiting times and explanations for delays where applicable.

During our return visit staff within the clinical assessment unit told inspectors that members of senior management team were more visible following our follow-up inspection in March 2026.

Updated requirement

Domain 2	
2	NHS Forth Valley must ensure staff awareness of risk assessments and of the suitability of patients to be cared for in contingency beds are recognized, and ongoing review of patients is carried out.

Domain 4.1 – Pathways, procedures and policies

Quality 4.1 – Pathways, procedures and policies

During our previous inspection we gave requirements to ensure patients receive assistance with mealtimes in a timely manner and patient dignity and privacy is maintained when cared for in additional beds. Additional requirements were given in relation to the appropriate care and management of patients with peripheral venous cannulas, hand hygiene practices, management of waste, including linen, and the use of personal protective equipment. We observed inconsistencies in the safe storage of medications and the completion and updating of patient care documentation.

This resulted in the following requirements.

Previous inspection (January 2024) requirements	
5	NHS Forth Valley must ensure that patients who require assistance at mealtimes receive this in a timely manner. **This requirement has been met.**
6	NHS Forth Valley must ensure effective processes are in place to ensure the safe management and care for patients with peripheral venous cannulas within the emergency department and clinical assessment unit. **This has not been met and will be carried forward.**
7	NHS Forth Valley must ensure that when additional beds are in use, patient privacy and dignity is maintained and that patients using doorbell type call bells are aware that they do not continuously ring once pressed. **To support more focused improvement, a new requirement has been given in Domain 6.**
8	NHS Forth Valley must ensure that all patient care documentation is accurately and consistently completed and reviewed. **This has not been met and will be carried forward.**
9	NHS Forth Valley must ensure all staff comply with hand hygiene, the use of gloves and appropriate wearing of jewellery. **This has not been met and will be carried forward.**
10	NHS Forth Valley must ensure that: - All staff comply with the safe management of waste including sharps and linen.

	All patient equipment is clean and ready for use, including mobile patient privacy screens. The hospital environment maintained and equipment must be stored in a manner to enable effective cleaning. **To support more focused improvement, an updated requirement has been given.**
11	NHS Forth Valley must ensure the safe storage and administration of medicines at all times. **To support more focused improvement, an updated requirement has been given.**

During this follow-up inspection, we observed mealtime coordinators within the majority of clinical areas. Staff were observed preparing patients for mealtimes, including assisting them to sit upright and offering hand hygiene. The mealtime coordinator was able to identify patients requiring support with eating and drinking and highlight any patients who may require a specific diet such as a textured diet due to clinical condition. Patients were receiving their meals in a timely manner, meals remained warm and patients who required assistance with nutrition were receiving help. Additionally, within the majority of wards patients were provided with hand wipes to perform hand hygiene before mealtimes.

Inspectors spoke with patients who described being happy with the meals they received. Within several wards we observed patients being offered alternative meals if they were not happy with their choice. Mealtimes were protected, therefore no additional, non-essential activity such as routine medication rounds or staff breaks were observed to be occurring during this time. Staff told inspectors this was to ensure prioritisation of mealtimes and ensure sufficient staff were available to assist with the distribution of meals and assist patients where required.

Peripheral venous cannulas are inserted into a vein to enable the administration of intravenous medication and fluids. Within the majority of areas inspected all documentation relating to the care of peripheral venous cannulas was complete with dates for review and removal documented. All peripheral venous cannulas were appropriately dressed, and the date of insertion was recorded on the dressing. However, inspectors observed several instances where intravenous infusions had been completed, and the intravenous giving set had been disconnected from the patient’s cannula and had not been disposed of. We spoke with nursing staff who explained that they would normally attach a sterile cap to the end of the intravenous giving set when not attached to the patient's cannula. In two areas inspectors observed that several lines without a sterile cap were at patient bedsides. This is not in line with NHS Forth Valley’s intravenous drug administration training and can increase the risk of contamination and lead to blood stream infection.

Within incident reports we observed three incidents of patients being discharged from the emergency department or assessment units with a peripheral venous cannula in place. This is a slight reduction following the inspection in January in 2024 where there were five. Staff within the clinical assessment unit told inspectors updates to patient notes has been useful to prompt staff to remove cannulas when discharging patients. Additionally, the implementation of a discharge checklist has also supported removal of cannulas prior to discharge. Despite the reduction in incidents, due to the findings on site relating to care of intravenous lines, an updated requirement has been given to support improvement in this area.

Inspectors observed that patients placed in contingency beds within treatment rooms had access to nurse call system and oxygen and suction. However, within the additional beds placed in four bedded bays patients did not have access to a fixed nurse call system, and patients were required to use a doorbell style buzzer that does not ring continually until answered. All patients inspectors spoke with within inpatient clinical areas confirmed they were aware of how to obtain assistance using the door bell buzzer and that the buzzer only rings once and should they not receive assistance they should press again. Patients placed within contingency beds in shared rooms have access to oxygen and suction and portable screens are available when required.

However, patients within the clinical assessment unit inspectors spoke with were unaware of the use of these door bell style buzzers. This was similar to our previous January 2024 inspection findings. Inspectors asked patients how they would summon assistance within the clinical assessment unit. They stated they would shout for a nurse or wave to gain attention as they were unaware of the door bell buzzers. Additionally, within the clinical assessment unit chaired area, patients told inspectors they were unaware of where they could go to carry out personal hygiene. We spoke to nursing staff regarding this who told us that there are no showering facilities available for patients within the clinical assessment unit, however there was an area available for patients to have a wash. Staff and senior managers acknowledged that this may not have been communicated to patients within the unit and that this would be improved moving forward.

During our return visit to the clinical assessment unit on 7 April 2026, patients told us they were aware of the use of the door bell buzzer and that this had been explained to them on arrival in the area. One patient told inspectors she had been assisted to the bathroom to carry out personal hygiene.

Care and comfort rounding is a structured, regular check by healthcare staff to proactively assess patients' comfort, safety, needs, and wellbeing, improving experience and reducing harm. Care and comfort rounding initial assessments should be carried out by registered nurse. Considerations within the care and comfort rounding include if the patient requires any time critical medications such as medicines for Parkinson's disease or requires insulin or anticoagulants. Any assistance for elimination or personal care is also recorded within the care and comfort rounding,

along with any offer of food fluid and nutrition. The care and comfort rounding documents we reviewed indicated that patients raised no concerns regarding pain and comfort.

Within the clinical assessment unit inspectors observed completed care and comfort rounding for patients. However, as discussed earlier in this report patients we spoke with raised concerns about not receiving pain relief, regular routine medicines and being extremely uncomfortable.

Three patients raised concerns with inspectors that they were extremely uncomfortable as they had been sitting on rigid high back chars for up to 23 hours whilst awaiting assessment and treatment. We raised this as a concern with senior managers at the time of inspection who were unaware of the length of time patients had been waiting. Senior managers attended the unit, spoke with the patients and expedited onward movement including transfer to the assessment unit and discharge home, while we remained onsite.

We raised concerns with senior managers who told us that where patients were required to remain overnight within the chaired area, they could be offered a bed provided the number of patients was four or less. Alternatively, staff could source recliner chairs from another department for use overnight. As mentioned earlier, this was only possible when there was seven or less patients within the area due to space. Where numbers exceed seven, patients will remain in high backed chairs with ongoing comfort monitoring.

During discussion with senior managers on Monday 30 March 2026 we were told that a number of recliner chairs had been ordered for the clinical assessment unit and were expected to be onsite within 3 - 4 weeks. In the meantime, staff can access recliner chairs for overnight use which are used within another area during the day. We also raised concerns with senior managers in relation to discrepancies within the care and comfort rounding. We were told that the importance of completing these accurately and reassessing patients would be communicated with staff. Additionally, patients will be advised to seek nursing assistance should anything change following completion of care and comfort rounding.

Within wards inspected, inspectors observed the majority of care plans and risk assessments to be completed and updated following any changes in patient condition. This included the completion of falls risk assessments which were observed to have been updated following a patient fall with additional actions identified.

However, within two wards inspectors observed gaps in care rounding documentation where it would appear patients had gone a prolonged period without any care input. This was raised at the time of the inspection and staff told inspectors this had been an oversight and provided evidence of patients having had clinical observations obtained

and recorded within this time frame. Inspectors spoke with staff on the clinical area and highlighted the importance of completing these documents.

Standard infection control precautions should be used by all staff at all times to minimise the risk of cross infection. Standard infection control precautions include patient placement, hand hygiene, the use of personal protective equipment (such as aprons and gloves), management of patient care equipment and the care environment, safe management of blood and fluid spillages, linen and waste management and prevention and exposure management (such as sharps injuries).

Within the majority of clinical areas, throughout all staff groups, inspectors observed poor compliance with hand hygiene practices. Similarly to our inspection in January 2024 inspectors observed the overuse of gloves within several clinical areas and a number of staff were observed wearing wrist watches.

Discussions with the infection control team highlighted a recent reduction in hand hygiene compliance identified in audits throughout the majority of wards. Improvement work has commenced with staff carrying out peer audits with a focus on providing real time feedback at the time of the audit and reviewing the placement of alcohol based hand rub at the point of use. From audit results submitted by NHS Forth Valley, the most common opportunities missed were before patient contact., this was observed onsite. Plans to increase education and awareness sessions are in progress.

We observed the appropriate segregation of clinical and general waste being managed in line with the National Infection Prevention and Control Manual. Inspectors also observed appropriate segregation of linen. However, there was no evidence of linen being tagged when ready for uplift from the clinical areas. The National Infection Prevention and Control manual states all used and infectious linen bags must be tagged with details of the clinical area and the date of disposal. This allows for traceability in case of any misplaced belongings.

Similar themes from the January 2024 were identified in relation to the safe management of sharps and hazardous cleaning products. Within three wards inspectors observed items protruding from sharps bins. This was highlighted to the nurse in charge at the time and the situation was rectified. Additionally, inspectors observed that several sharps boxes did not have temporary closures in place, these prevent needles or sharps protruding from the boxes, or from falling out if the box is dropped. Within one ward inspectors observed poor compliance with sharps management, observing an injection being administered and the needle being re-sheathed. Additionally, there was no sharps receptacle taken to the point of use, further posing a risk of sharps injury whilst transporting the used needle.

In the majority of wards we observed that hazardous cleaning products were not always stored securely and could therefore be accessed by patients or members of the

public. This is not in line with the Control of Substances Hazardous to Health Regulations.

All patient care equipment, including privacy screens were clean and ready for use. Due to lack of storage facilities, some equipment, such as moving and handling equipment and privacy screens were stored within large bathrooms. Staff told inspectors when the bathrooms are in use by patients, the equipment can be moved into the corridor to reduce the risk of any contamination.

Within all areas inspectors did not observe any patient medication being left on bedside tables unattended or any medication trolleys unsecured and unattended. Patient medication lockers at bedsides were all observed to be locked. The majority of preparation rooms were locked and where they were unlocked, the medication cupboards inside were locked. However, within one ward inspectors observed a preparation room lock was broken, with all medication cupboards inside unlocked and the controlled drug cupboard was observed to be unlocked with the keys in the lock. This was escalated to the nurse in charge at the time who told inspectors the room lock was reported in January 2026 and replacement of the lock was awaited. We escalated this to senior managers whilst onsite who told us they would action this as a matter of urgency.

Feedback provided by NHS Forth Valley in the week following our onsite visit states that the lock has now been repaired and the safe and secure handling of medicines will be raised at the hospital wide safety huddle in the forthcoming weeks to highlight importance of medicines management.

Area of good practice

Domain 4.1	
1	Patients were receiving assistance to carry out hand hygiene prior to mealtimes and being assisted with meals.

New requirement

Domain 4.1	
3	NHS Forth Valley must ensure safe intravenous line care practices to prevent the risk of infection.

Updated requirements

Domain 4.1	
4	NHS Forth Valley must ensure that all staff comply with the safe management and disposal of waste including sharps and linen.

5	NHS Forth Valley must ensure all hazardous cleaning products are securely stored.
6	NHS Forth Valley must ensure the safe storage of medicines at all times, including controlled drugs.

Domain 4.3 – Workforce planning

Quality 4.3 – Workforce planning

NHS Forth Valley uses an electronic real time staffing system for all nursing staff. Allied health professional groups such as dietetics, physiotherapy and occupational therapy do not yet use an electronic system.

Workforce data provided by NHS Forth Valley included the vacancy and sickness absence rates for the nursing staff within Forth Valley Royal hospital. Information was also provided relating to the use of supplementary staffing. We observed that throughout all nursing groups, since our previous inspection, actual establishments have increased by 60 staff overall. This increase is mainly band 3 healthcare support workers who have undergone further training to upskill from band 2 to band 3.

Within evidence submitted NHS Forth Valley demonstrated an over recruitment of band 5 registered nurses of 9.8% during the time of our inspection. Band 6 and band 7 nurses were also evidenced to be over recruited, with 43.5 whole time equivalent band 7 and 78 whole time equivalent band 6 nurses currently in post. Staff absence is higher at 9.8% than the planned 4%. However, this is in line with much of NHS Scotland.

We observed supplementary staffing usage appears high for both registered nurses and healthcare support workers. However, senior managers told us this is due to the high number of contingency beds in use throughout the hospital. Supplementary staffing includes substantive staff working additional hours, staff from the NHS board's staff bank or staff from an external agency. This high use of supplementary staffing would support the staffing requirement for the use of contingency beds.

The electronic staffing system provides a red, amber, green and grey (RAGG) status in relation to staffing levels and patient acuity. This is a traffic light assurance system used to summarise staffing risk, compliance, and professional judgement against safe staffing requirements under the Health and Care (Staffing) (Scotland) Act 2019. Levels can be summarised as grey (no issue identified and no risk escalated), green (staffing safe and appropriate), amber (staffing pressure with mitigations in place and ongoing monitoring) and red (unsafe staffing and significant risk requiring immediate escalation).

Evidence submitted demonstrated high frequency of risk status assessments being downgraded with evidence recorded of mitigations or actions taken. Across 984

staffing assessments carried out in February 2026, 78% were initially flagged as red risk. When a clinical area is highlighted as red there may be a number of reasons, such as the availability of staff, staff skill mix or patient acuity within the ward. Real-time mitigations were being implemented which reduced red episodes to 8%, with 92% of shifts operating at grey or amber. Mitigations such as redeployment of staff from other clinical areas, ward coordinator taking a clinical caseload and additional shifts being requested through the staff bank system as a matter of urgency.

Forth Valley Royal Hospital holds a staffing huddle prior to the hospital wide safety and capacity huddle. This huddle allows open discussions to be held between clinical areas to identify any potential staffing shortfalls and identify early redeployment of staff to other areas. We had the opportunity to attend this during the inspection. During the meeting one area was highlighted as red and not safe to start due to staffing numbers and patient acuity. Inspectors observed active discussions and decisions being made to ensure real time redeployment of staff from another clinical area to support. It was clear that staff felt psychologically safe to raise concerns regarding staffing and safety during these huddles.

We observed representation from all clinical areas at hospital wide safety huddles, including allied health professionals such as physiotherapists, occupational therapists and pharmacy staff. Representation was also observed from colleagues from the Scottish Ambulance Service, communicating current pressures within the system, any patients expected to hospital and any patients awaiting transfer offsite.

Time to lead is a legislative requirement under the Health and Care (Staffing) (Scotland) Act (2019). This is to enable clinical leaders to ensure they have protected time and resource to ensure appropriate staffing alongside other professional duties to provide the delivery of safe, high quality and person-centred healthcare. Staff we spoke with during our onsite visit told us they felt they had adequate time to lead and carry out sickness absence management and staff appraisals.

Area of good practice

Domain 4.3	
2	Safety and capacity huddles were inclusive, with staff being observed to raise concerns regarding staffing and safety.

Domain 6 – Dignity and respect

Quality 6.2 – Dignity and respect

During the previous inspection we raised concerns regarding the absence of legal paperwork relating to the care of patients detained under the Mental Health (Care and Treatment) (Scotland) Act.

This resulted in the following requirements.

Previous inspection (January 2024) requirements	
1	NHS Forth Valley must ensure the correct procedure is followed when patients are detained under the Mental Health (Care and Treatment) (Scotland) Act. **This requirement has been met.**

Inspectors observed that a number of patients had an Adults with Incapacity Section 47 certificate in place. These are legal documents which assist the patients, their family and staff to make decisions about the patient's care and treatment when the patient is unable to do so independently. We observed that these were completed and signed and had comprehensive personalised treatment plans in place.

In one clinical area two patients were detained under the Mental Health (Care and Treatment) (Scotland) Act. This is a piece of legislation in Scotland that maintains the rights and protection of people with mental health conditions. The provisions of the Act are intended to ensure that care and compulsory measures of detention can only be used when there is a significant risk to the safety and welfare of the patient or others. Inspectors observed that this patient had a short term detention certificate in place.

Within the 2024 improvement action plan submitted by NHS Forth Valley, it states, to improve management oversight of patients detained under the Mental Health (Care and Treatment) (Scotland) Act, discussions would be held at hospital wide safety huddles. However, whilst onsite inspectors did not observe any discussion in relation to patients who were detained. Senior managers told inspectors staff would be reminded to include this information within their updates relating to their clinical areas. Due to this a new recommendation has been given to support focused improvement.

During previous inspections, we raised concerns in relation to patients' privacy and dignity when being cared for in additional beds. An increased patient quota within the bay could impact on the privacy and dignity of all patients within the bay area during these times. During this inspection within one clinical area, on two separate occasions, staff were overheard discussing patients within the corridor. These conversations were not within a private area and there were multiple visitors within the clinical area at the time. On both occasions this was fed back to the nurse in charge. This was also fed back to senior managers from NHS Forth Valley whilst onsite. A requirement has been given to support improvement in this area.

New recommendation

Domain 6

1	NHS Forth Valley should ensure discussion regarding patients detained under Mental Health (Care and Treatment) (Scotland) Act are discussed at hospital wide safety and capacity huddles. This will allow staff to highlight any patient or staff safety concerns or patient care requirements and ensure management oversight.

New requirement

Domain 6	
7	NHS Forth Valley must ensure patient privacy and dignity is maintained at all times.

Appendix 1 - List of national guidance

The following national standards, guidance and best practice were current at the time of publication. This list is not exhaustive.

- Allied Health Professions (AHP) Standards (Health and Care Professionals Council Standards of Conduct, Performance and Ethics, September 2024)
- Ageing and frailty standards – Healthcare Improvement Scotland (Healthcare Improvement Scotland, November 2024)
- Delivering Together for a Stronger Nursing & Midwifery Workforce (Scottish Government, March 2025)
- Fire Scotland Act (Acts of the Scottish Parliament, 2005)
- Food, fluid and nutritional care standards – Healthcare Improvement Scotland (Healthcare Improvement Scotland, October 2014)
- Generic Medical Record Keeping Standards (Royal College of Physicians, November 2009)
- Health and Care (Staffing) (Scotland) Act (Acts of the Scottish Parliament, 2019)
- Health and Social Care Standards (Scottish Government, June 2017)
- Infection prevention and control standards – Healthcare Improvement Scotland (Healthcare Improvement Scotland, May 2022)
- National Infection Prevention and Control Manual (NHS National Services Scotland, January 2024)
- Healthcare Improvement Scotland and Scottish Government: operating framework (Healthcare Improvement Scotland, November 2022)
- Prevention and Management of Pressure Ulcers - Standards (Healthcare Improvement Scotland, October 2020)
- Professional Guidance on the Administration of Medicines in Healthcare Settings (Royal Pharmaceutical Society and Royal College of Nursing, January 2019)
- The quality assurance system and framework – Healthcare Improvement Scotland (Healthcare Improvement Scotland, September 2022)
- Staff governance COVID-19 guidance for staff and managers (NHS Scotland, August 2023)
- The Code: Professional Standards of Practice and Behaviour for Nurses and Midwives (Nursing & Midwifery Council, October 2018)

Appendix 2 - List of all requirements

New and updated requirements to be addressed from March 2026 inspection
1. NHS Forth Valley must ensure all staff are aware of fire risk assessments and processes in place regarding fire safety including awareness of the evacuation process.
2. NHS Forth Valley must ensure staff awareness of risk assessments and of the suitability of patients to be cared for in contingency beds are recognised and ongoing review of patients is carried out.
3. NHS Forth Valley must ensure safe intravenous line care practices to prevent the risk of infection.
4. NHS Forth Valley must ensure that all staff comply with the safe management and disposal of waste including sharps and linen.
5. NHS Forth Valley must ensure all hazardous cleaning products are securely stored.
6. NHS Forth Valley must ensure the safe storage of medicines at all times, including controlled drugs at all times.
7. NHS Forth Valley must ensure patient privacy and dignity is maintained at all times.
Outstanding requirements to be addressed from January 2024 inspection
1. NHS Forth Valley must ensure that nursing staff are provided with necessary paediatric training to safely carry out their roles within the emergency department and comply with the NMC Code, Professional standards of practice and behaviour for nurses, midwives and nursing associates.
2. NHS Forth Valley must ensure effective processes are in place to ensure the safe management and care for patients with peripheral venous cannulas within the emergency department and clinical assessment unit.
3. NHS Forth Valley must ensure that all patient care documentation is accurately and consistently completed and reviewed.
4. NHS Forth Valley must ensure all staff comply with hand hygiene, the use of gloves and appropriate wearing of jewellery.

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Improvement Action Plan

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Unannounced acute hospital safe delivery of care follow up inspection

Forth Valley Royal Hospital

NHS Forth Valley

16 - 18 March 2026

Improvement Action Plan Declaration

It is the responsibility of the NHS board Chief Executive and NHS board Chair to ensure the improvement action plan is accurate and complete and that the actions are measurable, timely and will deliver sustained improvement. Actions should be implemented across the NHS board, and not just at the hospital inspected. By signing this document, the NHS board Chief Executive and NHS board Chair are agreeing to the points above. A representative from Patient/Public Involvement within the NHS should be involved in developing the improvement action plan.

NHS board Chair

Signature: ______________________

Full Name: Neena Mahal

Date: 25th May 2026______________________

NHS board Chief Executive

Signature: ______________________

Full Name: Ross McGuffie

Date: 23rd May 2026______________________

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Produced by: HIS/NHS Forth Valley	Page: Page 1 of 14	Review Date: -
Circulation type (internal/external): Internal and external		

Ref:	Action Planned	Timescale to meet action	Responsibility for taking action	Progress	Date Completed
1	NHS Forth Valley must ensure all staff are aware of fire risk assessments and processes in place regarding fire safety including awareness of the evacuation process.	1 week: completed by 29/05/26 3 months: completed by 31/08/26 31/12/26	Chief Nurse, Acute Head of Service Head of Service	All areas are identifying responsible person on duty as fire Marshall each shift and this will be monitored daily at Safe Staffing Huddles. Fire risk assessments across all areas will be monitored by implementing monthly fire safety walk rounds reporting through Health & Safety Group which provides assurance to the Health and Safety committee, which reports to Staff Governance Committee for the Board. Forth Valley Royal Hospital Fire Safety compliance has increased to 81%. Our improvement aim is to achieve 90% in Fire Safety Awareness for all staff by December 2026.	

		29/06/26	Head of Service	The above actions will form part of Fire safety training measurement plan which will be developed with appropriate measures in place to monitor both delivery and impact. Regular reporting on progress through the Acute Health & Safety Group, which provides assurance to the Health & Committee, which reports to Staff Governance Committee for the Board will provide the governance arrangements to ensure sustained visibility and oversight of this action.	
2	NHS Forth Valley must ensure staff awareness of risk assessments and of the suitability of patients to be cared for in contingency beds are recognised and ongoing review of patients is carried out	29/06/26 31/08/26	Head of Service Head of Service/ Chief Nurse Acute	NHS Forth Valley already have mechanisms in place to monitor contingency bed usage. We acknowledge variation in completion and therefore we aim to improve risk assessment compliance to 95% by June 2026. Current baseline compliance ranges from 67% to 100% across the FVRH wards. Implement weekly measurement tool for risk assessment completion with data reported via ward and directorate clinical governance meetings including daily	

				reporting and review at the Whole Hospital Huddle.	
		29/06/26	Chief Nurse Practice Development Unit	Compliance with Contingency Risk Assessments will also be incorporated into Care Assurance Visits as part of the Boards Excellence in Care activity, assurance will be provided via safety steering group which covers all operational units across NHS Forth Valley.	
		31/08/26	Chief Nurse, Acute	Monthly audits will be undertaken to ensure assessment and review of contingency beds is reliable and consistent to provide Board assurance and highlight areas requiring support with process improvement.	
3	NHS Forth Valley must ensure safe intravenous line care practices to prevent the risk of infection.	31/07/26	Chief Nurse, Acute	NHS Forth Valley will measure reliability of intravenous line care through Care Assurance visits and ward quality monitoring processes. This will provide whole site intelligence to support improvement planning and education activity. Safety huddles are	

				being utilised across all clinical areas to promote and reinforce best practice, with defined measures of compliance, impact, and oversight provided through clinical governance.	
		31/07/26	Chief Nurse, Practice Development Unit	Best Practice is being reinforced during Care Assurance Visits which occur quarterly within the acute site. Reliability Data will report via the Safety Steering Group which governs Excellence in Care.	
		30/09/26	Chief Nurse, Practice Development Unit	The Practice Development Unit is delivering education within clinical areas highlighting best practices in Intravenous Fluid Management.	
4	NHS Forth Valley must ensure that all staff comply with the safe management and disposal of waste including sharps and linen.	30/09/26	Chief Nurse, Acute / Infection Prevention Control Lead	NHS Forth Valley undertake regular Environmental Walk rounds promoting Standard Infection Control Precautions (SICPS) and provide assurance through the Infection Control Committee to govern compliance and improvement planning. To provide enhanced oversight local teams will	

		30/09/26	Chief Nurse, Acute / Infection Prevention Control Lead	undertake additional inspection / audits of compliance and report reliability data through Acute Infection Control Meeting. Safe management and disposal of waste/sharps/linen practices are being monitored and reported through the Infection Prevention and Control audit programme and governed through local Infection Control groups, reporting to Infection Control Committee.	
5	NHS Forth Valley must ensure all hazardous cleaning products are securely stored.	31/06/26	Head of Service / Chief Nurse, Acute	The monitoring of safe storage for hazardous cleaning products is monitored through environmental walk rounds and reported through Acute Infection control group and subsequently to Infection Control Committee. Education and Improvement actions are activated when required improvement in this process is recognised through the embedded audit process. Increased monitoring of secure storage of hazardous cleaning products through Senior Nursing Leadership Oversight	

				presence through Ward quality walkarounds.	
6	NHS Forth Valley must ensure the safe storage of medicines at all times, including controlled drugs at all times.	Immediate 31/08/26 30/11/26	Chief Nurse, Acute / Associate director of Pharmacy Associate director of Pharmacy, Chief Nurse, Acute, Head of Service Chief Nurse, Acute / Associate director of Pharmacy	The Safe and Secure Handling of Medicines Group is coordinating compliance reporting to support the safe storage of medicines including controlled drugs. This provides compliance data and improvement support plan and assurance to the Board around meeting the required standards. NHS Forth Valley is pursuing a variation request to improve access and security of medicines through improvements to medicines swipe access. This will improve access to medicine storage areas and improve safe medicines management in terms of secure storage. NHS Forth Valley currently apply the standards of the Royal College of Pharmacy for safe management of medicines, however NHS Forth Valley is currently undertaking the development of a Forth Valley Safe and Secure Handling of Medicines Policy.	Completed

				This process has already commenced applying a collaborative Multi-Disciplinary Team approach.	
		31/07/26	Chief Nurse, Acute / Head of Pharmacy	Compliance with the Safe Storage of medicines will be monitored via the medicine safety group. Education and Improvement actions are activated when improvement in this process is recognised through the embedded audit process.	
		31/07/26	Chief Nurse, Acute / Head of Pharmacy	Increased monitoring of secure storage of hazardous cleaning products through Senior Nursing Leadership Oversight presence through Ward quality walkarounds.	
		31/06/26	Chief Nurse Practice Development Unit	Medicines safety adverse events are currently reported through the Acute Clinical Governance Group and Clinical Governance Working Group and Safer Management of Medicines Group. Further assurance is obtained through the Forth Valley Safety Steering Group where reliability data and safety action plans are overseen.	

				Medicines Safety Study Days will be delivered across FVRH. First session 8th June – 50 staff booked in and 30 in reserve	
7	NHS Forth Valley must ensure patient privacy and dignity is maintained at all times.	31/08/26 31/08/26	Chief Nurse, Practice Development Unit Chief Nurse, Practice Development Unit	A programme of education encompassing professionalism, confidentiality and information governance will be developed and delivered. This education will be data informed through the triangulation of data from care opinion, patient feedback and experience and adverse event reporting to help create a learning system. Insights gained from thematic analysis of this data will form part of local improvement plan. Increased visibility of clinical leadership will provide professional assurance of adherence to Nursing and Midwifery Council code of conduct.	
8	NHS Forth Valley must ensure that nursing staff are provided with necessary paediatric training to safely carry out their roles within the emergency department and comply with the NMC Code, Professional standards	31/10/26	Chief Nurse, Acute	NHS Forth Valley aims to have 90% of Emergency Department Staff trained in Paediatric Immediate Life Support by October 2026.	

	of practice and behaviour for nurses, midwives and nursing associates.			PILS Training has increased to 69% with additional 10 Staff booked on for in June aiming for an interim target of 80% staff trained by the end of June. Continued assurance of training and compliance will be reported through the Acute workforce Governance Group and then the Workforce Governance Committee.	
9	NHS Forth Valley must ensure effective processes are in place to ensure the safe management and care for patients with peripheral venous cannulas within the emergency department and clinical assessment unit.	31/08/26 31/07/26	Chief Nurse Acute, Chief Nurse, Practice Development Unit Chief Nurse, Acute	A targeted programme of education and awareness will be delivered to both staff and patients to reinforce best practice in peripheral venous cannula insertion, maintenance and documentation. This will be supported by a structured programme of audit and feedback to ensure consistent application of standards. A measurable improvement aim has been set to achieve and sustain ≥90% compliance with peripheral venous cannula care standards including timely removal, as evidenced through routine audit. Compliance, variation and improvement actions will be monitored and triangulated	

				through local governance arrangements, with formal reporting to the Acute Infection Prevention and Control Group. This will ensure ongoing oversight of performance, timely escalation of risks, and sustained assurance of safe practice. Oversight of peripheral venous cannula associated infection incidence is undertaken through the Acute Infection Control Group, where performance data is routinely reviewed, areas for improvement are identified, and any emerging risks are escalated appropriately. This is supported by established governance arrangements, with assurance provided to the Board through the Infection Prevention and Control Committee, ensuring effective scrutiny, organisational oversight, and continuous quality improvement.	

10	NHS Forth Valley must ensure that all patient care documentation is accurately and consistently completed and reviewed.	31/07/26	Chief Nurse, Practice Development Unit	A structured programme of education, audit and measurement will be implemented by July 26 to provide assurance on the accuracy and consistency of clinical documentation. Compliance and improvement will be routinely monitored and triangulated through established governance arrangements, with reporting and scrutiny via relevant groups. For example, nutritional screening compliance (e.g. Malnutrition Universal Screening Tool) will be overseen through the Nutrition and Hydration Committee, while documentation related to peripheral venous catheter care will be monitored through the Infection Prevention and Control Committee, ensuring consistent organisational oversight and assurance. Assurance of accuracy and constancy of documentation will be achieved through Care Assurance Visits as part of the Boards Excellence in Care activity, assurance will be provided via safety steering	

				group which covers all operational units across NHS Forth Valley.	
11	NHS Forth Valley must ensure all staff comply with hand hygiene, the use of gloves and appropriate wearing of jewellery.	31/12/26	Chief Nurse, Acute/ Deputy Medical Director and IPC Lead.	NHS Forth Valley is implementing a Hand Hygiene Improvement Package to reinforce expected standards. Ongoing education and training, supported by local leadership will be informed by routine audit and observational monitoring (e.g. hand hygiene compliance audits, environmental walkrounds, and care assurance visits) to assess adherence and identify areas for improvement. Targeted improvement actions in response to audit findings, including feedback at ward/department level and escalation of non-compliance.	
12	NHS Forth Valley should ensure discussion regarding patients detained under Mental Health (Care and Treatment) (Scotland) Act are discussed at hospital wide safety and capacity huddles. This will allow staff to highlight any patient or staff safety concerns, or patient care requirements and ensure management oversight (see page 30)	01/05/26	Chief Nurse, Acute / Chief Nurse, mental health.	All acute patients within Forth Valley Royal Hospital who are detained under the mental health act are identified at the daily site huddle to provide oversight to senior management and mental health team.	Completed

				The Senior Leadership Team will achieve oversight of these cases by accessing the relevant information within the Acute Hospital Duty Manager template.	

NHS Forth Valley

Forth Valley NHS Board

NHS Forth Valley

13. Healthcare Associated Infection (HAI) Report May 2026
Purpose: This report is for Assurance

Executive Sponsor: Karen Goudie, Executive Nurse Director
Author: Jonathan Horwood, Infection Control Manager & Clinical Lead

Executive Summary

The Healthcare Associated Infection Reporting Template (HAIRT) is mandatory reporting tool for the Board to have oversight of the HAI targets (Staph aureus bacteraemias (SABs), Clostridioides difficile infections (CDIs), device associated bacteraemias (DABs), incidents and outbreaks and all HAI other activities across NHS Forth Valley.

- Total SABS remain within control limits. There was one hospital acquired SAB in May.
- Total DABs remain within control limits. There were no hospital acquired DABs in May.
- Total CDIs remain within control limits. There were two hospital acquired CDIs in May.
- Total ECBs remain within control limits. There were two hospital acquired ECBs in May.
- Unverified data suggests NHSFV has met the SAB,ECB and CDI LDP targets.
- There were no mandatory surgical site infection in May.
- There were no outbreaks reported in May.

Action Required

The Forth Valley NHS Board is asked to:

(1) note the HAIRT report.
(2) note the performance in respect for SABs, DABs, ECBs & CDIs.
(3) consider if the report provides assurance that appropriate controls are in place to manage the identified risks, support the delivery of objectives and where improvements are needed, clear actions have been identified.

Governance Route to the Meeting and Previous Board Consideration

The HAIRT was most recently considered at the 5 May 2026 meeting of the Clinical Governance Committee.

Risk Assessment and Mitigation

Work is on trajectory to reduce all reducible SABs, DABs, ECBs and CDI infections across NHS Forth Valley to meet both national and local standards/expectations.

Impact Assessments

Equality & Diversity and Fairer Scotland Duty

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

Financial and Infrastructure Implications

None.

Workforce Implications

None.

Quality / Patient Care Implications
Healthcare associated infections (HAI) can result in poor outcomes for patients in terms of morbidity and mortality, increased length of stay and necessitate additional diagnostic and therapeutic interventions.

Population Health & Care Strategy
None.

Climate Change / Sustainability Implications
None.

Engagement and Communications
Was statutory engagement with stakeholders required? Yes ☐ No ☒

- If yes, please provide details.

Infection Prevention & Control Team, Infection Control Committee and Clinical Governance Committee.

Appendices
Appendix 1 – Main Report

Healthcare Associated Infection Reporting Template (HAIRT)

May 2026

Glossary of abbreviations

Following feedback from stakeholders below is a list of abbreviations used within this report:

HAI	Healthcare Acquired Infection
SAB	*Staphylococcus aureus* Bacteraemia
DAB	Device Associated Bacteraemia
CDI	*Clostridioides* Infection
ECB	Escherichia Coli Bacteraemia
AOP	Annual Operational Plan
NES	National Education for Scotland
IPCT	Infection Prevention & Control Team
HEI	Healthcare Environment Inspectorate
SSI	Surgical Site Infection
SICPs	Standard Infection Control Precautions
PVC	Peripheral Vascular Catheter

Definitions used for *Staph aureus,* device associated and *E coli* bacteraemias

Definition of a bacteraemia

Bacteraemia is the presence of bacteria in the blood. Blood is normally a sterile environment, so the detection of bacteria in the blood (most commonly accomplished by blood cultures) is always abnormal. It is distinct from sepsis, which is the host response to the bacteria. Bacteria can enter the bloodstream as a severe complication of infection (like pneumonia, meningitis, urinary tract infections etc), during surgery, or due to invasive devices such as PVCs, Hickman lines, urinary catheters etc. Transient bacteraemias can result after dental procedures or even brushing of teeth although this poses little or no threat to the person in normal situations.

Bacteraemia can have several important health consequences. The immune response to the bacteria can cause sepsis and septic shock, which has a high mortality rate. Bacteria can also spread via the blood to other parts of the body (haematogenous spread), causing infections away from the original site of infection, such as endocarditis (infection of the heart valves) or osteomyelitis (infection of the bones). Treatment for bacteraemia is with antibiotics for many weeks in some circumstances, however cases such as *Staph aureus* bacteraemia usually 14 days of antibiotic therapy is required.

Cause definitions for *Staph aureus* and device associated bacteraemia

Hospital acquired

- Hospital acquired is defined when a positive blood culture is taken >48 hours after admission i.e. the sepsis is not associated with the cause of admission. An example would a patient with sepsis associated from an infected peripheral vascular catheter.

Healthcare acquired

- Healthcare acquired is defined when a positive blood culture is taken <48 hours after admission but has in the last three month had healthcare intervention such as previous hospital admission, attending Clinics, GP, dentist etc. Note this does not necessarily mean that the sepsis is associated with the previous healthcare intervention.

Nursing home acquired

- Nursing home acquired is defined when a positive blood is taken <48 hours after admission and when symptoms associated with sepsis developed at the nursing home.

Healthcare Associated Infection Reporting Template (HAIRT)

The HAIRT Report is the national mandatory reporting tool and is presented bi-monthly to the NHS Board. This is a requirement by the Scottish Government HAI task Force and informs NHS Forth Valley (NHSFV) of activity and performance against Healthcare Associated Infection Standards and performance measures.

This section of the report focuses on NHSFV Board wide prevention and control activity and actions.

Performance at a glance:

***Staph aureus bacteraemia* - total number this month: 4**
- There was one hospital acquired SAB this month.
- There were three healthcare acquired SABs this month.
- Total SAB case numbers remained within control limits this month.

Device associated bacteraemia – total number this month: 4
- There were no hospital acquired DAB this month.
- There were 4 healthcare acquired DAB this month.
- Total DAB case numbers remained within control limits this month.

***Clostridioides difficile* infection – total number this month: 5**
- There was two hospital acquired CDI this month.
- There were three healthcare acquired CDIs this month.
- Total CDI case numbers remained within control limits this month.

***E coli* bacteraemia – total number this month: 10**
- There were two hospital acquired ECBs this month.
- There were seven healthcare acquired ECBs this month.
- There was one nursing home acquired ECBs this month.
- Total ECB case numbers remained within control limits this month.

Surgical site infection surveillance
- There were no mandatory reported surgical site infections this month.

Outbreaks
- There were no outbreaks reported this month.

HAI Surveillance

NHS FV has systems in place to monitor key targets and areas for delivery. Our surveillance and HAI systems and ways of working allow early detection and indication of areas of concern or deteriorating performance. The Infection Prevention & Control Team undertakes over 180 formal ward audits per month in addition to regular weekly ward visits by the Infection Control Nurse; infection investigation is also a significant function within the team as part of our AOP target reporting. This activity provides robust intelligence of how infection prevention is maintained across all areas in Forth Valley and is reported on a monthly basis to all appropriate stakeholders.

Staph aureus bacteraemias (SABs)

All blood cultures that grow bacteria are reported nationally and it was found that *Staph aureus* became the most common bacteria isolated from blood culture. As *Staph aureus* is an organism that is found commonly on skin it was assumed (nationally) the bacteraemias occurred via a device such as a peripheral vascular catheter (PVC) and as such a national reduction strategy was initiated and became part of the then HEAT targets in 2006. Following on from the 2019-2024 AOP targets, new targets are going to be set by the Scottish Government shortly.

Total number of SABs this month; **4** compared to **3** last month.
There was no data exceedance for SABs this month.

Total number of SABs (April 2026 – date) = **7**

- Hospital acquired = **1**
    - Unknown

  There was no data exceedance for hospital acquired SABs this month.

- Healthcare acquired = **3**
    - Ulcer
    - Wound
    - CVC

  There was no data exceedance for healthcare acquired SABs this month.

- Nursing Home acquired = **0**

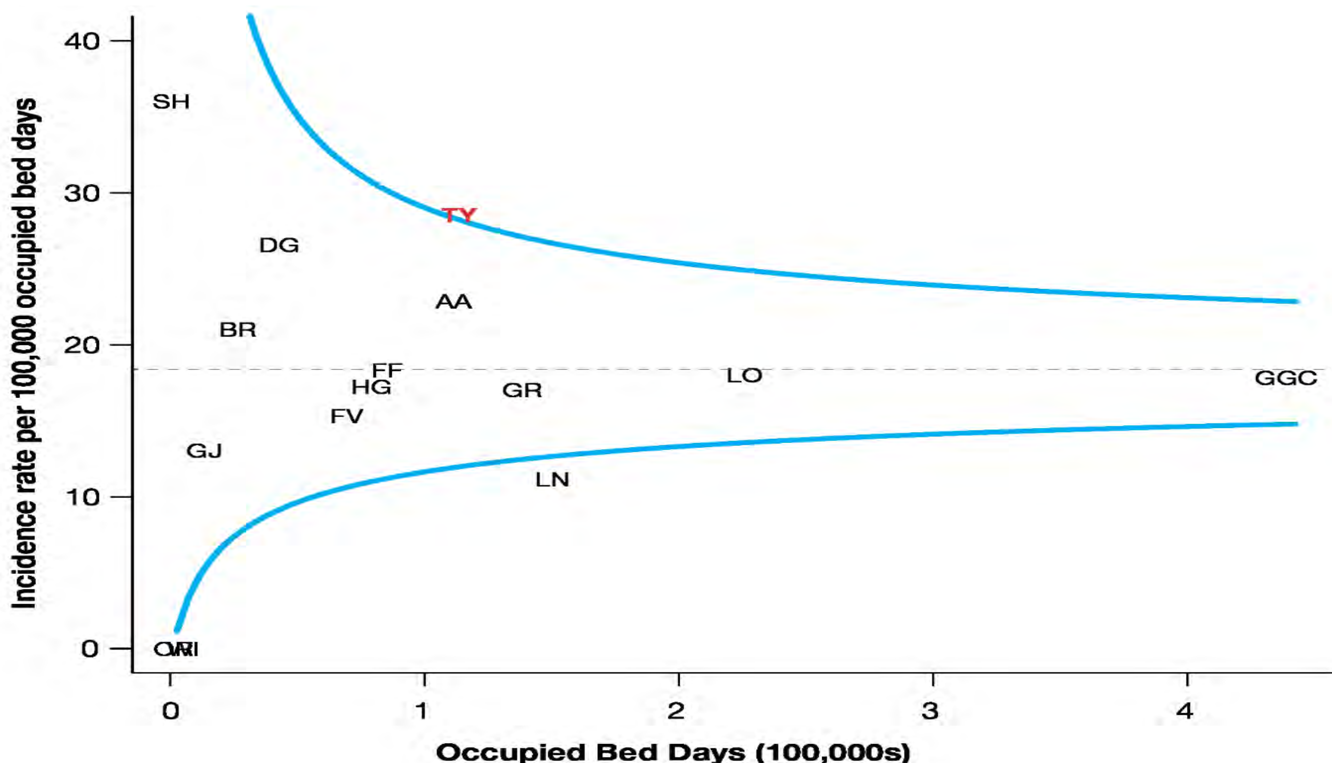
Hospital SABs

- **Unknown;** following investigations no definitive source of infection was identified.

NHS Forth Valley's approach to SAB prevention and reduction
All *Staph aureus* bacteraemias are monitored and reported by the IPCT. Investigations to the cause of infection consist of examining the patients notes, microbiology, biochemistry and haematology reports to identify potential causes of the infection; from this, in most cases, a provisional cause is identified, however this is discussed further with the clinical team responsible for the management of the patient to assist further with the investigation. Any issues identified during the investigations, such as incomplete bundle completion etc is highlighted at this time and where appropriate an IR1 is reported. Once a conclusion has been agreed, the investigations are presented to the Infection Control Doctor/Microbiologist for approval. The investigation is concluded with the IPCT reporting their findings to the clinical team and management.

This data is entered into the IPCT database collated, analysed and reported on a monthly basis. The analysis of the data enables the IPCT to identify trends in particular sources of infections, such as Hickman line infections etc and identifying areas requiring further support. The data also influences the direction of the HAI annual workplan.

National Context
All SABs are reported nationally and reported on a quarterly basis. This provides our board an overview and national context of our national position compared to other boards. Due to the national reporting, unfortunately the data publish is 3 months in arrears compared to the local data presented. The funnel plot below is based on the new national AOP targets ie hospital and healthcare are represented as healthcare and provides an indication of FVs position nationally. Below is an extract from the ARHAI Quarter 4 report (October – December 2025) highlighting Forth Valley's position compared to all other boards in Scotland.



Device Associated Bacteraemias (DABs)

In addition to the nationally set targets, infections from an invasive device caused by *Staph aureus* would be investigated fully and reported, any other organism causing the same infection was not mandated to report nationally or to be investigated. As a result of this, in 2014, the IPCT started reporting all bacteraemias attributed to an invasive device regardless of the bacterium causing the infection. Due to the importance and significance of this surveillance, it is now part of our local AOP.

NHS Forth Valley's approach to DAB prevention and reduction
Continual monitoring and analysis of local surveillance data enables the IPCT and managers to identify and work towards ways to reduce infections associated with devices. All DABs are reviewed and investigated fully and highlighted to the patients' clinicians, nursing staff and management. Where appropriate an IR1 is generated to enable infections that require learning is shared and discussed at local clinical governance meetings.

In addition, on a weekly basis the IPCT assess bundle compliance of three invasive devices (PVCs, urinary catheters, CVCs etc) as part of their ward visit programme and this is reported in the monthly Directorate Reports.

Total number of DABs this month; **4** compared to **2** last month.
There was no data exceedance for DABs this month.

Total number of DABs (April 2026 – date) = **6**

- Hospital acquired = **0**
  There was no data exceedance for hospital acquired DABs this month.

- Healthcare acquired = **4**
  - Urinary catheter long term
  - Urinary catheter short term
  - CVC x2

  There was no data exceedance for healthcare acquired DABs this month.

- Nursing Home acquired = **0**
  There was no data exceedance for nursing home acquired DABs this month.

Escherichia coli Bacteraemia (ECB)

NHS Forth Valley's approach to ECB prevention and reduction
E coli is one of the most predominant organisms of the gut flora and for the last several years the incidence of Ecoli isolated from blood cultures ie causing sepsis, has increase so much that it is the most frequently isolated organism in the UK. Following on from the 2019-2024 AOP targets, new targets are going to be set by the Scottish Government shortly. The most common cause of E coli bacteraemia (ECB) is from complications arising from urinary tract infections (UTIs), hepato-biliary infections (gall bladder infections) and urinary catheters infections.

Total number of ECBs this month - **10** compared to **10** last month.
There was no data exceedance for ECBs this month.

Total number of ECBs (April 2026 – date) = **20**

- Hospital acquired = **2**
    - Pancreatitis (No attributed ward)
    - Unknown (No attributed ward)

  There was no data exceedance for hospital acquired ECBs this month.

- Healthcare acquired = **7**
    - Urinary catheter long term
    - Urinary catheter short term
    - Hepatobiliary x3
    - Pyelonephritis
    - Unknown

  There was no data exceedance for healthcare acquired ECBs this month.

- Nursing Home acquired = **1**
    - Urinary tract infection
-

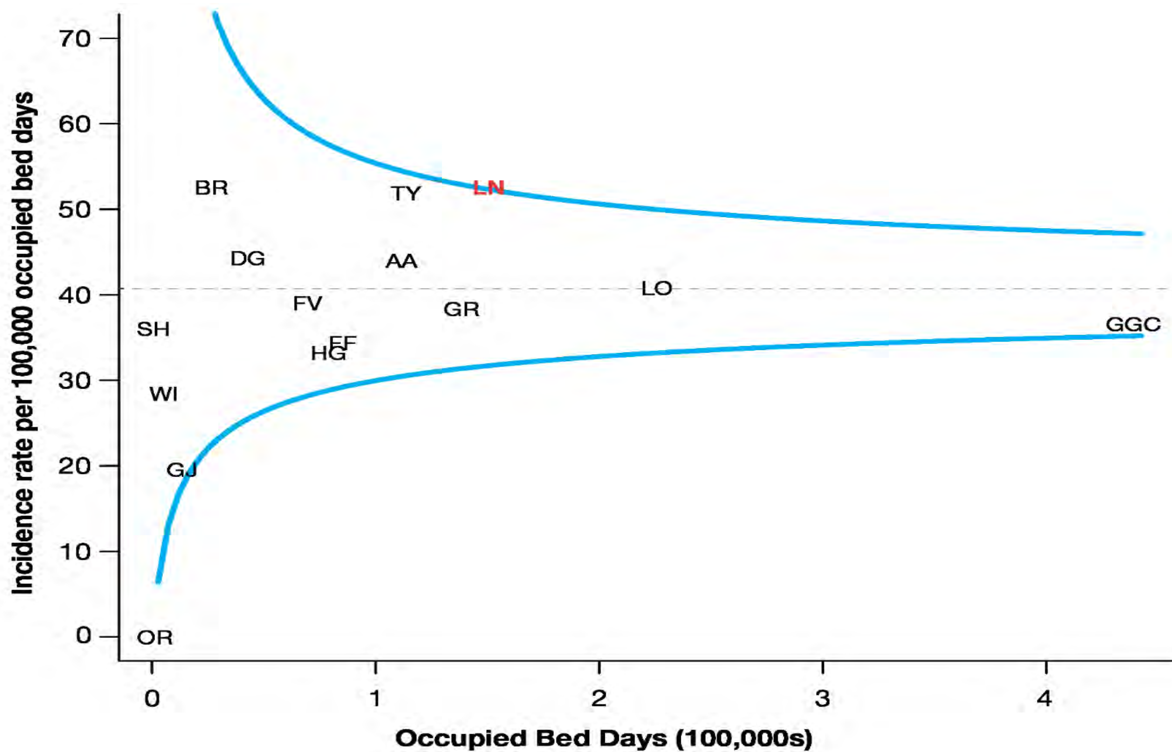
  There was no data exceedance for nursing home acquired ECBs this month.

Hospital ECBs

- **Hepatobiliary infection**; patient admitted with RUQ pain and following investigations confirmed as necrotising pancreatitis.
- **Unknown**; following investigations no definitive source of infection was identified.

National Context

All ECBs are reported nationally and reported on a quarterly basis. This provides our board an overview and national context of our national position compared to other boards. Due to the national reporting, unfortunately the data published is 3 months in arrears compared to the local data presented. The funnel plot below contains total case numbers of reported hospital and healthcare attributed infections and provides an indication of FVs position nationally. Below is an extract from ARHAIs Quarter 4 report (October – December 2025) highlighting Forth Valley's position compared to all other boards in Scotland.



Clostridioides difficile infection (CDIs)

Following the Vale of Leven outbreak in 2007 where 131 patients were infected with C. difficile resulting in 34 deaths, it became mandatory for all health boards to monitor, investigate and report all infections associated with C. difficile. NHSFV has met its targets over the years and has maintained a low rate of infection.

C. difficile can be part of the normal gut flora and can occur when patients receive broad spectrum antibiotics which eliminate other gut flora allowing C. difficile to proliferate and cause infection. This is the predominant source of infection in Forth Valley. C. difficile in the environment can form resilient spores which enable the organism to survive in the environment for many months and poor environmental cleaning or poor hand hygiene can lead to the organism transferring to other patients leading to infection (as what happened in the Vale of Leven hospital). Another route of infection is when patient receive treatment to regulate stomach acid which affects the overall pH of the gut allowing the organism to proliferate and cause infection.

Cause definitions for Clostridioides difficile infections

Hospital acquired

- Hospital acquired is defined when symptoms develop and confirmed by the laboratory >48 hours after admission which were not associated with the initial cause of admission.

Healthcare acquired

- Healthcare acquired is defined as having symptoms that develop and confirmed by the laboratory prior to or within 48 hours of admission and has in the last three months had healthcare interventions such as previous hospital admission, attending Clinics, GP, dentist etc.

Nursing home acquired

- Nursing home acquired is defined as having symptoms that develop and confirmed by the laboratory that developed at the nursing home prior to admission.

GP acquired

- GP associated CDI infections are not required to be reported nationally, however, locally it is considered important to monitor and report infections deriving from GP practices. All CDI infections from GPs are reviewed and investigated to the same standard as hospital infections to determine the cause of infection. In addition, data is shared with the Antimicrobial Management Group to allow the group to monitor overall antibiotic prescribing trends for individual GP practices.

NHS Forth Valley's approach to CDI prevention and reduction

Similar to our SABs and DABs investigation, patient history is gathered including any antibiotics prescribed over the last few months. Discussion with the clinical teams and microbiologists assist in the determination and conclusion of the significance of the organism, as sometimes the organism isolated can be an incidental finding and not the cause of infection. Data is shared with the antimicrobial pharmacist and cases are discussed at the Antimicrobial Management Group to identify inappropriate antimicrobial prescribing.

Total number of CDIs this month; **5** compared to **3** last month.
There was no data exceedance for CDIs this month.

Total number of CDIs (April 2026 – date) = **8**

- Hospital acquired = **2**
  There was no data exceedance for hospital acquired CDIs this month.

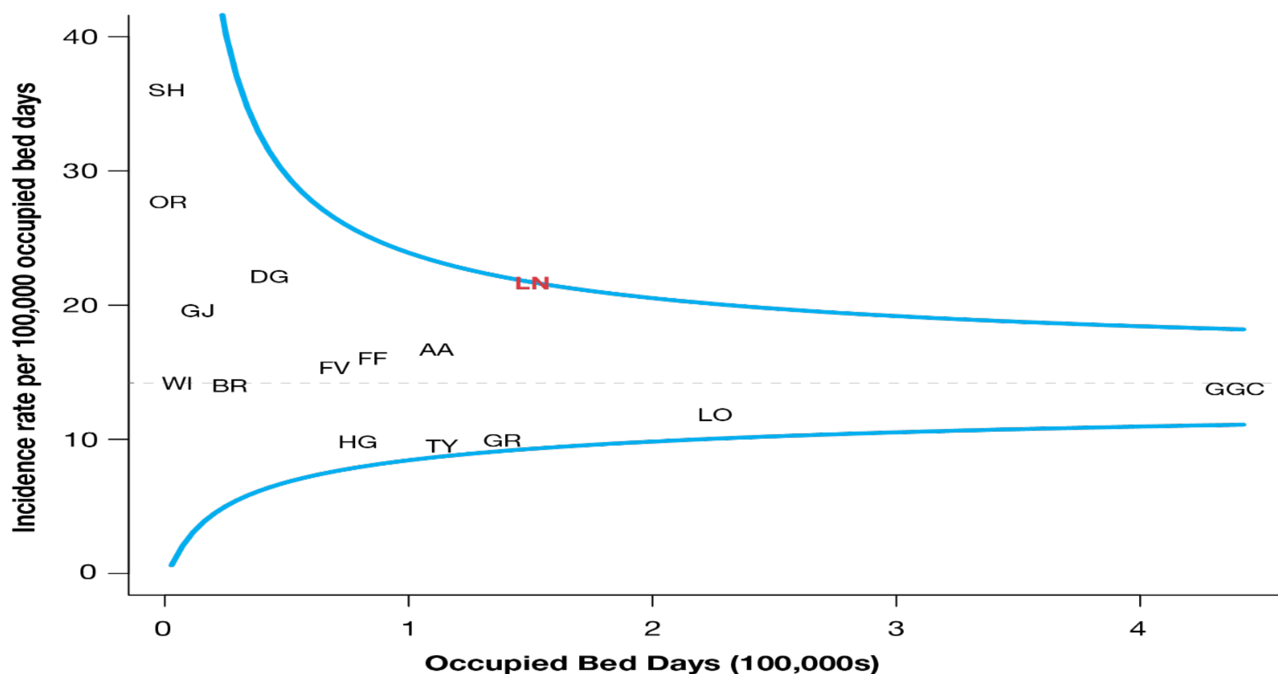
- Healthcare acquired = **3**
  There was no data exceedance for healthcare acquired CDIs this month.

- Nursing Home acquired = **0**
  There was no data exceedance for nursing home acquired CDIs this month.

- GP acquired = **0**
  (GP figures are not included in the total as it is not part of national reporting)

National Context

All CDIs are reported nationally and reported on a quarterly basis. This provides our board an overview and national context of our national position compared to other boards. Due to the national reporting, unfortunately the data published is 3 months in arrears compared to the local data presented. The funnel plots below are based on the new national AOP targets ie hospital and healthcare are represented as healthcare and provides an indication of FVs position nationally. Below is an extract from the ARHAI Quarter 4 report (October – December 2025) highlighting Forth Valley's position compared to all other boards in Scotland.



Surgical Site Infection Surveillance (SSIS)

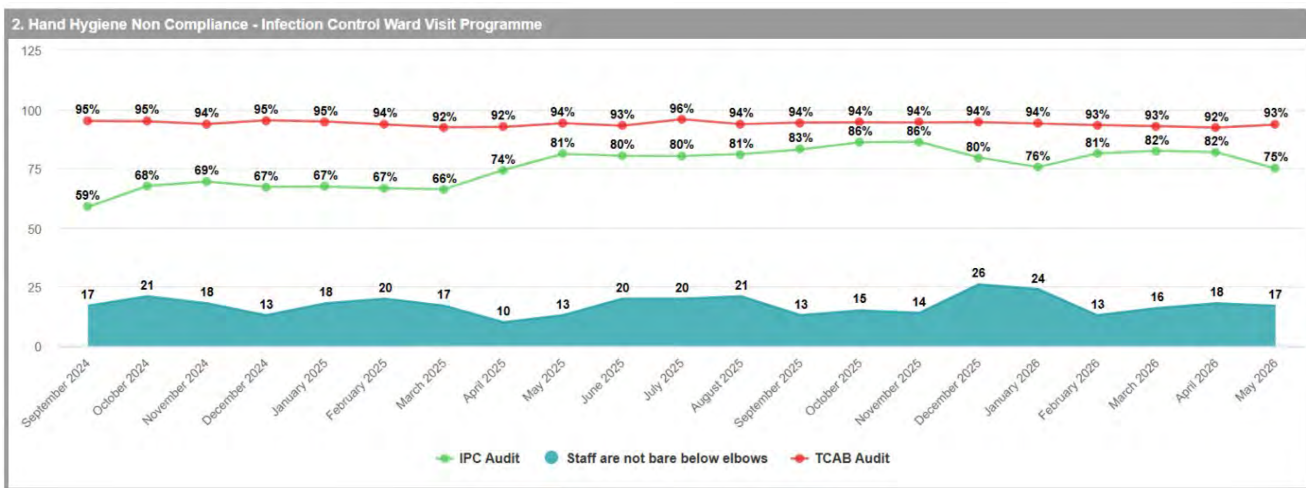
Surgical site infection surveillance is the monitoring and detection of infections associated with a surgical procedure. In Forth Valley, the procedures include, hip arthroplasty, Caesarean section, abdominal hysterectomy, major vascular surgery, large bowel, knee arthroplasty and breast surgeries. We monitor patients for 30 days post-surgery including any microbiological investigations from the ward/GP for potential infections and also hospital readmissions relating to their surgery. Any infection associated with a surgical procedure is reported nationally to enable board to board comparison. The NHS Forth Valley infection rates are comparable to national infection rates.

NHS Forth Valley's approach to SSI prevention and reduction
Surgical site infection criteria is determined using the European Centre for Disease Control (ECDC) definitions. Any infection identified is investigated fully and information gathered including the patient's weight, duration of surgery, grade of surgeon, antibiotics given, theatre room, elective or emergency etc can provide additional intelligence in reduction strategies. The IPCT monitor closely infection rates, and any increases of SSIs are reported to management and clinical teams to enable collaborative working to reduce infection rates. The table below also contains local surveillance with an extended surveillance period of 90 days. Surveillance has now been further extended to hernia repair and laparoscopic cholecystectomies.

Procedure	No of Procedures this month	No. of Confirmed SSIs this month (Mandatory 30 days)	No. of Confirmed SSIs this month (Local 90 days)
Abdominal Hysterectomy	11	0	0
Breast Surgery	35	0	0
Caesarean Section	82	0	0
Hip Arthroplasty	62	0	0
Knee Arthroplasty	36	0	0
Large Bowel Surgery	17	0	0

Hand Hygiene Monitoring Compliance (%) Board wide

The data below is an extract from the Pentana dashboard. It includes the total percentage of compliance that is recorded on TCAB by the nursing staff. It also includes the uptake of staff who have completed the hand hygiene training module in Turas along with the total number of hand hygiene non compliances that are recorded in the Infection Prevention and Control team SICP audits.



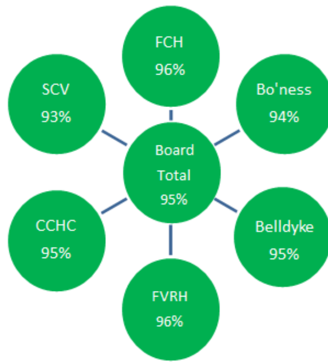
Estate and Cleaning Compliance (per hospital)

The data is collected through audit by the Domestic Services team using the Domestic Monitoring National Tool and areas chosen within each hospital is randomly selected by the audit tool. Any issues such as inadequate cleaning is scored appropriately and if the score is less than 80% then a re-audit is scheduled. Estates compliance is assessed whether the environment can be effectively cleaned; this can be a combination of minor non-compliances such as missing screwcaps, damaged sanitary sealant, scratches to woodwork etc. The results of these findings are shared with Serco/Estates for repair. Similar to the cleaning audit, scores below 80% triggers a re-audit.

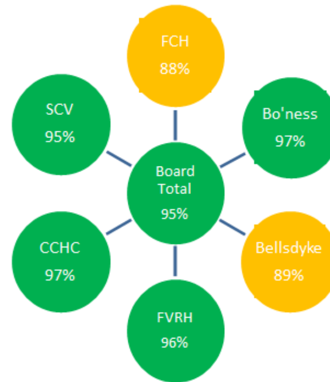
Falkirk Community Hospital and Bellsdyke Hospital Estate Scores

This quarter, the estate scores have remained relatively stable, Falkirk Community Hospital and Bellsdyke Hospital scores have decreased this quarter. Falkirk Community hospital is 88% compared to 89% the previous quarter and Bellsdyke is 89% compared to 91% the previous quarter.

Estates & Domestic Cleaning Scores from Cleaning Dashboard January – March 2026



Cleaning Compliance



Estates Compliance

Colour		Description
●	**Green**	compliance level 90% and above - Compliant
●	**Amber**	compliance level between 70% and 90% - Partially compliant
●	**Red**	compliance level below 70% - Non-compliant

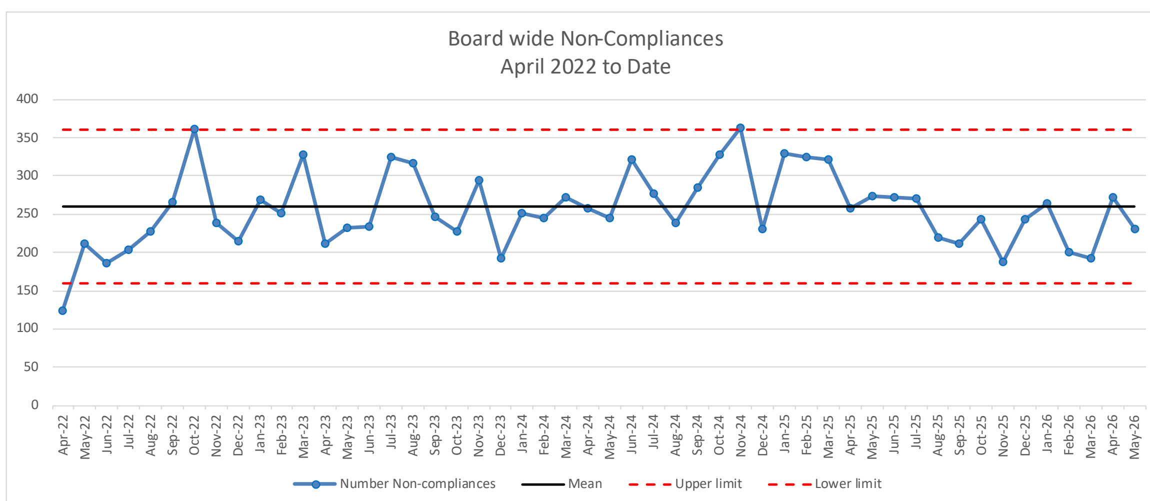
Ward Visit Programme

The purpose of these audits is to assess compliance to standard infection control precautions (SICPs); each aspect or SICP can be contributary factors to infection. All non-compliances are fed back to the nurse in charge immediately following the ward visit. A follow-up email is also sent to the ward and service manager. Details of each non-compliance are reported in the monthly HAI Service Reports and are discussed at the local Infection Control meetings.

The predominant non-compliance categories reported were Managing Patient Care Equipment category; non-compliances included equipment visibly dirty, items stored inappropriately, indicator tape/label missing. Control of the Environment, non-compliances included, area is not well maintained and in good state of repair, all stores are not above floor level and inappropriate items in clinical area. Non-compliances have decreased this month from 272 to 230 non-compliances.

All non-compliances were highlighted to the nurse in charge at the time of audit and any equipment with cleanliness issues was rectified immediately.

Below is an SPC chart detailing the non-compliances identified during the ward visits. A further breakdown of non-compliances is detailed in the appendix of this report.



Incidence / Outbreaks

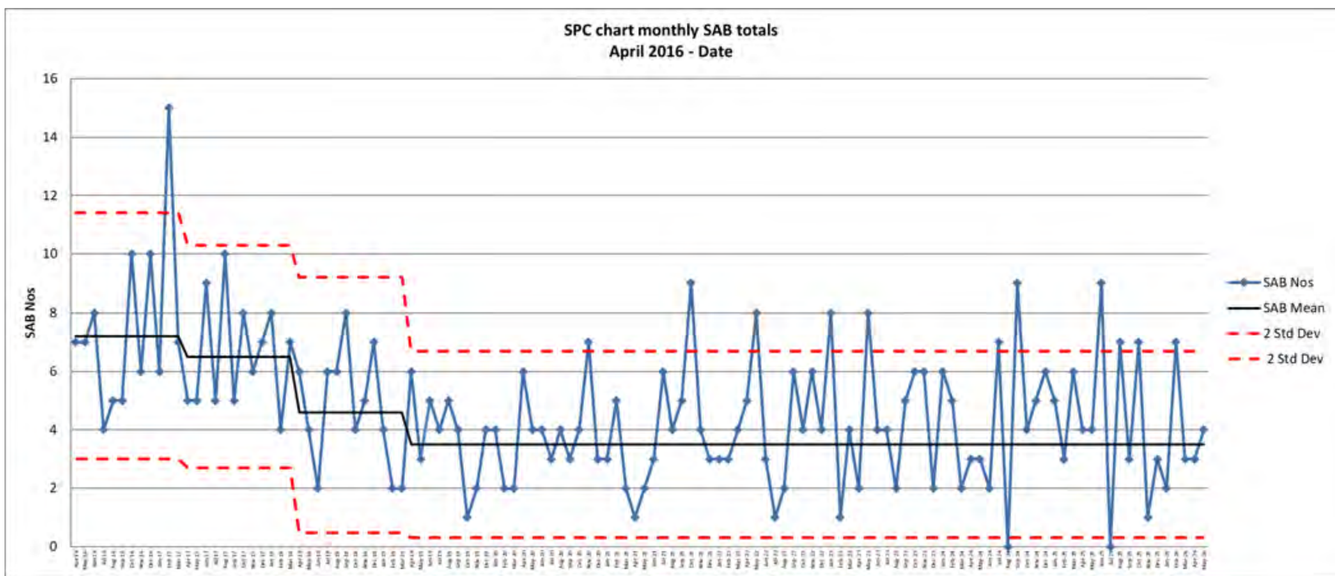
All outbreaks are notified to Health Protection Scotland and Scottish Government (see below for further details).

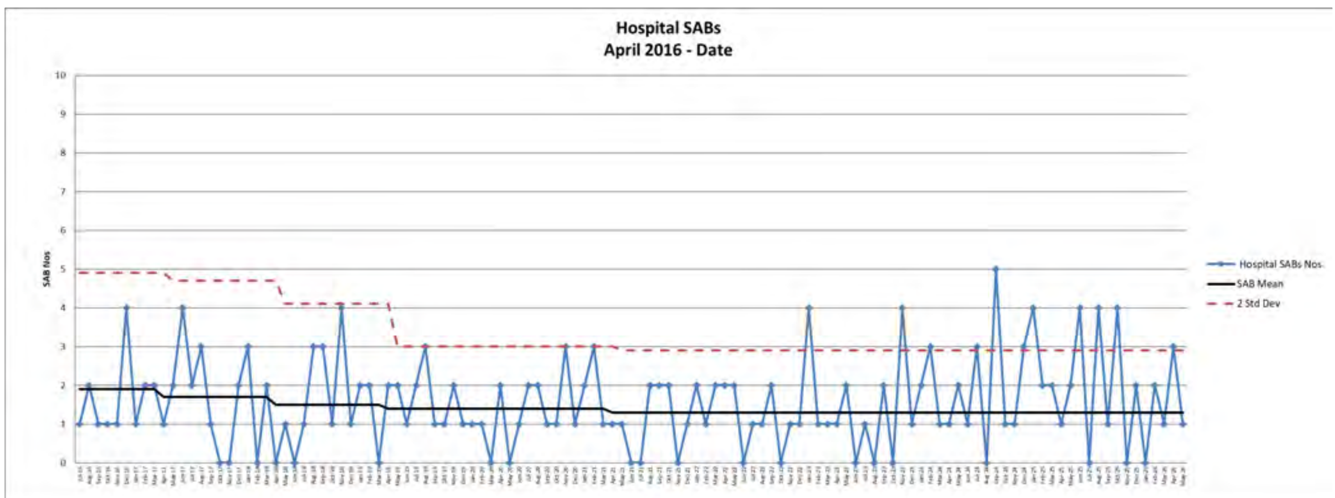
<u>Healthcare Acquired Infection Incident Template (HAIIT)</u>
The HAIIT is a tool used by boards to assess the impact of an incident or outbreak. The tool is a risk assessment and allows boards to rate the incident/outbreak as a red, amber, or green. The tool also directs boards whether to inform ARHAI Scotland/SG of the incident (if amber or red), release a media statement etc.

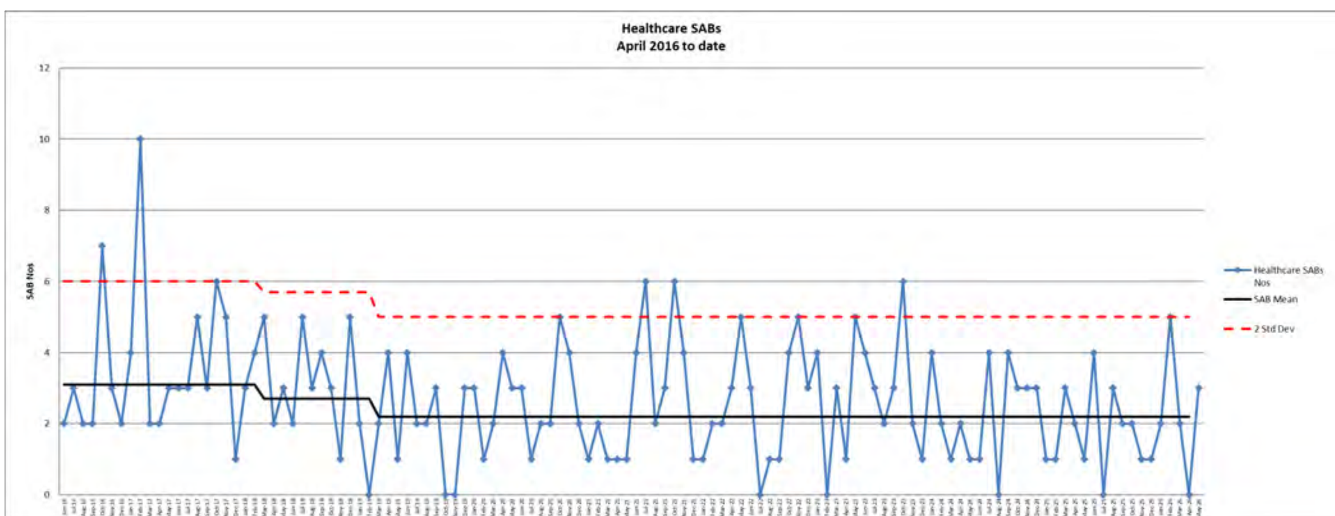
There were no outbreaks reported this month

HAI Surveillance Statistical Processing Charts

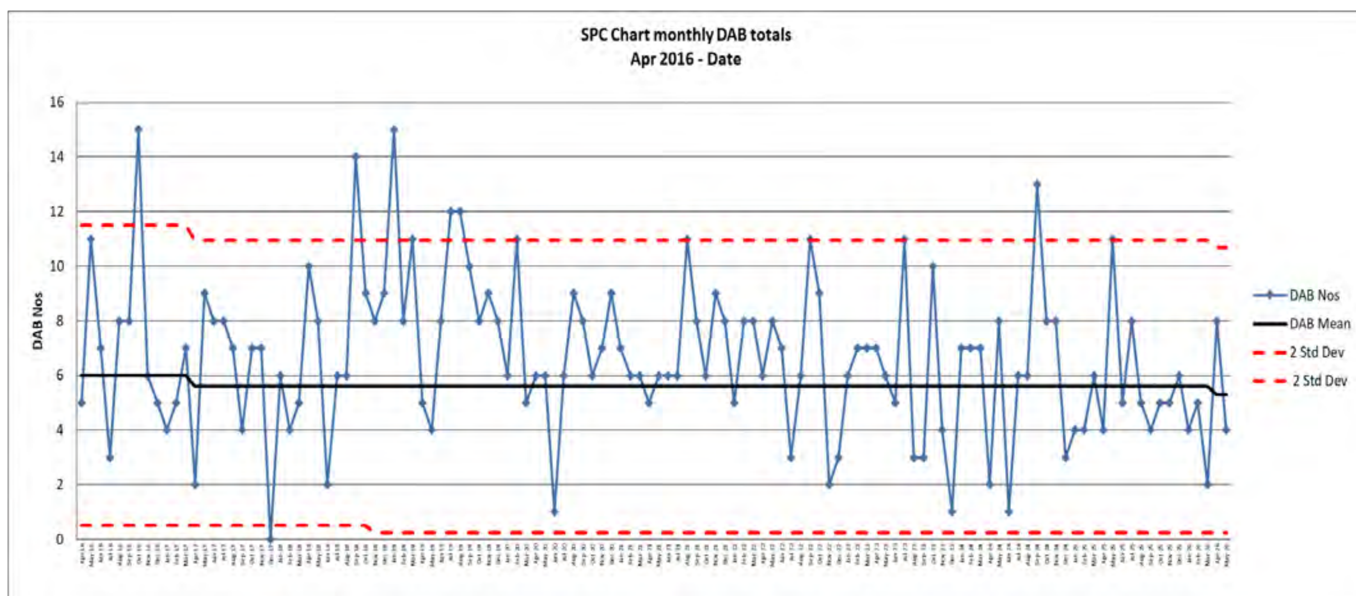
Staphylococcus aureus Bacteraemias (SABs)

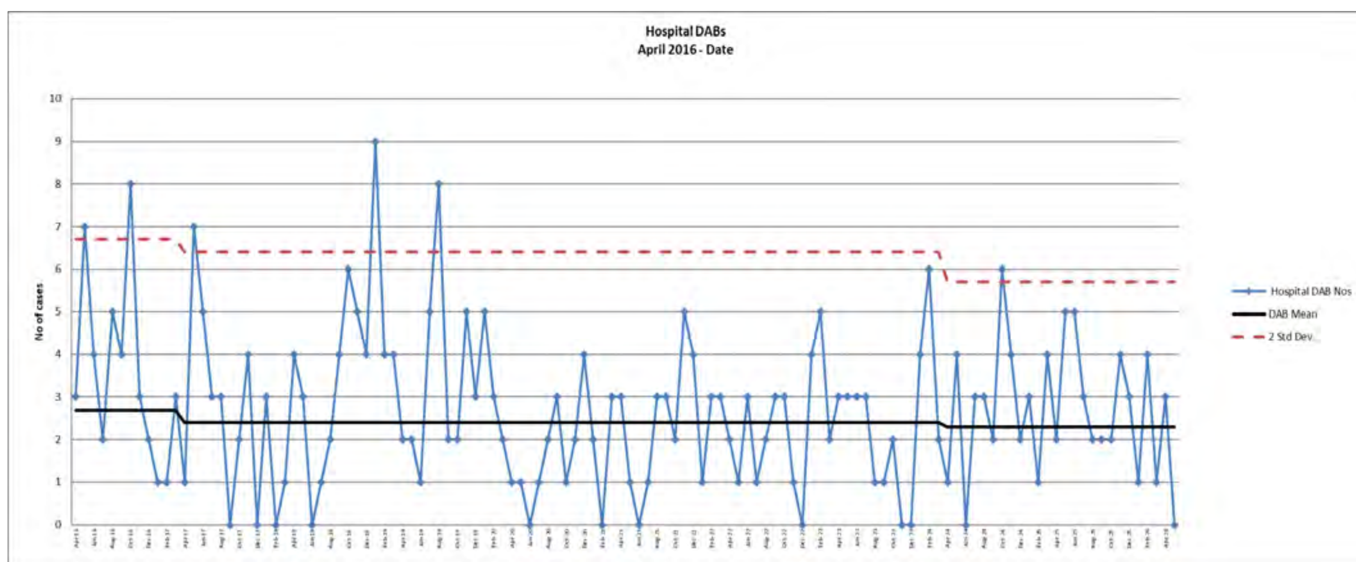


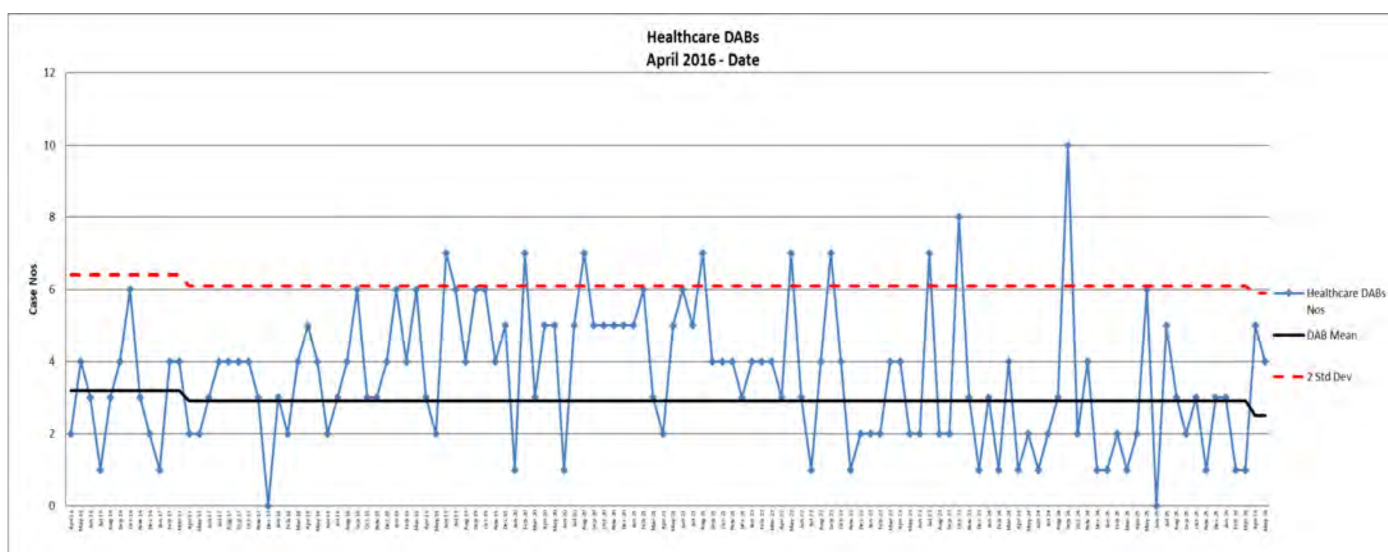




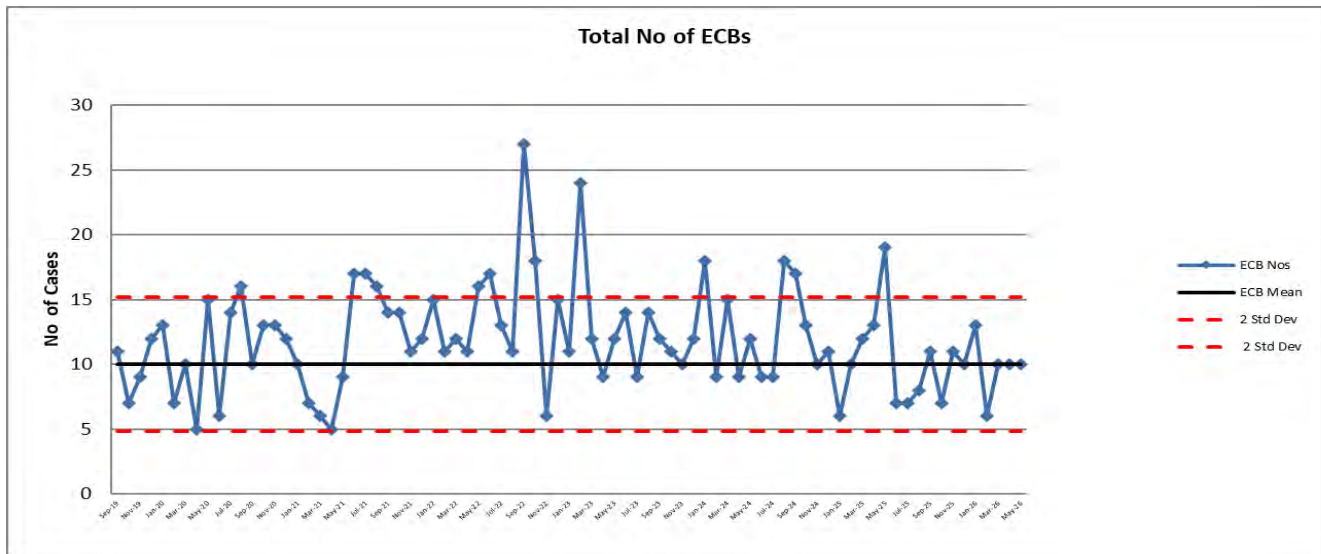
Device Associated Bacteraemias (DABs)

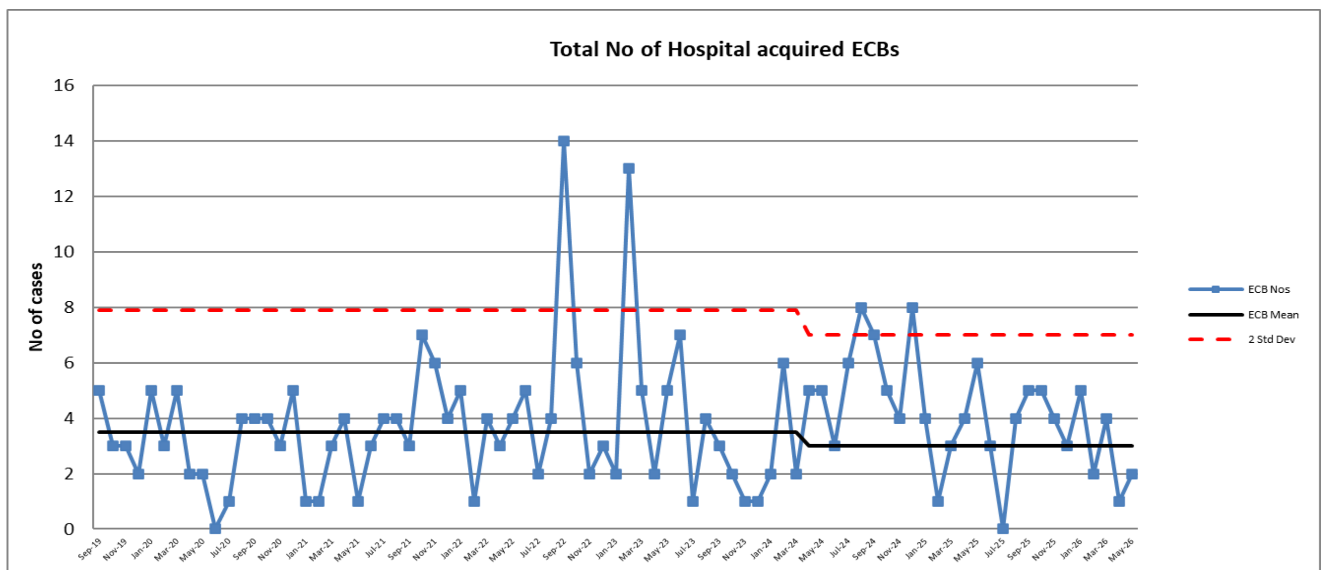


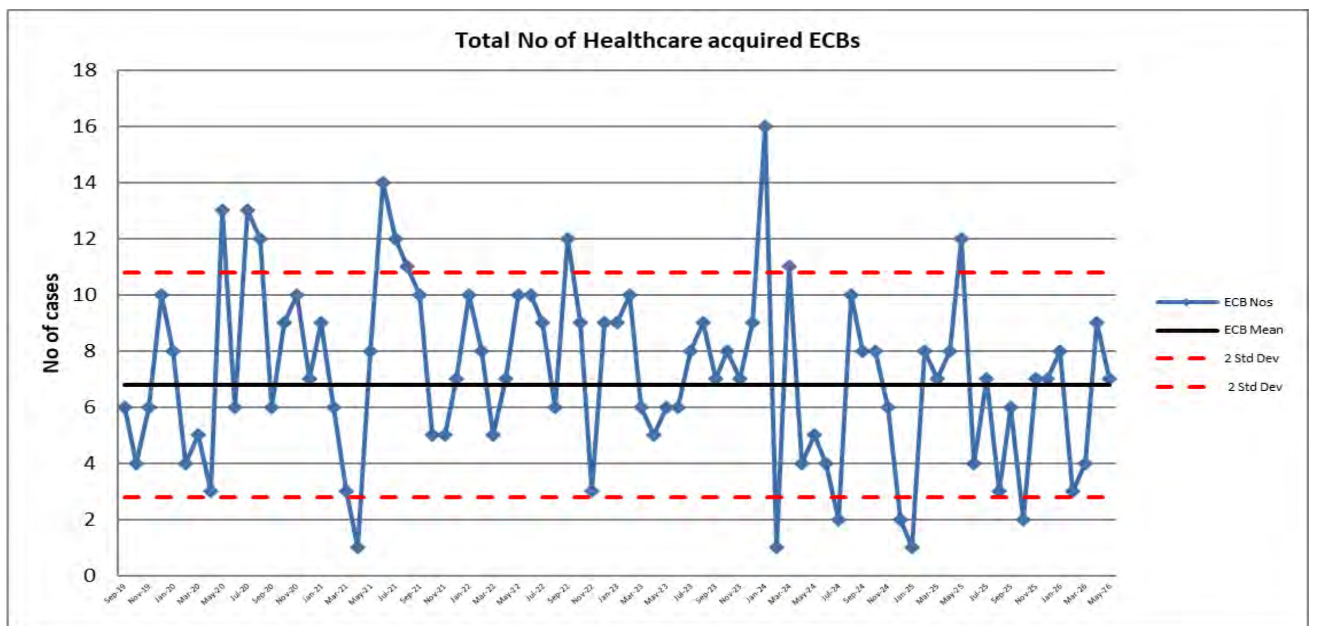




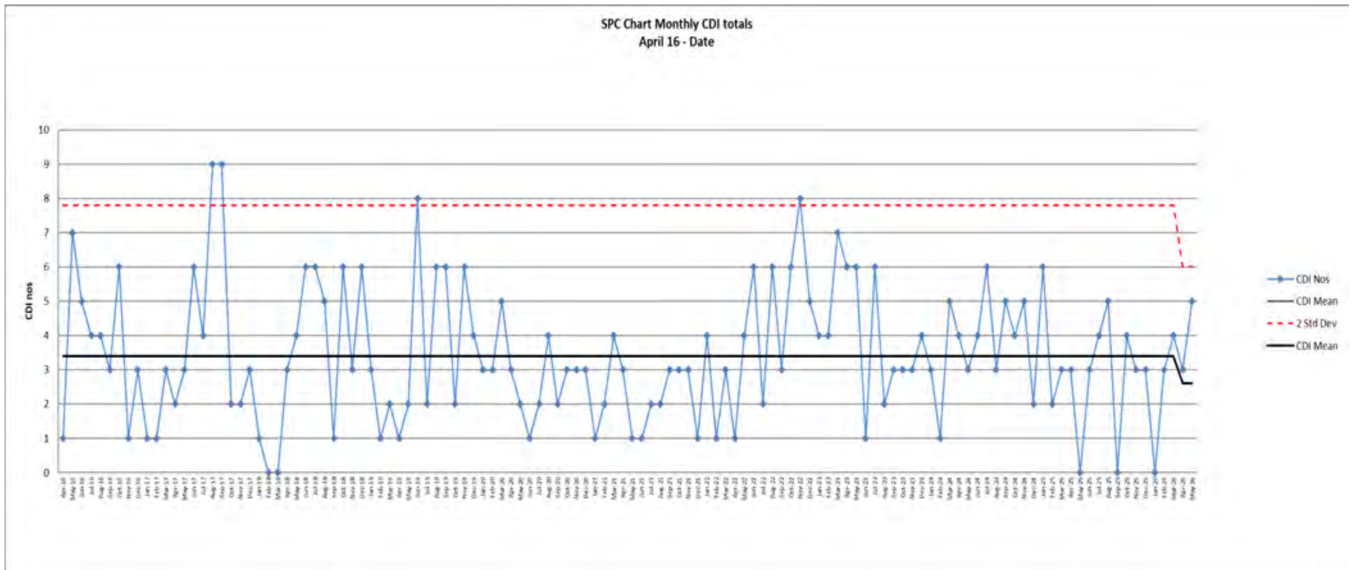
Escherichia coli Bacteraemias (ECBs)

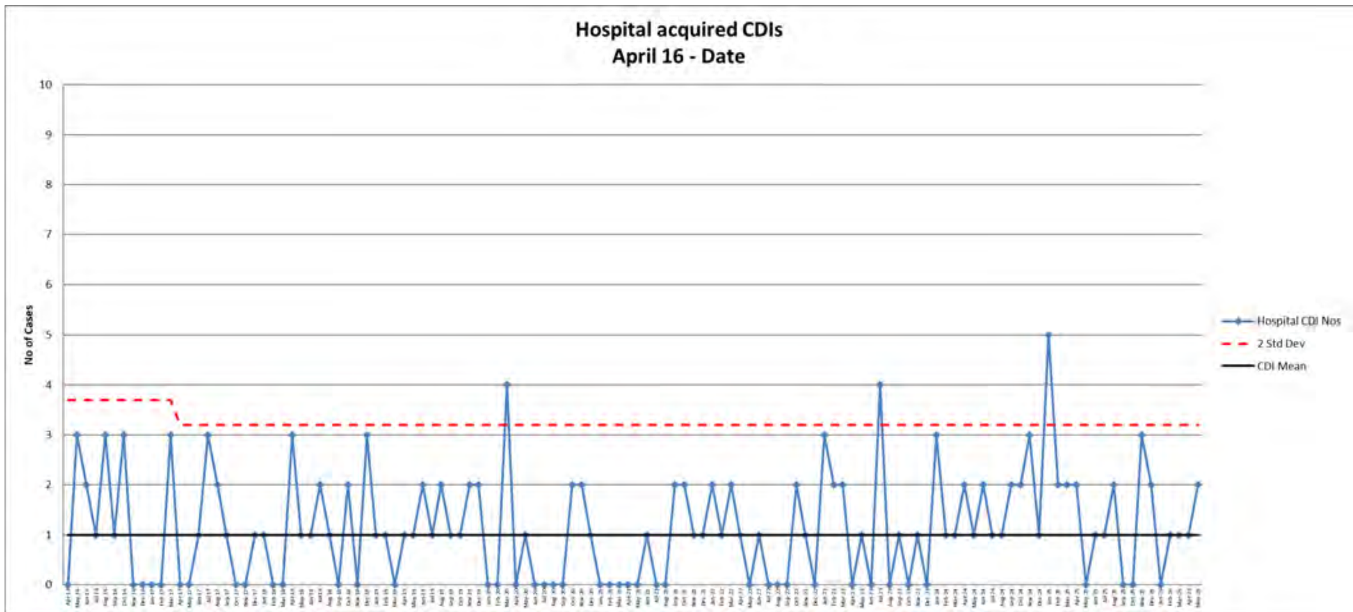


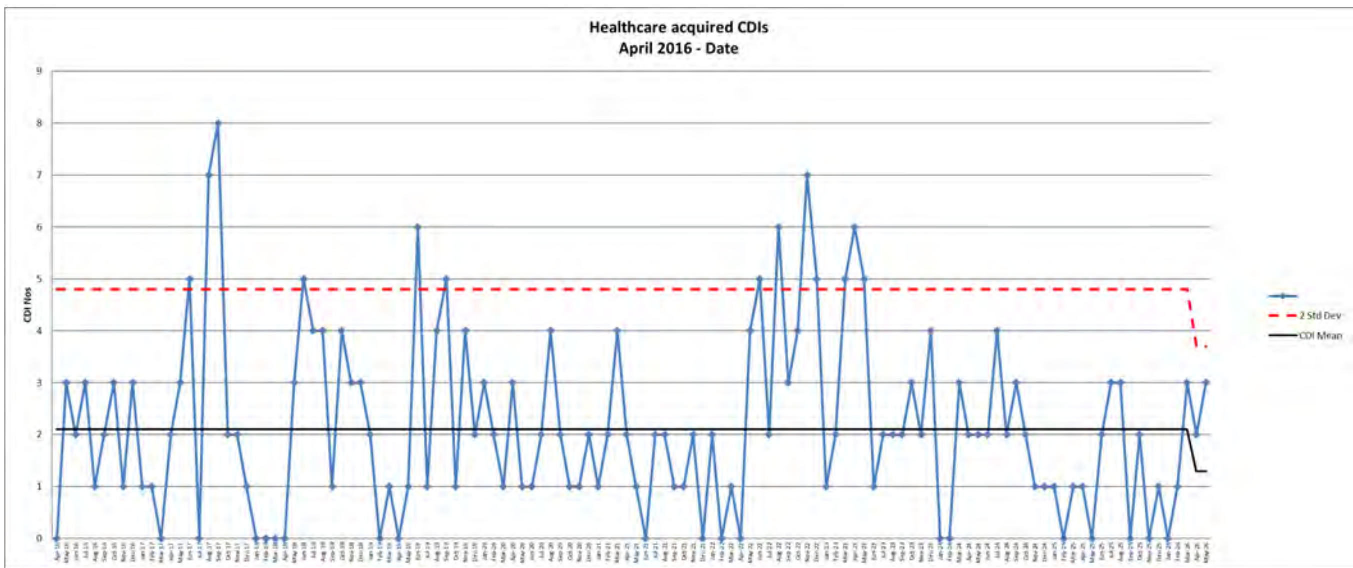




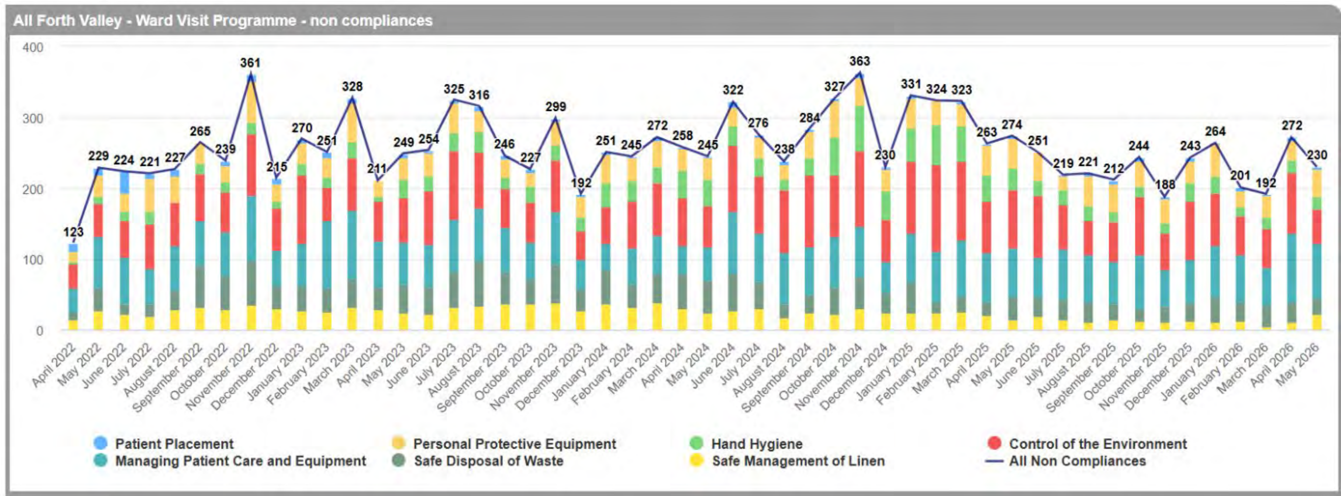
Clostridioides difficile Infections (CDIs)

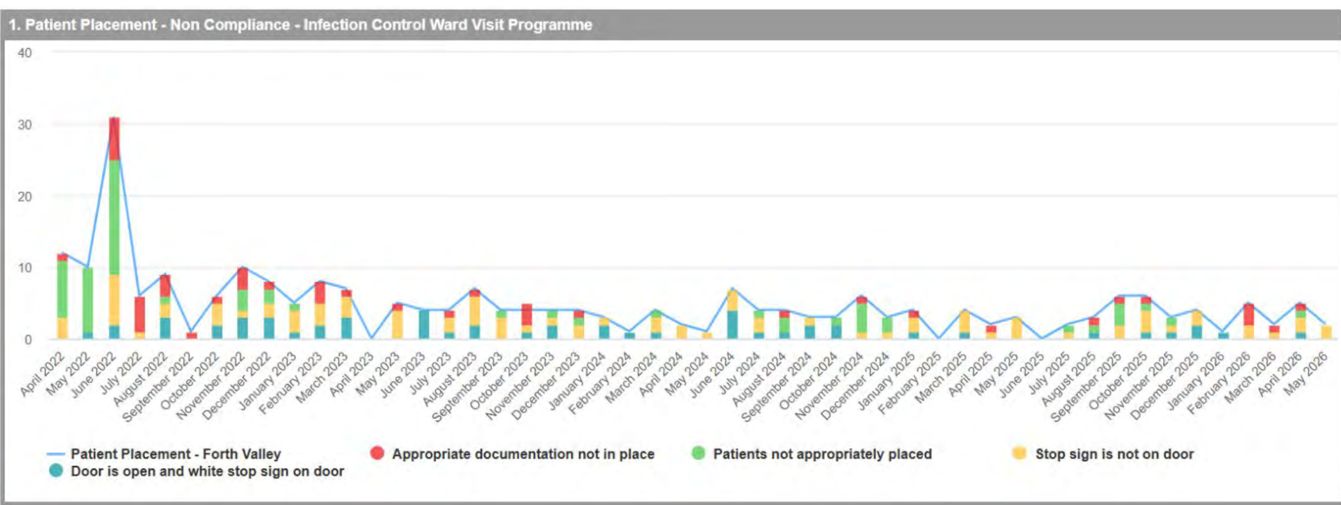


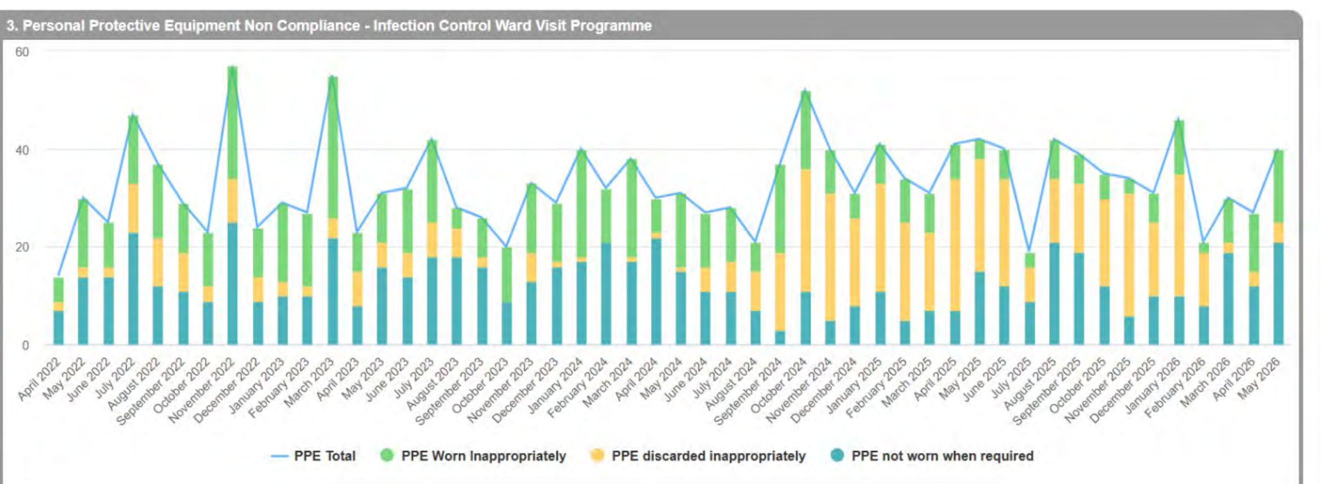


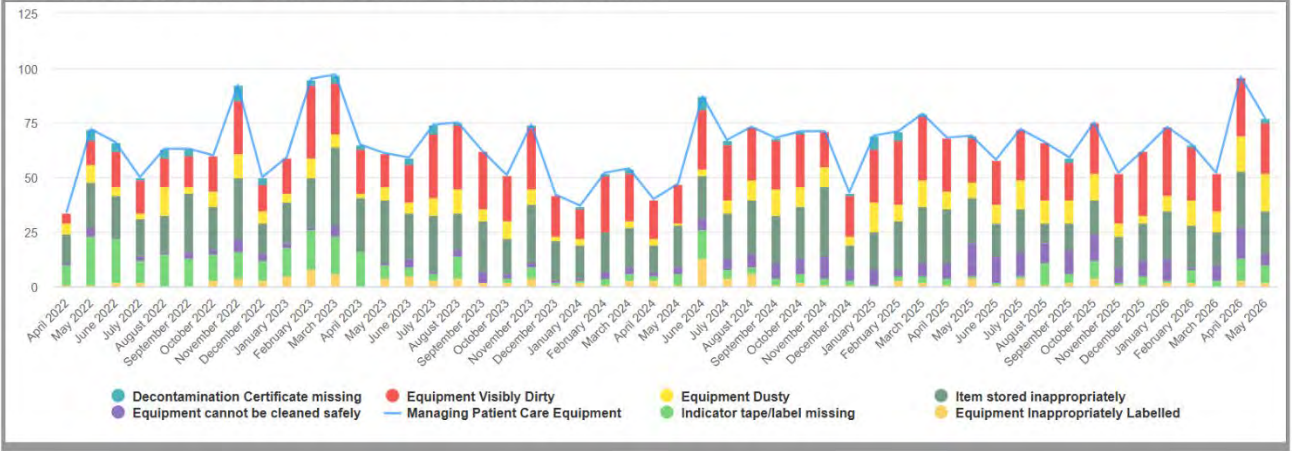


Ward Visit Non-Compliances by SICP








4. Managing Patient Care Equipment Non Compliance - Infection Control Ward Visit Programme
125
100
75
50
25
0
April 2022
May 2022
June 2022
July 2022
August 2022
September 2022
October 2022
November 2022
December 2022
January 2023
February 2023
March 2023
April 2023
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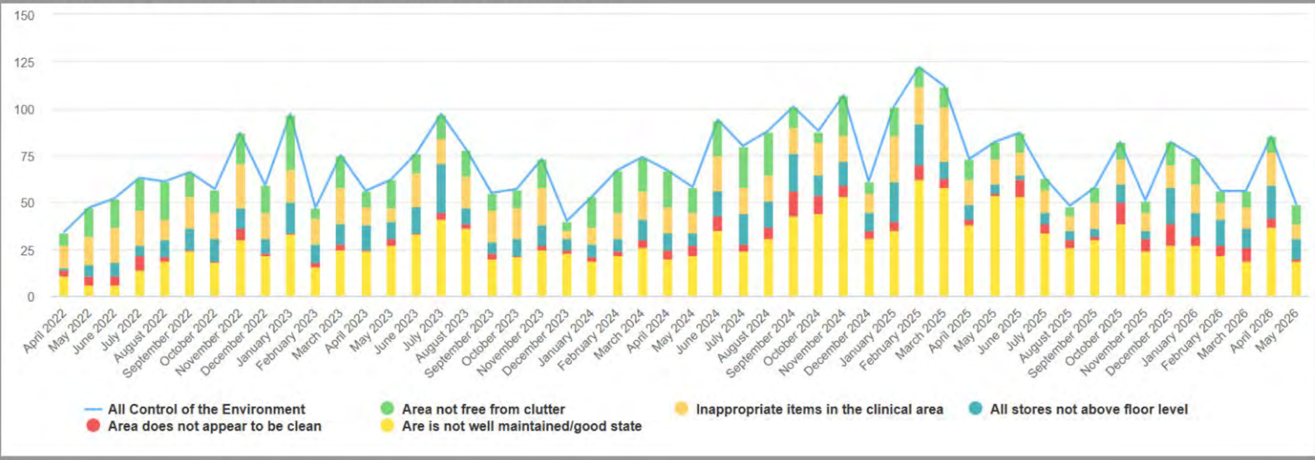
May 2025
June 2025
July 2025
August 2025
September 2025
October 2025
November 2025
December 2025
January 2026
February 2026
March 2026
April 2026
May 2026
Decontamination Certificate missing
Equipment Visibly Dirty
Equipment Dusty
Item stored inappropriately
Equipment cannot be cleaned safely
Managing Patient Care Equipment
Indicator tape/label missing
Equipment Inappropriately Labelled


5. Control of the Environment Non Compliance - Infection Control Ward Visit Programme
150
125
100
75
50
25
0
April 2022
May 2022
June 2022
July 2022
August 2022
September 2022
October 2022
November 2022
December 2022
January 2023
February 2023
March 2023
April 2023
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May 2025
June 2025
July 2025
August 2025
September 2025
October 2025
November 2025
December 2025
January 2026
February 2026
March 2026
April 2026
May 2026
All Control of the Environment
Area not free from clutter
Inappropriate items in the clinical area
All stores not above floor level
Area does not appear to be clean
Are is not well maintained/good state

6. Safe Management of Linen - Non Compliance - Infection Control Ward Visit Programme
50
40
30
20
10
0
April 2022
May 2022
June 2022
July 2022
August 2022
September 2022
October 2022
November 2022
December 2022
January 2023
February 2023
March 2023
April 2023
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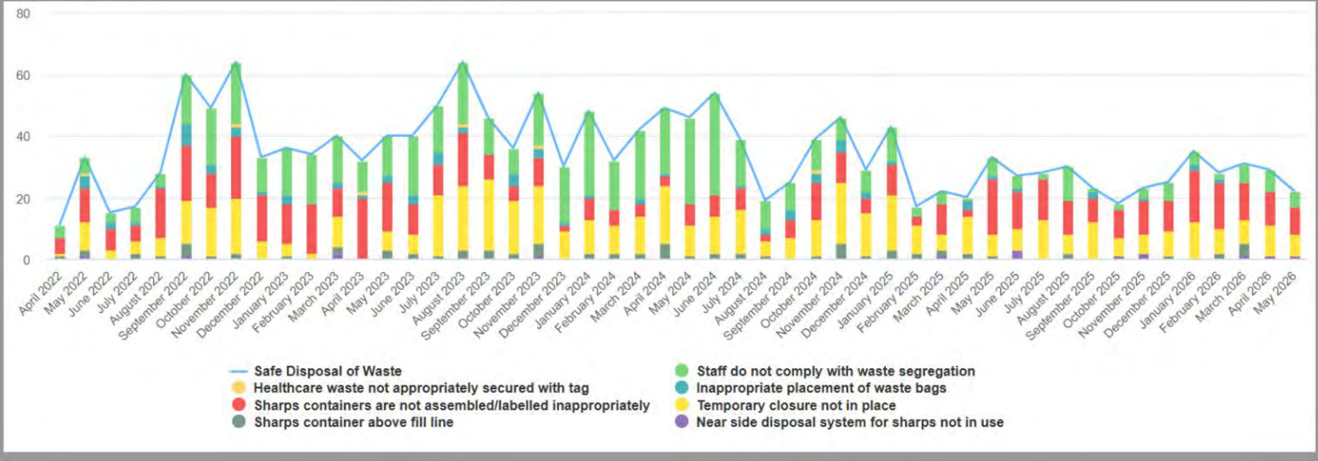
May 2025
June 2025
July 2025
August 2025
September 2025
October 2025
November 2025
December 2025
January 2026
February 2026
March 2026
April 2026
May 2026
Linen is not appropriately bagged
Safe Management of Linen
Linen receptacle not closed
Clean and Used linen is not stored separately
Linen is shaken/separated/rinsed or sorted on removal
Linen is placed on the floor or other surface


7.Safe disposal of waste Non Compliance - Infection Control Ward Visit Programme
80
60
40
20
0
April 2022
May 2022
June 2022
July 2022
August 2022
September 2022
October 2022
November 2022
December 2022
January 2023
February 2023
March 2023
April 2023
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May 2025
June 2025
July 2025
August 2025
September 2025
October 2025
November 2025
December 2025
January 2026
February 2026
March 2026
April 2026
May 2026
Safe Disposal of Waste
Healthcare waste not appropriately secured with tag
Sharps containers are not assembled/labelled inappropriately
Sharps container above fill line
Staff do not comply with waste segregation
Inappropriate placement of waste bags
Temporary closure not in place
Near side disposal system for sharps not in use

NHS Forth Valley

Forth Valley NHS Board

14. Whistleblowing Standards and Activity Report including Annual Report

Purpose: This report is for Assurance

Executive Sponsor: Karen Goudie, Executive Nurse Director

Author: Claire Peacock, PA to Executive Nurse Director

Executive Summary

The National Whistleblowing Standards set out how the Independent National Whistleblowing Officer (INWO) expects all NHS service providers to handle concerns that are raised with them, and which meet the definition of a 'Whistleblowing concern'.

The standards are applicable across **all NHS services** and are accessible to anyone working to deliver an NHS service, whether directly or indirectly. This includes current and former employees, bank and agency workers, contractors, including third sector providers, trainees and students, volunteers, non-executive directors, and anyone working alongside NHS staff, such as those in health and social care partnerships.

The National Whistleblowing Standards and Once for Scotland Whistleblowing Policy were introduced on 1 April 2021, and it is a requirement of the Standards to report Whistleblowing Performance to the NHS Board on a quarterly and an annual basis.

This paper is presented to the NHS Board to provide an update on Whistleblowing activity during Q4 2026 in NHS Forth Valley.

NHS Forth Valley Overall Position at a Glance

To date NHS Forth Valley has received an overall **total of 26 cases.**

- 10 cases were managed under Stage 1 of the Whistleblowing procedure and
- 16 cases under Stage 2 of the procedure.

The table below provides a breakdown of areas and total number of concerns received and investigated at each stage of the procedure:

	Stage 1	Closed	Stage 2	Closed
Acute	4	4	6	6
Corporate	0	0	3	3
Community	0	0	1	1
MH/LD/Prisons	4	4	2	2
Women & Children	1	1	3	3
HSCPs	0	0	0	0
Estates & Facilities	1	1	1	1
Total	**10**	**10**	**16**	**16**

Action Required

The Forth Valley NHS Board is asked to:

(1) **note** Whistleblowing performance in NHS Forth Valley in Q4 (Jan-Mar) 2026

(2) **note** Whistleblowing Annual Report 2025/26

(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

Noted below are the governance routes for assurance:

The Whistleblowing Board Quarterly Report and Annual Report 2025/26 was presented to the Staff Governance Committee on Tuesday 12th May.

The Staff Governance Committee was assured by the Whistleblowing performance outlined within the report and endorsed the Whistleblowing Annual Report.

Risk Assessment and Mitigation

Effective Whistleblowing processes can act as both detective and preventative risk management controls to support the organisation and its staff.

NHS Forth Valley promote the use of Business-as-Usual reporting for all areas of concern, however where these have been exhausted, or are felt by the reporter to be closed to them, then Whistleblowing routes should be used.

There is also a public confidence and reputational risk if Whistleblowing standards are not fully implemented and visible across the organisation.

Risks to the wellbeing and psychological safety of staff may emerge if NHS FV Senior Leaders are not committed to the process of investigating and learning from any concerns and issues raised by staff.

Impact Assessments

Equality & Diversity and Fairer Scotland Duty

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

Financial and Infrastructure Implications

No major impact other than the potential post noted in Workforce Implications below, and in addition a one-off cost of £4K and a recurring cost of approximately £300 per annum to support the further development of an additional incident page on Safeguard to data capture the Whistleblowing process.

Workforce Implications

An interim model of corporate support was initially agreed for the implementation of the standards and the ongoing co-ordination of the Whistleblowing process. The responsibilities associated with this role have now been formally integrated into the post holder's job description, ensuring clarity and alignment with organisational requirements.

Quality / Patient Care Implications

Whistleblowing is viewed by NHS Forth Valley as an important source of information that may highlight serious risks to the effectiveness and efficiency of the organisation, with individuals often being best placed to identify deficiencies and problems at the earliest opportunity. If the opportunity to investigate and address these concerns does not result in improvements then there is a potential risk to the quality, safety and experience of patients.

Population Health & Care Strategy

N/A

Climate Change / Sustainability Implications

None

Engagement and Communications
Was statutory engagement with stakeholders required? Yes ☐ No ☐x

- If yes, please provide details.

Appendices
Appendix 1 – Main Report
Appendix 2 – Annual Report

Appendix 1

Whistleblowing Activity Performance Report

1. Purpose of the Paper

1.1 This paper is presented to the NHS Board to provide an update on the Whistleblowing Performance in NHS Forth Valley during Q4 2026.

2. Position

2.1 The introduction of the Independent National Whistleblowing Standards aims to ensure everyone delivering NHS services in Scotland is able to speak up to raise concerns when they see harm or wrongdoing, putting patient safety at risk, confident that they can do so in a protected way that will not cause them personal detriment. It also aims to promote a culture of speaking up in the NHS and continues to be a key priority in NHS Forth Valley.

2.2 The standards are applicable across all NHS services and are accessible to anyone working to deliver an NHS service, whether directly or indirectly. This includes current and former employees, bank and agency workers, contractors, including third sector providers, trainees and students, volunteers, and anyone working alongside NHS staff, such as those in health and social care partnerships.

2.3 NHS Forth Valley is committed to managing the organisation in the best way possible and follows the revised national whistleblowing standards introduced across NHS Scotland. We strive to ensure that staff feel safe, supported, and have confidence in the fairness of the process whilst raising their concerns under the whistleblowing arrangements.

2.4 NHS Forth Valley's whistleblowing arrangements continue to evolve and strengthen, driven by a commitment to continuous improvement. We actively seek and encourage feedback from individuals who have engaged with the process, enabling us to gain valuable insight into their experiences and identify opportunities for enhancement.

2.5 In response to this feedback, we have introduced improvements across several areas, including refining internal processes and enhancing communication with staff involved in whistleblowing investigations. These developments are designed to reinforce governance, provide assurance to the Board, and build greater confidence in whistleblowing procedures among staff.

2.6 It has been recognised that numbers remain relatively low, similar to other Boards. NHS Forth Valley continue to promote the importance of raising concerns and this remains a key priority.

3. Whistleblowing Key Performance Indicators Rag Status

The format of this section of the report reflects the Scottish Government's mandate to capture performance of the board against the 9 key performance indicators.

The table (1) below provides a summary of each of the Key Performance Indicators. Progress on each of the indicators is provided throughout the report.

Table 1 – Key Performance Indicators

KPI	Measure
KPI 1	Learning from Whistleblowing Concerns
KPI 2	Whistleblowing Procedure Experience
KPI 3	Self Awareness & Training
KPI 4	Total Number of Concerns Received
KPI 5	Concerns Closed at Each Stage
KPI 6	Concerns Upheld or Not Upheld
KPI 7	Average Times
KPI 8	Closed in full within the timescales
KPI 9	Number of Cases where an extension is authorised

Key Performance Indicator One: Learning from Whistleblowing Concerns

NHS Forth Valley continues to strengthen its whistleblowing arrangements by embedding learning from concerns into both local services and organisational practice. Improvements arising from whistleblowing are implemented through robust action planning within local teams, with progress monitored and tracked to completion by the Whistleblowing Administrator to ensure accountability.

To support wider organisational learning, updates are disseminated via whistleblowing reports, newly introduced learning summaries, and publications on the internal webpage. These communications outline the nature of concerns raised and detail subsequent improvements, ensuring transparency and reinforcing confidence in the process. This approach remains iterative, with ongoing efforts to identify innovative and effective methods for sharing learning across the organisation.

The whistleblowing network plays a pivotal role in driving organisational learning, providing a forum for sharing insights and demonstrating improvements resulting from concerns. This continues to be an area of development, aimed at ensuring learning extends beyond individual services to influence broader organisational practice. Through these measures, NHS Forth Valley demonstrates its commitment to continuous improvement, governance assurance, and fostering a culture of trust and openness.

Independent National Whistleblowing Officer (INWO)

If a colleague remains unhappy with the response received from NHS Forth Valley, they have the right to contact the Independent National Whistleblowing Officer (INWO) to request an investigation into their complaint. The INWO is the final opportunity for the colleague using the NHS Whistleblowing Procedure and offers an independent view on whether the NHS has reasonably responded to a Whistleblowing concern.

The INWO has to date received a total of 6 cases relating to NHS Forth Valley Whistleblowing concerns. NHS Forth Valley have provided additional information which informs the INWO's decision on whether a full investigation is undertaken in relation to these cases.

Table 2 Provides detail of the outcomes overall from the INWO's investigations:

INWO Outcomes	Total Number
Fully Upheld	6
Partly Upheld	0
Not Upheld	0
No Investigation Conducted	0
Withdrawn	0

The published reports can be found here [Our findings | INWO (spso.org.uk)].

Feedback from the Independent National Whistleblowing Officer (INWO) has provided NHS Forth Valley with valuable insights to refine whistleblowing processes, strengthen governance, and enhance staff confidence in the system. This feedback has highlighted opportunities to learn from reporters' experiences and ensure that our approach remains robust, transparent, and aligned with national standards.

Key Performance Indicator Two: Whistleblowing Procedure Experience

The Whistleblowing Procedure requires NHS Forth Valley to actively seek feedback from individuals who raise concerns, ensuring their experience of the process informs ongoing improvement. This commitment reflects our core values of transparency, accountability, and responsiveness.

Every individual who raises a concern under the whistleblowing procedure is supported by designated Confidential Contact. The Confidential Contact/s provide a safe, respectful, and confidential environment for reporting, helping staff feel secure and empowered to speak up.

To strengthen our approach, NHS Forth Valley has established a structured mechanism to encourage feedback from reporters at key stages of the process. This feedback is invaluable in:

- Gaining insight into the reporter's experience
- Identifying barriers or challenges within the process
- Highlighting opportunities for improvement

Feedback received has directly informed enhancements to our whistleblowing arrangements, including:

- Process Refinement: Streamlined systems to improve timeliness and clarity.
- Communication Improvements: Clearer updates for reporters throughout investigations
- Training and Awareness: Additional guidance for managers and Confidential Contacts to ensure consistency and sensitivity

These changes aim to build confidence in the whistleblowing process for all involved, reinforcing a culture of trust and openness across NHS Forth Valley.

NHS Forth Valley recognises that feedback is not a one-off exercise but an ongoing dialogue. Continuous engagement with reporters ensures the whistleblowing process remains dynamic, transparent, and aligned with best practice standards.

Key Performance Indicator Three: Self Awareness and Training

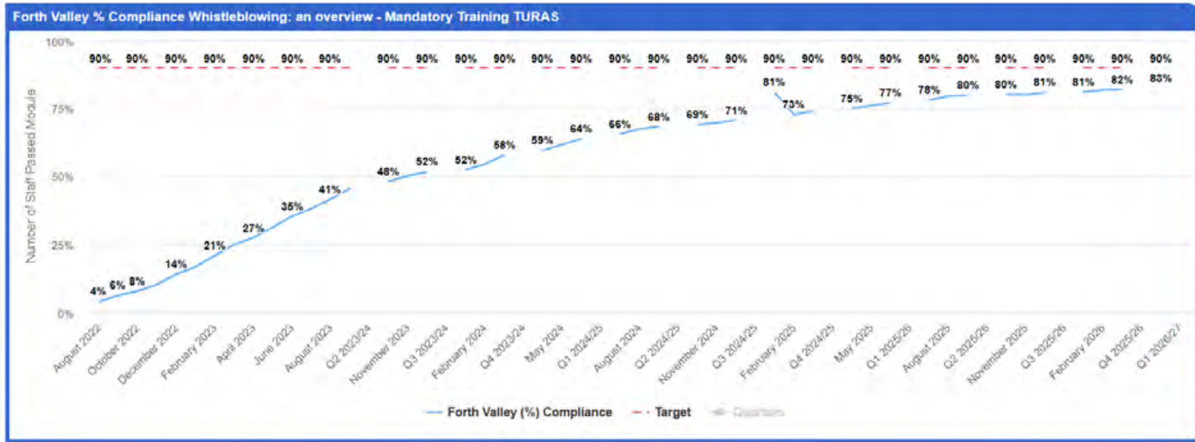
There is a requirement to report on levels of staff perceptions and awareness of training. As part of the Whistleblowing Standards there is requirement for staff to complete the training developed by the INWO. Whistleblowing training reports are now accessible from TURAS which in turn supports the developments of training arrangements.

Table 3 - provides an overview of numbers of staff who have completed the Whistleblowing Overview training to date, this equates to 83% of the organisation against a target of 90% and is an increase from the last reporting period.

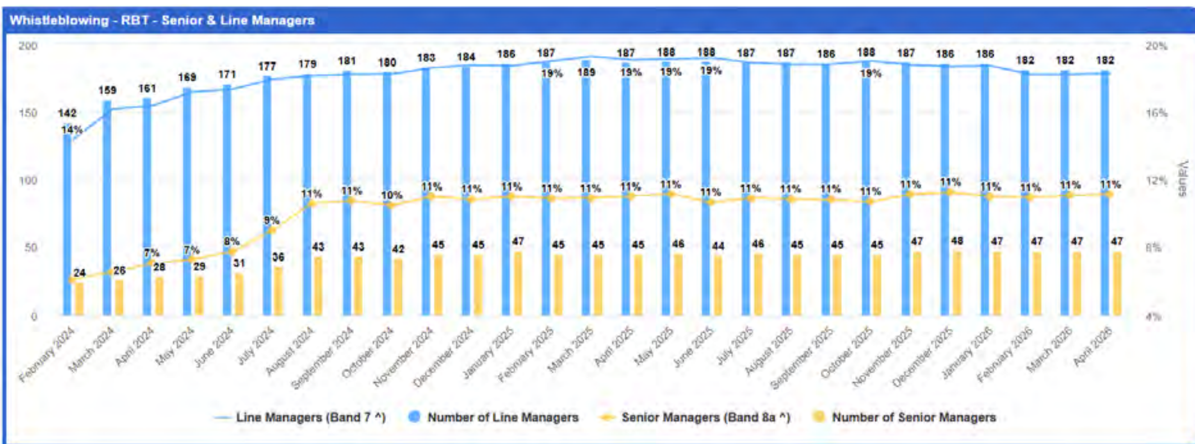
Whistleblowing Training	Completed Numbers	Eligible
All Staff "Overall"	5518	6816

The graphs below demonstrate the overall percentage of compliance of staff who have completed the training to date:

Graph 1 – An Overview



Graph 2 – Senior / Line Managers



The training modules are actively promoted across the organisation. Senior and Line Managers encouraged to complete the training and support staff in engaging with modules most relevant to their roles. While it is recognised that uptake has not yet reached the desired level, a focused and sustained effort is ongoing, and this remains a key priority.

Key Performance Indicator Four: Total number of Concerns Received

During this reporting period Q4 2026 there were 0 concerns received.

To date NHS Forth Valley have investigated or are investigating a total number of 26 concerns since the development of the whistleblowing arrangements. This includes 10 under Stage 1 and 16 under Stage 2 of the Whistleblowing Procedure.

Graph 3 – Overall number of concerns received to date

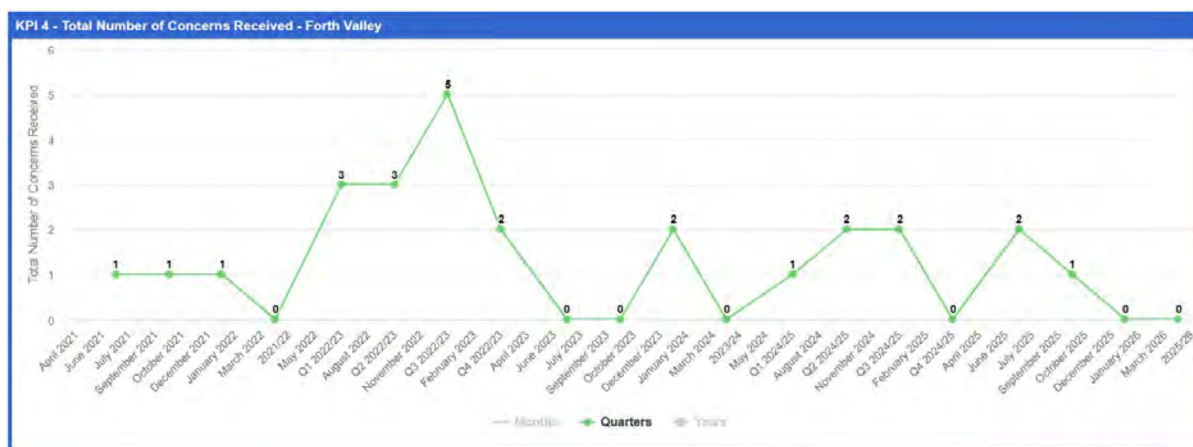


Table 4 – A breakdown of areas and total number of concerns received and investigated at each stage of the procedure:

	Stage 1	Closed	Stage 2	Closed
Acute	4	4	6	6
Corporate	0	0	3	3
Community	0	0	1	1
MH/LD/Prisons	4	4	2	2
Women & Children	1	1	3	3
HSCP	0	0	0	0
Estates & Facilities	1	1	1	1
Total	**10**	**10**	**16**	**16**

It is also worth noting that there have been occasions where individuals have raised concerns collectively. A breakdown of the number of reporters is provided below:

Table 5

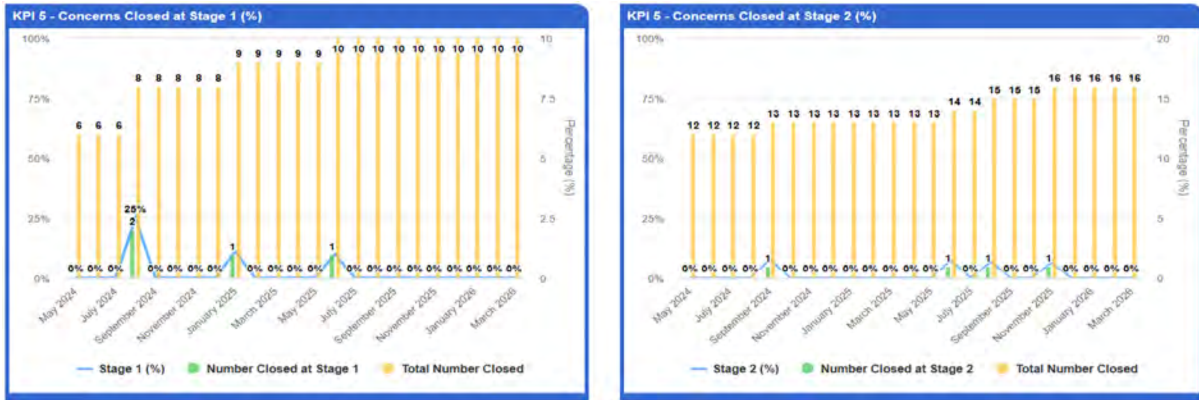
Area	Number of reporters raising concerns
Women & Children's Directorate	4
Mental Health	6
Mental Health	3

Key Performance Indicator Five: Concerns Closed at Each Stage

During Q4 2026 there were 0 concerns.

The graph below demonstrates a percentage of the total number of concerns closed at each Stage of the procedure.

Graph 4



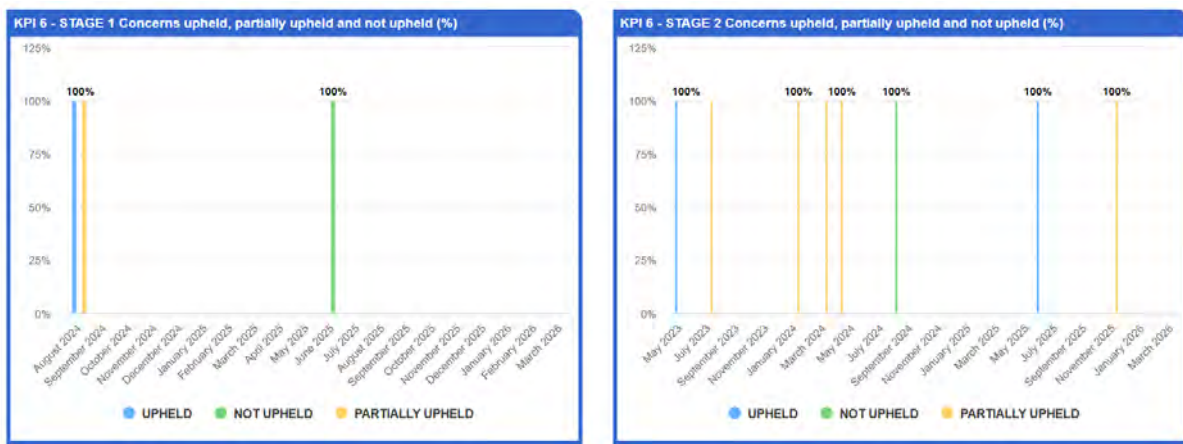
Key Performance Indicator Six: Concerns Upheld and Not Upheld

To meet the requirements of Indicator Six, NHS Forth Valley provides a breakdown of formal outcomes—upheld, partially upheld, or not upheld—across Stage 1 and Stage 2 whistleblowing concerns.

During Q4 there were 0 cases investigated.

The graph below demonstrates the Concerns upheld, partially upheld and not upheld at each stage of the Whistleblowing Procedure as a percentage (%) of all concerns closed at each stage:

Graph 5 - Concerns upheld, partially upheld and not upheld at each stage of the Whistleblowing Procedure



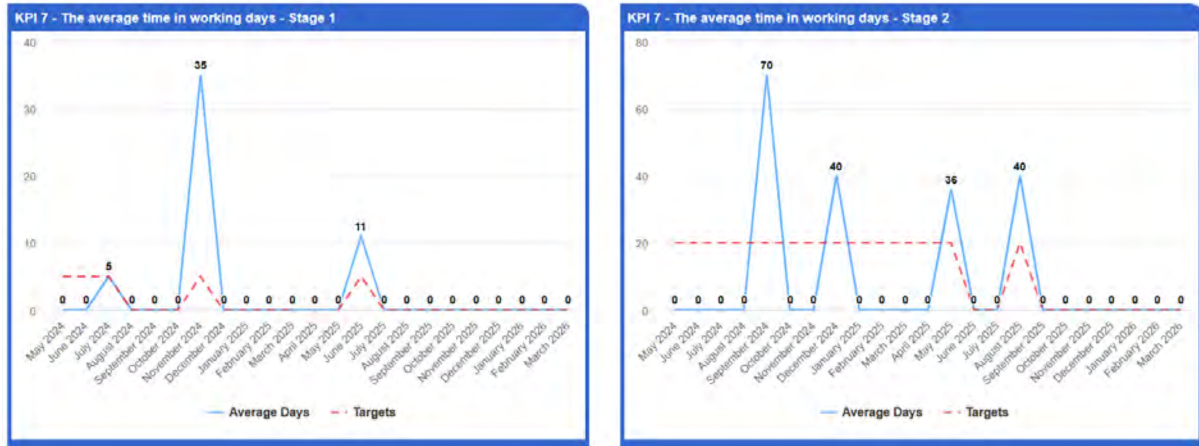
Key Performance Indicator Seven: Average Times

A reporting requirement of the Whistleblowing Procedure is to report on the average times in working days to close concerns at each stage.

There were 0 concerns closed during Q4 2026.

A detailed breakdown of the total average time in working days for a full response to concerns at each stage of the Whistleblowing Procedure is demonstrated in the graph below:

Graph 6 – Total average times in working days



As previously reporting It has been acknowledged that the average response time in working days, particularly for Stage 2 cases, remains an area of concern. This is primarily due to the complexity of the issues raised and the detailed investigations required. Performance in this area continues to be closely monitored as part of the ongoing review process.

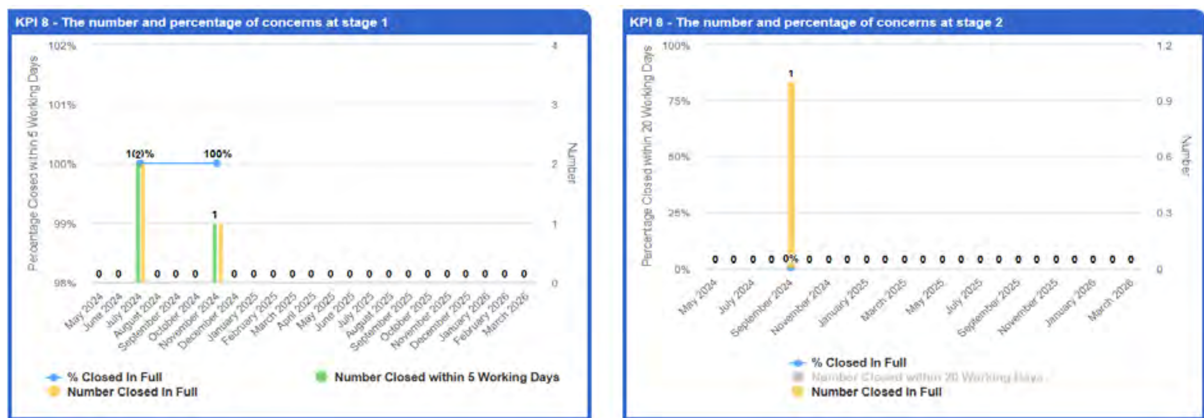
Key Performance Indicator Eight: Closed in Full within the Timescales

There were 0 concerns received during this reporting period.

Table 8 below provides the total number of concerns closed within timescale for each Stage of the procedure:

	Closed within timescale
Stage 1 (5 working days)	6
Stage 2 (20 working days)	3

Graph 7 Total number of concerns closed in full within the timescale:



As highlighted above, the timescales may not always be met due to the complexity of the issues raised and the comprehensive level of investigation required, however this is an area of focus and continues to be monitored as part of the process.

Key Performance Indicator Nine: Number of Cases where an Extension is Authorised

It is important that we respond to concerns timeously however not all investigations will be able to meet the timeline. The Whistleblowing Procedure allows an extension where it is necessary to complete the investigation.

There were 0 concerns received during this reporting period.

Graph 7 – total number of cases where an extension is authorised.

As highlighted previously there continues to be a particular focus on strengthening governance around the authorisation and management of extensions to whistleblowing investigations. In response, a structured monitoring system was implemented, which includes weekly check-ins between the administrator and the investigator to track progress and identify any challenges requiring escalation.

5. Conclusion

5.1 NHS Forth Valley continues to demonstrate a strong commitment to the principles of the National Whistleblowing Standards, ensuring that all staff and stakeholders have access to clear, safe, and effective mechanisms for raising concerns. The organisation has successfully managed and closed all whistleblowing cases received to date, embedding learning from these concerns into both local and organisational practice.

5.2 NHS Forth Valley's Annual Report demonstrates and describes the progress made during 2025/26. We continue to promote a culture of speaking up and this remains a key priority. NHS Forth Valley is committed to continually reviewing and refining our processes to ensure staff feel safe, supported, and have confidence in the fairness of the process whilst raising their concerns under the whistleblowing arrangements.

Appendix 2

Annual Report 2025/26

NHS Forth Valley

NHS Forth Valley Whistleblowing Annual Report 2025/26

Date
V1

Introduction to National Whistleblowing Standards

Whistleblowing is defined in the Public Services Reform (the Scottish Public Services Ombudsman) (Healthcare Whistleblowing) Order 2020 as: “when a person who delivers services or used to deliver services on behalf of a health service body, family health service provider or independent provider (as defined in section 23 of the Scottish Public Services Ombudsman Act 2020) raises a concern that relates to speaking up, in the public interest, about an NHS service, where an act or omission has created, or may create, a risk of harm or wrong doing”

The National Whistleblowing Standards and the Once for Scotland Whistleblowing Policy were introduced on 1 April 2021. NHS Forth Valley recognises whistleblowing as an important source of information, enabling early identification of serious risks to organisational effectiveness, efficiency and patient safety.

The Independent National Whistleblowing Standards support everyone delivering NHS services in Scotland to speak up and raise concerns about harm or wrongdoing, confident they can do so in a protected way and without fear of personal detriment. Promoting a culture of openness and speaking up remains a key priority for NHS Forth Valley.

While many workplace concerns can be resolved informally, the organisation acknowledges that more serious issues — such as risks to patient safety, professional misconduct or financial malpractice — can feel difficult for staff to raise. Concerns may arise due to uncertainty, fear of repercussions, or worry about raising issues in the wrong way.

NHS Forth Valley remains fully committed to the National Whistleblowing Standards and strives to ensure staff feel safe, supported and confident in the fairness and integrity of the whistleblowing process.

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Date: March 2026
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Executive Summary

The National Whistleblowing Standards set out how the Independent National Whistleblowing Officer (INWO) expects all NHS service providers to handle concerns that are raised with them, and which meet the definition of a 'whistleblowing concern'.

Karen Goudie
Executive Nurse Director/
Executive Lead for Whistleblowing

The standards are applicable across all NHS services and are accessible to anyone working to deliver an NHS service, whether directly or indirectly. This includes current and former employees, bank and agency workers, contractors, including third sector providers, trainees and students, volunteers, non-executive directors, and anyone working alongside NHS staff, such as those in health and social care partnerships.

In line with the Standards, NHS Forth Valley reports whistleblowing performance to the Board on both a quarterly and annual basis.

This Annual Whistleblowing Report consolidates annual performance for 2025/26, providing assurance of governance arrangements, learning, staff experience, and compliance against the nationally mandated Key Performance Indicators (KPIs).

During 2025/26, NHS Forth Valley managed **3 cases** all of which were progressed through the established procedures. The organisation continues to strengthen governance arrangements, investigator capacity, learning mechanisms, and communication with reporters, while recognising that timescales for complex investigations, particularly Stage 2 – remain an area for ongoing improvement. The organisation has managed and closed all whistleblowing cases received to date, embedding learning from these concerns into both local and organisational practice.

NHS Forth Valley continues to demonstrate a strong commitment to the principles of the National Whistleblowing Standards, ensuring that all staff and stakeholders have access to clear, safe, and effective mechanisms for raising concerns.

NHS Forth Valley Whistleblowing Arrangements

NHS Forth Valley is committed to ensuring that staff feel safe, supported, and confident in the fairness and integrity of the whistleblowing process. We recognise the importance of providing a working environment where staff can raise concerns without fear, and where openness, honesty and transparency are actively encouraged.

NHS Forth Valley aims to foster a culture in which individuals feel supported to speak up, confident that their concerns will be taken seriously, listened to, and addressed appropriately through fair, objective, and robust policies and procedures.

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In addition to its formal whistleblowing arrangements, NHS Forth Valley operates a Speak Up Service, which is designed to promote an open, responsible and supportive culture across the organisation. The service provides staff with a safe and confidential route to raise concerns and seek advice.

The service is led by a Speak Up Ambassador, who also fulfils the role of Confidential Contact for formal whistleblowing concerns. The Ambassador is supported by Speak Up Advocates, who offer a confidential and impartial service, enabling staff to discuss concerns in a safe environment or seek guidance in confidence. These roles have been integrated to provide seamless support across both the Speak Up and formal Whistleblowing processes.

Accessible routes for raising concerns, include:

- Dedicated Whistleblowing confidential contacts and Speak Up service
- Email channels and telephone lines
- Access to the National Whistleblowing Standards, local procedures and Confidential Contacts on StaffNet
- Safeguard reporting
- Awareness-raising continues through mandatory training, intranet content, and governance reporting mechanisms

As part of the Board quarterly reporting it was thought helpful to provide a clear explanation of the differences between the two services outlining their respective roles, scope, and how staff can access support through each of the services. Posters were designed and distributed widely across the organisation and information was displayed on the staff intranet.

It has been recognised that Whistleblowing figures remain relatively low. To provide reassurance to staff NHS Forth Valley is actively promoting the importance of raising concerns through a range of communication and engagement approaches aimed at fostering an open, honest and transparent culture. This includes regular communications to staff, attendance at forums and engagement events, and the use of the staff intranet to raise awareness of the Speak Up Service and formal Whistleblowing arrangements.

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Date: March 2026
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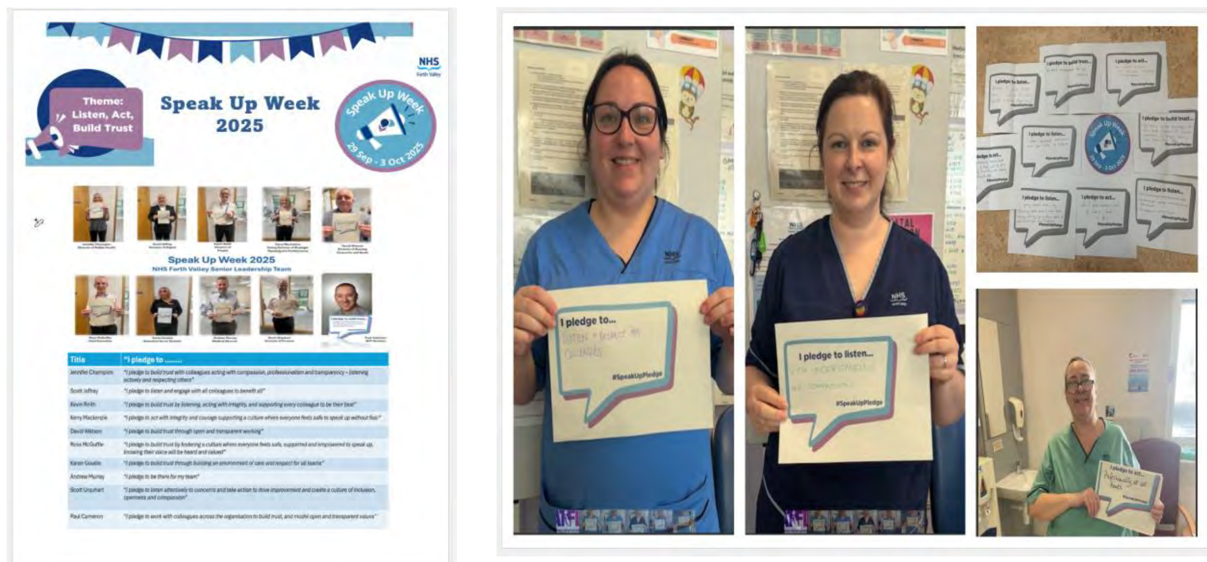
Key messages focus on encouraging staff to speak up, reassuring them that concerns will be listened to and addressed appropriately, and reinforcing the support available to them throughout the process. These activities support staff confidence and help ensure that opportunities to raise concerns are visible, accessible and well understood across the organisation.

National Speak Up Week

NHS Forth Valley once again participated fully in the annual National Speak Up Week, which took place between 29th September and 3rd October 2025. The theme was "Listen, Act, Build and Trust.

Resources were shared widely with teams and staff were encouraged to discuss and promote a culture of speaking up, share resources widely with their teams and complete pledges. Pledges were greatly received from all levels of staff including our Executive Board members.



Furthermore, as part of the arrangements, we gathered perspectives from our new Executive Lead for Whistleblowing on the importance of "building trust", alongside NHS Forth Valley's Whistleblowing Champion. Recordings were shared widely with staff across the organisation and publicised on the Staff Intranet.

In addition, a live forum was hosted by NHS Forth Valley's Lead Confidential Contact to provide further engagement and discussion.

There were also a series of live events hosted by SPSO (Scottish Public Services Ombudsman) which were publicised widely for interest.

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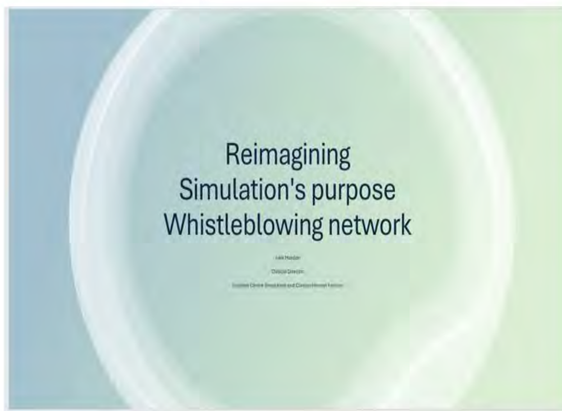
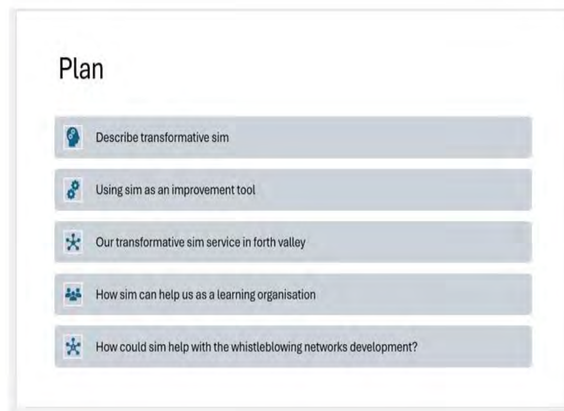
Whistleblowing Network

The Whistleblowing Network provides a forum for sharing learning from whistleblowing activity, with a particular focus on strengthening processes, improving communication with reporters, supporting effective investigation, and embedding organisational learning arising from whistleblowing investigations. The Network is chaired by the Executive Lead for Whistleblowing and co-chaired by the Whistleblowing Champion. It brings together all staff involved in our whistleblowing processes and provides an open forum for discussion, sharing learning and improving practice.

In 2025 simulation training was delivered to those directly involved in the Whistleblowing process. The purpose of the training was to give exposure to realistic scenarios to enhance skills and to support decision making abilities as part of the Whistleblowing process. Further training is scheduled to take place during 2026.





NHS Forth Valley – Whistleblowing Performance

Whistleblowing activity is presented to the NHS Board to reflect the Scottish Government's mandate to capture performance of the Board against the 9 Key Performance Indicators as outlined in the Whistleblowing Procedure and below:

KPI	Measure
KPI 1	Learning from Whistleblowing Concerns
KPI 2	Whistleblowing Procedure Experience
KPI 3	Self-Awareness & Training
KPI 4	Total Number of Concerns Received
KPI 5	Concerns Closed at Each Stage
KPI 6	Concerns Upheld or Not Upheld
KPI 7	Average Times
KPI 8	Closed in full within the timescales
KPI 9	Number of Cases where an extension is authorised

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Date: March 2026
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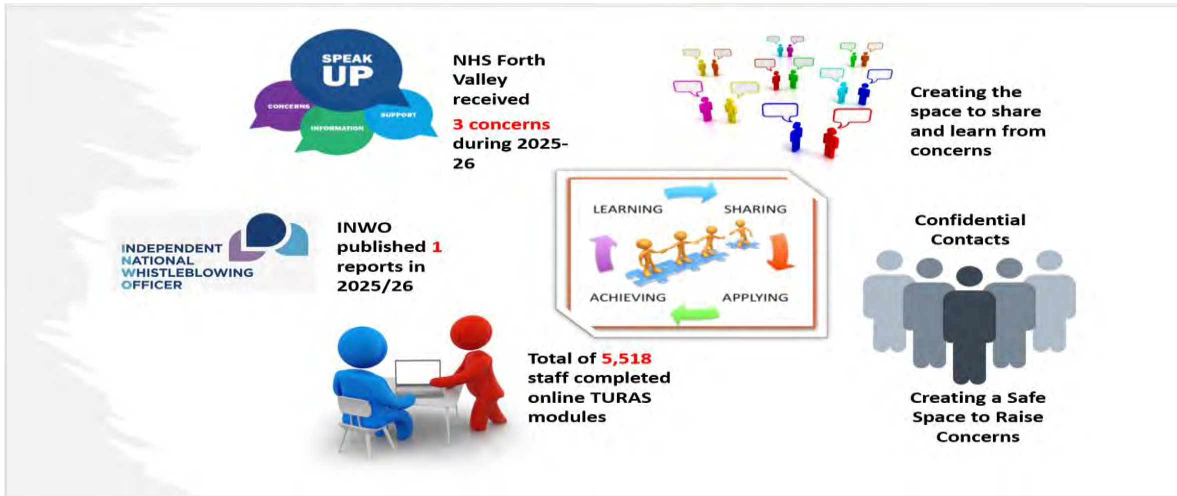
Performance across the key indicators is presented to the Board on a quarterly basis as per the requirement of the standards.

Performance At a Glance 2025/26



The information provided below provides an overview of the annual performance for 2025-26 across NHS Forth Valley against each of the Key Performance Indicators.

During 2025/26 there were a total of **3** concerns investigated and closed.

The table below demonstrates the total number of concerns received and closed at each stage of the procedure:

Table 1

Stage 1	Closed	Stage 2	Closed
1	1	2	2

Following completion of the Stage 1 investigation, the case was progressed to Stage 2 for further consideration.

To date NHS Forth Valley has received an overall total of 26 concerns.

- 10 cases were managed under Stage 1 of the Whistleblowing procedure and
- 16 cases under Stage 2 of the procedure.

Key Performance Indicator 1- Learning from Whistleblowing

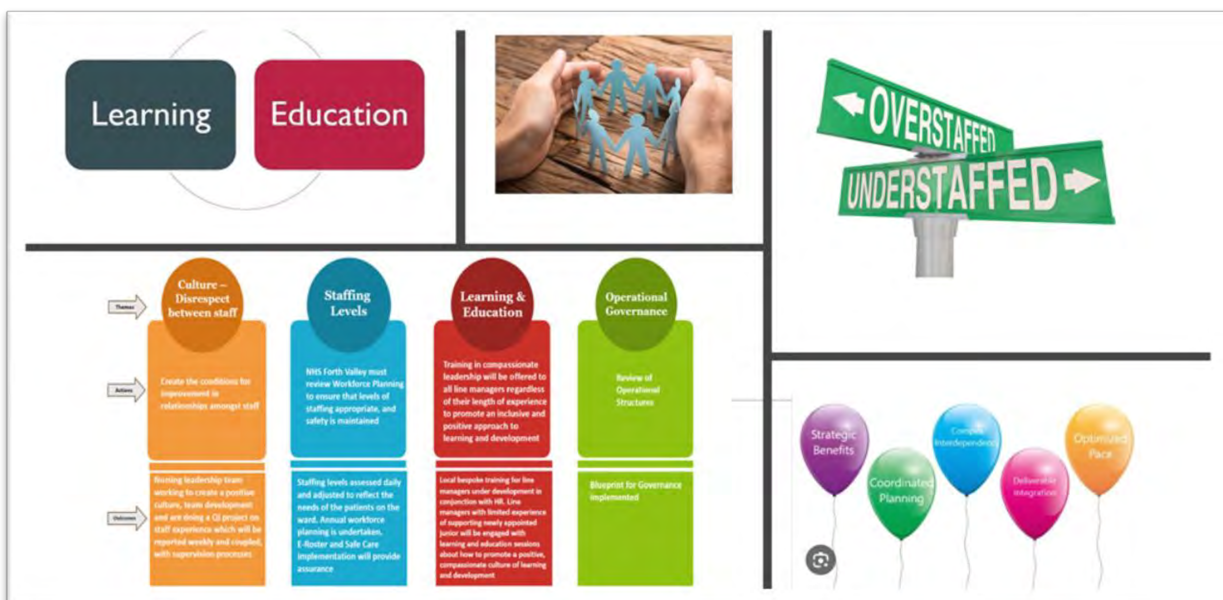
The indicator requires NHS Forth Valley to demonstrate how whistleblowing concerns have resulted in changes or improvements to services or procedures.

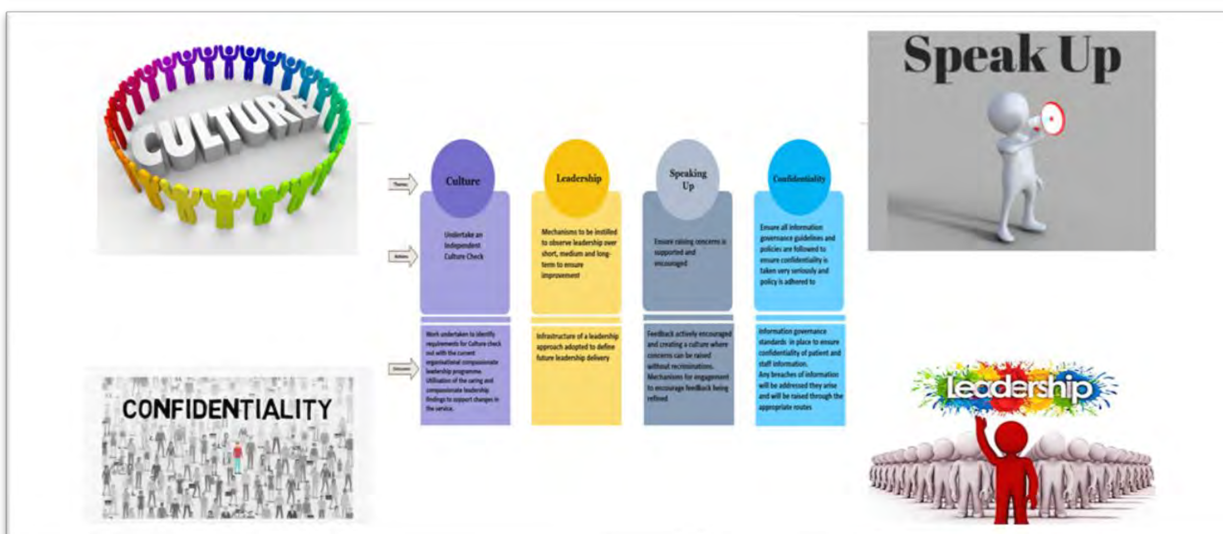
Organisational learning from whistleblowing concerns is overseen through the Whistleblowing Network. This remains an area of ongoing development, with continued focus on ensuring that learning is embedded at an organisational level, rather than being limited to individual services.

As outlined earlier in the report, the Whistleblowing Network provides a forum for all relevant parties to share learning arising from whistleblowing cases and enables NHS Forth Valley to evidence improvements made as a direct result of these concerns.

Work to strengthen organisational learning from whistleblowing continues and has been aligned with wider system activity focused on learning from complaints and Significant Adverse Event Reviews (SAERs), ensuring a consistent and robust approach to organisational learning.

The infographic below highlights some of the key themes, actions and learning identified from whistleblowing cases within NHS Forth Valley.





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Key Performance Indicator 2 - Whistleblowing Procedure Experience

The Whistleblowing Procedure requires NHS Forth Valley to seek feedback on the experience of all individuals involved in the whistleblowing process.

Individuals who raise concerns under the Whistleblowing Procedure are supported throughout by Confidential Contacts, who provide ongoing follow-up and guidance. A feedback mechanism has been built into the local whistleblowing arrangements to capture the views of reporters on their experience of using the process. This feedback is intended to support continuous improvement and further strengthen local arrangements. In addition, a survey was developed to gather feedback from those who have used the whistleblowing process; however, response levels have been limited to date. Increased promotion of this survey will be taken forward to encourage participation in future.

Feedback received from early cases has been used by Confidential Contacts to enhance communication with reporters during investigations. This has included offering more regular contact throughout the process and following the conclusion of cases, to ensure individuals feel supported and informed.

Organisational learning arising from whistleblowing concerns is initially identified within local teams through robust action planning and service improvement activity. These actions are tracked to completion by the Whistleblowing Administrator. Wider organisational learning is shared through whistleblowing reports and learning summaries, as well as via the internal whistleblowing webpages, which outline the types of concerns raised and the improvements implemented as a result. This remains an iterative and developing process, with ongoing reflection on how learning can be shared more widely and in more accessible and innovative ways to ensure staff benefit from organisational learning.

Again as highlighted earlier in this report, the Whistleblowing Network comprising staff involved in the administration and investigation of whistleblowing concerns—regularly reviews whistleblowing cases. The network considers both the effectiveness of the whistleblowing process and opportunities to further develop and refine arrangements. Feedback from reporters is used to inform improvements and identify opportunities to enhance the experience of individuals raising concerns.

Key Performance Indicator 3 - Self-Awareness and Training

There is a requirement to report on levels of staff perceptions and awareness of training. As part of the Whistleblowing Standards there is necessity for staff to complete the training developed by the INWO.

Whistleblowing training was made mandatory across NHS Forth Valley in August 2022 and reports are now accessible from TURAS which further supports the developments of training arrangements.

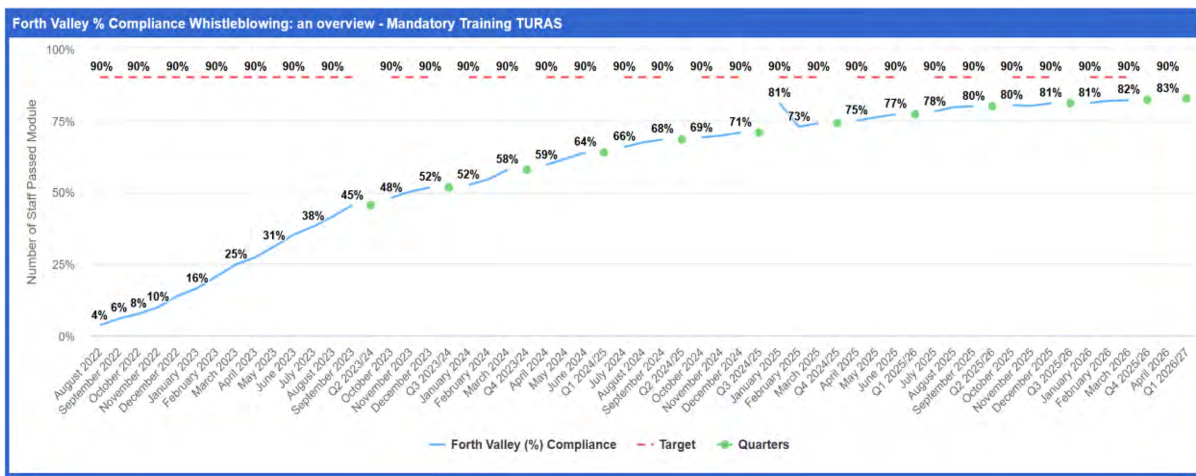
Whistleblowing training continues to be promoted across the organisation and is accessible via TURAS.

The table below demonstrates training compliance (as of March 2026)

Table 2

• **Staff trained**	**5,518**
• **Eligible staff**	**6,816**
• **Compliance level**	**83%**
• **Target:**	**90%**

Graph 1 - An Overview



Graph 2 - Senior / Line Managers

Training compliance has increased steadily across the year. The training modules are actively promoted across the organisation. Senior and Line Managers are encouraged to complete training and support staff engagement most relevant to their roles. While it

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is recognised that uptake has not yet reached the desired level, a focused and sustained effort is ongoing, and this remains a key priority.

Key Performance Indicator 4 - Total Number of Concerns Received

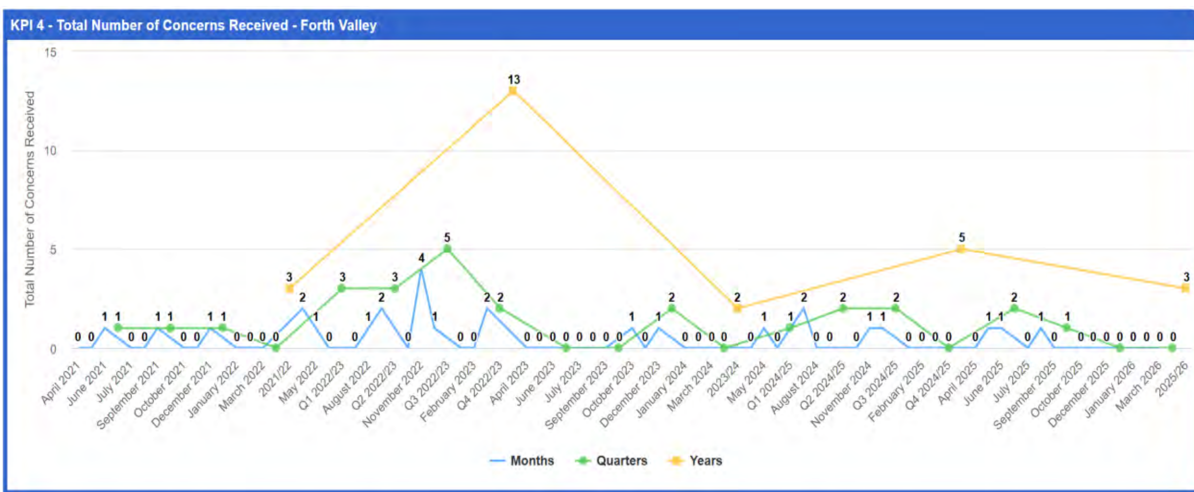
During 2025/26 there was a total number of 3 concerns received.

To date NHS Forth Valley has investigated or are investigating a total number of 26 concerns since the development of the whistleblowing arrangements. This includes 10 under Stage 1 and 16 under Stage 2 of the Whistleblowing Procedure.

To date NHS Forth Valley has investigated a total of 26 concerns. This includes:
Table 3

Stage	Received	Closed
Stage 1	10	10
Stage 2	16	16

Graph 3 – Overall number of concerns received to date



Overall trend data demonstrates relatively low volumes, with peaks reflecting complex themes rather than systemic reporting issues.

The table below provides a breakdown of areas and total number of concerns received and investigated at each stage of the procedure:

Table 4

	Stage 1	Closed	Stage 2	Closed
Acute	4	4	6	6
Corporate	0	0	3	3
Community	0	0	1	1
MH/LD/Prisons	4	4	2	2
Women & Children	1	1	3	3

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HSCPs	0	0	0	0
Estates & Facilities	1	1	1	1
Total	**10**	**10**	**16**	**16**

For noting there have been occasions where individuals have raised concerns collectively. A breakdown of the number of reporters is provided below:

Table 5

Area	Number of reporters raising concerns
Women & Children's Directorate	4
Mental Health	6
Mental Health	3

Key Performance Indicator 5 - Concerns Closed at Each Stage

During 2025/26 **3** cases were investigated – 1 case was managed under Stage 1 of the Whistleblowing Procedure and 2 cases under Stage 2 of the procedure. The Stage 1 progressed to Stage 2 for further investigation.

Table 6 – concerns closed at each stage

	Stage 1	Closed	Stage 2	Closed
Acute	1	1	2	2

All concerns received in 2025/26 were progressed and closed, reflecting effective oversight and case management.

The graphs below provide the total number of concerns closed at each stage of the procedure as a percentage % of all concerns closed.

Graph 4 Total number of concerns closed:

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Key Performance Indicator 6 - Concerns Upheld / Not Upheld

The table below provides an overview of the outcomes arising from the 3 investigations undertaken during 2025/26.

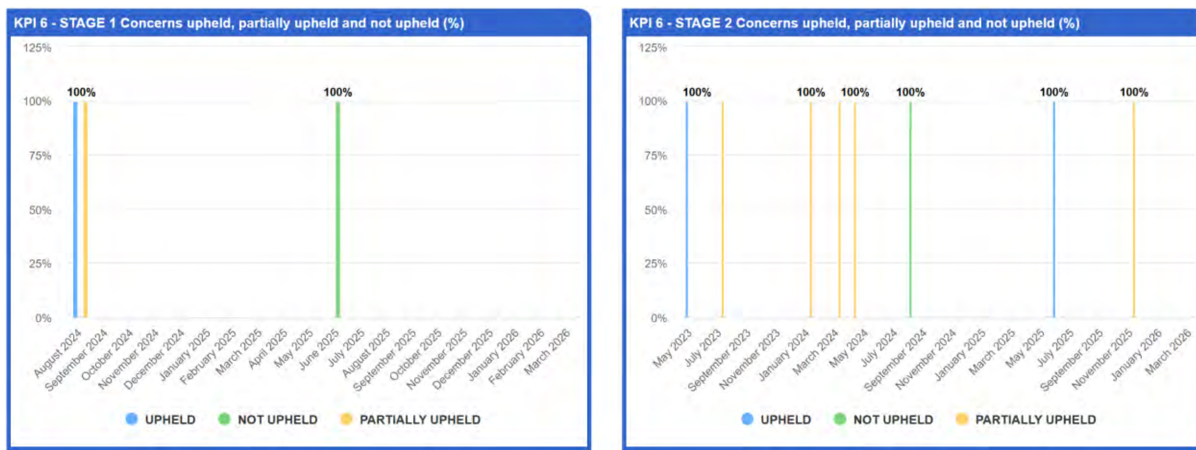
Table 7

Outcome	Stage 1	Stage 2	Total
Upheld	0	1	1
Partially Upheld	0	1	1
Not Upheld	1	0	1

As mentioned earlier in the report the Stage 1 case progressed to Stage 2 for further investigation. The distribution of the outcomes reflects the complexity of concerns raised and supports ongoing learning and improvement.

The graph below provides the total number of concerns Upheld/Not Upheld/Partially Upheld.

Graph 5 – total number of Concerns Upheld / Not Upheld



Key Performance Indicator 7 - Average Timescales

A reporting requirement of the Whistleblowing Procedure is to report on the average times in working days to close concerns at each stage.

A detailed breakdown of the total average time in working days for a full response to concerns at each stage of the Whistleblowing Procedure is demonstrated in the graph below:

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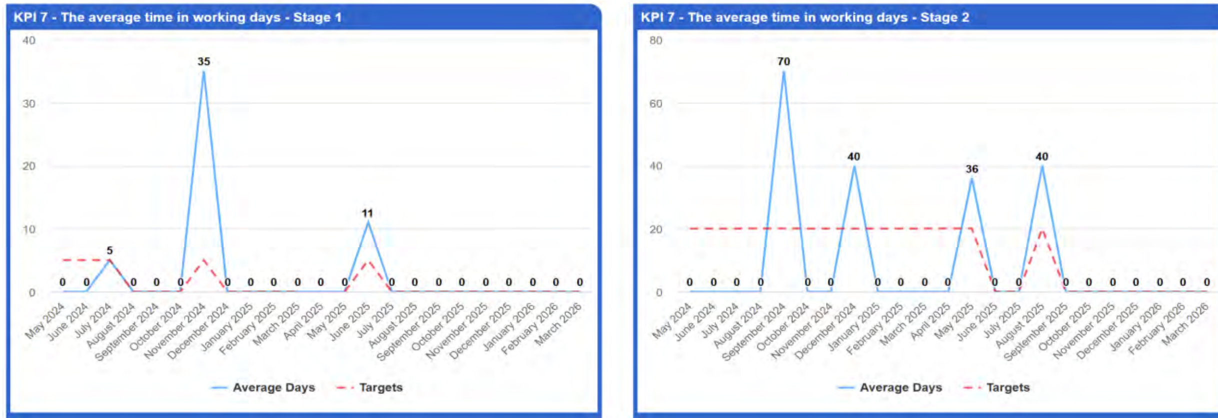
Graph 6 – Average time in working days



It has been recognised that the average response time in working days, particularly for Stage 2 cases, remains an area of concern. This is primarily due to the complexity of the issues raised and the detailed investigations required. The recent increase in the number of Lead Investigators has already helped to improve response times and is expected to drive further progress. Performance in this area continues to be closely monitored as part of the ongoing review process.

Key Performance Indicator 8 – Closed in Full Within Timescales

From the 3 cases investigated during 2025/26 – none of the cases were closed in full within the timescale.

The table below provides the total number of concerns closed within timescale for each Stage of the procedure:

Table 8

Stage	Closed in Timescale
Stage 1 (5 days)	6
Stage 2 (20 days)	3

The timescales may not always be met due to the complexity of the issues raised and the comprehensive level of investigation required, however this is an area of focus and continues to be monitored as part of the process.

Key Performance Indicator 9 - Extensions Authorised

It is important that we respond to concerns timeously however not all investigations will be able to meet the timeline. The Whistleblowing Procedure allows an extension where it is necessary to complete the investigation.

During 2025/26: 2 Stage 2 cases required an authorised extension.

Author: Claire Peacock
Date: March 2026
V1

Graph 7 - total number of concerns where an extension was authorised:

There has been a continued focus on strengthening governance arrangements relating to the authorisation and management of extensions to whistleblowing investigations. In response, a structured monitoring approach has been implemented, including weekly check-ins between the Whistleblowing Administrator and the Investigating Officer to monitor progress and identify any issues requiring escalation.

Further work has been undertaken to enhance the overall process, including the introduction of regular progress updates and a formalised procedure for approving extensions to investigation timescales. These improvements are intended to strengthen transparency, accountability and timeliness in the management of whistleblowing concerns.

Additional Information

It is worth noting that an additional 4 concerns were received via the Whistleblowing arrangements. The concerns were considered by the Whistleblowing Decision Making Panel, which determined that they did not meet the criteria for whistleblowing. Reporters were informed of this decision and, where appropriately advised of alternative routes through which their concerns could be raised, depending on the nature of the issues identified.

In addition, since the Speak Up Service was established in December 2021, a total of 65 enquiries has been received, some of which involved multiple members of staff. All enquiries were managed appropriately, with staff supported and signposted to relevant processes or services as required.

The key themes emerging from enquiries raised through the Speak Up Service include:

- Bullying and harassment
- Patient and staff care, including staffing levels
- Re-banding

Author: Claire Peacock
Date: March 2026
V1

Independent National Whistleblowing Officer (INWO)

The INWO will investigate complaints and, where needed, recommend action for the NHS organisation to take. In addition to complaints, the INWO has a national leadership role providing support and guidance to NHS organisations, focusing on appropriate early resolution, and good practice in whistleblowing handling, recording, reporting, learning and improvement. The ultimate aim is to ensure that patients received a good, safe service from a well-run NHS in Scotland.

The INWO is the **final stage of the process** for those raising concerns.
The INWO can consider complaints about:

- Any actions taken by your organisation in response to your concerns
- Whether your organisation followed the process laid out in the Standards
- How you were treated during and after you raised a concern
- How the organisation supports a culture of speaking up

The INWO is able to investigate complaints and, if appropriate, carry out an external review to come to a decision. If individuals are unhappy with a decision on their complaint, they will have an opportunity to provide comments and express why they feel the decision is not correct.

More information about the Independent Whistleblowing Officer and their role can be found on the INWO website. Independent National Whistleblowing Officer | INWO

NHS Forth Valley Position - the INWO have investigated and upheld a total of 6 cases. The published reports can be found here Our findings | INWO

INWO feedback highlighted opportunities to further strengthen timeliness, communication, and learning, which has directly informed improvements to governance, monitoring of extensions, and communication with reporters. This feedback has been a key driver for quality improvement throughout the year.

Conclusion

NHS Forth Valley continues to demonstrate a strong commitment to the principles of the National Whistleblowing Standards, ensuring that all staff and stakeholders have access to clear, safe, and effective mechanisms for raising concerns. The organisation has successfully managed and closed all whistleblowing cases received to date, embedding learning from these concerns into both local and organisational practice.

Throughout the year, NHS Forth Valley has continued to strengthen whistleblowing arrangements, with particular focus on investigation oversight, communication with reporters, and organisational learning. While investigation timescales, particularly for complex Stage 2 cases remain an area for improvement, actions have been taken to strengthen governance, monitoring of extensions, and investigator capacity.

Author: Claire Peacock
Date: March 2026
V1

The Speak Up Service and Confidential Contacts continue to support an open and supportive culture where staff are encouraged to raise concerns.

NHS Forth Valley remains committed to continuous improvement, ensuring whistleblowing arrangements are fair, transparent and effective, and that learning from concerns is used to support staff confidence, patient safety and service improvement.

Furthermore, feedback from the Independent National Whistleblowing Officer has informed further improvement and quality assurance activity and this will be a future focus for 2026/27.

Closing Remarks

Over the past year, I have been pleased to provide assurance to the Board that NHS Forth Valley remains compliant with the national Whistleblowing Standards. While the number of cases remains low, in common with other similar boards, we continue to work to improve our processes and to publicise whistleblowing throughout the organisation.

I am grateful for the hard work of the many people involved in our Whistleblowing Network, all of whom bring great professionalism and commitment to their roles. We will continue to work together to improve further, and I look forward to supporting and participating in our ongoing collective efforts.

Gordon Johnston
Non-executive board member & Whistleblowing Champion

Author: Claire Peacock
Date: March 2026
V1

NHS Forth Valley
Forth Valley NHS Board

15. Finance Report
Purpose: This report is for Assurance

Executive Sponsor: Ross McGuffie, Chief Executive
Author: Scott Urquhart, Director of Finance / Jillian Thomson, Deputy Director of Finance

Executive Summary
This report provides a high-level overview of the financial results for the first two months of the 2026/27 financial year.

A net funding gap of £38.0m was identified for 2026/27 through the financial planning process. A programme of cost improvement plans and efficiency initiatives has been developed to address this shortfall, with an aim of achieving a breakeven position. However, the initial review of Month 2 results indicates continuing financial pressure, with a £2.4m overspend reported as at 31 May 2026 (see Appendix 1). This is concerning at this early stage in the year and requires prompt corrective action within the first quarter.

Targeted communications have already been issued to budget managers setting out key priorities for the early part of 2026/27, including the need to secure early savings and maintain tight budgetary control. The *Making the Most of our Resources* toolkit (a practical resource providing guidance, prompts and examples to support effective stewardship) has also been launched via the staff intranet to support budget managers and leaders in delivering these actions. In addition, a staff wide initiative to generate savings ideas and proposals has been introduced, with a positive response to date. Further communications are planned over the coming weeks, including whole-system engagement to share examples of effective stewardship and local best practice.

We will continue to engage regularly with the Scottish Government during 2026/27 to review progress towards achieving financial balance. Key risks to delivery of a breakeven position will be considered in detail at the forthcoming quarter 1 review meeting. Managing expenditure within approved resources in-year is a statutory requirement and every effort must be made to deliver financial targets in year.

Action Required
Forth Valley NHS Board is asked to:

(1) Note the level of financial risk and challenge for 2026/27, with an overspend of £2.4m reported for the first two months of the financial year - prompt corrective action is required during the first quarter to reset a path towards financial balance.
(2) Note that an in-depth review of the overall financial position, including savings delivery, changes in key planning assumptions, key financial risks and initial forecast outturn projections for the year, will be undertaken following receipt of the quarter 1 financial results in July.
(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
The SPP&RC and the NHS Board receive regular updates on the financial position, plans and risk as a standing agenda item.

Risk Assessment and Mitigation
Financial sustainability continues to be reported as very high risk in the NHS Board's strategic risk register. This reflects the financial impact of ongoing operational service and demand pressures.

An in-depth review and assessment of the financial risk approach took place during April and May, which included a refresh of the risk descriptor, clearer differentiation between short term (in-year) and longer-term risks, and alignment of supporting mitigation actions.

Impact Assessments

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

Financial and Infrastructure Implications
The Capital and Revenue financial implications are considered in the main body of the report.

Workforce Implications
There are no immediate workforce implications associated with this report. However, it is recognised that workforce costs account for a significant proportion of total operating expenditure and is therefore a key financial risk area.

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

Population Health & Care Strategy
It is recognised that improving population health outcomes and shifting resources to early intervention/more preventative measures can reduce future demand on services. Adopting the principles of values-based health and care and Realistic Medicines is a key feature of our financial planning process.

Climate Change / Sustainability Implications
There are no direct climate change/sustainability implications arising from this report. Climate Change and Sustainability initiatives contribute to efficiency savings, reducing waste, cost avoidance and productivity gains across the five priority areas for NHS Scotland (i.e. Sustainable Buildings & Land; Sustainable Travel; Sustainable Goods & Services; Sustainable Care; and Sustainable Communities). A range of climate change and sustainability initiatives are already included in our cost improvement programme.

Engagement and Communications
Was statutory engagement with stakeholders required? Yes ☐ No ☒
This report was prepared in consultation with Senior Finance colleagues.

Appendices
Appendix 1 – Overview of 2026/27 Month 2 financial performance

Appendix 1 - Overview of 2026/27 Month 2 Financial Performance

1.1 Revenue year to date results – Month 2

An overspend of £2.4m is reported for the first two months of the financial year as summarised in table 1 below:

TABLE 1: NHS Forth Valley 2026/27 Finanical performance	Annual Budget £m	April - May Budget £m	April - May Expenditure £m	Underspend/ (Overspend) £m
Set Aside & Non-Delegated Functions*				
Acute Services	268.737	46.642	51.205	(4.563)
Woman Children and Families	69.416	11.544	11.820	(0.276)
Cross Boundary Flow/External SLAs	75.539	12.563	12.660	(0.097)
Non-delegated Community Services	44.024	7.375	8.057	(0.683)
Facilities	120.879	19.967	20.132	(0.165)
Digital	27.006	4.469	4.333	0.136
Corporate Functions	44.819	7.424	7.588	(0.164)
Ringfenced and Contingency Budgets	43.158	3.500	0.000	3.500
Income	(41.209)	(6.828)	(6.757)	(0.070)
Sub total	**652.369**	**106.656**	**109.039**	**(2.383)**
Delegated Functions				
Operational Services	149.134	25.212	24.443	0.770
Universal Services	183.779	33.210	34.141	(0.932)
IJB reserves	21.831	0.162	(0.000)	0.162
Sub total	**354.744**	**58.584**	**58.584**	**0.000**
Reserve transfers (to)/from IJB				
Clackmannanshire & Stirling IJB	0.000	0.000	0.000	0.000
Falkirk IJB	0.000	0.000	0.000	0.000
Sub total	**0.000**	**0.000**	**0.000**	**0.000**
TOTAL	**1,007.113**	**165.240**	**167.623**	**(2.383)**

* Note that these budgets include specialties defined as "large hospital services" which form part of IJB Set Aside budgets. The total Set Aside budget included in the total of £652.369m above is £91.415m. An overspend of £2.463m is reported at month 2.

Work is progressing with services and budget managers to review year-to-date performance and agree financial projections. Although the year-to-date overspend is lower than at the same point last year, a number of risks are emerging at this early stage of the financial year.

The majority of the Month 2 overspend is driven by cost pressures in the Acute Services Directorate, particularly in relation to medical pay costs which are overspent by £3.0m and nurse pay costs which are overspent by £0.9m at this early stage in the year. Pressures are also reported against drug costs (£1.4m overspent, mainly within oncology) and medical devices and surgical sundry budgets (£1.5m). Note that similar issues are also reported in relation to Women and Children's services and Non-Delegated Community services in terms of medical staffing costs and surgical sundries. Key drivers of the Facilities overspend relate to energy and non-emergency patient transport.

1.2 Efficiency Savings

The updated Financial Sustainability Action Plan for 2026/27 sets out the broad range of local and national cost improvement initiatives and efficiency schemes intended to mitigate the £38.0m funding gap identified through the financial planning process.

To date, the plan includes savings schemes across 6 workstreams as summarised in table 2 below which are aligned to the to the refreshed national "15-point grid" and the 3% recurring savings target set by the Scottish Government[1].

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: Finanical Management	
Contract Management	618
Transport	1,287
Estates & Facilities	2,116
Sub total: Finanical Management	**4,021**
Other local savings plans	
Facilities	12
Digital	901
Service reform & redesign	2,457
Procurement	101
Workforce	1,835
Non-pay	9,670
Savings still to be indentified	2,867
sub total: Other local savings plans	**17,843**
TOTAL	**37,480**
Recurring	22,954
Non-recurring	15,082
TOTAL	**38,036**

[1] The 3% recuring savings target for 2026/27 equates to £24.6m. The Board's share of the target is £18.4m with the balance of £6.2m relating directly to IJBs.

1.3 Other Value and Efficiency measures

A series of other local and national initiatives focused on value and efficiency are also under way, including:

- Enhanced communications across the whole-system in relation to the NHS Board's financial position, focusing on sharing examples of effective stewardship and the associated benefits and incentives, rather than solely emphasising the continual need for cost savings. It is recognised that "savings fatigue" is a potential issue for many budget managers.

- Further action to embed Value Based Health and Care (VBHC) principles and continuation of the improvement work under our VBHC Collaborative in Paediatric Continence, Microbiology, Orthopaedics and Vascular service areas. The first learning event relating to these 4 areas was held on 7 May, with further events scheduled for the latter half of the financial year.

- Development and implementation of early intervention and prevention programmes (which will play into the new national preventative spend advisory board).

- Submission of local bids under the national invest to save framework in respect of electronic health records, digitally enabled diagnostic demand management in radiology and various prevention projects.

- Further output and guidance from the sub-national planning structures in terms of the financial impact and opportunities arising from the strategic themes contained in the consolidated financial plans of Scotland West and Scotland East.

- Progress to take forward the Business Services Programme, a national transformation initiative designed to streamline and unify core business systems across all territorial and special Boards. This involves the replacement of HR, Payroll, Finance and Procurement legacy IT systems with a modern, cloud-based ERP solution which is expected to deliver significant productivity efficiencies together with improved data quality and data analysis capability to inform better decision making and strategic planning.

1.4 Capital year to date results

The total annual net capital budget for 2026/27 is currently estimated at £14.9m as summarised in table 3 below. This reflects the formula allocation of £6.7m as advised by the Scottish Government, together with £8.4m of anticipated allocations, a £3.0m receipt from anticipated land sales of £3.0m and a £3.2m capital to revenue transfer in respect of non-valued added capital expenditure in year.

A balanced position is reported against the Capital Resource Limit (CRL) for the first two months of the year as summarised table 3 below.

TABLE 3: 2025/26 NHS Forth Valley Capital Position	Annual Budget £m	April - May Budget £m	April - May Expenditure £m	Underspend/ (Overspend) £m
Elective Care	0.400	0.098	0.098	0.000
Information Management & Technology	6.144	0.280	0.280	0.000
Medical Equipment	3.304	0.016	0.016	0.000
Facilities & Infrastructure	7.033	0.112	0.112	0.000
NHS Board corporate projects	0.083	0.000	0.000	0.000
Right of Use Assets IFRS16	1.130	0.000	0.000	0.000
Total Available Capital Funding	**18.094**	**0.505**	**0.505**	**0.000**
Indirect Capital Charged to Revenue	(3.200)	0.000	0.000	0.000
Forecast net Capital Resource Limit	**14.894**	**0.505**	**0.505**	**0.000**

Note that a relatively low level of capital expenditure has been incurred during the month of April and May which is not unusual at this early stage in the financial year. Expenditure to date is primarily related to capitalisation of staff costs linked to posts that are supporting the implementation of a number of capital projects across the organisation.

NHS Forth Valley

Forth Valley NHS Board

16. Performance Report
Purpose: This report is for Assurance

Executive Sponsor: Ross McGuffie, Chief Executive
Author: Claire Alexander, Senior Performance Manager; Garry Fraser, Director of Acute Services; Marie Gardiner, Head of Acute Services; Deborah Lynch, Unscheduled Care, Programme Manager; Kerry Mackenzie, Acting Director of Strategic Planning & Performance; Fiona Murray, Head of Emergency Care & Inpatients, Ross Cheape, Interim Director of Mental Health and Learning Disability Services, Susie Porteous, Interim Director of Psychological Services

Executive Summary

NHS Forth Valley routinely reports performance against a range of non-financial performance metrics. The Performance Report is presented to update the Board in respect of NHS Forth Valley's performance against a range of national and local measures with information provided to support effective monitoring and management of system-wide performance.

The scorecard provides an 'at a glance' view of measures with work on-going to ensure accuracy of data, and that all the definitions and reporting periods remain appropriate and meaningful. The scorecard is continually reviewed to ensure appropriate revisions or amendments are included in a responsive and timely manner.

The overall approach to performance within NHS Forth Valley underlines the principle that performance management is integral to the delivery of quality improvement and core to sound management, governance, and accountability.

Action Required

The Forth Valley NHS Board is asked to:

(1) consider the latest performance data within the Performance Report noting the Area of Focus – Urgent & Unscheduled Care and Priority Areas of Performance.
(2) consider the progress made in reducing the number of patients waiting over 52 weeks for a new inpatient appointment and for an inpatient/daycase procedure.
(3) consider if the report provides assurance that appropriate controls are in place to manage the identified risks, support the delivery of objectives and where improvements are needed, clear actions have been identified.

Governance Route to the Meeting and Previous Board Consideration

This paper has previously been considered by the Strategic Planning, Performance & Resources Committee on 26 May 2026 with questions invited.

Urgent and Unscheduled Care was considered as a separate agenda item however the Committee noted that increased front door demand is being experienced locally and nationally, with rising referrals from NHS24 and wider demographic pressures, including

an ageing population with more complex co-morbidities. It was highlighted that Scottish Government is reviewing referral pathways, and alternative models, such as consultant-led triage, are being explored elsewhere.

Committee members sought assurance on the patient profile attending ED and the potential impact of the planned GP Walk-in Centre. While it is too early to assess impact, there is a clear ambition to safely redirect appropriate attendances from ED, supported by the ongoing development of Community Frailty Pathways.

In relation to Hospital at Home, committee members explored recruitment risks and potential competition across Boards. It was noted that recruitment remains positive, with flexibility in the financial model allowing for redeployment of underspend to support alternative care provision, including additional care packages.

The importance of strengthening public communications to ensure people are supported to access the right care in the right setting at the right time was discussed.

While progress has been made in reducing the use of contingency beds, members emphasised the need to avoid normalisation, noting associated impacts on staff wellbeing, sickness absence, training and compliance. Continued focus was placed on improving flow and reducing length of stay to mitigate reliance on contingency capacity.

Committee members received an in-depth update in respect of Mental Health and Learning Disability issues and performance. Progress on the anti-ligature programme was noted, with high-risk areas identified and prioritised and early delivery underway, including commencement of the Ward 3 window replacement programme. Ongoing oversight is maintained through SLT, with challenges relating to the multi-partner nature of the work and associated cost pressures noted.

Assurance on how progress is reported to SPPRC and the Board was sought. While updates are currently provided through the Clinical Governance and Health and Safety Committees, further consideration will be given to strengthening Board oversight and visibility of progress.

A briefing on Alcohol and Drug Partnership activity in relation to substance use was requested. A forthcoming report to the June Clackmannanshire & Stirling IJB will be shared to support this.

It was noted that whilst 12-week waits in Scheduled Care were discussed, reporting and improvement focus remains aligned to the national priority of 52-week performance.

Risk Assessment and Mitigation

Adequate monitoring, scrutiny and management of performance supports the organisation to manage its risk with performance reporting linked to Strategic Risks:

SRR.002 Urgent & Unscheduled Care

If NHS Forth Valley does not have enough whole system capacity and flow to address key areas of improvement there is a risk that we will be unable to deliver safe, effective, and person-centred unscheduled care resulting in a potential for patient harm, increases

in length of stay, placement of patients in unsuitable places, and a negative impact on patients and staff experience.

SRR.004 Scheduled Care
If NHS FV does not consider and plan for current and future changes to population and associated demand/case-mix, there is a risk that the model for delivery of planned care will not meet demand or prioritise effectively, resulting in poorer patient outcomes, avoidable harm and failure to meet targets.

In addition, there is linkage to Organisational Risks in respect of Waiting Times, Radiology/Imaging Capacity, Delayed Discharge, Mental Health Services – Psychological Therapies and the 62-day cancer target.

These risks are reviewed and updated by the responsible risk owners with the Strategic Risk Register update presented as a standing item to NHS Board Assurance Committees and the NHS Board.

Impact Assessments

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

Financial and Infrastructure Implications
Financial implications and sustainability are being considered on an ongoing basis working closely with Scottish Government colleagues and Health & Social Care Partnership Chief Finance Officers. The Finance Report is a standing item on the Performance & Resources Committee and Forth Valley NHS Board meeting agendas.
Financial Breakeven is detailed on the Strategic Risk Register as a Very High risk for NHS Forth Valley. As such it is reviewed and managed as a risk assigned to the Strategic Planning, Performance & Resources Committee.

SRR.005: Financial Breakeven
If our recurring budget is not sufficient to meet the recurring cost base there is a risk there will be an increasing recurring gap in our finances, resulting in an inability to achieve and maintain financial sustainability, and a detrimental impact on current/future service provision.

Workforce Implications
Workforce is a limiting factor in our ability to delivery services with specific workforce issues aligned to areas of performance highlighted within the report. The Workforce Plan 2026/27 is currently being developed, and it is anticipated that the draft will be presented to the Staff Governance Committee in March ahead of issue in April 2026.

Quality / Patient Care Implications
There are no specific quality or patient care implications in respect of this paper.

Population Health & Care Strategy
Monitoring performance and the ongoing development of relevant performance frameworks will support the monitoring of local and national strategy implementation.

Climate Change / Sustainability Implications
Describe any implications in relation to climate change / sustainability.

Engagement and Communications
Was statutory engagement with stakeholders required? Yes ☐ No ☐
- If yes, please provide details.

Cognisance has been taken of feedback and comments from Non-Executive and Executive Director colleagues.

Appendices
Appendix 1: Performance Report May 2026

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Performance Report

May 2026

Report format

- The report is split into 4 sections
    - Section 1: Performance Summary
    - Section 2: Area of Focus
        - Mental Health & Learning Disabilities including Psychological Services
        - Urgent and Unscheduled Care
    - Section 3: Performance Report
        - Priority Areas of Performance
        - Other Areas of Performance
    - Section 4: Performance Scorecard

- Section 1: Performance Summary
    - Section 1 provides a summary overview of key areas of performance.

- Section 2: Area of Focus
    - Section 1 will focus on a particular area of performance with a detailed discussion in respect of areas of challenge and key areas of improvement.

- Section 3: Performance Report
    - This section details key performance issues, measures, and graphs.
    - Measures, graphs and key performance issues narrative are linked and should be viewed collectively.
    - The Scotland comparison has been included where possible in the Key Performance Measures and Key Performance Graphs sections. Note that the Scotland figures are typically a month or quarter behind.

- Section 4: Performance Scorecard
    - The Performance Scorecard details the measure, target, current position (monthly or quarterly), previous reported position, previous year position and the Scotland position (where available).
    - The notes section provides a definition and detail in relation to the indicators and targets.

Performance data and graphs continue to be developed within the Pentana Performance and Risk Management System with graph and table detail from Pentana informing the report.

Section 1: Performance Summary

Priority Areas of Performance

Unscheduled Care
Overall compliance with the 4-hour emergency access standard (EAS) in April 2026 was 61.3%; Minor Injuries Unit 99.2%, Emergency Department 49.7%. A total of 2,808 patients waited longer than the 4-hour target across both the ED and Minor Injuries Unit (MIU); with 1,281 waits longer than eight hours, 524 waits longer than 12 hours and 35 waits longer than 23 hours. The main reason for patients waiting beyond 4 hours continues to be wait for first assessment with a cohort of 1,692 patients, noting this was 1,423 in April 2025. Wait for a bed accounted for 622 patients waiting beyond 4 hours with clinical reasons accounting for 175 breaches. In April there were 527 new attendances to Rapid Assessment and Care Unit (RACU), 108 of which were via ED. It is worth noting 829 patients that attended ED did not wait in April 2026 compared with 678 in April 2025.

Delayed Discharges
The April 2026 census position in relation to standard delays (excluding Code 9 and guardianship) is 47 delays; this is compared to 96 in April 2025. There was a total of 45 code 9 and guardianship delays, with the total number of delayed discharges noted as 92. The number of bed days occupied by delayed discharges (excluding code 9 and 100) at the April 2026 census was 1,010, this is a reduction from 4,018 in April 2025.

Scheduled Care
At the end of April 2026, the number of patients on the waiting list for a first outpatient appointment was 18,653 (18,517 excluding mutual aid) compared with 14,104 in April 2025 with the number waiting beyond 12 weeks 7,072 (7,020 excluding mutual aid) compared to 3,511 in April 2025.

In April 2026, the number of inpatients/daycases waiting was 7,518 (7,257 excluding mutual aid and NTC) compared with 6,851 in April 2025. An increase from the previous year in those waiting beyond 12 weeks from 4,329 to 4,763 was also noted.

At the end of April 2026, 693 patients were waiting beyond the 6-week standard for imaging with 50 patients were waiting beyond 6 weeks for endoscopy.

Cancer target compliance in March 2026:

- 62-day target – 76.4% of patients waited less than 62 days from urgent suspicion of cancer referral to first cancer treatment. This is compared with the March 2025 position of 67.9%.
- 31-day target – 99.1%.

The position for the October to December 2025 quarter is that 70.3% of patients were treated within 62 days of referral with a suspicion of cancer. This is a decrease from 85.9% the previous quarter. During the same period, 99.7% of patients were treated within 31 days of the decision to treat.

Psychological Therapies
In April 2026, draft data shows that 75.8% of patients started treatment within 18 weeks of referral.

Section 2: Area of Focus

Mental Health and Learning Disability Services

Specialist Mental Health and Learning Disability (MHLD) Services provided by NHS Forth Valley encompass community-based Mental Health Teams, Community Learning Disability Teams, inpatient wards, and a range of highly-specialised services, including Eating Disorder, Perinatal and Forensic Services. These services are delivered by multidisciplinary teams comprising a wide range of health and care professionals, each operating within their respective professional governance frameworks.

All highly-specialised and inpatient MHLD services are operationally delivered through the Clackmannanshire and Stirling Health and Social Care Partnership (C&S HSCP), while Falkirk HSCP delivers community-based MHLD services within Falkirk. Child and Adolescent Mental Health Services (CAMHS) remain within the Acute Directorate; however, these services are formally linked to the wider MHLD portfolio through established clinical and professional governance arrangements. Within Clackmannanshire and Stirling, the operational management structure reflects the breadth and complexity of the MHLD portfolio and is supported by a range of clinical, operational and professional governance fora. These arrangements provide assurance, coordination and oversight across multiple reporting lines, ensuring coherence and alignment across the service system.

The Mental Health and Wellbeing Strategy 2025-2035

The NHS Forth Valley Mental Health and Wellbeing Strategy 2025–2035 provides the overarching strategic framework for the planning, commissioning and delivery of mental health and wellbeing services across the Forth Valley system. The Strategy sets a clear ten-year vision and strategic direction, aligned to national policy and informed by extensive partnership engagement, including people with lived experience. It adopts a whole-system, life-course approach, with a strong focus on prevention, early intervention and effective support for people with complex and enduring needs.

Delivery of the Strategy is supported by defined governance, accountability and performance arrangements designed to provide assurance to the Board that strategic priorities are being translated into sustained service improvement. This includes a dedicated Mental Health and Wellbeing Strategy Board, responsible for overall system oversight, and supporting strategic planning and commissioning mechanisms to align investment, workforce and service redesign with agreed priorities. Although this work is at an early stage, reporting will mature to ensure that progress is monitored through an associated performance framework, incorporating national and local indicators, enabling the Board to maintain oversight of delivery, system risks, and the effectiveness of mitigating actions in the context of growing demand, workforce pressures and financial constraint.

Healthcare Improvement Scotland Inspection

The unannounced Healthcare Improvement Scotland (HIS) inspection of mental health inpatient services at Forth Valley Royal Hospital (FVRH), undertaken on 25–26 August 2025, provided a comprehensive external assessment of the safe delivery of care within the mental health unit.

The inspection identified a number of strengths, including evidence of compassionate care delivery and positive patient experience in key areas. However, it also highlighted significant areas requiring improvement, particularly in relation to patient safety, governance and assurance arrangements, adult support and protection, and the consistency of key operational practices such as ligature risk assessment processes.

In response, a comprehensive and structured improvement programme has been mobilised. Governance and oversight arrangements have been strengthened, with enhanced operational and executive-level groups providing increased scrutiny, pace and coordination of delivery. This is

underpinned by a detailed project plan developed and supported through the Corporate Programme Management Office (CPMO), ensuring robust tracking, risk management and accountability across all workstreams.

Progress to date has been substantive. At 18 weeks post-publication of the inspection report, over 70% of improvement actions have been completed, with the remainder on track for delivery in line with agreed timescales. The programme remains focused on embedding sustainable improvements in governance, assurance

The MHLD Estate

The built environment for MHLD Services has not entirely kept pace with the changes in the demographic and characteristics of the patient who the service cares for. An estates oversight group has been established to provide coordinated governance and oversight of key strands of the service's estates improvement work. This includes ligature risk reduction, enhancement of sexual safety through environmental design and layout, implementation of the Mental Health Built Environment Standards, and systematic consideration of findings and recommendations arising from Mental Welfare Commission and Healthcare Improvement Scotland inspections.

The most significant element of the work on the estate relates to the ligature reduction work. NHS Forth Valley continues to carry a significant strategic risk in relation to ligature points within MHLD inpatient environments, arising from delays in delivering essential environmental remediation works required to reduce risk to as low as is reasonably practicable. Despite a sustained programme of risk assessment and mitigation, progress in addressing the highest-risk ligature points, particularly windows and doors, has not met required timescales, resulting in ongoing exposure to patient safety risk and regulatory scrutiny.

The challenge for the organisation is to accelerate delivery of capital works and environmental mitigations at pace, while maintaining effective interim risk controls, in order to achieve compliance with the Health and Safety Executive Improvement Notice and respond to findings from Healthcare Improvement Scotland. This requires strengthened grip on programme delivery, contract management and escalation, alongside clear Board-level oversight to ensure that risk is being actively reduced rather than managed over prolonged periods. Failure to do so risks continued harm, loss of external confidence, and increased regulatory intervention, with implications for service sustainability and public assurance.

The Learning Disability Services Redesign

The work to redesign the Learning Disability Services is focused on fundamentally reshaping the Learning Disability system to address three interrelated pressures, financial unsustainability, delayed discharge, and insufficient provision for people with complex needs, by shifting the balance of care away from high-cost models towards more sustainable, community-based and integrated approaches.

Central to this is a programme of whole-system redesign built around three aligned priorities: reducing inpatient reliance through enhanced community pathways and step-up/step-down provision; reforming the Community Residential Resource model to improve value for money while retaining strategic commissioning oversight; and modernising day opportunities and community services to deliver greater flexibility, personalisation and alignment with Self-Directed Support principles. These changes are underpinned by a move towards stronger community capacity, prevention of admission and readmission, and improved flow through the system, ensuring individuals are supported in the least restrictive setting. The programme is aligned with the national *Coming Home* agenda and is being supported through the National Support Panel (NSP) pilot, which brings together senior leaders from across public and independent sectors, including Scottish Government, to analyse complex cases and make recommendations that enable timely and sustainable discharge.

Alongside this, the direction of travel includes optimisation of Community Learning Disability Teams to strengthen care management, reduce high-cost packages through systematic review, and improve consistency in applying eligibility criteria. Collectively, the approach aims to deliver a more sustainable, equitable and outcome-focused model of care that maximises available resources, supports earlier intervention and transition planning, and enables reinvestment into priority areas while maintaining quality and person-centred support.

The delivery of this redesign is managed through a steering group which has three sub-groups, demonstrated in the graphic below:

The services engaged in this work are mostly delivered through the Clackmannanshire and Stirling HSCP, but this work is being delivered across Forth Valley with key stakeholders from Falkirk HSCP actively engaged in the process.

The detailed proposals for change are still in development and subject to consultation with staff, patients, service users, service providers and unpaid carers. However, the process is planned to move at pace with implementation of elements of the new ways of working in late summer 2026.

This work is aligned with and being supported by input from the National Support Panel (NSP), linked to the *Coming Home* agenda. The pilot of the NSP brings senior leaders from across public and independent sectors, including representatives from Scottish Government to analyse, understand and make recommendations for change to ensure discharge is realised.

Substance Use Services

Substance Use Services (SUS) have been engaged in a programme of redesign over an extended period, originating from strategic direction set by the Alcohol and Drugs Partnership (ADP) and subsequently endorsed by the Integration Joint Board (IJB) in Clackmannanshire and Stirling (C&S). The overarching aim has been to shift service delivery closer to communities and primary care settings. Progress in advancing this direction has been complex, reflecting the interdependencies between financial management, commissioning and contract arrangements, alongside the need to maintain safe and effective clinical practice and risk oversight.

Achieving full alignment between the ADP's strategic intent and the perspectives of key stakeholders across the system has presented challenges, including the need to strengthen engagement with senior clinical and NHS leadership. While a revised service model has now been developed, further

work is required to ensure alignment with the available financial envelope and existing contractual commitments, and to support a deliverable and sustainable implementation approach.

Inpatient Nursing Staffing

The key strategic challenge facing inpatient Mental Health and Learning Disability services is a growing mismatch between existing nursing establishments and the level of demand now presented by a more complex, high-acuity patient population. Workforce pressures are being driven by sustained increases in patient risk, complexity and multi-morbidity, alongside rising requirements for continuous interventions and specialist activity such as ECT (electro-convulsive therapy). This has resulted in persistent reliance on non-core staffing to maintain safe services, compounded by high sickness absence and the need to meet regulatory expectations following Healthcare Improvement Scotland inspection findings. Collectively, this creates ongoing risks to care quality, staff wellbeing, continuity of care and financial sustainability if not addressed.

The proposed strategic response is a targeted and phased investment in core nursing capacity, underpinned by a robust, evidence-based Nursing Workforce Blueprint approach that aligns staffing to patient need rather than historic establishments. This includes a planned uplift in registered nurses and healthcare support workers to reduce reliance on temporary staffing, improve resilience, and support compliance with regulatory standards. A phased implementation over multiple years is recommended to balance affordability with service assurance, while enabling continued evaluation of emerging demand. This approach aims to stabilise inpatient services, improve patient outcomes and staff experience, and place the service on a more sustainable long-term footing. This work is being led through the Department of Nursing, Midwifery and Allied Health Professionals (NMAHP) and is subject to financial support from the board.

Older Adult Mental Health Services

Older Adult Community Mental Health Services are currently delivered separately by the HSCPs in Falkirk and Clackmannanshire and Stirling, with a small number of pan-area specialist functions (including Care Home Liaison, Dementia Outreach and Old Age Psychiatric Liaison) operating across the wider system. Service Managers across both Partnerships are working collaboratively with staff and trade union representatives to explore opportunities to redesign the service configuration. This work is focused on reducing duplication, minimising service fragmentation and transitions, and establishing more robust, streamlined delivery models that improve efficiency, consistency, and overall system effectiveness.

Operational Management & Oversight

Changes in personnel has enabled a strategic redesign of leadership and management arrangements within Mental Health and Learning Disability (MHLD) services to strengthen governance, improve operational effectiveness, and support financial sustainability. The changes are based on a principle of Service Managers operating across no more that two employing organisation and developing a post which has a specific focus on the Social Work and Social Care Teams. Reconfiguration in this way reduces organisational complexity by aligning management more closely across the three employing authorities, improving clarity of accountability, consistency of practice, and managerial capacity. These changes are intended to deliver stronger professional leadership, more effective operational oversight, and a more integrated and sustainable service model for the HSCP. The new model is currently being implemented with recruitment underway.

Psychological Services

Psychological Services and Delivery of Psychological Therapies

Psychological Services for adults are operationally delivered by Clackmannanshire and Stirling HSCP on a pan Forth Valley basis, led by the Director of Psychological Services who also has responsibility for the professional leadership of the psychologists working within both Children and Young People's Services and Occupational Health Services which are operationally managed within NHS Forth Valley's Acute Services. Psychological Services provide direct clinical care to patients in the form of psychological therapies and interventions, and crucially also support the wider workforce to deliver psychologically informed and psychologically skilled care. In addition to psychological therapies delivered within the afore-mentioned services some psychological therapies for adults are delivered by the wider workforce mainly in community mental health and learning disabilities teams. Staff delivering these therapies have completed specific trainings, have agreed time within their roles, and require clinical supervision. They are not operationally or professionally managed within Psychological Services but generally receive clinical supervision via Psychological Services and report therapeutic delivery via the Psychological Therapies and Eating Disorders Clinical Governance Group. All enhanced and specialist therapies, irrespective of the service within which they are provided, are included in the waiting times figures and monthly submissions to PHS, with the exception of therapies delivered within Occupational Health to staff.

Psychological Services are resourced by a multi-professional psychological therapy workforce within 12 specialty areas with the additional provision of supported Digital Therapies. Delivering care in specialty areas is consistent with practice across Scotland and ensures psychological therapists with expertise in particular clinical presentations and therapies effectively and efficiently contribute to the best clinical outcomes for patients. Examples include: Adult Psychological Therapies providing specific evidence based therapies such as EMDR or trauma-focused CBT for people who have been referred by their GP with complex Posttraumatic Stress Disorder; Clinical Health Psychology delivering therapies including ACT and CBT to address significant psychological difficulties which are impacting on adherence to agreed medical treatments; Learning Disabilities psychologists leading on a tiered framework of Positive Behaviour Support.

A particular challenge is that the Psychological Services' budget arises from different funding streams, some driven by national priorities with specific parameters for spend (e.g. Scottish Government funding for maternity and neonatal / perinatal mental health). Consequently, budget is not aligned with local demand and there are limitations to the flexibility of Psychological Services resources. Such nuances compromise the accuracy of capacity and trajectory modelling at whole service level and mean that narrative around performance data is vital.

Performance

Performance against the RTT for psychological therapies has increased over time partly due to the increasingly good use made in Forth Valley, compared with other health boards, of instantly available Digital Therapies. There has been a fairly consistent pattern of around 70% or above compliance with the RTT since June 2024. The most recently ratified data confirm compliance in March 2026 was 75.9%. The draft RTT compliance for April 2026 is 75.8%.

While Psychological Services as a whole are not meeting the RTT of 90% of people starting therapy within 18 weeks, 4 specialties (forensic, older people, prisons, and psychotherapy) are meeting the target, and a further specialty (Learning Disabilities) is approaching the target due to a higher proportion of more recent demand being for shorter term input rather than longer term therapy. Three specialties (arts therapies, eating disorders and substance use) had been close to the target previously but performance has dropped due to: the impact of long-term sickness absence on a very small specialty; the reduction of Mental Health Outcomes Framework funding; and a vacancy previously funded from a wider service budget not being approved for recruitment. Two specialties

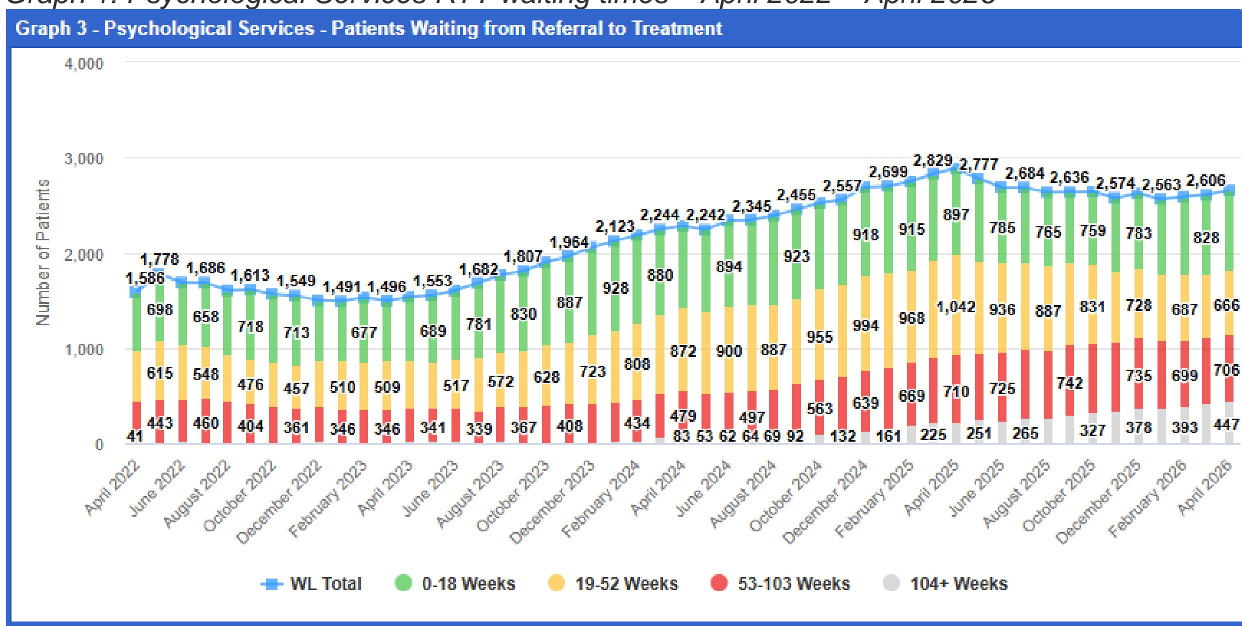
(clinical health psychology and secondary care) are not close to the target due to vacancies and the impact of maternity leave which has not been backfilled. While performance is predicted to improve in these specialties as vacancies are filled there are challenges in that both specialties comprise different subspecialties related to geographic location, multi-disciplinary team set-up, or funding arrangements meaning that flexing the available resource is particularly limited.

The 2 specialties with the poorest compliance with the RTT are Adult Psychological Therapies and Neuropsychology. Both specialties have large numbers of people waiting, long waiting times, and a significant disparity between demand and capacity.

Waiting times

The graph below (labelled graph 3 due to copying from Pentana) shows all the patients waiting for psychological therapy.

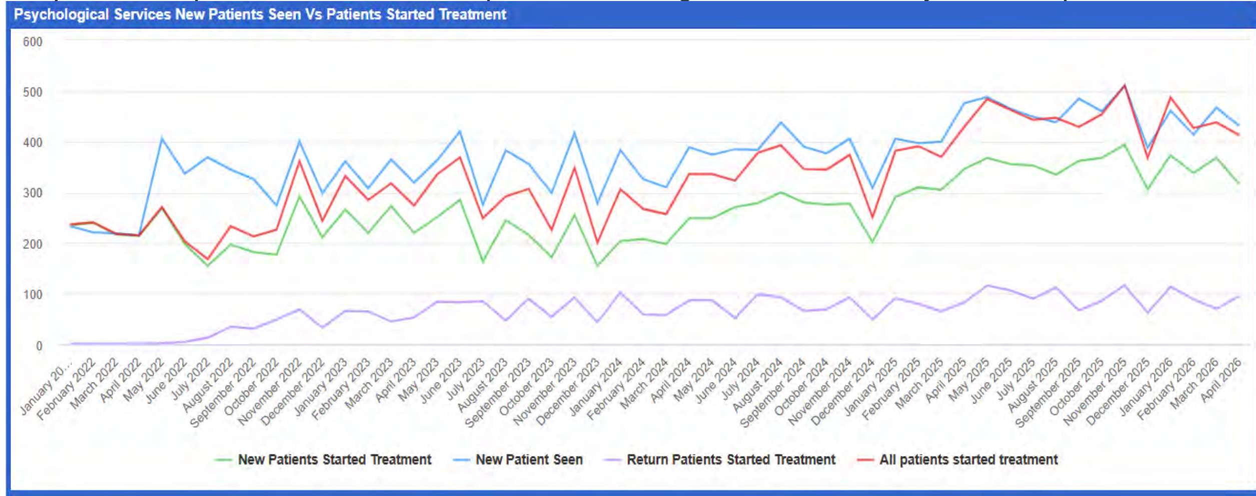
Graph 1: Psychological Services RTT waiting times – April 2022 – April 2026



In April 2025 an Improvement Plan was developed and submitted to Scottish Government. Since then, the overall waiting list size has reduced (from 2882 to 2643), the number of people waiting 0-18 weeks has reduced (from 897 to 826), the number of people waiting 19-52 weeks has reduced (from 1042 to 664), and the number of people waiting between 53-103 weeks has reduced slightly (from 710 to 706).

These developments reflect service improvement work outlined in the Improvement Plan that were focused on managing incoming demand to ensure improved matching of treatment offer to presenting problem including promotion of Digital Therapy, and an increased suite of group offerings. Increased focus on caseload management, and training in managing expectations of therapy and ending therapy have all enhanced throughput meaning that more people have started therapy in the past year as evidenced by the red line in the graph below.

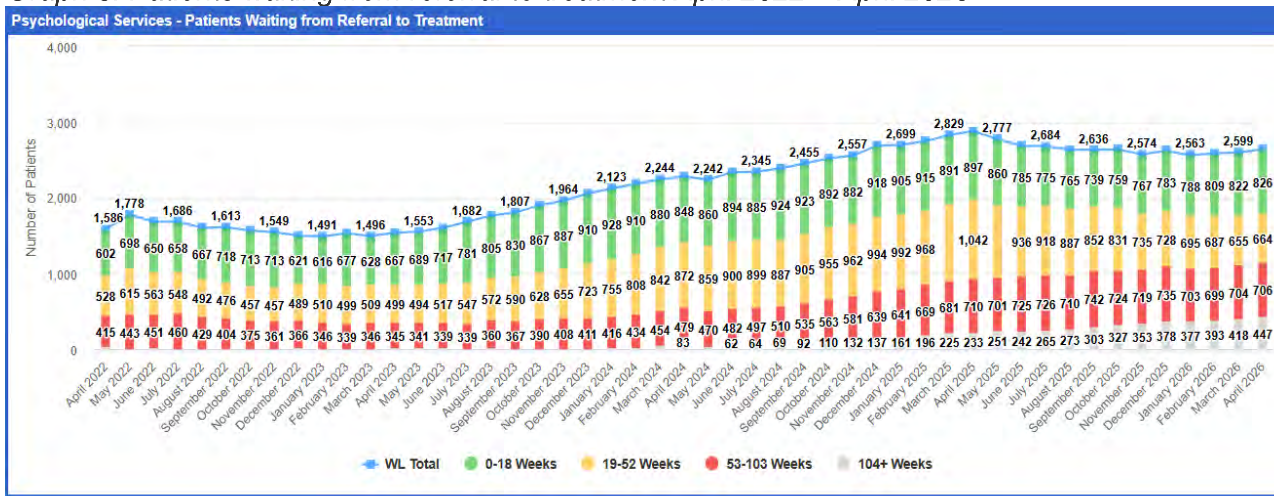
Graph 2: New patients Seen vs New patients starting treatment January 2022 – April 2026



By contrast to progress made with the short end of the queue there has been an increase in numbers waiting over 104 weeks for treatment (from 233 in April 2025 to 447 in April 2026). An increase in referral demand especially in the largest specialty of Adult Psychological Therapies, greatly exceeding capacity, was observed from Q2 of 2023/2024. Those people who were referred at that time reached the 104 week waiting time in Q2 of 2025/2026. All those people are waiting within the Adult Psychological Therapies specialty.

The graph below depicts patients waiting within Adult Psychological Therapies. Service Improvement work included a review of those who had been waiting longest and transferring their care to other specialties with shorter waits where expertise matched the presenting problem. This resulted in 30 people who had been waiting over 104 weeks starting therapy quickly.

Graph 3: Patients waiting from referral to treatment April 2022 – April 2026



The people waiting over 104 weeks are those with the most complex needs which require specific individual therapies that are delivered over a longer period than average and can only be delivered by the most highly trained and costly professionals (clinical and counselling psychologists) within the muti-professional workforce. The demand exceeds capacity which was disproportionately affected by maternity leave and long-term sickness absence over the past year, contributing to the increasing numbers waiting. The Service was permitted to offer extra hours to part-time staff in early 2026 which resulted in additional people who had been waiting over 104 weeks starting therapy. The Service has now been given £250 000 on a non-recurring basis to manage those people who have been waiting longest. Consideration had been given to advertising fixed term band 8a clinical/counselling

psychologist posts however while there is an available workforce seeking permanent posts there does not seem to be an appetite for fixed term work given a neighbouring board's recent inability to recruit to fixed term posts. We are exploring alternative options including: recruiting on a permanent basis; offering a secondment opportunity to a higher banded post which incorporates responsibility for managing incoming demand to release clinical time from staff who currently fulfil these duties; recruiting fixed term assistant psychologist time to deliver Waiting Well calls following a successful pilot earlier in the year which highlighted the need for further capacity to continue this initiative. Recruitment processes are planned to commence week beginning 25 May 2026.

Within the Neuropsychology Specialty the longest waiting times for therapy for FND presentations are increasing. Data quality improvements have highlighted that it will take over 2 years to clear the current queue over 52 weeks by offering individual therapy. A plan to develop short term groups as an alternative to lengthy individual therapy where appropriate requires additional capacity. Employing a fixed term band 5 assistant psychologist with some of the non-recurrent funding to co-facilitate groups in addition to delivering Waiting Well calls would be an efficient use of resource while offering an attractive job.

Trajectory Modelling

In April 2025 waiting list projections were requested by Scottish Government and conducted by Public Health Scotland on NHS Forth Valley's behalf. These indicated that we will not meet the RTT without significant investment in additional resource unless demand greatly reduces, however demand over the past year has continued to exceed capacity. Repeat projections conducted locally in February 2026 reinforce this position. Available PHS trajectory models make several assumptions (stable resource, stable demand, and continuation of service delivery models) which are often not the reality. They are also set up to predict numbers of people waiting over 18 weeks. Forth Valley has around half the number of people in Scotland who are waiting over 52 weeks to start therapy, with a significant number of those waiting over 104 weeks. Forecasting when all patients waiting over 104 and 52 weeks will be seen would be beneficial; however, manual modelling is resource-intensive and introduces a risk of inaccuracy without a standardised, automated approach.

Challenges

Reduced capacity because of financial savings and the reduced Mental Health Outcomes Framework allocation were highlighted in the Service Improvement Plan 2025. Further challenges to capacity this year include the loss of the equivalent of 3 WTE as a result of the implementation of the second phase of the Reduced Working Week. Mitigations include asking part-time staff if they wish to retain their hours and requesting funding for backfill where hours are not retained.

Maternity leave and long-term sickness have impacted the Service's capacity over the last 12 months. Clinician sickness levels were at 5% for 5 of the last 7 months which is higher than they have ever been. When therapists are off on a short-term basis the clinical work is not covered and throughput is slower, contributing to longer waiting times. With fixed term arrangements for backfill for longer term absences having largely been stopped, the RTT compliance can be impacted. Permitting consideration of backfill when vacancies affect areas with the longest waits can make a reasonable difference.

Forensic psychology input to the Bellsdyke site has been impacted by absence this year, although the specialty's waiting times are still compliant with the RTT. The reduced input was noted during the Mental Welfare Commission to Hope House in February 2026. Mitigation included delivering care on a Bellsdyke site wide basis as opposed to a ward basis to optimise the available resource, however a subsequent resignation from a post which was funded on a temporary basis has exacerbated the reduced capacity. Service delivery models and funding arrangements are currently being explored.

Service Improvements which involve changing the model of clinical care can require changed or additional administrative capacity to be implemented effectively and efficiently. Of particular relevance is the move towards increased group therapies which require intensive admin support at key time points. An Admin Review across Clackmannanshire and Stirling HSCP is in progress and will inform future admin provision which may have implications for psychological therapies improvements.

Leadership capacity has been affected by absence and vacancies over the past 2 years. Having some leadership capacity in place has allowed the Improvement Plan to be developed and driven forward resulting in aforementioned improvements to the overall waiting list size without additional capacity. The senior leadership team is not yet at full capacity due to interim arrangements which are likely to continue until October. At that point further Improvements can be put in place including further data improvements, and the development of guidelines and procedures which will improve efficiencies.

The Service was receiving Enhanced Support from the Psychology Advisor to Scottish Government until March 2026. This has ended due to the post, which was fixed term, being vacated. It has not been decided whether the post will be replaced, however Heads of Psychology Scotland (HOPS) have advocated for a professional representative at Scottish Government.

Key Successes

Progress has been made against the Improvement Plan which is aligned with the Psychological Therapies and Interventions Specifications. Developments which have not yet been mentioned in this report include: improved waiting times information for referrers; development of peer support worker job descriptions; a scoping of clinical supervision arrangements with a view to developing a process for evidencing uptake of supervision.

A Service Development Day focusing on sharing learning from implementing the Improvement Plan was held in February and attended by 100 staff from across Psychological Services and Children and Young People's Psychological Services. Care Opinion feedback has consistently highlighted positive patient outcomes and experiences.

Psychological Services provide placements for the 3-year duration of training for the Edinburgh University, Doctor of Clinical Psychology Course. Recent feedback recognised Forth Valley as a very positive training experience for trainees. Trainees contribute to clinical capacity and conduct service-related research supervised by Psychological Services staff. An example is a recently published article in Tizard Learning Disability Review. *Using Positive Behaviour Support (PBS) in context:an audit of a PBS pathway highlights strengths and challenges. Maisie Satchwell-Hirst and Ginny Avery.* Findings from the audit will be used to refine the pathway.

Next Steps

Progress against the Service Improvement Plan and Psychological Therapies Specifications is reviewed monthly within Psychological Services. The following are forthcoming priorities:

<u>May 2026</u>: complete first quarterly capacity models at specialty level; recruit to additional capacity on the basis of £250,000 non-recurring.
<u>June 2026</u>: match service priorities with final year clinical psychology trainees' training needs and promote opportunities amongst trainees; understand ongoing psychology resource for Bellsdyke site; have agreed date for improved specialty level data and revised clinician level data provided by Information Analyst.
<u>July 2026</u>: have updated new:return ratios for each specialty area to understand service throughput and inform caseload management; update trajectory models based on updated new:return ratios.
<u>August 2026</u>: have supervision scoping complete; have Psychological Services component of FND pathway agreed.

Section 3: Performance Report - Priority Areas of Performance

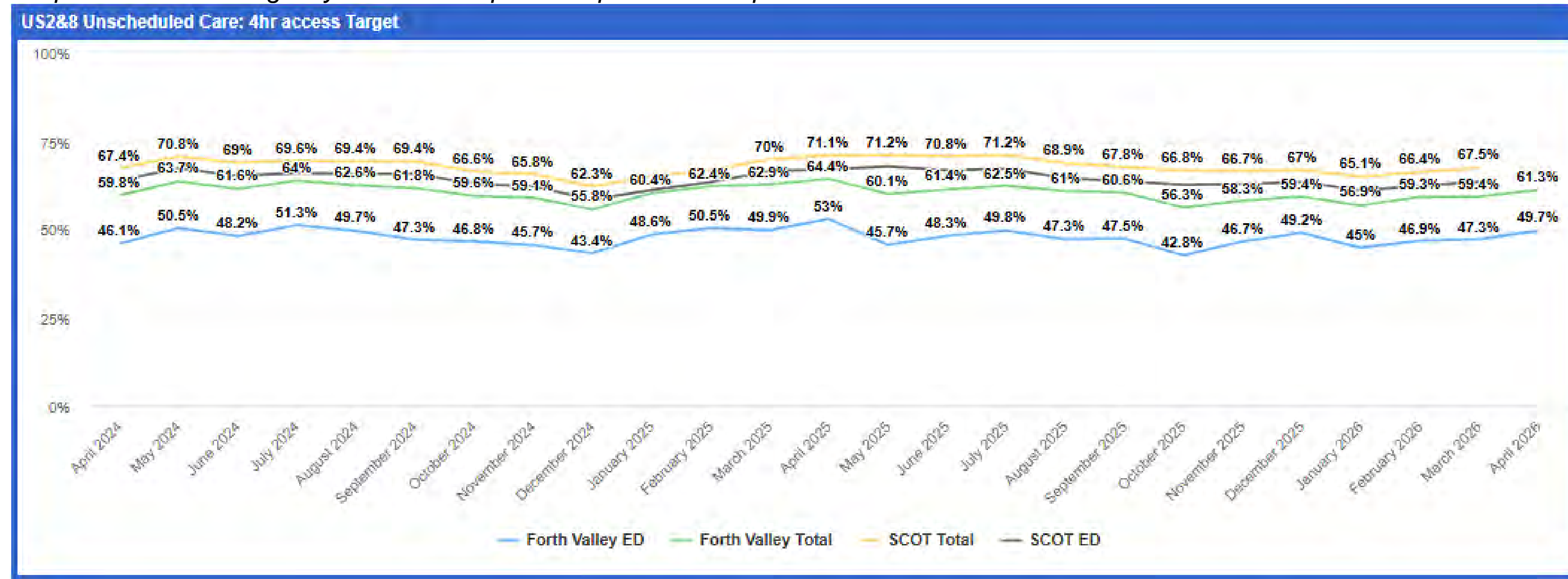
Unscheduled Care

4-hour Access Standard

Percentage of patients waiting less than 4 hours from arrival to admission, discharge or transfer for accident and emergency treatment - 95% standard.

FREQUENCY	MEASURE	DATE	TARGET	CURRENT POSITION	PREVIOUS REPORTING PERIOD	PREVIOUS YEAR	DIRECTION OF TRAVEL (YEAR ON YEAR)	SCOTLAND POSITION	SCOTLAND DATE
Monthly	Emergency Department % compliance against 4 hour access target	30-Apr-26	95%	49.7%	47.3%	53.0%	▼	63.6%	31-Mar-26
Monthly	NHS Forth Valley Overall % compliance against 4 hour target	30-Apr-26	95%	61.3%	59.4%	64.4%	▼	67.5%	31-Mar-26

Graph 4: 4-hour Emergency Access Compliance April 2024 to April 2026

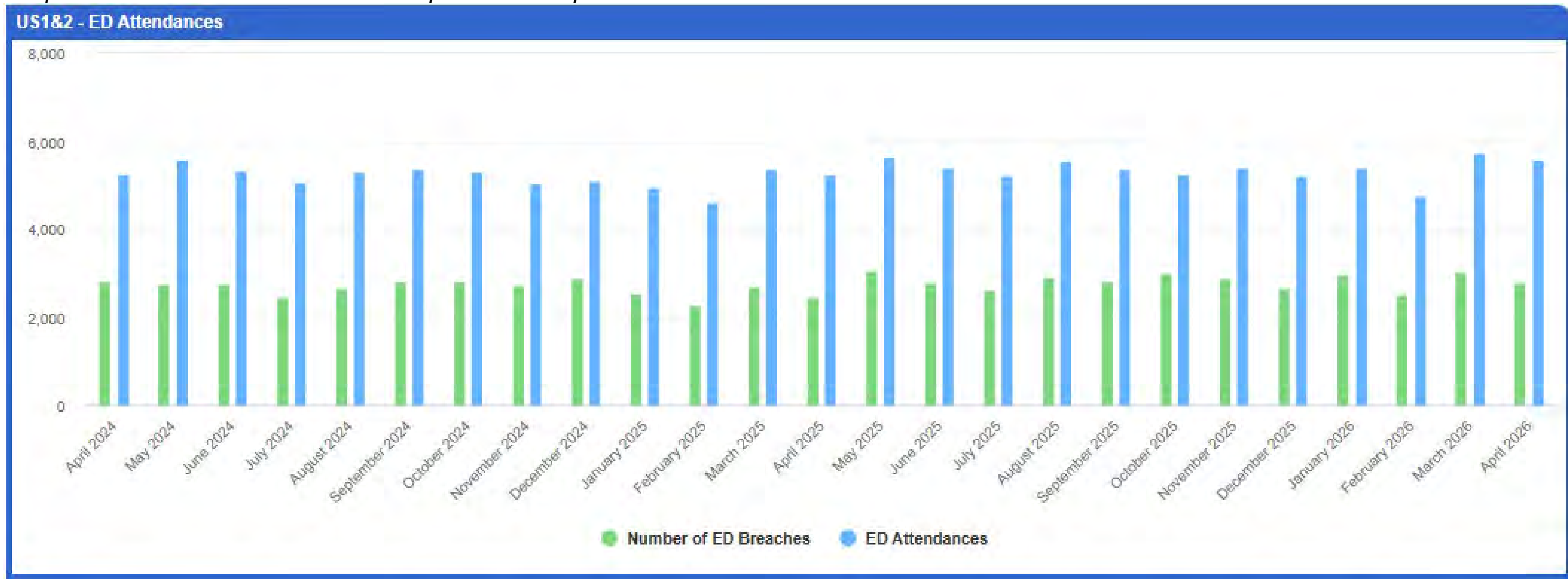


Overall compliance with the 4-hour emergency access standard (EAS) in April 2026 was 61.3%; Minor Injuries Unit 99.2%, Emergency Department 49.7%. A total of 2,808 patients waited longer than the 4-hour target across both the ED and Minor Injuries Unit (MIU); with 1,281 waits longer than eight hours, 524 waits longer than 12 hours and 35 waits longer than 23 hours.

Emergency Department

FREQUENCY	MEASURE	DATE	TARGET	CURRENT POSITION	PREVIOUS REPORTING PERIOD	PREVIOUS YEAR	DIRECTION OF TRAVEL (YEAR ON YEAR)	SCOTLAND POSITION	SCOTLAND DATE
Monthly	Total Number of ED Attendances	30-Apr-26	Reduction	5,585	5,755	5,271	▼	-	-
Monthly	Number that waited >4 hours in ED	30-Apr-26	Reduction	2,808	3,032	2,476	▼	-	-

Graph 5: Number of ED Attendances April 2024 to April 2026



The main reason for patients waiting beyond 4 hours continues to be wait for first assessment with a cohort of 1,692 patients, noting this was 1,423 in April 2025. Wait for a bed accounted for 622 patients waiting beyond 4 hours with Clinical reasons accounting for 175 breaches. It is worth noting 829 of patients attending ED in April 2026 did not wait.

Work continues to support delivery of actions aligned to the various workstreams and projects underway system wide to support ongoing improvements in performance. In addition, NHS Forth Valley has joined the Discharge without Delay Collaborative which will influence the structure of how we align the ongoing actions in, and reporting through, one consolidated Urgent and Unscheduled Care/Delayed Discharge plan.

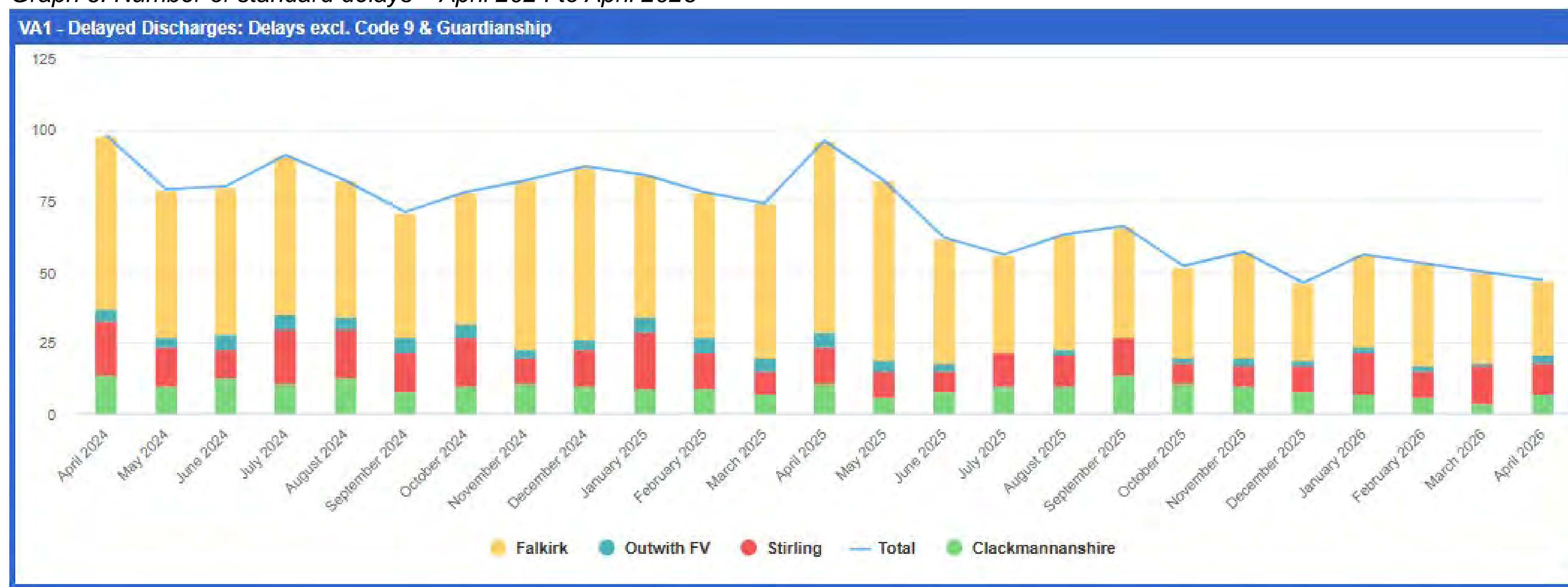
The Discharge without Delay programme underpins the work already underway in Forth Valley and focusses on four integrated delivery workstreams: Planned Date of Discharge and Integrated Discharge Hubs; Discharge to assess / Home First; Frailty at the Front Door; Community Hospital and Step-Down Rehabilitation Units. The aim is to improve the patient and staff experience, building towards better performance and flow through the hospital. This in turn will reduce patient length of stay and support a reduction in the financial burden.

Contingency Bed Utilisation has continued to decrease since January. April had a monthly contingency bed usage of 29 compared with 46 in March. This has reduced significantly from 2024 where contingency beds occupied in April 2024 was 69.

Delayed Discharge

FREQUENCY	MEASURE	DATE	TARGET	CURRENT POSITION	PREVIOUS REPORTING PERIOD	PREVIOUS YEAR	DIRECTION OF TRAVEL (YEAR ON YEAR)	SCOTLAND POSITION	SCOTLAND DATE
Monthly	Delayed Discharges - excl. Code 9 & Guardianship (Standard Delays)	30-Apr-26	Reduction	47	50	96	▲	-	-
Monthly	Code 9 & Guardianship Delays	30-Apr-26	Reduction	45	48	42	▼	-	-
Monthly	Total Bed Days Occupied by Delayed Discharges (Standard Delays)	30-Apr-26	Reduction	1,010	1,523	4,018	▲	-	-

Graph 6: Number of standard delays – April 2024 to April 2026



The April 2026 census position in relation to standard delays (excluding Code 9 and guardianship) is 47 delays; this is compared to 96 in April 2025.

There was a total of 45 code 9 and guardianship delays, with the total number of delayed discharges noted as 92.

In addition, there were 2 code 100 patients. (These patients are undergoing a change in care setting and should not be classified as delayed discharges however are monitored).

The number of bed days occupied by delayed discharges (excluding code 9 and 100) at the April 2026 census was 1,010, this is a reduction from 4,018 in April 2025. Local authority breakdown is noted as Clackmannanshire 209, Falkirk 513, Stirling 266. In addition, there were 22 bed days occupied by delayed discharges for local authorities' out with Forth Valley.

The issue of delayed discharges aligned to urgent & unscheduled care and system flow, is receiving considerable daily focus by the respective HSCP Chief Officers and their teams, jointly with the Acute hospital site, with weekly meetings in place. There is a continued focus on refining processes across our whole system discharge and flow activity. This includes process improvements around assessment and for adults with incapacity. Colleagues are visiting other board areas to learn from what is working well elsewhere and developing tests of change locally.

It should be noted that delayed discharges across Scotland are a particular focus of attention at Scottish Government and COSLA.

Scheduled Care

Outpatients

The percentage of patients waiting less than 12 weeks from referral to a first outpatient appointment – 95% Target.

FREQUENCY	MEASURE	DATE	TARGET	CURRENT POSITION	PREVIOUS REPORTING PERIOD	PREVIOUS YEAR	DIRECTION OF TRAVEL (YEAR ON YEAR)	SCOTLAND POSITION	SCOTLAND DATE
Monthly	Total Number of New Outpatients Waiting	30-Apr-26	Reduction	18,653	18,782	14,104	▼	-	-
Monthly	Number of New Outpatients waiting over 12 weeks	30-Apr-26	Reduction	7,072	6,740	3,511	▼	-	-
Monthly	Number of New Outpatients waiting over 52 weeks	30-Apr-26	0	20	5	151	▲	-	-
Monthly	New Outpatients waiting under 12 weeks %	30-Apr-26	95%	62.1%	64.1%	75.1%	▼	50.5%	31-Mar-26

Graph 7: Outpatient waits over 12 weeks – April 2024 to April 2026

NHS Forth Valley concurrently treat patients that require urgent clinical care as well as those waiting for long periods, in line with associated Scottish Government guidance and targets.

At the end of April 2026, the number of patients on the waiting list for a first outpatient appointment was 18,653 (18,517 excluding mutual aid) compared with 14,104 in April 2025 with the number waiting beyond 12 weeks 7,072 (7,020 excluding mutual aid) compared to 3,511 in April 2025. Note 62.1% (62.1% excluding mutual aid) of patients were waiting less than 12 weeks for a first appointment; a decline in performance from 75.1% the same period the previous year.

The Scottish Government target for 2025/26 that 0 patients waiting over 52 weeks for a New Outpatient appointment. The graph and table below show the numbers and breakdown by specialty. Most specialties have no waits over 52 weeks and those that do are minimal.

The Scottish Government published updated waiting times guidance on 4 December 2023. The guidance aims to ensure consistency in how waiting lists are managed and to this end includes revisions to the ways in which adjustments can be made in relation to clock pauses and resets.

The 2023 Waiting Times Guidance revisions require changes to local patient management systems and the national waiting times data mart which is managed by Public Health Scotland.

Public Health Scotland data publications are now consistent with the 2023 guidance.

As NHS Forth Valley is progressing with implementation of the 2023 guidance in our patient management system, we are currently still accessing waiting times data based on calculations compliant with previous guidance. Resulting in differences in waiting times data provided from local system by NHS Forth Valley in comparison to data provided by Public Health Scotland in the interim period.

Graph 8: Number waiting over 52 weeks for new outpatient appointment - April 2024 to April 2026

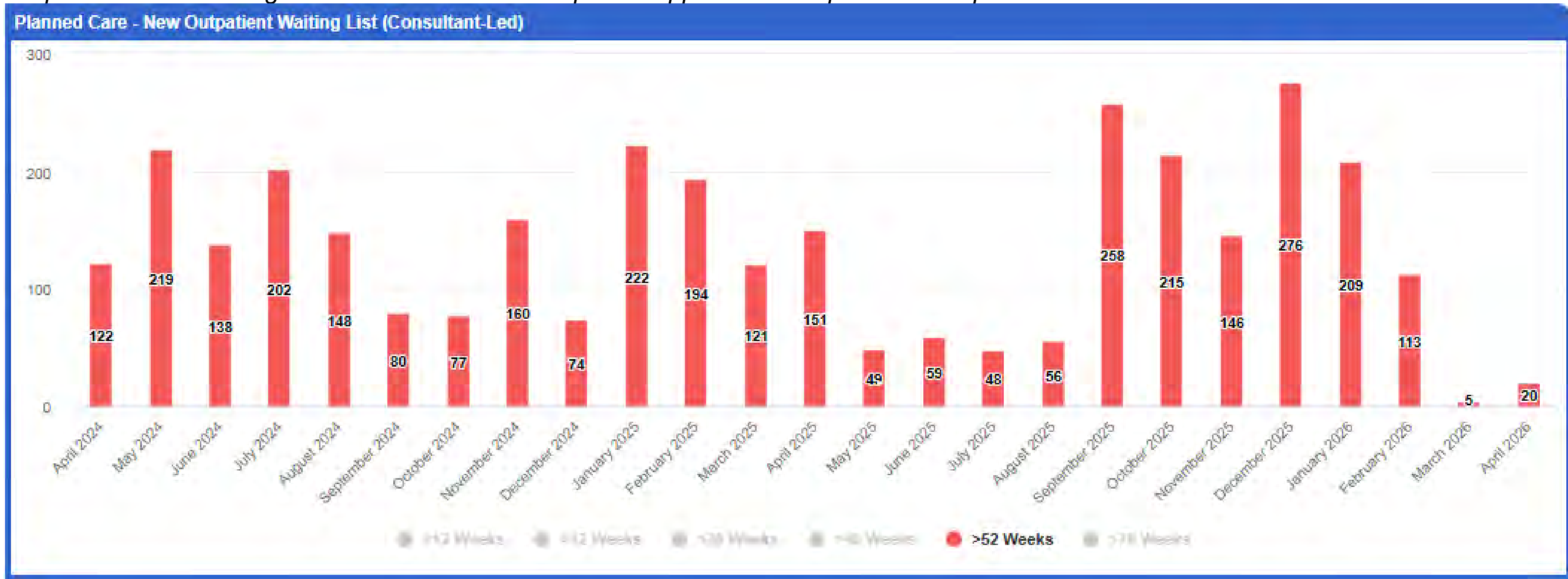


Table 1: Number waiting over 52 weeks for New Outpatient appointment by Specialty – April 2026

Planned Care - New outpatient >52 Week waits

LG Service Area	Value	Numerator ▼	Denominator
Respiratory Medicine	2.1%	13	628
Dermatology	.1%	2	3,626
Haematology	1.7%	1	58
General Medicine	.0%	0	100
Cardiology	.0%	0	1,389

1 of 6

Inpatients

Treatment Time Guarantee (TTG) - Eligible patients who start to receive their day case or inpatient treatment within 12 weeks of the agreement to treat – 100% Target.

FREQUENCY	MEASURE	DATE	TARGET	CURRENT POSITION	PREVIOUS REPORTING PERIOD	PREVIOUS YEAR	DIRECTION OF TRAVEL (YEAR ON YEAR)	SCOTLAND POSITION	SCOTLAND DATE
Quarterly	Number of patients that waited >12 weeks - Completed Wait	31-Mar-26	0	2,223	1,847	1,533	-	-	-
Quarterly	% Compliance with 12 week TTG Standard	31-Mar-26	100%	31.1%	35.4%	44.3%	▼	54.5%	31-Mar-26
Monthly	Total Number of Inpatients/Day cases Waiting	30-Apr-26	Reduction	7,518	7,363	6,851	▼	-	-
Monthly	Number of Inpatients/Day cases waiting over 12 weeks	30-Apr-26	Reduction	4,763	4,679	4,329	▼	-	-
Monthly	Number of Inpatients/Day cases waiting over 52 weeks	30-Apr-26	0%	105	98	520	▲	-	-
Monthly	Percentage of Inpatients/Day cases waiting under 12 weeks	30-Apr-26	100%	36.6%	36.5%	36.8%	▼	39.8%	31-Mar-26

Graph 9: Inpatients/Daycase waits over 12 weeks – April 2024 to April 2026

In April 2026, the number of inpatients/daycases waiting increased to 7,518 (7,257 excluding mutual aid and NTC) from 7,363 (7,138 excluding mutual aid and NTC) the previous month. An increase from the previous year in those waiting beyond 12 weeks from 4,329 to 4,763 was also noted.

The aim for 2025/26 is that there will be no patients waiting beyond 52 weeks for Inpatient / Daycase treatment. Graph 19 and table 2 below show the numbers and breakdown by specialty respectively as at end of April. Weekly monitoring of the specialties with the largest numbers waiting over 12 weeks would suggest, based on progress so far, that we are on track to meet the target for end of March 2026. Details are included in the specialty sections below.

Graph 10: Number waiting over 52 weeks for Inpatient/Daycase – April 2024 to April 2026

Table 2: Number waiting over 52 weeks for Inpatient/Daycase by Specialty – April 2026

Planned Care - TTG >52 Week waits

LG Service Area	Value	Numerator	Denominator
Trauma and Orthopaedic Surgery	1.3%	33	2,476
Gynaecology	5.0%	30	600
Ear, Nose and Throat (ENT)	3.0%	24	809
Urology	3.7%	15	405
General Surgery	.4%	3	732

1 of 1

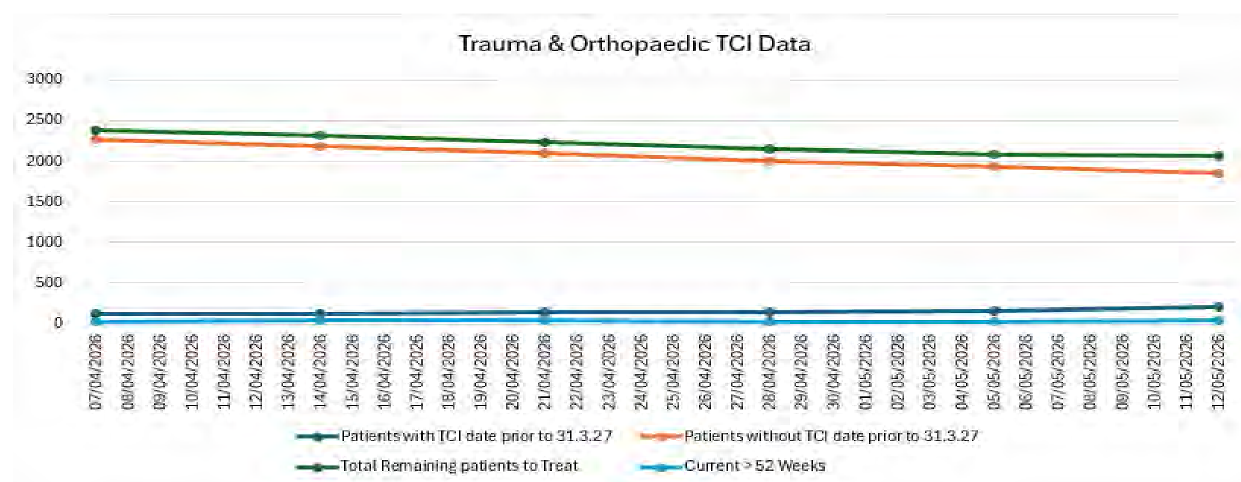
The following specialty level sections detail the weekly position of the waiting lists with the largest numbers waiting over 52 weeks, these show the numbers waiting in total and the numbers dated To Come In (TCI). Further breakdowns show the numbers waiting over 52 weeks and the numbers and percentages of these which are dated to come in and of which are currently unavailable.

Trauma and Orthopaedic Surgery

Table 3: Trauma and Orthopaedic clearance of IPDC >52-week waiters

		Included: Trauma and Orthopaedic Surgery Patients who would be waiting 52 weeks or over at 31st March 2027									
CensusPoint	SpecialtyName	Patients with TCI date prior to 31.3.27	Patients without TCI date prior to 31.3.27	Total Remaining patients to Treat	Current > 52 Weeks	Current > 78 Weeks	Longest Wait (weeks)	No > 52 Weeks Dated	No > 52 Weeks Unavailable	% of 52 Weeks Dated	% of 52 Weeks Unavailable
07/04/2026	Trauma and Orthopaedic Surgery	128	2262	2390	33	0	73	1	6	3	18
14/04/2026	Trauma and Orthopaedic Surgery	127	2187	2314	34	0	74	2	5	5	14
21/04/2026	Trauma and Orthopaedic Surgery	144	2092	2236	34	0	75	9	5	26	14
28/04/2026	Trauma and Orthopaedic Surgery	149	1995	2144	33	0	72	10	6	30	18
05/05/2026	Trauma and Orthopaedic Surgery	155	1929	2084	29	0	73	6	3	20	10
12/05/2026	Trauma and Orthopaedic Surgery	213	1857	2070	37	0	74	7	5	18	13

Graph 11: Trauma and Orthopaedic reduction of the target cohort

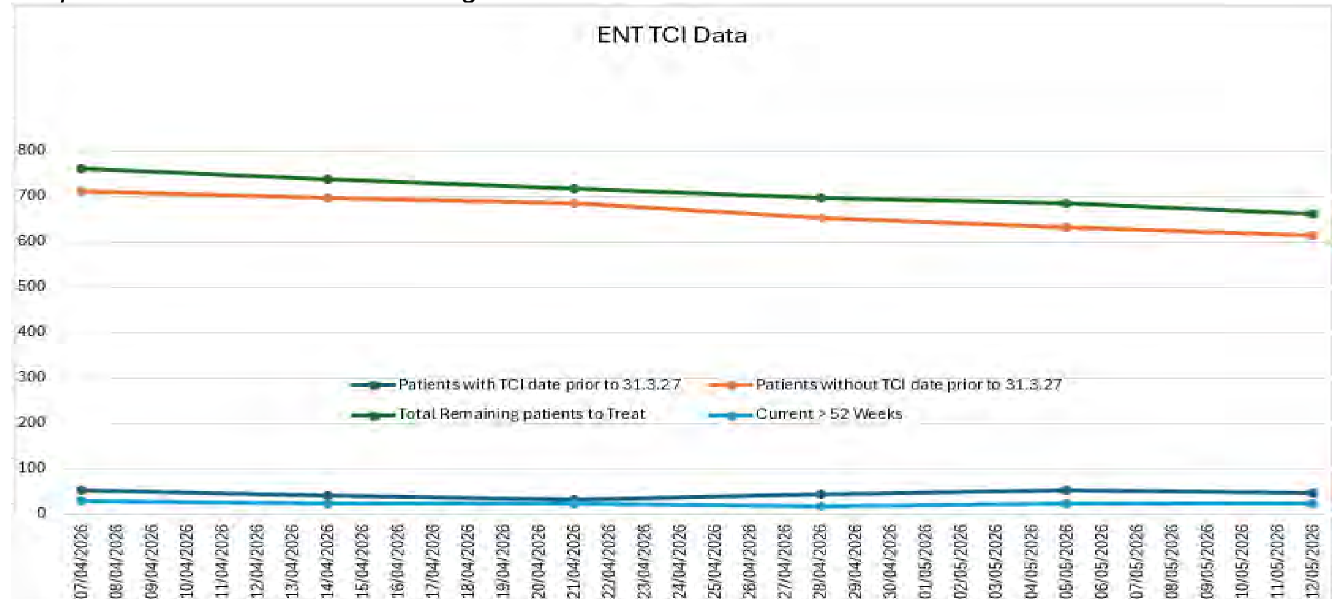


Ear, Nose and Throat

Table 4: ENT clearance of IPDC >52-week waiters

		Included: ENT Patients who would be waiting 52 weeks or over at 31st March 2027									
CensusPoint	SpecialtyName	Patients with TCI date prior to 31.3.27	Patients without TCI date prior to 31.3.27	Total Remaining patients to Treat	Current > 52 Weeks	Current > 78 Weeks	Longest Wait (weeks)	No > 52 Weeks Dated	No > 52 Weeks Unavailable	% of 52 Weeks Dated	% of 52 Weeks Unavailable
07/04/2026	Ear, Nose and Throat (ENT)	51	710	761	30	0	65	19	4	63	13
14/04/2026	Ear, Nose and Throat (ENT)	41	697	738	23	0	65	10	4	43	17
21/04/2026	Ear, Nose and Throat (ENT)	33	685	718	22	0	62	6	2	27	9
28/04/2026	Ear, Nose and Throat (ENT)	44	651	695	18	0	63	8	3	44	16
05/05/2026	Ear, Nose and Throat (ENT)	52	631	683	23	0	64	9	4	39	17
12/05/2026	Ear, Nose and Throat (ENT)	46	614	660	22	0	65	7	4	31	18

Graph 12: ENT reduction of the target cohort

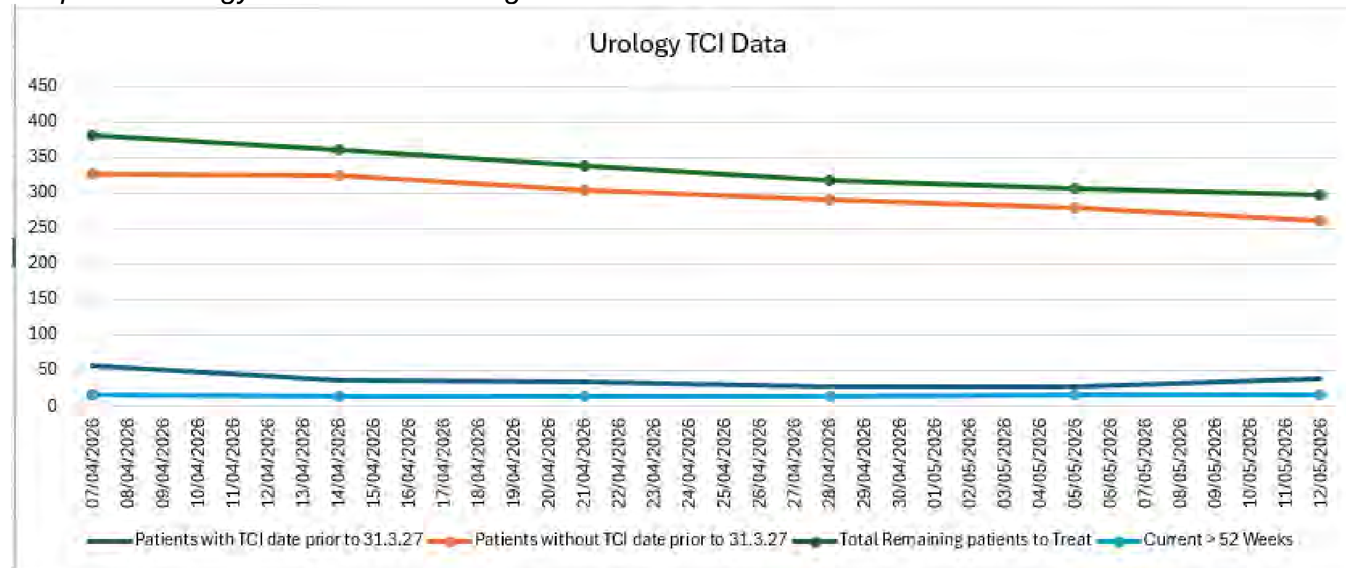


Urology

Table 5: Urology clearance of IPDC >52-week waiters

CensusPoint	SpecialtyName	Patients with TCI date prior to 31.3.27	Patients without TCI date prior to 31.3.27	Total Remaining patients to Treat	Current > 52 Weeks	Current > 78 Weeks	Longest Wait (weeks)	No > 52 Weeks Dated	No > 52 Weeks Unavailable	% of 52 Weeks Dated	% of 52 Weeks Unavailable
		Included: Urology Patients who would be waiting 52 weeks or over at 31st March 2027									
07/04/2026	Urology	56	326	382	16	0	68	3	4	18	25
14/04/2026	Urology	37	324	361	13	0	69	0	5	0	38
21/04/2026	Urology	34	304	338	14	0	70	0	5	0	35
28/04/2026	Urology	28	290	318	14	0	70	0	6	0	42
05/05/2026	Urology	27	279	306	15	0	70	1	5	6	33
12/05/2026	Urology	38	260	298	17	0	70	1	4	5	23

Graph 13: Urology reduction of the target cohort

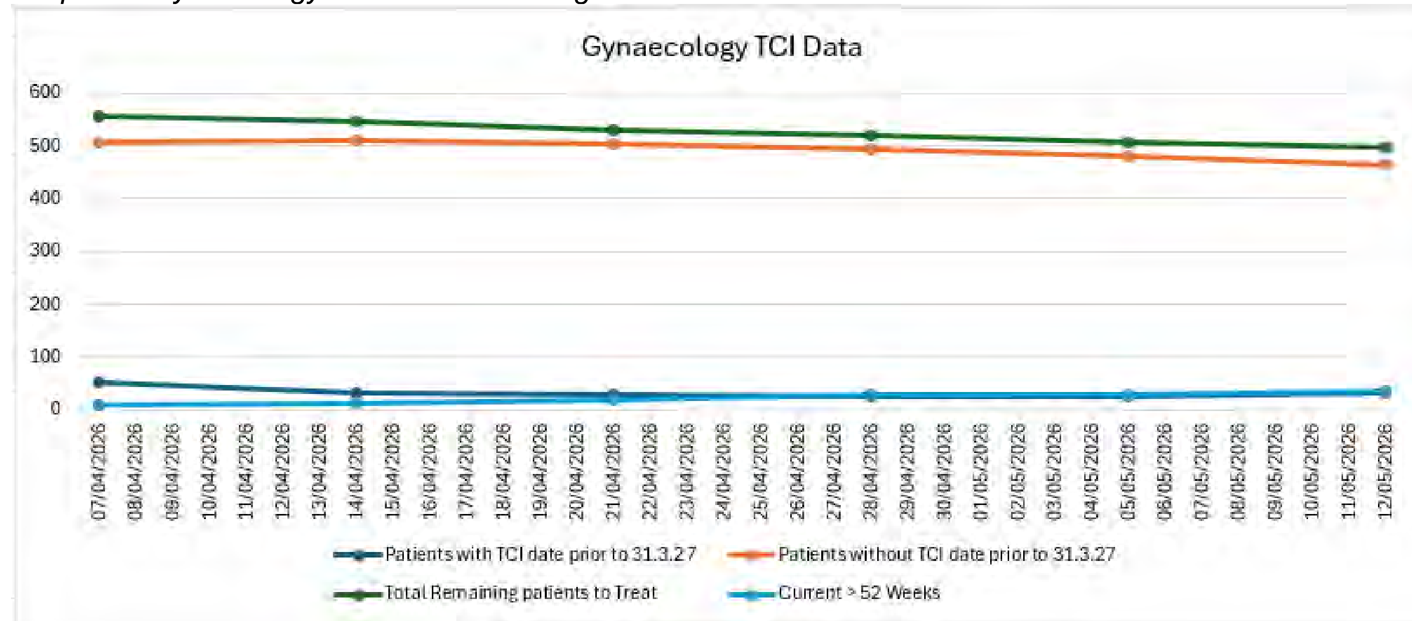


Gynaecology

Table 6: Gynaecology clearance of IPDC >52-week waiters

		Included: Gynaecology Patients who would be waiting 52 weeks or over at 31st March 2027										
CensusPoint	SpecialtyName	Patients with TCI date prior to 31.3.27	Patients without TCI date prior to 31.3.27	Total Remaining patients to Treat	Current > 52 Wee	Current > 78 Wee	Longest Wait (week	No > 52 Weeks Date	No > 52 Weeks Unavailab	% of 52 Weeks Date	% of 52 Weeks Unavailab
07/04/2026	Gynaecology	51	505	556	10	2	93	5	1	50	10
14/04/2026	Gynaecology	34	511	545	13	2	94	4	0	30	0
21/04/2026	Gynaecology	28	503	531	18	0	66	4	0	22	0
28/04/2026	Gynaecology	27	492	519	28	0	67	8	0	28	0
05/05/2026	Gynaecology	27	479	506	29	0	68	6	0	20	0
12/05/2026	Gynaecology	33	465	498	35	0	64	7	1	20	2

Graph 14: Gynaecology reduction of the target cohort

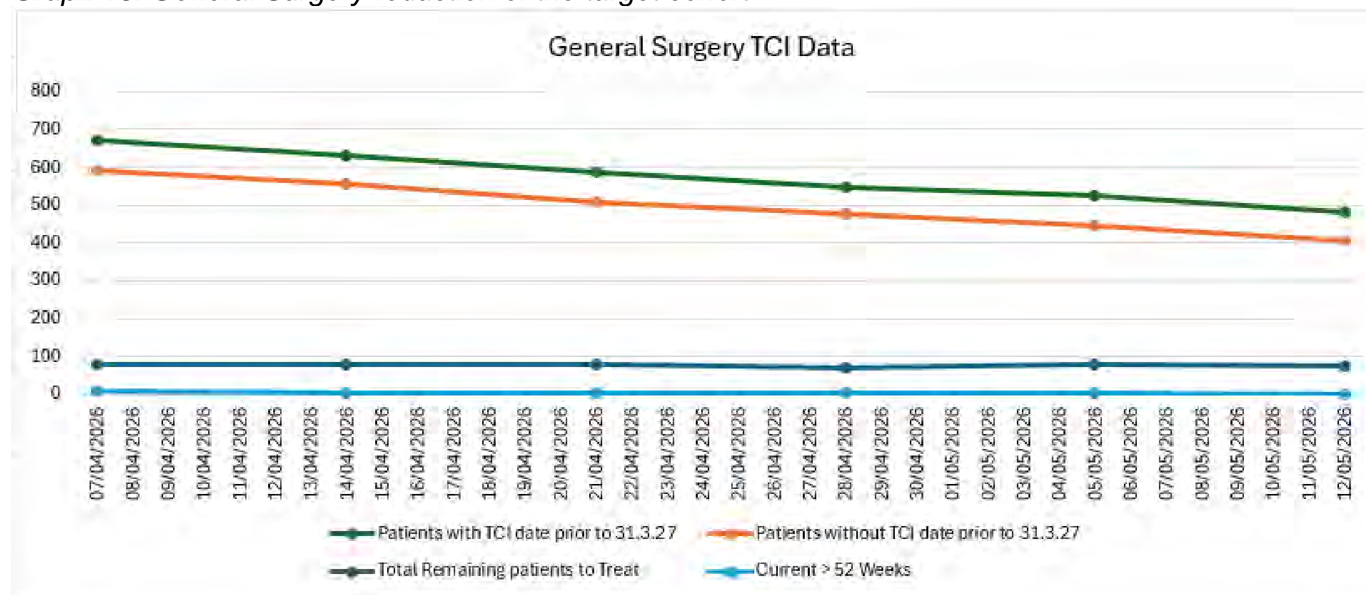


General Surgery

Table 7: General Surgery clearance of IPDC >52-week waiters

		Included: General Surgery Patients who would be waiting 52 weeks or over at 31st March 2027									
CensusPoint	SpecialtyName	Patients with TCI date prior to 31.3.27	Patients without TCI date prior to 31.3.27	Total Remaining patients to Treat	Current > 52 Weel	Current > 78 Weel	Longest Wait (weeks)	No > 52 Weeks Date	No > 52 Weeks Unavailab	% of 52 Weeks Date	% of 52 Weeks Unavailabl
07/04/2026	General Surgery	79	590	669	7	0	70	4	1	57	14
14/04/2026	General Surgery	77	556	633	3	0	70	1	1	33	33
21/04/2026	General Surgery	79	509	588	3	0	70	2	1	66	33
28/04/2026	General Surgery	70	478	548	5	0	71	3	0	60	0
05/05/2026	General Surgery	80	445	525	3	0	66	3	0	100	0
12/05/2026	General Surgery	73	408	481	1	0	60	1	1	100	100

Graph 15: General Surgery reduction of the target cohort



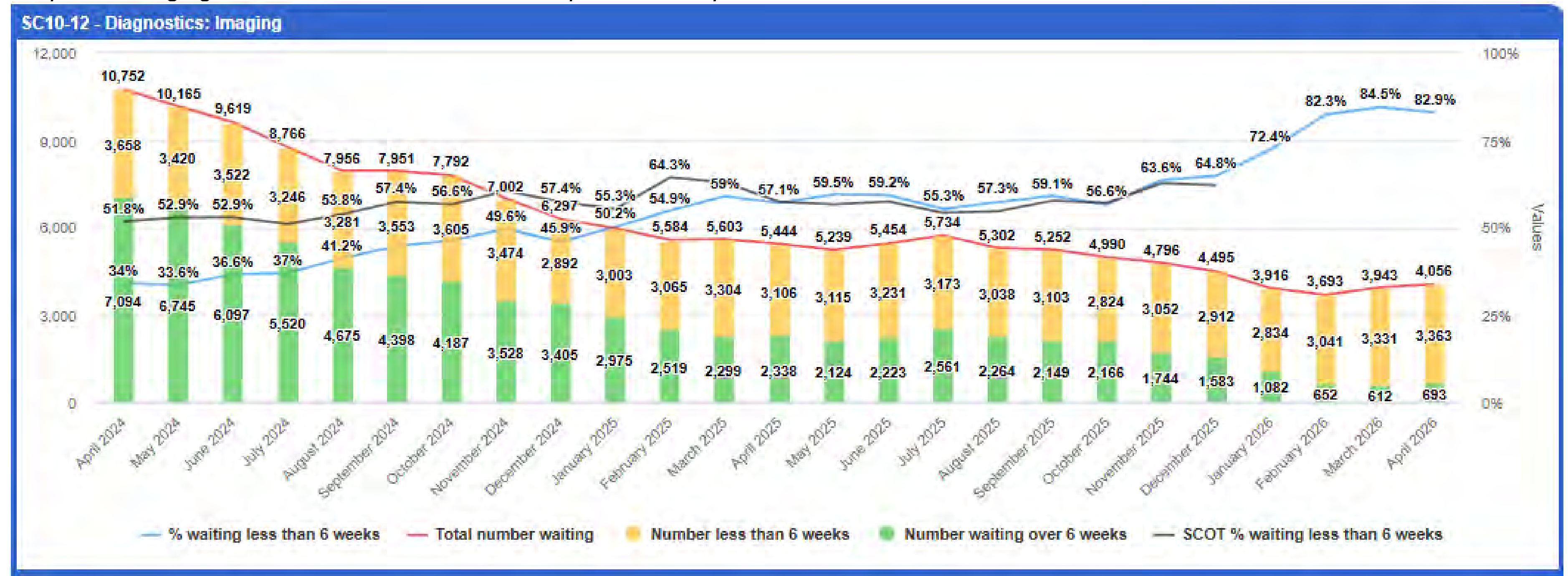
Diagnostics

The Diagnostic Waiting Times Standard states patients should be waiting no more than six weeks for one of the eight key diagnostic tests and investigations.

Imaging

FREQUENCY	MEASURE	DATE	TARGET	CURRENT POSITION	PREVIOUS REPORTING PERIOD	PREVIOUS YEAR	DIRECTION OF TRAVEL (YEAR ON YEAR)	SCOTLAND POSITION	SCOTLAND DATE
Monthly	Total number waiting - Imaging	30-Apr-26	Reduction	4,056	3,943	5,444	▲	-	-
Monthly	Number waiting beyond 42 days - Imaging	30-Apr-26	0%	693	612	2,338	▲	-	-
Monthly	Percentage waiting less than 42 days - Imaging	30-Apr-26	100%	82.9%	84.5%	57.1%	▲	62.1%	31-Dec-25

Graph 16: Imaging waits over 6 weeks and total – April 2024 to April 2026



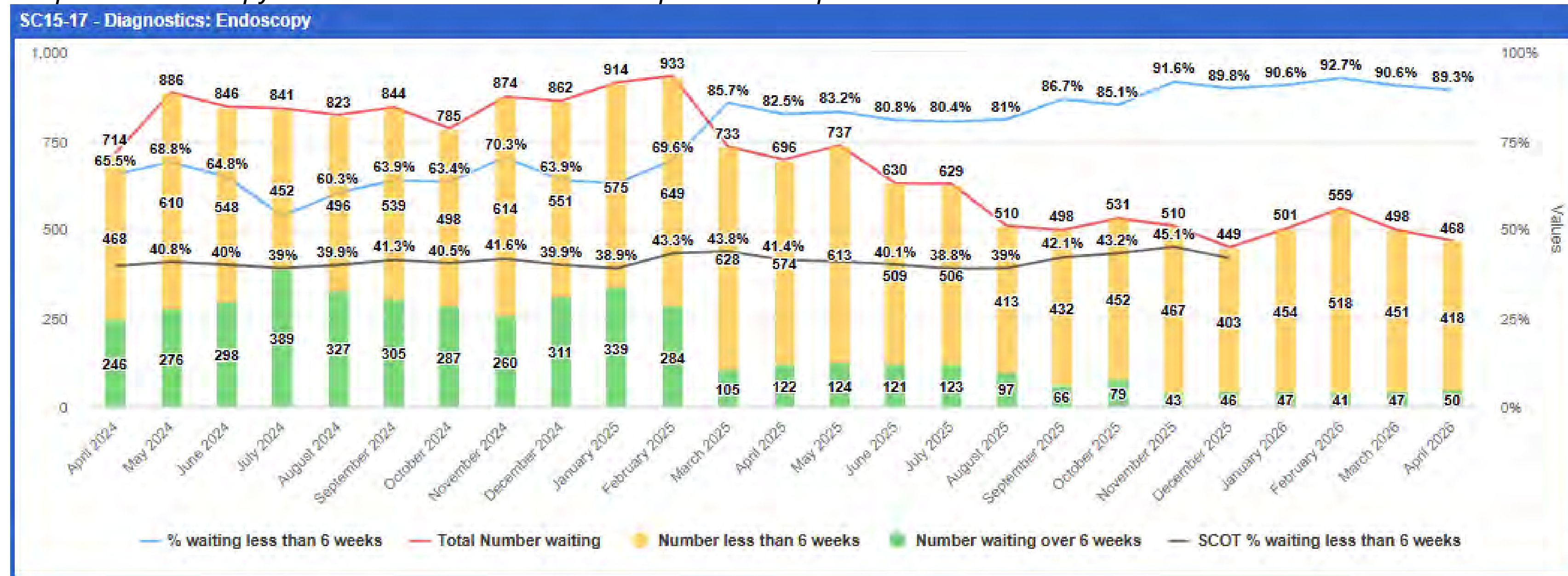
At the end of April 2026, 693 patients were waiting beyond the 6-week standard for imaging, a reduction from 2,338 in April 2025. Compliance with the 6 weeks standard was 82.9%.

Patients continue to be seen on a priority basis with waiting lists actively monitored and managed on an ongoing basis. The total number of patients waiting for imaging in April 2026 was 4,059; compared with 5,444 in April 2025.

Endoscopy
Waiting times standard is that patients should be waiting no more than six weeks for one of the eight key diagnostic tests and investigations.

FREQUENCY	MEASURE	DATE	TARGET	CURRENT POSITION	PREVIOUS REPORTING PERIOD	PREVIOUS YEAR	DIRECTION OF TRAVEL (YEAR ON YEAR)	SCOTLAND POSITION	SCOTLAND DATE
Monthly	Total number waiting - Endoscopy	30-Apr-26	Reduction	468	498	733	▲	-	-
Monthly	Number waiting beyond 42 days - Endoscopy	30-Apr-26	0	50	47	122	▲	-	-
Monthly	Percentage waiting less than 42 days - Endoscopy	30-Apr-26	100%	89.3%	90.6%	82.5%	▲	41.8%	31-Dec-25

Graph 17: Endoscopy waits over 6 weeks and total - April 2024 to April 2026



The current waiting list size for endoscopy in April 2026 is 468, compared to 733 in April 2025. NHS Forth Valley Endoscopy team is moving towards achieving the 6-week diagnostic standard. The size of the waiting list continues to reduce and the number of patients waiting over 6 weeks is also reducing. Performance has continued to be over 80% of patients accessing endoscopy within 6 weeks. April 2026 compliance was 89.3% compared with 82.5 in April 2025.

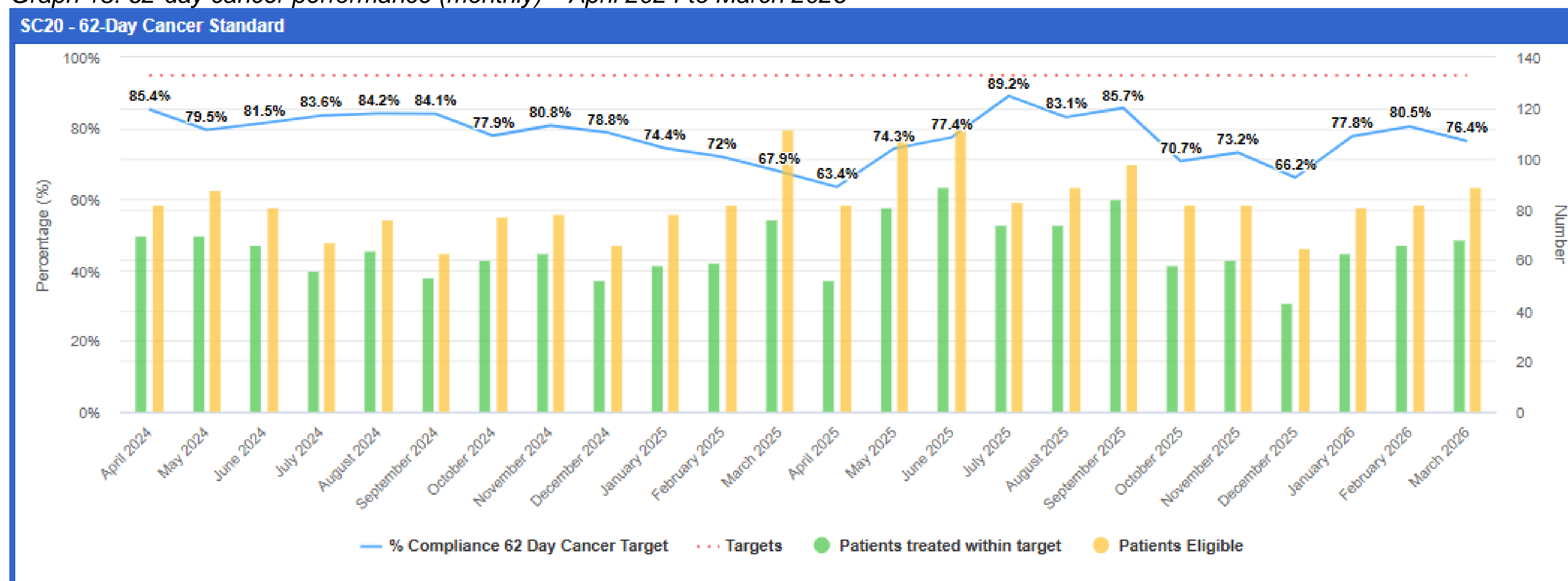
Based on the last published figures the NHS Scotland average performance for Endoscopy is 41.8% of patients were waiting less than the 6 week standard.

62-day Cancer Standard

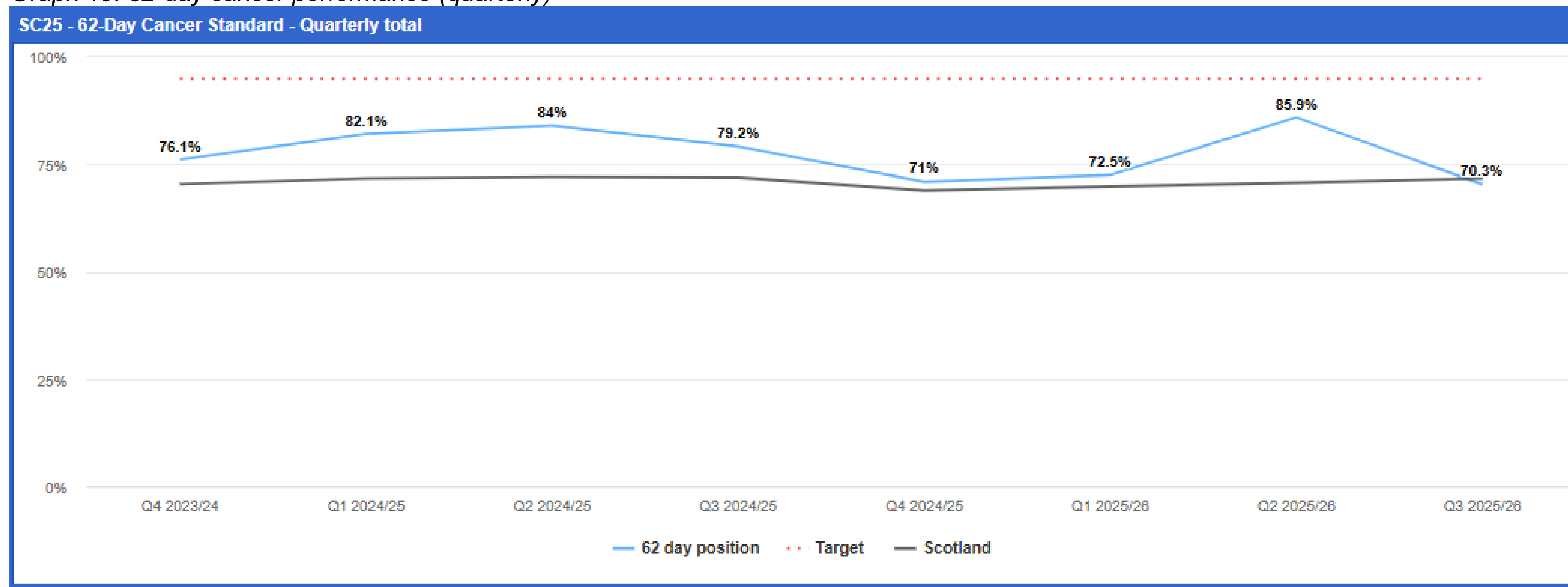
The 62-day standard states that 95% of eligible patients should wait no longer than 62 days from urgent suspicion of cancer referral to first cancer treatment.

FREQUENCY	MEASURE	DATE	TARGET	CURRENT POSITION	PREVIOUS REPORTING PERIOD	PREVIOUS YEAR	DIRECTION OF TRAVEL (YEAR ON YEAR)	SCOTLAND POSITION	SCOTLAND DATE
Monthly	62 Day Cancer Target - Percentage compliance against target	31-Mar-26	95%	76.4%	80.5%	67.9%	▲	74.0%	31-Mar-26
Monthly	62 Day Cancer - Number seen within target against total	31-Mar-26	-	68/89	66/82	76/112	-	-	-
Quarterly	62 Day Cancer Target - Percentage compliance against target	31-Dec-25	95%	70.3%	85.9%	79.2%	▼	71.7%	31-Dec-25

Graph 18: 62-day cancer performance (monthly) – April 2024 to March 2026



Graph 19: 62-day cancer performance (quarterly)



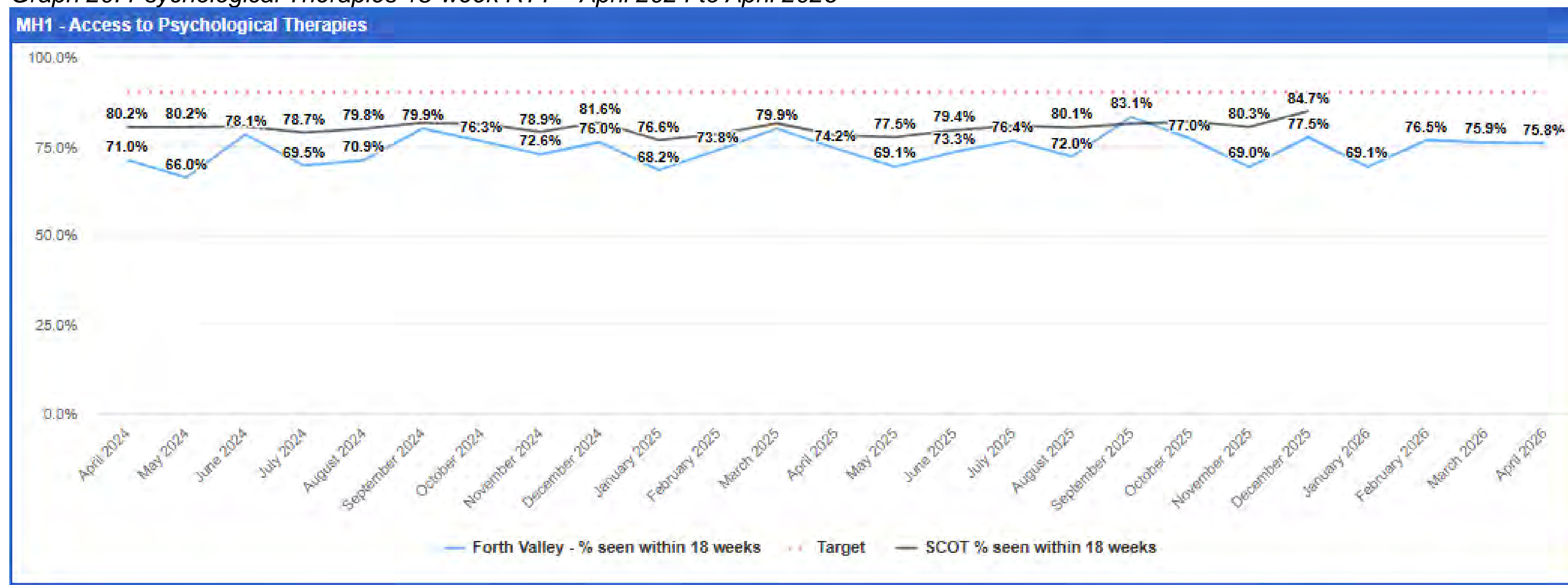
Cancer services remain a priority for scheduled care. All Urgent Suspicion of Cancer referrals are tracked to support achievement of the 31-day and 62-day access targets. In areas where this is not reached priority measures are taken to address this. A robust monitoring system has been established to identify reasons for breaches and ensure a plan is in place to prevent further non-compliance where possible. Currently challenges remain in achieving the 95% target in urology with plans in place to address this on ongoing basis along with our tertiary service providers.

The number of patients being tracked on the 62-day cancer pathway is currently approximately 889 of which 15% are confirmed cancer patients.

Psychological Therapies
The national target is that 90% of patients should wait no longer than 18 weeks from referral to treatment for psychological therapies.

FREQUENCY	MEASURE	DATE	TARGET	CURRENT POSITION	PREVIOUS REPORTING PERIOD	PREVIOUS YEAR	DIRECTION OF TRAVEL (YEAR ON YEAR)	SCOTLAND POSITION	SCOTLAND DATE
Monthly	Psychological Therapies - 18 week RTT compliance	30-Apr-26	90%	75.8%	75.9%	74.2%	▲	84.7%	31-Dec-25
Monthly	Total Number Waiting for Pyschological Therapies Initial Assessment	30-Apr-26	Reduction	1,040	1,072	1,071	▲	-	-
Quarterly	Psychological Therapies - 18 week RTT compliance	31-Mar-26	90%	73.6%	74.1%	73.8%	▼	82.1%	31-Dec-25

Graph 20: Psychological Therapies 18-week RTT – April 2024 to April 2026



April 2026 draft compliance with the RTT target was 75.8% continuing a relatively consistent position of performance at around 70% compliance or above since June 2024. Monthly fluctuations are related to seasonal variation with peak holiday periods and winter illnesses adversely impact the numbers of people starting therapy with a clinician; the timing of therapeutic groups which enable a large number of people to start therapy simultaneously; and staff turnover.

In April 2025 waiting list projections were requested by Scottish Government and produced by Public Health Scotland on NHS Forth Valley's behalf. These indicated that it would be extremely challenging to meet the RTT target without significant investment in additional resource.

May 2025 through to November 2025 has seen a reduction in numbers waiting for assessment which reflects service improvement work focusing on ensuring that all referrals accepted to the service met clear referral criteria, with referrals which did not meet criteria being redirected to more appropriate services. Improvement work within the service, including managing referral demand and rolling out Waiting Well calls is projected to positively impact the numbers of people waiting for an assessment by the end of this quarter. The total waiting list size for treatment had been slowly reducing since the introduction of an Improvement Plan in May 2025.

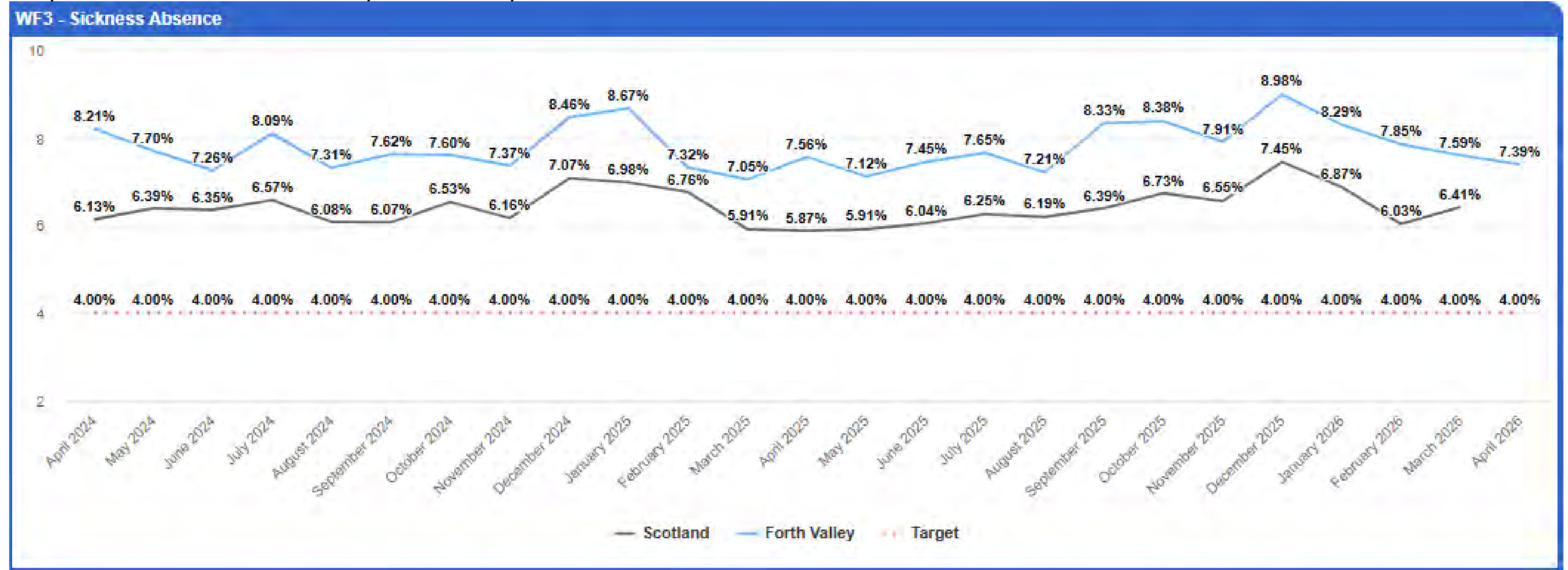
Patients that have been waiting an extended period are those with the most complex needs which require specific therapies that are delivered over a longer than average period and can only be delivered by the most highly trained professionals within the multi-professional service. Approval has been given to fund some additional capacity to deliver clinical sessions from January to March 2026. These sessions will be solely for those who have been waiting longest. This, in combination with a new clinical psychologist commencing in January after a period of vacancy, will support a reduction in the number of long waiting patients.

Section 3: Performance Report - Other Areas of Performance

Workforce
To reduce sickness absence to 4%

FREQUENCY	MEASURE	DATE	TARGET	CURRENT POSITION	PREVIOUS REPORTING PERIOD	PREVIOUS YEAR	DIRECTION OF TRAVEL (YEAR ON YEAR)	SCOTLAND POSITION	SCOTLAND DATE
Monthly	Overall Absence	30-Apr-26	4.0%	7.39%	7.59%	7.56%	▲	6.51%	31-Mar-26
Rolling 12 mth	Overall Absence	30-Apr-26	-	7.88%	7.92%	7.73%	▼	6.60%	31-Mar-26

Graph 21: Sickness Absence – April 2024 to April 2026



The sickness absence target is 4.0%. Absence remains above the target at 7.39% in April 2026 noting deterioration from 7.56% in April 2025. The 12-month rolling average April 2025 to March 2026 is noted as, NHS Forth Valley 8.02%; Scotland 6.60%. Anxiety/stress/depression/other psychiatric illnesses are consistently the most reported reason for sickness absence with Musculoskeletal the second highest reason.

The management of absence and the improvement of staff wellbeing remain key priorities for NHS Forth Valley noting a 2% reduction in absence has been included in the Executive Leadership Team objectives. This issue is being addressed through Directorate reviews and through the Whole System Leadership Team.

Work to improve attendance is focussed on the 3 key areas of Attendance Management, Occupational Health and Staff Wellbeing. The launch of the new Workforce Wellbeing Framework 2025-2029 is intended to ensure a comprehensive and coordinated approach to enabling and supporting the wellbeing and mental health of our workforce. In addition, an Attendance Management Plan has been developed in partnership with staff side colleagues with regular progress updates to the Staff Governance Committee

A range of Occupational Health clinical services are providing staff with pathways to counselling, psychology, physiotherapy, management and self-referrals to align with Once for Scotland Policies. Awareness sessions, aimed at improving managers ability to make more accurate referrals to OH clinical pathways are delivered regularly to educate managers through a Management Referral training package. A proactive Occupational Health consultation advice line is established and increases a person-centred approach to enable individuals with access the right care at the right time.

Issues in relation to sickness absence and workforce continue to be examined and discussed at the bi-monthly Staff Governance Committee.

Unavailability

FREQUENCY	MEASURE	DATE	TARGET	CURRENT POSITION	PREVIOUS REPORTING PERIOD	PREVIOUS YEAR	DIRECTION OF TRAVEL (YEAR ON YEAR)	SCOTLAND POSITION	SCOTLAND DATE
Monthly	Outpatient Unavailability	30-Apr-26	Monitor	0.7%	0.5%	0.6%	▼	0.8%	31-Mar-26
Monthly	Inpatient/Day case Unavailability	30-Apr-26	Monitor	5.0%	4.4%	3.9%	▼	3.4%	31-Mar-26

Monitoring of patient unavailability is an Audit Scotland recommendation and refers to the percentage of outpatient or inpatient/daycase unavailability as a proportion of the total waiting list size.

- Outpatient unavailability in April 2026 was 0.7% of the total waiting list.
- Inpatient/daycase unavailability in April 2026 was 5.0% an increase from 3.9% in April 2025. The unavailability rate is less than 6% for most specialties except Cardiology 50% (4/8), Oral & Maxillofacial 10.8% (12/111), Orthopaedics 8.5% (206/2415), General Surgery 7.9 (58/731), General Surgery – Breast 6.35% (4/63). The highest in terms of numbers are Orthopaedics with 206 patients unavailable and General Surgery with 58 patients unavailable.

Did Not Attend (DNA)

FREQUENCY	MEASURE	DATE	TARGET	CURRENT POSITION	PREVIOUS REPORTING PERIOD	PREVIOUS YEAR	DIRECTION OF TRAVEL (YEAR ON YEAR)	SCOTLAND POSITION	SCOTLAND DATE
Monthly	New Acute Services Outpatient % DNA	30-Apr-26	5%	4.6%	5.1%	4.7%	▲	6.1%	31-Mar-26
Monthly	Return Acute Services Outpatient % DNA	30-Apr-26	5%	4.9%	4.2%	5.2%	▲	-	-

The new outpatient DNA rate across acute services in April 2026 is noted as 4.6% which is a decrease from the position in April 2025 of 4.7%. Variation across specialties continues with rates ranging from 14.29% to 0%. The biggest impact in terms of the number of DNAs can be seen in Ophthalmology 6.93% (75 patients).

The return outpatient DNA rate across acute services in April 2026 was 4.9%. There continues to be a high number of DNAs in Ophthalmology with 249 patients (4.1%), Orthopaedics 126 patients (5.5%), Dermatology 124 patients (4.87%) and Diabetes 168 patients (11.44%).

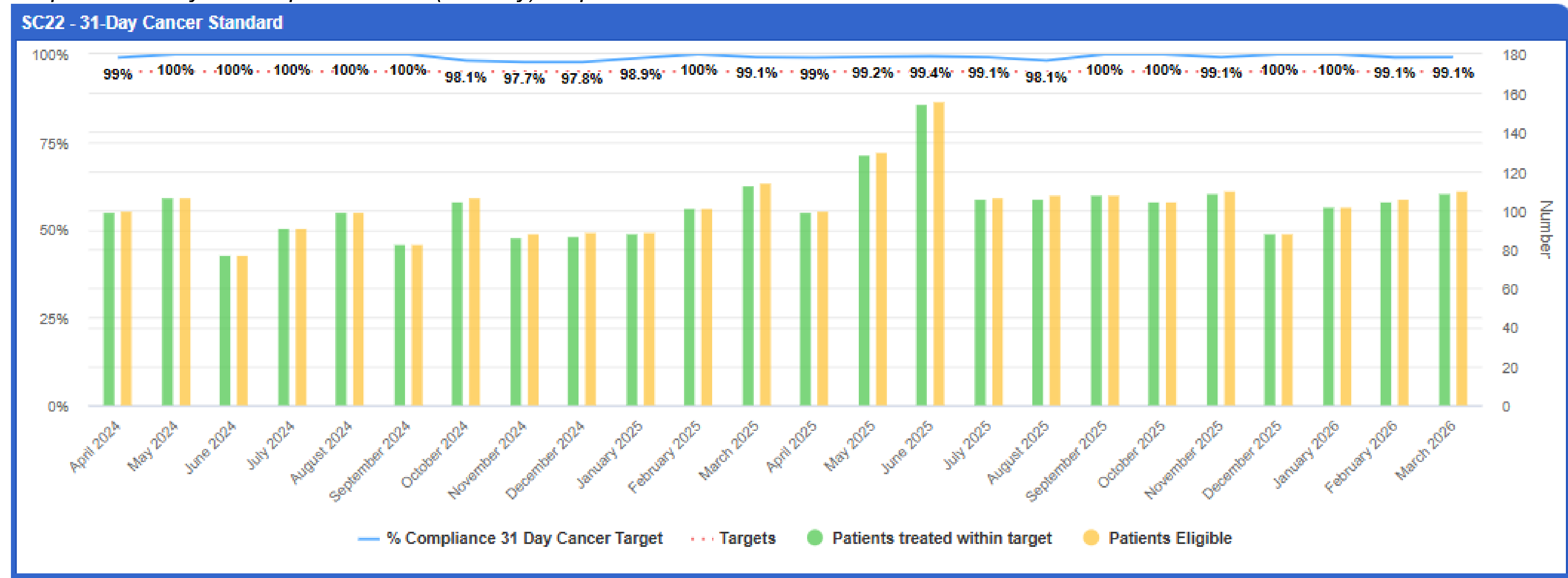
A number of actions are ongoing to support a reduction in the number of DNAs including the roll out of patient focus booking. Application of the Access Policy is actively supported and there is ongoing benchmarking against national DNAs and removal rates. Patient information provides detail on the process to cancel or change an appointment with the relevant contact information.

31- Day Cancer Standard

The 31-day standard states that 95% of all patients should wait no more than 31 days from decision to treat to first cancer treatment.

FREQUENCY	MEASURE	DATE	TARGET	CURRENT POSITION	PREVIOUS REPORTING PERIOD	PREVIOUS YEAR	DIRECTION OF TRAVEL (YEAR ON YEAR)	SCOTLAND POSITION	SCOTLAND DATE
Monthly	31 Day Cancer Target - Percentage compliance against target	31-Mar-26	95%	99.1%	99.1%	99.1%	◀▶	94.6%	31-Mar-26
Monthly	31 Day Cancer Target - Number seen within target against total	31-Mar-26	-	109/110	105/106	113/114	-	-	-
Quarterly	31 Day Cancer Target - Percentage compliance against target	31-Dec-25	95%	99.7%	99.1%	97.9%	▲	95.5%	31-Dec-25

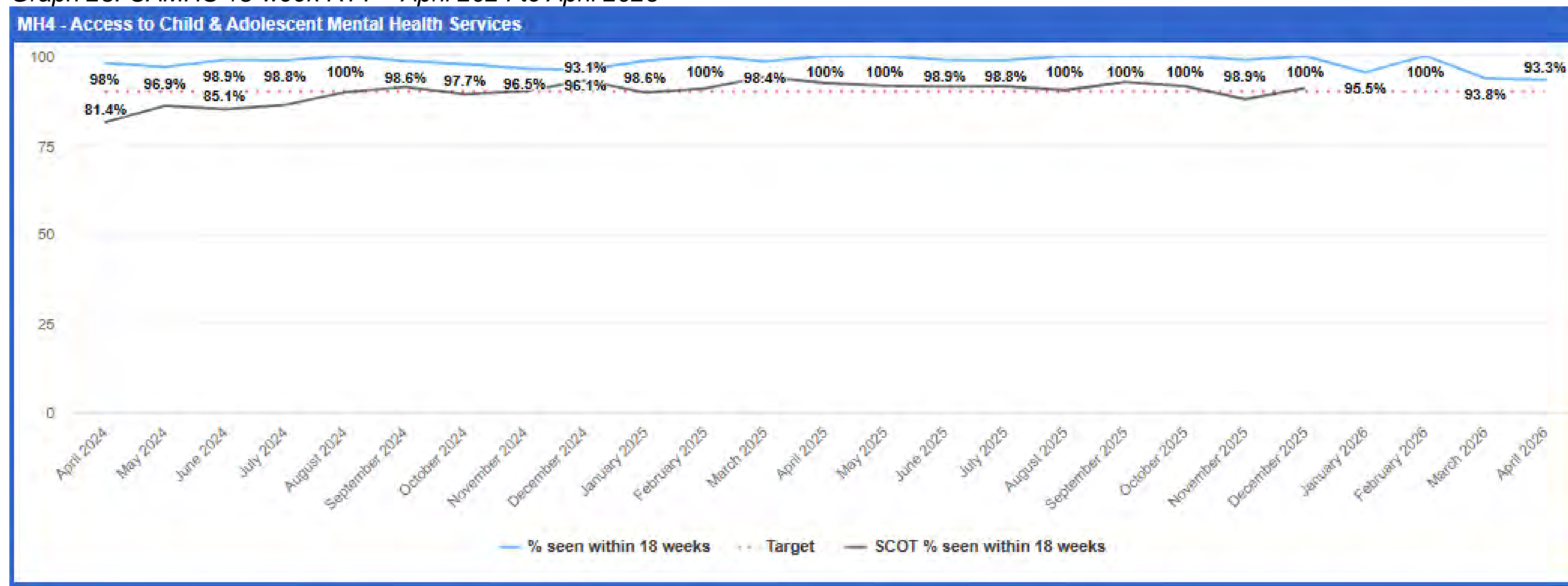
Graph 22: 31-day cancer performance (monthly) – April 2024 to March 2026



Child & Adolescent Mental Health Services (CAMHS)

FREQUENCY	MEASURE	DATE	TARGET	CURRENT POSITION	PREVIOUS REPORTING PERIOD	PREVIOUS YEAR	DIRECTION OF TRAVEL (YEAR ON YEAR)	SCOTLAND POSITION	SCOTLAND DATE
Monthly	Child & Adolescent Mental Health Services - 18 week RTT compliance	30-Apr-26	90%	93.3%	93.8%	100.0%	▼	90.9%	31-Dec-25
Monthly	Total Number Waiting for CAMHS Initial Assessment	30-Apr-26	Reduction	322	353	70	▼	-	-
Quarterly	Child & Adolescent Mental Health Services - 18 week RTT compliance	31-Mar-26	90%	96.3%	99.4%	99.1%	▼	90.0%	31-Dec-25

Graph 23: CAMHS 18-week RTT – April 2024 to April 2026



May 2026 numbers show we are continuing to perform above target with 93.3% of patients started treatment within 18 weeks of referral.

Section 4: Performance Scorecard

BETTER CARE													
REF	Target Type	FREQUENCY	MEASURE	DATE	TARGET	CURRENT POSITION	PREVIOUS REPORTING PERIOD	PREVIOUS YEAR	DIRECTION OF TRAVEL (YEAR ON YEAR)	SCOTLAND POSITION	SCOTLAND DATE	RUN CHART	NOTES
HOSPITAL STANDARDISED MORTALITY RATE													
MR1	SG	Rolling 12 mth	Hospital Standardised Mortality Ratio (HSMR)	31-Dec-25	</= 1.00	0.94	0.94	0.98	▲	1.00	31-Dec-25	-	Hospital Standardised Mortality Ratio (HSMR) is a measure of mortality adjusted to take account of some of the factors known to affect the underlying risk of death. The data is calculated on a rolling 12 months and published quarterly.
UNSCHEDULED CARE													
	FV	Monthly	Total Number of ED Attendances	30-Apr-26	Reduction	5,585	5,755	5,271	▼	-	-	-	
US1	SG	Monthly	Number of ED Attendances (4 hour access target)	30-Apr-26	Reduction	5,585	5,755	5,271	▼	-	-	-	Number of ED attandances and a target of 'Reduction' is relevant in relation to capacity and flow. National standard for A&E waiting times is that unplanned and new planned attendances at an A&E service should be seen and then admitted, transferred or discharged within four hours. This standard applies to all areas of emergency care such as EDs, assessment units, minor injury units, community hospitals, anywhere where emergency care type activity takes place. The measure is the proportion of all attendances that are admitted, transferred or discharged within four hours of arrival. 95% of patients should wait no longer than four hours from arrival to admission, discharge or transfer for A&E treatment.
US2	SG	Monthly	Emergency Department % compliance against 4 hour access target	30-Apr-26	95%	49.7%	47.3%	53.0%	▼	63.6%	31-Mar-26	✓	
US3	S5	Monthly	Number that waited >4 hours in ED	30-Apr-26	Reduction	2,808	3,032	2,476	▼	-	-	-	
US4	SG	Monthly	Number that waited >8 hours in ED	30-Apr-26	Reduction	1,281	1,462	998	▼	-	-	-	
US5	SG	Monthly	Number that waited >12 hours in ED	30-Apr-26	Reduction	524	618	411	▼	-	-	-	
US6	SG	Monthly	Number that waited >23 hours in ED	30-Apr-26	Reduction	35	54	5	▼	-	-		
	FV	Monthly	Total Number of MIU Attendances	30-Apr-26	Reduction	1,703	1,714	1,705	▲	-	-	-	
US7	SG	Monthly	Number of MIU Attendances (4 hour access target)	30-Apr-26	Reduction	1,703	1,714	1,705	▲	-	-	-	
US8	SG	Monthly	Minor Injuries Unit % compliance against 4 hour target	30-Apr-26	95%	99.2%	99.8%	99.7%	▼	-	-	-	
US9	SG	Monthly	NHS Forth Valley Overall % compliance against 4 hour target	30-Apr-26	95%	61.3%	59.4%	64.4%	▼	67.5%	31-Mar-26	✓	
US12	FV	Monthly	Number of Rapid Assessment and Care Unit New Attendances	30-Apr-26	-	527	513	517	-	-	-	-	
US13	FV	Monthly	Number of Rapid Assessment and Care Unit Scheduled Return Attendances	30-Apr-26	-	145	195	149	-	-	-	-	
US14	FV	Monthly	Number of Re-directions from ED	30-Apr-26	-	533	602	519	-	-	-	-	Redirections from ED to a more suitable setting enabling receipt of the right care, in the right place at the right time
US15	FV	Monthly	Re-directions from ED %	30-Apr-26	-	9.5%	10.5%	9.9%	-	-	-	-	
US16	FV	Monthly	Number of Emergency Admissions	30-Apr-26	Reduction	3,437	3,712	3,349	▼	-	-	-	Admission to a hospital bed following an attendance at an A&E service.
OUT OF HOURS													
OH1	FV	Monthly	Number of Out of Hours Presentations	30-Apr-26	Reduction	5,348	4,957	4,958	▼	-	-	-	
	FV	Monthly	Advice	30-Apr-26	-	3,595	3,270	3,438	-	-	-	-	
	FV	Monthly	Attend OOH Appointment	30-Apr-26	-	1,475	1,445	1,209	-	-	-	-	
	FV	Monthly	Home Visit	30-Apr-26	-	238	214	209	-	-	-	-	
	FV	Monthly	Mental Health	30-Apr-26	-	40	27	34	-	-	-	-	
	FV	Monthly	SAS In Attendance	30-Apr-26	-	0	0	65	-	-	-	-	
	FV	Monthly	Remote Consultation	30-Apr-26	-	0	1	3	-	-	-	-	
OH2	FV	Monthly	Out of Hours % Rota Fill	30-Apr-26	-	99%	98%	99.5%	▼	-	-	-	

SCHEDULED CARE													
OUTPATIENTS													
SC1	SG	Monthly	Total Number of New Outpatients Waiting	30-Apr-26	Reduction	18,653	18,782	14,104	▼	-	-	✓	An outpatient is categorised as a new outpatient at his first meeting with a consultant or his representative following an outpatient referral. Outpatients whose first clinical interaction follows an inpatient episode are excluded. Scotland position now monthly for SOT.
			Forth Valley	30-Apr-26	Reduction	18,517	18,528			-	-	-	
			Mutual Aid	30-Apr-26	Reduction	136	254			-	-	-	
SC2	SG	Monthly	Number of New Outpatients waiting over 12 weeks	30-Apr-26	Reduction	7,072	6,740	3,511	▼	-	-	✓	
			Forth Valley	30-Apr-26	Reduction	7,020	6,604			-	-	-	
			Mutual Aid	30-Apr-26	Reduction	52	136			-	-	-	
		Monthly	Number of New Outpatients waiting over 52 weeks	30-Apr-26	0	20	5	151	▲	-	-	✓	
			Forth Valley	30-Apr-26	0	14	5						
			Mutual Aid	30-Apr-26	0	6	0						
SC3	SG	Monthly	New Outpatients waiting under 12 weeks %	30-Apr-26	95%	62.1%	64.1%	75.1%	▼	50.5%	31-Mar-26	✓	
			Forth Valley	30-Apr-26	95%	62.1%	64.4%			-	-	-	
			Mutual Aid	30-Apr-26	95%	61.8%	46.5%			-	-	-	
SC6	Audit	Monthly	Outpatient Unavailability	30-Apr-26	Monitor	0.7%	0.5%	0.6%	▼	0.8%	31-Mar-26	✓	Unavailability, for patients without a date for treatment, is a period of time when the patient is unavailable for treatment. Unavailability can be for medical or social reasons. Scotland position quarterly
SC7	FV	Monthly	New Acute Services Outpatient % DNA	30-Apr-26	5%	4.6%	5.1%	4.7%	▲	6.1%	31-Mar-26	-	A patient may be categorised as did not attend (DNA) when the hospital is not notified in advance of the patient's unavailability to attend on the offered admission date, or for any appointment. Scotland position quarterly
SC8	FV	Monthly	Return Acute Services Outpatient % DNA	30-Apr-26	5%	4.9%	4.2%	5.2%	▲	-	-	-	
DIAGNOSTICS - Imaging													
SC10	SG	Monthly	Total number waiting - Imaging	30-Apr-26	Reduction	4,056	3,943	5,444	▲	-	-		Waiting times standard is that patients should be waiting no more than six weeks for one of the eight key diagnostic tests and investigations - Xray, Ultrasound, CT, MRI, Colonoscopy, Upper Endoscopy, Lower Endoscopy, Cystoscopy Scotland position monthly, available quarterly
SC11	SG	Monthly	Number waiting beyond 42 days - Imaging	30-Apr-26	0	693	612	2,338	▲	-	-	-	
SC12	SG	Monthly	Percentage waiting less than 42 days - Imaging	30-Apr-26	100%	82.9%	84.5%	57.1%	▲	62.1%	31-Dec-25	✓	
DIAGNOSTICS - Endoscopy													
SC15	SG	Monthly	Total number waiting - Endoscopy	30-Apr-26	Reduction	468	498	733	▲	-	-		
SC16	SG	Monthly	Number waiting beyond 42 days - Endoscopy	30-Apr-26	0	50	47	122	▲	-	-	-	
SC17	SG	Monthly	Percentage waiting less than 42 days - Endoscopy	30-Apr-26	100%	89.3%	90.6%	82.5%	▲	41.8%	31-Dec-25	✓	
CANCER													
SC20	SG	Monthly	62 Day Cancer Target - Percentage compliance against target	31-Mar-26	95%	76.4%	80.5%	67.9%	▲	74.0%	31-Mar-26	✓	Cancer services remain a priority for scheduled care. All Urgent Suspicion of Cancer referrals are tracked to support achievement of the 62 and 31 day access targets. In areas where this is not reached priority measures are taken to address this. A robust monitoring system has been established to identify reasons for breaches and ensure a plan is in place to prevent further non-compliance.
SC21	SG	Monthly	62 Day Cancer - Number seen within target against total	31-Mar-26	-	68/89	66/82	76/112	-	-	-	-	
SC22	SG	Monthly	31 Day Cancer Target - Percentage compliance against target	31-Mar-26	95%	99.1%	99.1%	99.1%	◄►	94.6%	31-Mar-26	✓	
SC23	SG	Monthly	31 Day Cancer Target - Number seen within target against total	31-Mar-26	-	109/110	105/106	113/114	-	-	-	-	
SC24	SG	Quarterly	62 Day Cancer Target - Percentage compliance against target	31-Dec-25	95%	70.3%	85.9%	79.2%	▼	71.7%	31-Dec-25	✓	
SC25	SG	Quarterly	31 Day Cancer Target - Percentage compliance against target	31-Dec-25	95%	99.7%	99.1%	97.9%	▲	95.5%	31-Dec-25	✓	
INPATIENTS & DAYCASES													
SC26	SG	Quarterly	Number of patients that waited >12 weeks - Completed Wait	31-Mar-26	0	2,223	1,847	1,533	-	-	-	-	Treatment Time Guarantee (TTG) - There is a 12 week maximum waiting time for the treatment of all eligible patients who are due to receive planned treatment delivered on an inpatient or day case basis. Scotland position quarterly
SC27	SG	Quarterly	% Compliance with 12 week TTG Standard	31-Mar-26	100%	31.1%	35.4%	44.3%	▼	54.5%	31-Mar-26	-	
SC28	SG	Monthly	Total Number of Inpatients/Day cases Waiting	30-Apr-26	Reduction	7,518	7,363	6,851	▼	-	-	✓	
			Forth Valley	30-Apr-26	Reduction	7,257	7,138		-	-	-	-	
			Mutual Aid	30-Apr-26	Reduction	1	17		-	-	-	-	
			NTC	30-Apr-26	Reduction	260	208		-	-	-	-	
SC29	SG	Monthly	Number of Inpatients/Day cases waiting over 12 weeks	30-Apr-26	Reduction	4,763	4,679	4,329	▼	-	-	✓	
			Forth Valley	30-Apr-26	Reduction	4,574	4,522		-	-	-	-	
			Mutual Aid	30-Apr-26	Reduction	0	12		-	-	-	-	
			NTC	30-Apr-26	Reduction	189	145		-	-	-	-	
		Monthly	Number of Inpatients/Day cases waiting over 52 weeks	30-Apr-26	0	105	98	520	▲	-	-	✓	
			Forth Valley	30-Apr-26	0	95	91		-	-	-	-	
			Mutual Aid	30-Apr-26	0	0	0		-	-	-	-	
			NTC	30-Apr-26	0	10	7		-	-	-	-	
SC30	SG	Monthly	Percentage of Inpatients/Day cases waiting under 12 weeks	30-Apr-26	100%	36.6%	36.5%	36.8%	▼	39.8%	31-Mar-26	✓	
			Forth Valley	30-Apr-26	100%	37.0%	36.6%		-	-	-	-	
			Mutual Aid	30-Apr-26	100%	100.0%	29.4%		-	-	-	-	
			NTC	30-Apr-26	100%	27.3%	30.3%		-	-	-	-	
SC33	Audit	Monthly	Inpatient/Day case Unavailability	30-Apr-26	Monitor	5.0%	4.4%	3.9%	▼	3.4%	31-Mar-26	✓	Unavailability, for patients without a date for treatment, is a period of time when the patient is unavailable for treatment. Unavailability can be for medical or social reasons. Scotland position quarterly.

READMISSIONS													
R1	FV	Monthly	Readmissions - Surgical 7 day	30-Apr-26	Reduction	2.4%	2.2%	2.6%	▲	-	-	-	This is the measure of patients readmitted as an emergency to a medical/surgical specialty within 7 days or 28 days of the index admission. Emergency readmissions as a percentage of all admissions.
R2	FV	Monthly	Readmissions - Surgical 28 day	30-Apr-26	Reduction	5.1%	5.2%	6.2%	▲	-	-	-	
R3	FV	Monthly	Readmissions - Medical 7 day	30-Apr-26	Reduction	1.6%	1.4%	1.5%	▼	-	-	-	
R4	FV	Monthly	Readmissions - Medical 28 day	30-Apr-26	Reduction	4.1%	3.9%	4.0%	▼	-	-	-	
MENTAL HEALTH													
PSYCHOLOGICAL THERAPIES													
MH1	SG	Monthly	Psychological Therapies - 18 week RTT compliance	30-Apr-26	90%	75.8%	75.9%	74.2%	▲	84.7%	31-Dec-25	✓	The 18 Weeks RTT is a whole journey waiting time standard from initial referral to the start of treatment. The standard has been determined by the Scottish Government and states that 90.0% of patients should have a completed pathway within 18 weeks.
MH2	FV	Monthly	Total Number Waiting for Pyschological Therapies Initial Assessment	30-Apr-26	Reduction	1040	1072	1071	▲	-	-	-	
MH3	SG	Quarterly	Psychological Therapies - 18 week RTT compliance	31-Mar-26	90%	73.6%	74.1%	73.8%	▼	82.1%	31-Dec-25	✓	
CHILD & ADOLESCENT MENTAL HEALTH SERVICES													
MH4	SG	Monthly	Child & Adolescent Mental Health Services - 18 week RTT compliance	30-Apr-26	90%	93.3%	93.8%	100.0%	▼	90.9%	31-Dec-25	✓	
MH5	FV	Monthly	Total Number Waiting for CAMHS Initial Assessment	30-Apr-26	Reduction	322	353	70	▼	-	-	-	
MH6	SG	Quarterly	Child & Adolescent Mental Health Services - 18 week RTT compliance	31-Mar-26	90%	96.3%	99.4%	99.1%	▼	90.0%	31-Dec-25	✓	
SUBSTANCE USE													
SM1	SG	Quaterly	% Compliance with the 3 Week target - ADP (excluding Prisons)	31-Dec-25	90%	100.0%	100.0%	98.1%	▲	92.7%	31-Dec-25	✓	The Scottish Government set a Standard that 90% of people referred for help with problematic drug or alcohol use will wait no longer than three weeks for specialist treatment that supports their recovery.
SM2	SG	Quaterly	% Compliance with the 3 Week target - Prisons	31-Dec-25	90%	100.0%	100.0%	100.0%	◄►	96.9%	31-Dec-25	✓	
COMPLAINTS													
C1		Monthly	% Compliance Forth Valley (inc. prisons)	31-Mar-26	100%	80.8%	78.7%	64.3%	▲	-	-	✓	Complaints monitoring and feedback is a standing item on the Clinical Governance Committee agenda
C2		Monthly	% Compliance Stage 1 (inc. prisons)	31-Mar-26	100%	75.9%	76.4%	43.6%	▲	-	-	✓	
C3		Monthly	% Compliance Stage 2 (inc. prisons)	31-Mar-26	100%	49.5%	45.5%	4.3%	▲	-	-	✓	
BETTER WORKFORCE													
REF	**Target Type**	**FREQUENCY**	**MEASURE**	**DATE**	**TARGET**	**CURRENT POSITION**	**PREVIOUS POSITION**	**PREVIOUS YEAR**	**DIRECTION OF TRAVEL (YEAR ON YEAR)**	**SCOTLAND POSITION**	**SCOTLAND DATE**	**RUN CHART**	
WF3	SG	Monthly	Overall Absence	30-Apr-26	4.0%	7.39%	7.59%	7.56%	▲	6.51%	31-Mar-26	✓	Hours lost due to sickness absence / total hours available (%). Short Term Absence - a period of sickness absence of 28 days or less Long Term Absence - a period of sickness absence lasting over 28 days Absence Management is a standing item on the Staff Governance Committee agenda.
WF4	FV	Monthly	Short Term Absence	30-Apr-26	-	2.36%	2.59%	2.43%	▲	-	-	-	
WF5	FV	Monthly	Long Term Absence	30-Apr-26	-	5.03%	5.00%	5.13%	▲	-	-	-	
WF6	FV	Rolling 12 mth	Overall Absence	30-Apr-26	-	7.88%	7.92%	7.73%	▼	6.60%	31-Mar-26	-	

REF	Target Type	FREQUENCY	MEASURE	DATE	TARGET	CURRENT POSITION	PREVIOUS POSITION	PREVIOUS YEAR	DIRECTION OF TRAVEL (YEAR ON YEAR)	SCOTLAND POSITION	SCOTLAND DATE	RUN CHART	
BETTER VALUE													
DELAYED DISCHARGES													
VA1	FV	Monthly	Delayed Discharges - excl. Code 9 & Guardianship (Standard Delays)	30-Apr-26	Reduction	47	50	96	▲	-	-	✓	A delayed discharge is a hospital inpatient who has been judged clinically ready for discharge by the responsible clinician in consultation with all agencies involved in planning that patient's discharge, and who continues to occupy the bed beyond the ready for discharge date
			Falkirk	30-Apr-26	Reduction	26	32	67	▲	-	-	✓	
			Clackmannanshire	30-Apr-26	Reduction	7	4	11	▲	-	-	✓	
			Stirling	30-Apr-26	Reduction	11	13	13	▲	-	-	✓	
			Outwith Forth Valley	30-Apr-26	Reduction	3	1	5	▲	-	-	✓	
VA2	FV		Code 9 & Guardianship Delays	30-Apr-26	Reduction	45	48	42	▼	-	-	✓	
			Falkirk	30-Apr-26	Reduction	17	17	20	▲	-	-	✓	
			Clackmannanshire	30-Apr-26	Reduction	12	11	11	▼	-	-	✓	
			Stirling	30-Apr-26	Reduction	14	18	8	▼	-	-	✓	
			Outwith Forth Valley	30-Apr-26	Reduction	2	2	3	▲	-	-	✓	
VA3	FV		Total Bed Days Occupied by Delayed Discharges (Standard Delays)	30-Apr-26	Reduction	1,010	1,523	4,018	▲	-	-	✓	
			Falkirk	30-Apr-26	Reduction	513	1,139	3,129	▲	-	-	✓	
			Clackmannanshire	30-Apr-26	Reduction	209	72	404	▲	-	-	✓	
			Stirling	30-Apr-26	Reduction	266	309	179	▼	-	-	✓	
			Outwith Forth Valley	30-Apr-26	Reduction	22	3	312	▲	-	-	✓	
VA4	FV	Daily	Number waiting for a Community Bed	30-Apr-26	Reduction	31	46	29	▼	-	-	-	
AVERAGE LENGTH OF STAY													
VA4	FV	Monthly	FVRH Acute Wards Average Length of Stay (Days)	30-Apr-26	Reduction	5.90	6.04	6.32	▲	-	-	-	This is the mean length of stay (in days) experienced by inpatients in FVRH Acute wards, does not include MH or W&C.
EFFICIENCY													
E1	FV	Monthly	ED Attendances per 100,000 of the population - Forth Valley	30-Apr-26	Reduction	1,845	1,901	1,741	▼	-	-	-	
E2	FV	Rolling 12 mth	Acute Emergency Bed days per 1,000 population - Forth Valley	30-Apr-26	Reduction	673	669	883	▲	-	-	-	
E3	FV	Monthly	% Bed Occupancy - FVRH	30-Apr-26	Reduction	99.7%	102.5%	110.9%	▲	-	-	-	The percentage occupancy is the percentage of average available staffed beds that were occupied by inpatients during the period. 85% is the nationally agreed standard supporting optimum flow
E4	FV	Monthly	% Bed Occupancy - Assessment Units	30-Apr-26	Reduction	80.1%	85.2%	106.7%	▲	-	-	-	
E5	FV	Monthly	% Bed Occupancy - ICU	30-Apr-26	Reduction	75.6%	76.4%	82.6%	▲	-	-	-	
EQUITABLE													
EQ1		Rolling 3 year	Scottish Breast Screening Programme	2020/23	70%	76.4%	74.4%	76.4%	◄►	75.9%	2020/23	-	Percentage uptake (three-year rolling periods), females aged 50-70 years
EQ2		Annually	Scottish Cervical Screening Programme	2023/2024	-	66.9%	66.3%	72.5%	▼	63.3%	2023/24	-	The percentage of eligible women who are up-to-date with their screening participation
EQ3		Rolling 2 year	Scottish Bowel Screening Programme	2022/24	60%	66.2%	66.6%	66.6%	▼	65.7%	2022/24	-	Overall uptake of screening - percentage of people with a final outright screening test result, out of those invited (2 year reporting period)
EQ4		Annually	Scottish Abdominal Aortic Aneurysm (AAA) screening programme	2023/24	75%	73.4%	24.1%	24.1%	▲	77.3%	2023/24	-	Percentage of eligible population who are tested before age 66 and 3 months
		Annually	Surveillance AAA scan (quarterly)	2023/24	90%	100.0%	84.4%	81.0%	▲	94.3%	2023/24	-	Due to attend quarterly surveillance and tested within 4 weeks of due date
		Annually	Surveillance AAA scan (annually)	2023/24	90%	91.8%	84.4%	84.4%	▲	94.4%	2023/24	-	Due to attend annual surveillance and tested within 6 weeks of due date
EQ5		Quarterly	NHS stop smoking services: Local Delivery Plan (LDP) - Number of 12-week quits	31-Mar-25	87	57	51	79	▼	-	-	-	The LDP Standard for NHS Scotland in 2024/25 is to achieve at least 7,026 self-reported successful twelve-week quits through smoking cessation services in the 40% most deprived areas
EQ6		Quarterly	NHS stop smoking services: 12-week quits as a % of the LDP Quarterly Target	31-Mar-25	100%	66.0%	59.0%	91.1%	▼	64.0%	31-Dec-24	-	
FINANCE													
F1	SG	FYTD	Year to date revenue position	30-Apr-26	Breakeven	-£1.966m	£0.245m	-£2.197m	▲	-	-	-	

Scorecard Detail	
Target Type	FV - Local target/measure set and agreed by NHS Forth Valley; SG - Target/measure set by Scottish Government
Frequency	Frequency of monitoring in relation to scorecard
Measure	Brief description of the measure
Date	Date measure recorded
Target	Agreed target position
Current Position	As at date
Previous Reporting Period	Previous year, quarter, month, week or day dependent on frequency of monitoring
Previous Year	Same reporting period in previous year
Run Chart	✓ - indicates run chart associated with measure is available
Key to Direction of travel	▲ - Improvement in period or better than target
	▼ - Deterioration in period or below target
	◄► - Position maintained
Scotland Position	Scotland measure
Scotland Frequency	Frequency of Scotland measure
Notes	

Forth Valley NHS Schedule of Business 2026/27									
		28 April	16 June (Private)	30 June	25 August	27 October	15 December	23 February	Comments
Standing Items	**Lead**								
Minute of previous meeting	Chair	☑	☑	☑	☑	☑	☑	☑	
Action Log	Chair	☑		☑	☑	☑	☑	☑	
Chair's Update	Chair	☑		☑	☑	☑	☑	☑	
Board Seminar Update (reported to next available Board meeting)	Chair	☑		☑	☑	☑	☑		
Board Executive Team Report	Chief Executive	☑		☑	☑	☑	☑	☑	
Strategic Risk Register	Head of Risk	☑		☑	☑	☑	☑	☑	
Spotlight on Services / Patient/Staff Story	END	☑			☑	☑	☑	☑	
Finance Report	DoF	☑		☑	☑	☑	☑	☑	
Performance Report	DoSPP	☑		☑	☑	☑	☑	☑	
Healthcare Associated Infection Reporting Template	END	☑		☑	☑	☑	☑	☑	
Quality & Safety Report	END / MD	☑			☑	☑	☑	☑	
Schedule of Business	BSec	☑		☑	☑	☑	☑	☑	
Minutes	Comm. Chair								
Assurance Committee Minutes	Comm. Chair	☑		☑	☑	☑	☑	☑	
Advisory Committees Minutes	Comm. Chair	☑		☑	☑	☑	☑	☑	
IJB Minutes: C & S and Falkirk	Comm. Chair	☑			☑	☑	☑	☑	
Finance									
Annual Accounts	DoF		☑						
Draft Financial Plan 2026/2027	DoF							☑	
Performance									
HSCP Annual Performance Reports	Chief Offs						☑		
Person Centred Complaints Feedback Annual Report	END					☑			
Safe Staffing Annual Report	END	☑							
Whistleblowing Annual Report	END			☑				☑	
Whistleblowing Standards and Activity Report	END			☑	☑		☑		
Strategy									
Access Policy	DoA								
Annual Delivery Plan	DoSPP				☑				

Climate Emergency & Sustainability Strategy and Action Plan 2023-2026 – Annual Update	DoFacilities					☑			
Communications Priorities	Head of Comms	☑							
Communications Update	Head of Comms				☑			☑	
Digital and eHealth Plan	DoD	☑		☑					
Equality Outcomes and Mainstreaming Annual Report – tbc	DoP								
Innovation Plan Annual Update	MD				☑				
Mental Health & Wellbeing Strategic Commissioning Plan	C&S Chief Officer				☑				
Participation & Engagement Strategy Update	Head of Comms								
Quality Strategy Annual Update	MD				☑				
Shifting the Balance of Care Business Case / Whole System Urgent & Unscheduled Care Plan	DoA Chief Officers							☑	
Stirling Children's Services Annual Report					☑				
Whole System Plan – tbc									
Winter Plan	DoA						☑		
Governance									
Board Assurance Framework – Annual Review (including Performance Framework)	DoSPP								
Code of Corporate Governance – Annual Review	BSec	☑							
Corporate Objectives	Chief Executive							☑	
Corporate Objectives 2025/26 Progress Update	Chief Executive				☑			☑	
Dates of Meetings	BSec					☑			
Development Plan Against Self-Assessment Progress Report	Chair				☑				
Statutory and national quality reports, including updates informed by HIS, Audit Scotland or other external scrutiny bodies where applicable.	As appropriate	As required		☑					