There will be a meeting of the **Forth Valley NHS Board** via **MSTeams** on **Tuesday 31 May 2022 at 10.30am**

Janie McCusker
Chair

AGENDA

1.	**Apologies for Absence**	
2.	**Declaration (s) of Interest (s)**	
3.	**Minute of Forth Valley NHS Board meeting held on 29 March 2022**	Seek Approval
4.	**Matters Arising from the Minute**	Items 1 to 4 *5 minutes*
5.	**Patient/Staff Story**	*15 minutes*
6.	**FOR APPROVAL**	
6.1	**Primary Care Premises Programme Initial Agreement (PIA)** (Paper introduced by Mrs Cathie Cowan, Chief Executive, and led by Mrs Kathy O'Neill, General Manger)	Seek Approval *20 minutes*
6.2	**Establishing Anchor Institution** (Presentation led by Mrs Cathie Cowan, Chief Executive)	Seek Approval *15 minutes*
7.	**BETTER CARE**	
7.1	**Healthcare Associated Infection Reporting Template** (Paper presented by Mrs Gillian Morton, Interim Executive Nurse Director)	Seek Assurance *10 minutes*
7.2	**Recovery & Performance Scorecard** (Paper presented by Mrs Cathie Cowan, Chief Executive)	Seek Assurance *10 minutes*
7.3	**Whistleblowing Standards and Activity Report** (Paper presented by Mrs Gillian Morton, Interim Executive Nurse Director)	Seek Assurance *10 minutes*
8.	**BETTER VALUE**	
8.1	**Finance Report** (Paper presented by Mr Scott Urquhart, Director of Finance)	Seek Assurance *10 minutes*
9.	**BETTER GOVERNANCE**	

9.1 **Climate Change and Sustainability: National Direction and Local Response** — Seek Assurance *10 minutes*
(Paper introduced by Mrs Cathie Cowan, Chief Executive and led by Jonathan Procter, Director of Facilities & Infrastructure/ Digital & eHealth Lead)

9.2 **ED Improvement Action Plan** — Seek Assurance *10 minutes*
(Paper led by Mrs Cathie Cowan, Chief Executive, Mrs Gillian Morton, Interim Executive Nurse Director, Mr Andrew Murray, Medical Director, Ms Linda Donaldson, Human Resource Director)

9.3 **Governance Committee Minutes** — Seek Assurance *15 minutes*

9.3.1 **Performance & Resources Committee Update: 26/04/2022**
Performance & Resources Committee Minute: 01/03/2022
(Paper presented by Mr Martin Fairbairn, Committee Chair)

9.3.2 **Audit & Risk Committee Update: 25/03/2022**
Audit & Risk Committee Minute: 21/01/2022
(Paper presented by Mr Scott Urquhart, Director of Finance)

9.3.3 **Staff Governance Committee Minute: 18/03/2022**
(Paper presented by Mr Allan Rennie, Committee Chair)

9.3.4 **Clinical Governance Update: 17/05/2022**
(Paper presented by Dr Michelle McClung, Committee Chair)

10. ANY OTHER COMPETENT BUSINESS

10.1 Emerging Topics

11. DATE OF NEXT MEETING

Friday 24 June 2022 at 8:00am (Special Board)
Tuesday 26 July 2022 at 10.30am

Closed Session Agenda – 31 May 2022

Item of business	Grounds for consideration in Closed Session as detailed within the Code of Corporate Governance
• Minute of the NHS Board Closed Session held on 29 March 2022	
• Code of Conduct	The Board is still in the process of developing proposals on its position on certain matters and needs time for private deliberation
• National Treatment Centre Forth Valley	The business relates to the commercial interests of any person and confidentiality is required, e.g., when there is an ongoing tendering process or contract negotiation.

FORTH VALLEY NHS BOARD
TUESDAY 31 MAY 2022

For Approval

Item 3 - DRAFT Minute of the Forth Valley NHS Board Meeting held on Tuesday 29 March 2022 at 10.30am via MS Teams

Present: Ms Janie McCusker (Chair)

Ms Kirstin Cassels
Mr Robert Clark
Mrs Cathie Cowan
Mr Martin Fairbairn
Mr John Ford
Dr Graham Foster
Mr Gordon Johnston
Mr Stephen McAllister
Cllr Susan McGill
Mr Andrew Murray
Mr Allan Rennie
Cllr Les Sharp
Mr Scott Urquhart
Prof Angela Wallace

In Attendance:

Annemargaret Black, Director of Health & Social Care
Elsbeth Campbell, Head of Communications
Patricia Cassidy, Director of Health & Social Care
Linda Donaldson, Human Resources Director
Sinead Hamill (Minute), Board Secretary
Kerry Mackenzie, Head of Policy & Performance
Jackie McEwan, Corporate Business Manager
Kathy O'Neil, General Manager
Jonathan Procter, Director of Facilities & Infrastructure
Phyllis Wilkieson, Acting Acute Services Director

---

1. Apologies for Absence

The Chair welcomed everyone to the meeting.

Apologies were noted on behalf of Cllr Fiona Collie and Mr John Stuart.

2. Declaration(s) of Interest(s)

There were no declarations of interest raised.

3. Minute of Forth Valley NHS Board meeting held on

The minute of the meeting on Tuesday 29 January 2022 was approved as an accurate record.

4. Matters Arising from the Minute

Board members noted that there were no matters arising from the minute.

5. 'Fiona's Story - The Wedding'

Professor Angela Wallace, Executive Nurse Director introduced a patient story which was captured at the beginning of the Pandemic. Prof Wallace highlighted to Board members that the story being presented was based on an end of life experience supported by the Macmillan One to One team (Pilot Project).

Board members heard about a patient called Fiona who had received a terminal diagnosis. Fiona had one last wish and that was to marry her partner, David. Prof Wallace introduced Ms Jane Niblo, Manager/Macmillan Community Care Nurse who played a huge part in supporting Fiona's wish. Throughout the video Fiona identifies how Ms Niblo from Macmillan made her last wish come true. Having secured a special license Fiona and her partner David got married. Board members shared in Fiona's experience including the lead up to the wedding and having her hair and make-up done for her 'big day'. Fiona described this as being the best day of her life.

Prof Wallace informed Board members that Fiona had passed away not long after being married. Board members noted the magnificent team effort to ensure Fiona's last wishes were granted alongside providing the right care and support. Prof Wallace identified that Fiona's husband David had been contacted for consent to share Fiona's story with the Board. The Chair asked Prof Wallace to pass on the Board's thanks to Fiona's husband David for allowing Fiona's story to be shared with Board members.

Mr Ford wished to seek clarity on how the Macmillan Nurses initially got involved. Ms Niblo confirmed the One to One Team had built up a credible service whilst working within the community and in doing so had a strong relationship with the Clinical Nurse Specialists who often sent on referrals to the Team.

Prof Wallace also informed Board members that Mr Murray had also been leading on a piece of work to look at palliative end of life care at a strategic level. Mrs Cowan in acknowledging the work led by Mr Murray on refreshing the Palliative Care Strategy wished to thank Ms Niblo for her very moving person-centred support. Mrs Cowan also thanked Prof Wallace for her leadership in supporting Board-wide person-centred care.

Mr McAllister identified that he had attended a Strategic Planning Group session that the Falkirk IJB had organised where it was identified that there had been some issues with HSCP referrals to support patients going home for end-of-life care and/or delays on accessing hospice care. Prof Wallace agreed to look into this with Partnership colleagues.

The Chair asked how the patient's families are also supported. Ms Niblo confirmed that the Macmillan One to One Team work alongside both the patient and their family in their end of life care and offer pre and post bereavement support. The Chair wished to thank the Macmillan One to One team on behalf of the Board for their work and support to patients and their families.

6. FOR APPROVAL

6.1 Financial Plan 2022/23 to 2026/27

The NHS Board considered a paper 'Financial Plan 2022/23 to 2026/27' presented by Mr Scott Urquhart, Director of Finance. Board members noted the report as set

out sought approval for the five-year revenue and capital plans, the Integration Authorities (IAs) annual budgets, and the cost improvement plan and proposed approach.

Board members noted the Plan as presented set out a balanced financial plan and the savings (£29.3m) required to achieve a balanced 2022/23 outturn. Board members noted the delivery of the savings needed would be a significant challenge and carried a high level of risk at this stage.

A Cost Improvement Plan was noted for 2022/23 with an early focus on resetting core financial and budgetary controls. Board members noted that a process for developing a future pipeline of a cost improvement scheme through a structured programme mandate had been established. A single reporting process would be adopted to avoid any risk of double counting against Directorate/Partnership Plans. Further updates on savings plans and delivery would be presented to the Performance and Resources Committee.

The total initial Budget for 2022/23 was noted as £598.158m including a 2.0% Core uplift, NRAC Funding and Employers National Insurance Contribution Uplift. The indicative allocation letter was also noted which confirmed additional funding for NHS Scotland patient outcome priorities including primary care and elective waiting times.

Board members noted that the non-recurring funding to support delivery of specific service priorities was anticipated at values similar to those in 2021/22. Mr Urquhart informed Board members that the process developed over the last two years to identify and report Covid-19 related costs will continue into 2022/23. Covid-19 costs would require to be managed within available ring-fenced funding resources which had not yet been confirmed. Mr Urquhart highlighted that the Covid-19 impact would continue to drive a significant level of increased costs and that clarity on funding arrangements and affordability would be a critical factor in delivering financial balance.

Mr Urquhart set out three broad areas of anticipated expenditure: Baseline Costs, new Inflationary Costs, and new Investment Costs. Board members noted that Projected pay inflation costs for 2022/23 are based on pay metrics set out in the Public Sector Pay Policy report published in December 2021, and that pay rates remained subject to final agreement.

Board members noted that there had previously been discussion at a Performance and Resources Committee regarding Integration Authority budgets including additional allocations for the health functions delegated to the Integration Authorities. The funding for ‘Set Aside’ services for IA strategic planning purposes was also set out. Mr Urquhart identified that the Financial Plan confirms that NHS Forth Valley had met its requirements in funding uplifts to both Integration Authorities in line with required timescales set out within the approved Integration Schemes.

Board members in noting the savings target acknowledged due to the current development stage of planning across the cost improvement schemes, a significant proportion of the plans as yet had been assessed as high risk for 2022/23.

Cllr Susan McGill wished to seek clarity regarding the National Insurance contribution continuing. Mr Urquhart informed Board members that the National insurance contribution will be a recurring baseline allocation.

Mr Rennie welcomed the Board's continued emphasis on financial sustainability and in doing so sought clarity on the workforce related savings theme and how this related to the current overspends in both agency and bank costs. Mr Urquhart identified workforce to be the biggest area of spend and highlighted that there is an opportunity to reduce supplementary and temporary staffing which will form part of the Cost Improvement Plan for 2022/23.

Mr Rennie also wished to seek clarity regarding the energy costs and estimated year on year uplifts and whether these were based on national of local cost estimates. Mr Urquhart identified that the energy costs had been benchmarked with other NHS Boards and in discussion with the Scottish Government based on current and future projected upward cost trends.

Mr Urquhart confirmed that the Scottish Government had asked for a Board one year revenue plan and a 5-year capital plan. Mr Urquhart also confirmed that a Cost Improvement Oversight Group had been established which he leads on. The Group will meet quarterly, supported by CPMO colleagues.

Cllr Sharp identified that Clackmannanshire Council had put in a Social Work bid to support prison related costs. Cllr Sharp wanted to know if there had been any collaboration for an integration approach for the Prison bid. Ms O'Neil identified that the prison bid submitted by the Council had been a collaborative process involving NHS colleagues.

The Forth Valley NHS Board:

- ***Approved the Financial Plan 2022/23 - 2026/27 detailed in Annex A***
- ***Approved the Capital Plan 2022/23 - 2026/27 detailed in Annex B***
- ***Approved the 2022/23 budgets for Integration Authorities***
    - ***Falkirk £ 170.853m***
    - ***Clackmannanshire/Stirling £ 155.125m***
- ***Approved the cost improvement plan and approach***
- ***Noted the financial risks highlighted for 2022/23 and for future years***
- ***Noted the ongoing financial impact of Covid-19 and the requirement to contain spend within available resources***

6.2 Corporate Objectives

The NHS Board considered a presentation 'Corporate Objective' presented by Mrs Cathie Cowan, Chief Executive.

Mrs Cowan highlighted that the Corporate Objectives are those that relate to the NHS Board as a whole and are intended to support the Board achieve its key priorities and goals for the period 2022/2023. Board members noted that the approval of the Corporate Objectives would in turn help inform the Board's staff personal objective setting and appraisal processes.

Mrs Cowan by way of introduction proposed only minor changes to the current Board Corporate Objectives notably to add prevention to support objective 2 (improve the health and wellbeing of the people of Forth Valley whilst reducing health inequalities) and to add sustainability to objective 3 (Improve our focus on safety and quality). Board members agreed that prevention be referred to in objective 2 and it was agreed to add 'protect' to this objective.

Board members agreed to add sustainability to objective 3.

Mr Rennie wished to know if the recommendations will be lifted and incorporated into the new Code of Corporate Governance. Mrs Cowan confirmed that the Code would be updated once the Corporate Objectives are approved. Mr Rennie also supported adding 'protect' to objective 2 and referenced the link to equality and equity and sought clarity on how this linked to improving population health and wellbeing. Mrs Cowan proposed you need both equity and equality given not everyone starts at the same place or needs the same level of resource or opportunity to succeed.

Mr Clarke in agreeing with sustainability being added to objective 3 proposed that this needed to also cover environmental as well as service sustainability and the Board's commitment to being regarded as an anchor organisation. Mrs Cowan agreed and confirmed a paper setting out the Board's role as an anchor organisation would be presented to the May Board meeting. Mrs Cowan agreed to update the Corporate Objectives following the Board meeting and to share these with Board Members to approve virtually, this was supported.

Ms Mackenzie highlighted that guidance will be received before the end of April 2022 in relation to developing the NHS Board's Annual Delivery Plan. The guidance would set out the national policy directions and timetable for submission to Scottish Government to comply with the delivery contract between NHS Boards and Government.

The Forth Valley NHS Board:

- ***Agreed to support the proposal to seek virtual approval for the updated Corporative Objectives***

6.3 Code of Corporate Governance

The NHS Board considered a paper 'Code of Corporate Governance' presented by Mrs Cathie Cowan, Chief Executive.

Mrs Cowan confirmed that NHS Forth Valley's Code of Corporate Governance is based on the principles of the UK Corporate Governance Code. The key principle refers to every institution being headed up by an effective Board, which is collectively responsible for the success of the organisation. Board members reaffirmed their collective understanding of their role and their commitment to providing leadership whilst operating within a framework of producent and effective controls which allow risks to be assessed and managed. Mrs Cowan in inviting Ms Mackenzie to highlight the key issues for consideration thanked Ms Mackenzie for her leadership in developing the Code being presented.

Ms Mackenzie reminded Board members that the Code of Corporate Governance was initially presented to the Board September 2021 where feedback received was then incorporated into an updated version and resubmitted to the Board for approval in November 2021. Board members noted that the Code of Corporate Governance was recently presented to the Audit and Risk Committee and endorsed for presentation to the NHS Board.

Ms Mackenzie informed Board Members that she had summarised the key changes within the Code which were mostly in relation to the Assurance Committees Terms of Reference. Ms Mackenzie wished to highlight that there is no change to the Code of Conduct; however, a draft Model Code of Conduct for the Health Boards is being developed nationally. Board members who serve on public bodies including NHS Boards would be expected to comply with the provisions set out within the Code. Board members noted that an agreement from Board Chairs will be sought and thereafter each Board will be asked to officially approve the revised Code of Conduct. Once the revised Code of Conduct has been approved it will be included within the

Board's Code of Corporate Governance and published on NHS Forth Valley's website.

Ms Mackenzie highlighted that there had been no changes made to the Standards of Business Conduct for NHS Staff. Changes to the Fraud Standards were identified to ensure linkage to Whistleblowing arrangements. No changes were noted towards the Standing Financial Instructions throughout the Code of Corporate Governance.

Ms Mackenzie highlighted that there had been no changes made to the Risk Management section however the Risk Management Strategy had been reviewed and included comments from Internal Audit colleagues. Board members noted that this review work had been paused whilst recruitment for the post of Corporate Risk Manager was undertaken. Ms Mackenzie identified that NHS Forth Valley new Corporate Risk Manager will take up post on the 21 April 2022 and work will begin to refresh the Strategy.

Board members noted that the Code of Corporate Governance will be kept under review and amended as necessary to ensure it reflects current national policy and guidance. A full review and update will be undertaken in March 2023.

The Forth Valley NHS Board:

- ***Noted the amendments to the Code of Corporate Governance***
- ***Noted the updated Terms of Reference within Section A - Standing Orders***
- ***Noted further updates will be made to the Code of Corporate Governance as necessary to ensure it reflects current policy and guidance***
- ***Approved the Code of Corporate Governance ahead of presentation to the Board Assurance Committees***

6.4 Draft Strategic Risk Register Q3 Report

The NHS Board considered a paper 'Draft Strategic Risk Register Q3 Report' presented by Mr Scott Urquhart, Director of Finance.

Mr Urquhart informed Board members that the Draft Strategic Risk Register Q3 Report was considered at the Audit and Risk Committee and wished to thank Ms Kerry Mackenzie, Head of Policy & Performance, and her team for preparing the report. Board members noted that the report sets out 12 Active Strategic Risks with 7 being noted as Very High and 5 being High. Mr Urquhart also identified a new strategic risk SRR.016.

Mr Urquhart informed Board members that he had received an update from Mr Procter in relation to risk SRR.015. Board members noted that the update identified an increase in international risk of cyber-attacks which both Mr Procter and his team had further reviewed and identified that there is an expectation that the score is going to increase, and this would be reflected in the next quarterly update. Mr Urquhart identified that there had been an investment towards Cyber Resilience solutions and equipment to mitigate the risk as far as possible.

Cllr McGill highlighted that the Stirling and Clackmannanshire IJB risk register identified a risk related to delegation of services with the date of August 2021 which was ongoing and was highlighted as red. Cllr McGill wished to seek clarity on why this was not reflected in the Board's risk register.

Mr Urquhart referred to the discussion regarding Cllr McGill's query at the Audit and Risk Committee with assurance provided on Board statutory compliance in regard to delegation of functions and budgets as also set out within the approved Integration Schemes. Cllr McGill and the Audit and Risk Committee whose members include both external and internal auditors had been assured by the update given. Mr Urquhart also highlighted that it had been agreed to revisit the 'set aside' medical staffing budget (no agreement had been reached at the time of approving the Integration Schemes). Mr Urquhart confirmed that NHS Forth Valley in agreeing to this review had taken a paper (November 2021) through the System Leadership Team. The review had been finalised and approvals to include the medical staffing budgets in the Set Aside budget had been approved to inform strategic planning decisions. Mr Urquhart confirmed that the original Public Bodies Act risk had been presented to the Board in August 2019 for de-escalation and this had been approved. The Chair before moving on sought assurance that Cllr McGill had received the clarity, she had sought from the update received, Cllr Mc Gill confirmed this to be the case.

Mr Fairbairn wished to note that under certain circumstance a couple of the risks currently had the same score pre controlled and after controls. Mr Fairbairn highlighted that in the longer term the Board would expect there to be a difference in the controls applied.

Mr Johnston wished to seek clarity on who will have ownership of the new risk SRR.016. Mrs Cowan identified that this risk should go through both the Staff Governance Committee and Clinical Governance Committee to make sure that clinically the service is safe and sustainable, this was supported.

Cllr Sharp welcomed the new risk SRR.016. Cllr Sharp whilst acknowledging the staffing challenges wished the Board to also consider service demand and Board capacity. Mrs Cowan confirmed that the Board was committed to delivering local services in and out of hours. The opportunities to build an integrated out of hours response was being developed in collaboration with both Partnerships. It was noted that this work had been paused during the pandemic.

Mr Rennie highlighted that SRR.014 mitigations had not progressed, and events planned had been cancelled due to Covid and system wide pressures. Mrs Cowan agreed with Mr Rennie and reassured Board members that work was ongoing to support a review of the Healthcare Strategy and how this aligns with other key strategic plans notably e.g., the Health Improvement Strategy being led by the established Programme Board. It was likely that this would now be presented to the Board for approval in October to allow time for effective stakeholder including partners and staff engagement.

The Forth Valley NHS Board:

- ***Considered the assurance provided regarding the effective management and escalation of Strategic Risks***
- ***Approved the proposed changes to the Strategic Risk Register for Quarter 3 2021/22***

7. BETTER CARE

7.1 Pandemic Update

The NHS Board considered a paper 'Pandemic Update' presented by Dr Graham Foster, Director of Public Health.

Dr Foster referred Board members to the appendices attached to the paper. The first appendix identified the Scotland's Strategic Framework Update, and the second appendix focused upon the Test and Protect Transition Plan.

Board members noted that from the end of March 2022 patients with Covid-19 symptoms will no longer be directed to NHS 24 111 helpline services and will be advised to contact their GP in a return to pre-pandemic arrangements.

Dr Forster identified that as predicted the Omicron cases had increased very rapidly causing a high peak around Christmas 2021. Board members noted that the combined impact of the national protection measures plus public caution and widespread use of Lateral Flow Device testing helped blunt the modelled pandemic wave which peaked in early January 2022.

Dr Foster identified that a new subtype of Omicron called B.A2 was recently identified which was s-gene positive and had become the dominant type during March 2022.

Board members noted that vaccinated individuals can still transmit Covid-19 to others. Dr Forster identified that individuals can still catch Covid even if vaccinated but assured the Board that those who are vaccinated tend to have milder symptoms and are prevented from falling seriously unwell.

A high level of the B.A2 Omicron in the population was noted with NHS Forth Valley Test and Protest Service being very busy. Dr Foster identified that there are measures in place as NHS Forth Valley have a highly immunised population and know how to look after Covid-19 along with the new anti-viral treatments. Board members noted that Covid-19 is a much less significant disease in terms of causing death and intensive care demand but is still causing a demand throughout hospital services.

Dr Foster informed Board members that routine Contact Tracing will end on 30 April 2022 which will propose a different Covid update for the next Board meeting.

Dr Foster sought clarity from Ms Cassidy whose hand was up on whether she wished to come in at this stage. It was confirmed that Ms Cassidy wished to contribute to the previous item. The Chair having moved on acknowledged she would take contributions to item 6.4 offline given the Board member who raised the concern had confirmed being assured by the response.

The Chair sought clarity on the Test and Protect workforce, and the future deployment arrangements for staff.

Mr McAllister also sought clarity and identified that the chance of their not being another variant is very slim and wished to know if test and protect standards will still be in place. Mrs Cowan wished to invite Miss Donaldson, HR Director to provide an update to reassure Board members on Test & Protect arrangements and the deployment of staff, the Chair agreed.

Miss Donaldson identified that there are 34 whole time equivalent staff that have short term contracts for Contact Tracing. Board members noted that a process for the redeployment of these staff members will be followed in line with the normal HR process. This would support staff who have contracts to be redeployed where they can be.

In addition, Miss Donaldson confirmed that a number of staff who are employed on the Staff Bank provide regular work for Test & Protect as does staff working in notably corporate roles within NHS Forth Valley. These staff groups could be reinstated if this was required and/or directed. Board members noted that Dr Foster and his team would also support in the event of a future surge in Covid-19.

The Forth Valley NHS Board:

- ***Considered the latest public health Forth Valley updates and assurance provided in responding to the pandemic***

7.2 Healthcare Associated Infection Reporting Template (HAIRT)

The NHS Board considered a paper 'Healthcare Associated Infection Reporting Template' presented by Prof Angela Wallace, Executive Nurse Director.

Prof Wallace identified that the HAIRT Reported presented is a positive report for February 2022.

Covid numbers for February 2022 were noted as relatively low. However, an increase in Covid presentations throughout March 2022 was identified with increased Covid Outbreaks also being highlighted in Care homes.

Performance in relation to control measures was also noted throughout the HAI Summary. Prof Wallace identified that there was a small number of infection relation to SABs, DABs, CDIs, and ECBs.

Prof Wallace highlighted that she had previously informed Board members that NHS Forth Valley is most likely not going to meet the E Coli Bacteraemia target. Board Members were informed that no NHS Board's will meet this target. Board members noted that there were no surgical site infections and no MRSA or C. difficile recorded deaths reported for the month.

Prof Wallace informed the Board that the Care Home Oversight arrangements remained in place and will continue for another year. It was noted the Oversight Group would continue to meet weekly moving forward.

The Forth Valley NHS Board:

- ***Noted the HAIRT report***
- ***Noted the performance in respect of the AOP Standards for SABs, DABs, CDIs & ECBs***
- ***Noted the detailed activity in support of the prevention and control of Health Associated Infection***

7.3 Recovery & Performance Scorecard

The NHS Board considered a paper 'Recovery and Performance Scorecard' presented by Mrs Cathie Cowan, Chief Executive.

Mrs Cowan wished to put on record her thanks to staff for their ongoing commitment and efforts to manage ongoing significant system wide pressures and the management of the risks associated with these pressures. Mrs Cowan also thanked Ms Mackenzie and her Team for the work that goes into producing weekly and monthly performance data for managers to use to inform their decision making.

At the outset Mrs Cowan apologised to the people of Forth Valley for the delays experienced when presenting to unscheduled care services despite the efforts of staff to create flow particularly within the acute hospital site. The 4-hour emergency access standard remained well below the 95% standard - the performance yesterday was 61.8% however the week before performance had been reported at 47%. Mrs Cowan reported high surges notably in the evening and work to better understand the reasons behind this were being looked into. System wide delays (92 delayed discharges including also 36 patients waiting to be transferred to a community health or social care bed) were contributing to long waits despite the increase in bed capacity including the use of additional beds and treatment rooms across both acute and community beds.

Hospital covid numbers remained high and were adding to the challenges in flow as staff adhered to strict infection prevention and control measures which meant high boarding levels.

Staff covid related absences were impacting on both health and care services as played out in overall system performance. In response to clarity on waiting times Mrs Cowan confirmed that in the main people presenting to the Emergency Department were being triaged within 15 minutes.

Mrs Cowan reported a drop (FV 76.4%, Scotland 75.5%) in the 62-day cancer target with notably challenges in urology services. The 31-day target was noted at 94.1% and Board members noted this was the first time that the compliance had dropped below 95% since January 2019, although this was likely to be back to within the standard range based on data being reviewed.

Mrs Cowan invited Ms Mackenzie to present the remining standards within the Recovery and Performance Scorecard. Ms Mackenzie identified in relation to Cancer Pathways that there is a number of patients being tracked week on week. Ms Mackenzie informed Board members of the provisional figures for February 2022 identifying that that the 31-day target did look likely to be back up to 100%. Board members noted that there still seems to be challenges for the 62-day target for February 2022 notably in urology services.

Ms Mackenzie wished to highlight areas in relation to scheduled care. Board members noted that the number of patients waiting for outpatient appointments had reduced for February 2022. Activity against the agreed Remobilisation Plan trajectory highlighted the cumulative position from April 2021 to February 2022 as 96% compliance. Ms Mackenzie identified that compliance for February itself was noted as 102%.

An increase for patients waiting for an inpatient and day case appointment had increased for those waiting beyond 12 weeks in February 2022. The activity against the agreed Remobilisation Plan trajectory highlighted the cumulative position from April 2021 to February 2022 with 82% compliance.

Board members noted that at the end of February 2022: 2063 patients were waiting beyond 6 weeks for imaging with 65.1% compliance and 270 patients were waiting beyond 6 weeks for endoscopy with 55.0% compliance. Ms Mackenzie wished to highlight that patients continue to be seen on a priority basis and the waiting lists are actively monitored and managed. Mrs Cowan confirmed plans were in place to increase diagnostic capacity notably in CT scanning.

Ms Mackenzie informed Board members of the DNA rates. A month-on-month reduction on DNAs was noted with work in place to support this ongoing reduction.

Board members noted that for February 2022 60.0% of patients started psychological therapies treatment within 18 weeks of referral. Ms Mackenzie informed the Board that this was a reduction from the previous month but was a better performance compared to February 2021 which was 53.8%. The Remobilisation Plan trajectory of 60% was exceeded in December and was also 60% for March 2022 which identifies that this was still being achieved. An improvement was also noted for CAHMS with 71.4% of patients starting treatment within 18 weeks of referral for February 2022.

Mr Rennie referred back to the DNA rates and wished to know if this was due to the booking system or if it was cultural and if there was a communication strategy in place to target those who are not turning up for appointments. Ms Mackenzie informed Board members that there is work being undertaken to understand some of the reasons for DNA rates.

Mrs Campbell identified that when moving over to the new system for issuing patients appointments that the letter did mention that patients could cancel their appointment online. Mrs Campbell also identified that the appointment letter had previously asked all patients to phone up to confirm that they will be attending their appointment. Board members noted that a lot of patients were giving up when trying to phone and cancel appointments due to frustration of the phone lines being too busy. Mrs Campbell informed the Board that the letter had now been turned around. Board members noted that changes had also been made to the reminder text message to ask patients who are not able to attend to cancel in advance to allow the space to be filled.

Cllr McGill was happy to see an improvement in CAHMS performance and asked how much of an impact on performance there may be due to the CAPA approach. Mrs Cowan informed Board members that ‘choice and partnership approach’ based on evidence suggests by matching resources to need improves patient and family satisfaction as well as improving access to care. The approach was being implemented although it was too early to attribute any improvement in performance to this as yet. Mrs Cowan informed Board members that this would be shared with members as part of a planned deep dive to the Performance and Resources Committee. Ms Mackenzie highlighted this will be brought back to the Performance and Resources June 2022 meeting.

Mr McAllister wished to know if there had been any work done on an app that could help with the DNAs and if this is something that NHS Scotland can be looking at across the Boards. Mrs Cowan confirmed the Board does use Netcall and we would have data on this which could be shared.

The Forth Valley NHS Board:

- ***Noted the current key performance issues***
- ***Noted the detail within the Recovery & Performance Scorecard***

7.4 Whistleblowing Standards

The NHS Board considered a paper 'Whistleblowing Standards' presented by Prof Angela Wallace, Executive Nurse Director.

Prof Wallace informed Board members that this was the third report being presented to the Board in relation to the Whistleblowing Standards. Board members noted that NHS Forth Valley are continuing to report against the ongoing development of standards and are handling concerns appropriately through the Whistleblowing Standards when raised.

Prof Wallace identified that NHS Forth Valley are reporting their position against the standards. The number of Whistleblowing cases was identified as being low. The Whistleblowing cases which had been identified had been completed adopting the standards and within the timeframe. Board members noted that there is one case which had not yet been closed due to the Whistleblowing group still working with the individual.

Prof Wallace informed the Board that the KPIs are currently not meaningful due to the cases being low at this stage. Board members noted that the Standards continue to be implemented.

Mr Johnston identified that numbers are low nationally and an awareness campaign is being looked into nationally which will be helpful to raise greater awareness.

Mrs Cowan confirmed Prof Wallace had been presenting the report to the Area Partnership Forum and that this had been well received. Prof Wallace wished to inform the Board that Mr Martin Fairbairn had contacted her to provide some helpful feedback which will be reflected upon in relation to training numbers.

The Forth Valley NHS Board:

- ***Noted that the full implementation of the National Whistleblowing Standards across NHS Forth Valley***
- ***Noted Whistleblowing activity in NHS Forth Valley in Quarter 3 of 2021/22***

8. BETTER VALUE

8.1 Finance Report

The NHS Board considered a paper 'Finance Report' presented by Mr Scott Urquhart, Director of Finance.

Mr Urquhart informed Board members that the Finance Report presented is a summary of the 2021/2022-year end. Board members noted that NHS Forth Valley outturn projections remained on track to deliver all three financial requirements, subject to External Audit review.

Board members noted that the workforce related costs remain a key area of risk given the additional capacity needed to support system wide pressures. Mr Urquhart confirmed annual leave accrual was yet to be factored in the revenue position although this was accounted for in end of year forecasts.

Board members noted that NHS Forth Valley staff are working closely with Health and Social Care Partnership colleagues regarding Covid-19 funding. A direction by

Scottish Government to carry forward Covid-19 earmarked funding using the IJB reserves process was being progressed.

Mr Urquhart informed Board Members that NHS Forth Valley whilst projecting a capital break even position for the year the commitment to the National Treatment Centre was yet to be finalised.

The Forth Valley NHS Board:

- ***Noted a projected break-even financial position against revenue and capital resource limits for 2021/22 year-end, subject to External Audit review and to key risks highlighted in the report***

9. BETTER GOVERNANCE

9.1 Communications Update

The NHS Board considered a paper 'Communications Update' presented by Mrs Elsbeth Campbell, Head of Communications.

Mrs Campbell shared the Communication Report from November 2021 to March 2022 to reflect the wide-ranging communication activity for this period.

Mrs Campbell informed Board members that the Cabinet Secretary had visited Dunblane Medical Centre in February 2022 this being the first visit by Mr Yousaf to NHS Forth Valley.

Board members also noted with pride that the Gold Medal Winner Nurse Vicky Wright had returned to work after her success at the Winter Olympics. A story regarding one of NHS Forth Valleys local patients was also identified as the patient had achieved a World Guinness after coming up to 50 years of having a heart valve replacement. Board members noted that the patient continues to be supported by the Cardiology team at Forth Valley Royal Hospital.

Board members acknowledged the work by Mrs Campbell and her Team.

The Forth Valley NHS Board:

- ***Noted the update and ongoing activity to support the response to the ongoing Covid-19 pandemic, service remobilisation and ongoing development of internal and external communications***

9.2 Governance Committee Minutes

9.2.1 Performance & Resources Committee Update: 01/3/22
Performance & Resources Committee Minute: 18/01/2022

Mr Ford informed Board members that the Performance and Resources Committee had approved after seeking assurance from Scottish Government the 'Sustainability Loan' for a GP Practice. Board members noted that the application was the first of a number of GP Practices in NHS Forth Valley to reach this stage of the process.

Board members noted that an update on poverty was presented to the Performance and Resources Committee by the Community Planning Partnership where the level of poverty was noted throughout Scotland. Mr Ford informed Board members that Clackmannanshire, Falkirk and Stirling Community Planning Partnerships had

focused on tackling poverty for a number of years with all three Local Outcome Implementation Plans having a strong emphasis on this.

Mr Ford informed Board members that a presentation was received noting the Clinical Governance arrangements to support oncology services. The Framework for the Effective Cancer Management had been discussed as part of this presentation. An update on the Integration Join Board 2022/23 Financial Planning was also presented to the Performance and Resources Committee.

The NHS Board noted the assurance provided through the minutes of the Performance and Resources Committee Meeting 18/01/22.

9.2.2 Audit & Risk Committee Minute: 21/1/2022

Cllr Sharp informed Board members that the approved ICE Report was being disseminated to the various standing committees for in-depth consideration and to ensure that the relevant Committee is overseeing and seeking assurance on each of their respective recommendations. Board members noted that the Audit follow up report had been red, amber, green rated and presented at the last Audit and Risk Committee Meeting. Cllr Sharp informed Board members that there are remaining outstanding audit follow up actions being pursued and would be considered at the next meeting of the Committee.

The NHS Board noted the assurance provided through the minutes of the Audit & Risk Committee Meeting 21/01/22.

9.2.3 Staff Governance Committee Minute: 10/12/2021

Mr Rennie informed Board members that a focused discussion on system pressures had been a highlight of the meeting. Mr Rennie acknowledged that staff wellbeing remained a key priority given the ongoing significant challenges that staff including manager continue to respond to. Board members also noted that the ED HR Review had been incorporated into the Staff Governance Work Plan. The importance of future Staff Feedback in relation to the ED HR Review was also noted.

The NHS Board noted the assurance provided through the minutes of the Staff Governance Committee Meeting 10/12/21.

9.2.4 Clinical Governance Update: 22/2/2022
Clinical Governance Minute: 16/11/2021

Dr McClung informed Board members that the remaining recommendations from the ED Report continue to be progressed and monitored by the Clinical Governance Committee. Dr McClung also wished to highlight that NHS Forth Valleys Hospital Standardised Mortality Ratio continues to be one of the best in Scotland.

The NHS Board noted the assurance provided through the minutes of the Clinical Governance Committee Meeting 16/11/21.

9.2.5 Endowment Committee Minute: 21/01/2022

Cllr Sharp informed Board members that the Investment Performance was benchmarked and that there was a proposal for a staff benefit grant to be established which had been approved.

The NHS Board noted the assurance provided through the minutes of the Endowment Committee Meeting 21/01/22.

9.2.6 Area Clinical Forum Minute: 20/01/2022

The NHS Board noted the assurance provided through the minutes of the Area Clinical Forum Meeting 20/01/22.

10. ANY OTHER COMPETENT BUSINESS

Mrs Cowan wished to bring to Board members attention that NHS Forth Valley is participating in a new national scheme set up to provide financial support to people who had experienced past child abuse in NHS Residential Care Settings across Scotland. Board members noted that The Redress Scheme seeks to acknowledge and provide recognition of passed harm and its impact on survivors. Mrs Cowan informed the Board that this Scheme will be published and put on NHS Forth Valleys website along with links to key documents to enable people who have been affected to have access.

The Chair wished to thank Non-Executive Board Members Mr John Ford and Councillor Les Sharp for their dedicated service to the Board.

The Chair also wished to thank Executive Nurse Director, Professor Angela Wallace for her dedicated service to the Board as she leaves to take up her new post at NHS Greater Glasgow and Clyde.

There being no other competent business the Chair Closed the meeting.

FORTH VALLEY NHS BOARD
TUESDAY 31 MAY 2022

6.1 Primary Care Premises Programme Initial Agreement (PIA)
For Approval

Executive Sponsor: Cathie Cowan, Chief Executive

Author: Kathy O'Neill, General Manager, Primary Care & Mental Health Directorate

---

Executive Summary

- The Scottish Government's vision for the future of primary care services is that "general practice and primary care at the heart of the healthcare system. People who need care will be more informed and empowered, will access the right professional at the right time and will remain at or near home wherever possible. Multidisciplinary teams (MDTs) will deliver care in our communities and be involved in the strategic planning of our services".
- In April 2021 the Health Board agreed to establish a Project to progress the development of a Programme Initial Agreement (PIA) for primary care premises across NHS Forth Valley. This has been developed in line with the requirements of the Scottish Government Capital Investment Manual and follows the submission of the Strategic Assessment in 2019.
- The aim of the PIA is "To Improve GP services for all: Ensuring all GP practices have adequate capacity to deliver core general medical services with access to extended community services within "fit for purpose" premises; responsive to current and changing practice populations."
- The project is being directed by Kathy O'Neill, and supported by NHS Forth Valley Corporate Portfolio Management Office (CPMO) and Buchan + Associates, a specialist external partner in health and social care consultancy and planning.
- This Report presents a draft Programme Initial Agreement document for **approval**, for onward submission to the Scottish Government Capital Investment Group.
- The draft Programme Initial Agreement was endorsed by the FCH & Primary Care Premises Programme Board on 22nd April 2022 and was considered by the Executive Leadership Team on 9th May 2022.
- Integration Joint Boards have received updates on the Initial Agreement as it has developed and following Health Board approval, the Initial Agreement will be presented to both Integration Joint Boards in June.

Recommendation:

Forth Valley NHS Board is asked to:

- **approve** the Primary Care Initial Agreement document for onward submission to the Scottish Government Capital Investment Group.
- **note** that following approval of the PIA, work would commence to progress with 4 separate Outline Business Cases; (one for each locality where capital investment is required), assuming the Falkirk Central locality requirements (fifth locality) are addressed as part of the FCH Master Planning project.

Key Issues to be Considered:

Emerging Model of Care & Locality Impact

- The focus of the PIA has been to explore with stakeholders the role of primary care within a transformed, integrated care system including how primary care reform may evolve in Forth Valley, noting the current and significant General Practice premises challenges.
- An area wide programme approach has been taken in order to try and maximise interdependencies and opportunities for effective and efficient investment which can benefit the breadth of primary care and the wellbeing of the population of Forth Valley as a whole.
- A preferred service model for the future delivery of primary care services is proposed. Underpinning the proposed service model is the need to assure General Medical Service delivery at local population level and to develop existing and new "hub" based models of care. A key element of these models is to provide some elements of primary and community-based services within larger premises. For example, the podiatry service post-pandemic has moved to providing the majority of clinical sessions in fewer locations while at the same time increasing the number of sessions for patients.
- Digital transformation requires to be at the heart of any future reform. Future business cases will ensure that next generation digital services are core to creating sustainable, quality services. This includes the expansion of virtual appointments, remote health monitoring, remote desktop server solutions and new primary care eHealth systems, ensuring that technology supports a more inclusive, patient led experience
- The diagrams below (tables 1 and 2) summarise the future service delivery options for primary care aligned services and how each service might be provided within the future model:

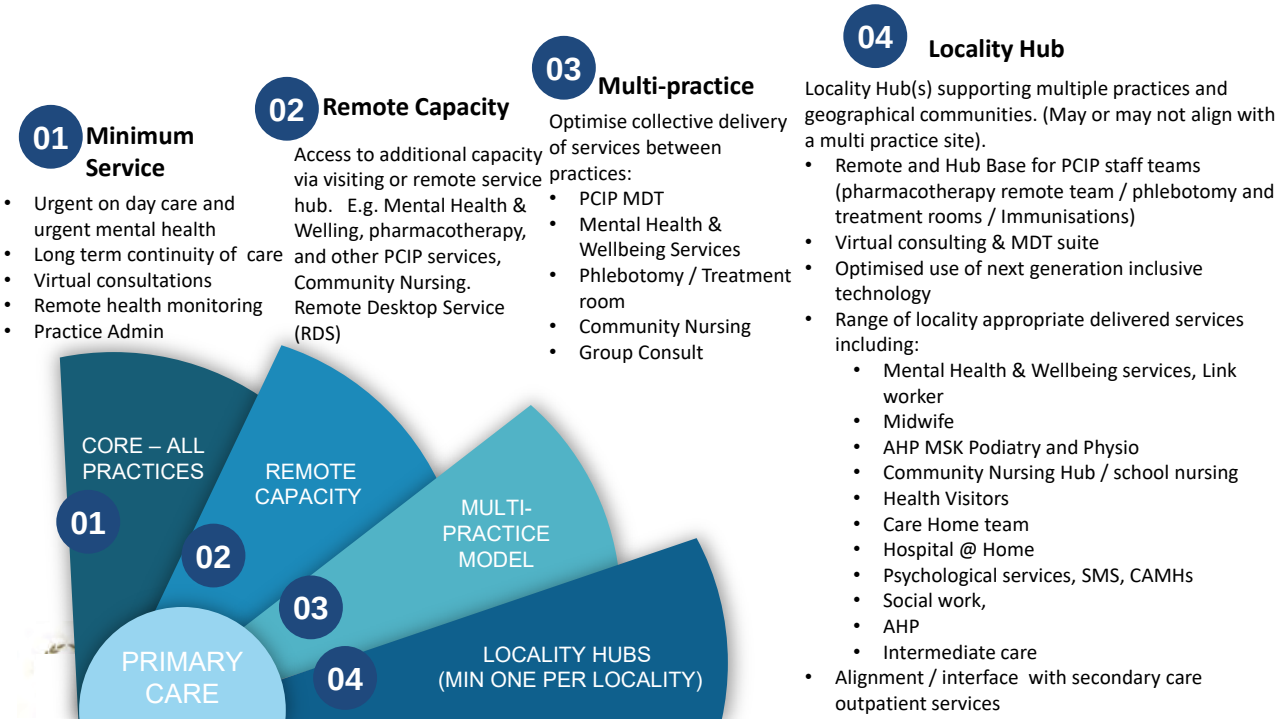


Table 1

Locality options	Proposed Configuration	Benefits	Impact
Option / Level 01	All 50 GP practices in Forth Valley require to deliver contracted, sustainable, person centered General Medical Service to people at community level.	Prioritised, targeted investment has the potential to: • improve a service limited by poor building quality and include a shift of practice owned premises to HB owned • improve services limited by a lack of space	• Re-location of a small number of non GMS community teams and services to strengthen existing and new locality hub models will facilitate space for first contact MDT access in general practice.

		• address new Housing Demand	• Example: - Reprovision of Cowie and Plean • Release of space in Meadowbank
Option / Level 02	Optimise the benefits which can be created through co-location of practices, particularly in urban areas served by more than one GP practices. Opportunity to collaborate and optimise the delivery of care and use of space and technology.	In addition to Level 01 benefits, targeted investment has the potential to: • Facilitate collective and dynamic models of MDT care such as Community Treatment, phlebotomy, pharmacotherapy, mental health, MSK and urgent care through effective delivery of Primary Care Implementation Plan Multidisciplinary Team between practices, • Group consultation approaches • Digital and remote support for wider community model.	• Example:- reprovision of premises for up to 4 practices in central Falkirk • Improved service provision in existing co located premises - Stenhousemuir, CCHC, Meadowbank. (a multipractice may or may not be a hub)
Option / Level 03	A hub and spoke option links GMS capacity within Community Hub with stand alone or multipractice models through service hubs or remote / digital support.	• In addition to Level 01 benefits practices would benefit from efficient locality delivered or in reach services such as Community treatment, phlebotomy, remote pharmacotherapy or other shared remote consultation approaches to improve access for patients	• Example – Support for rural practices
Option / Level 04	Provide co-ordinated and collocated non GMS locality teams and services.	• Build on existing models such as Stenhousemuir, Carronbank, CCHC, and Stirling Health & Care Village, to provide modern digitally enabled quality locality services. • Through a planned approach to community services, provide equitable access to patients both at general practice and community service level • To facilitate space for first contact MDT access in general practice.	• Targeted investment to re-locate / consolidate a small number of non GMS community teams and services. • May be in alignment with multipractice investment e.g. Falkirk Community Hospital. • Optimise the use of existing hub facilities

Table 2: Description of options with examples.

Project Management & Stakeholder Engagement

- To support the PIA development, a number of workshops have been held, attended by a range of stakeholders including extended project team (all locality managers, lead GPs, representation from patient/user/carer groups). Table 3 sets out the range of engagement events and workshops which have taken place. Integration Joint Boards and their Strategic Planning Groups have been updated on progress with the development of the Initial Agreement and are supportive.

Workshop	When	Purpose
Need for change	29th July 2021	Summarise the need for change. Identifying the key reasons for change in primary care, effect and why action required. Briefing papers issued to all attendees prior to session setting out purpose and role.
Benefits, Risks, Investment Objectives	19th August 2021	Develop the investment objectives, benefits & risks.
Service Model	8th October 2021	Develop and assess the proposed service options for each service. Follow up locality based meetings with locality manager, lead GP and patient /user/carer reps
Cross Check event	4th November 2021	Large stakeholder group from both PIA and FCH project including all patient user/carer reps. Each sub-group lead presented on their future clinical model and to identify service impact or dependencies
AEDET	17th November 2021	Undertake the evaluation of current estate using AEDET (Achieving Excellence Design Evaluation Toolkit); facilitated by Health Facilities Scotland
Design Statement	19th November 2021	Develop the Design Statement of non-negotiables for public, staff and users; facilitated by Architecture & Design Scotland.
Falkirk Central Practices	6th December 2021 13th January 2022 8th February 2022	Early engagement with potentially interested practices from Falkirk central locality who may wish to relocate to the proposed primary care component to the new Falkirk Health & Care facility. This investment proposal is likely to be picked up as part of the Falkirk Master planning Project; within the overarching shared programme of work.

Table 3

A number of other key activities have been undertaken in the development of the PIA:

- A survey was issued to general practices.
- Ongoing engagement with the GP sub-committee to ensure support with the proposed direction of travel and ongoing stakeholder engagement.
- A site visit to a new primary care facility in Clydebank.
- A workshop has been delivered by NHS Assure to give an overview of the project and provide an understanding of the Assure process and the specific requirements.
- Ongoing engagement with Health Facilities Scotland regarding design requirements and facilitation of a local design workshop.

External Assurance

As required by Scottish Government, the Programme IA has been subject to certain key external approvals processes:

- The IA has achieved 'Supported' status via the National Design Assessment Process (NDAP), though it is recognised that some further work is required to the Design Statement to address the recommendations from the review. It is anticipated that this will be completed prior to the CIG meeting but does not affect the status at this time.
- NHS Scotland Assure have been engaged in relation to the Key Stage Assurance Review and it has been confirmed that, due to their other commitments and in agreement with Scottish Government, a full review is not to be undertaken at this time. The alternative, a

Lessons Learned workshop with a view to informing the Outline Business Cases, is planned for 10 June 2022.

- In relation to Sustainability, at this stage a commitment is given to application of the Sustainable Design and Construction Guide from OBC onwards.

Approval Process and next steps

- The approvals process is outlined below:

Body	Action	Timescale
GP Sub-Committee	Endorse model of care	15th February 2022
Project Team	Endorsement	3rd March 2022
Programme Board	Endorsement	22 April 2022
ELT	Endorsement	9th May 2022
NDAP (Design Statement Submission)	Approval	May 2022
NHS Assure Workshop	Noting	June 2022
NHS Forth Valley Board	Sign off	31st May 2022
Falkirk Integration Joint Board	IA endorsement	10 June 2022
Clacks & Stirling Integration Joint Board	IA endorsement	29 June 2022
Capital Investment Group	Approval	Submission 18th May 2022 for 29th June 2022 meeting

Table 4

- Following approval of the PIA, work would commence to progress with 4 separate Outline Business Cases (one for each locality where capital investment is required), assuming the Falkirk Central locality requirements are addressed as part of the FCH Master planning project.

- Dependent on the outcome of the approval processes including the June Capital Investment Group, the estimated timeline to complete the investment is summarised below:

Task	Assumptions	Timeline
Locality Based Outline Business Cases	4 OBCs each 6 months plus 4 months approval	September 2022-July 2024
Locality Based Full Business Cases	4 FBCs each 6 months plus 4 months approval	August 23-September 2025
Construction & Commissioning	4 projects; each 18 month construction; 3 months commissioning	June 2024-December 2027
Operating facilities		May 2026 – January 2028

Table 5

A prioritisation exercise has been carried out to determine the order of locality based Outline Business Cases. This considered a number of measurable criteria and resulted in the following proposed programme:

1. Stirling city with the eastern villages, Bridge of Allan & Dunblane Locality

2. Falkirk East Locality
3. Clackmannanshire Locality
4. Falkirk West Locality

Conclusions

- Significant engagement has been undertaken over the last 9 months in the development of the programme of investment across primary care within NHS Forth Valley. A key component of this has been the development of a sustainable equitable model of care. The work has been undertaken with a range of stakeholder groups including significant input from members of the Strategic Planning Groups of both Integration Joint Boards.

- A significant programme of investment in proposed over the next 6 years, dependent on the availability of capital funding from the Scottish Government.

- The PIA development to date has focussed on the service model options; work to determine the specific locations of locality hubs and GP practice investments will be appraised and evaluated as part of the Outline Business Case which will follow.

Financial Implications
These are as outlined in the Programme Initial Agreement and will be further developed in the Outline Business Case.

There is an exercise currently underway reviewing recharges to GP Practices for heat, light and power to reflect present market conditions. Once complete, this review will inform running costs included within the Primary Care Initial Agreement and the figures contained within the current PC IA will be revised.

Workforce Implications
There are no significant workforce implications arising from this Paper, these will be developed further as the Programme progresses. Note the significant expansion in PCIP workforce of around 200 additional posts which underpin the need for this business case.

To support the work to develop outline business cases, a resourcing plan is in development.

Risk Assessment
A Risk Register is in place and reviewed monthly by the Project Group.

Relevance to Strategic Priorities
The Programme has a strong fit with strategic priorities, both nationally in relation to the GMS contract implementation and locally in relation to the Health Board Strategy and IJB Strategic Plans.

Equality Declaration
The author can confirm that due regard has been given to the Equality Act 2010 and compliance with the three aims of the Equality Duty as part of the decision making process.

Further to an evaluation it is noted that:

- Screening completed - no discrimination noted

Consultation Process
This is included within the paper and includes consultation with both Integration Joint Boards and the GP Sub Committee.

User engagement has been central to the development of the IA, particularly locality service delivery options and IA workshops. Whilst no significant service change is proposed, evidence of user engagement has been shared with HIS and a statement of support has been confirmed.

Appendices

Appendix 1 Primary Care Premises Initial Agreement

Appendix 2 Primary Care Premises Initial Agreement : Supporting documents

Programme Initial Agreement
Primary Care – Volume of Appendices

NHS Forth Valley

17th May 2022

APPENDIX A: GP PRACTICES BY LOCATION, INC. POPULATIONS SERVED

HSCP Name	Practice Name	Code	Address Line 1	Address Line 2	Postcode	Population served @Oct-21
Clackmannanshire and Stirling	**Aberfoyle and Buchlyvie Medical Centres**	25968	Aberfoyle and Buchlyvie Medical Centres	**Station Road**	FK8 3NB	2379
	Airthrey Park Medical Centre	25559	Airthrey Park Medical Centre	**Hermitage Road**	FK9 4NJ	7501
	Allan Park Medical Practice	25686	Allan Park Medical Practice	**19 Allan Park**	FK8 2QD	3804
	Alva Medical Practice (branch Tullibody)	25046	Alva Medical Practice	**West Johnstone Street**	FK12 5BD	13033
	Balfron Health Centre	25051	Balfron Health Centre	**41-47 Buchanan Street**	G63 0TS	2955
	Bridge Of Allan Health Centre	25101	Bridge Of Allan Health Centre	**Fountain Road**	FK9 4EU	6942
	Callander Medical Practice	25121	Callander Medical Practice	**Geisher Road**	FK17 8LX	4495
	Clackmannan and Kincardine Medical Practice	25135	Clackmannan and Kincardine Medical Practice	**Main Street**	FK10 4JA	7001
	Dollar Health Centre	25210	Dollar Health Centre	**Park Place**	FK14 7AA	5273
	Doune Health Centre	25224	Doune Health Centre	**Springbank Road**	FK16 6DU	4198
	Drymen Health Centre	25898	Drymen Health Centre	**2 Old Gartmore Road**	G63 0DP	1561
	Dunblane Medical Practice	25243	Dunblane Medical Practice	**Health Centre**	FK15 9AL	10620
	Edenkiln Surgery	25065	Edenkiln Surgery	**12 Dumbrock Road**	G63 9EG	2494
	Fallin, Cowie & Airth Health Centre	25169	Fallin Health Centre	**Stirling Road**	FK7 7JD	6330
	Forth Medical Group, Bannockburn*	26015	Bannockburn Health Centre	**Firs Entry**	FK7 0HW	23384 split: Bannockburn 30% Hallpark 30% Kersiebank 40%
	Hallpark, Forth Medical Group*		Clackmannanshire Community Healthcare Centre	**Hallpark Road**	FK10 3JQ	
	Kersiebank, Forth Medical Group*		Grangemouth Health Centre	**Kersiebank Aveenue**	FK3 9EL	
	Ochil Medical Practice	25027	Clackmannanshire Community Healthcare Centre	**Hallpark Road**	FK10 3JQ	10532
	Killearn Health Centre	25347	Killearn Health Centre	**Killearn**	G63 9NA	4596
	Killin Medical Practice	25351	Killin Medical Practice	**Laggan Leigheas**	FK21 8TQ	1540
	Kippen Surgery	25366	Kippen Surgery	**Castlehill Loan**	FK8 3DZ	2211
	Orchard House Health Centre	25525	Orchard House Health Centre	**Orchard House Health Centre**	FK8 1PH	4155
	Park Avenue Medical Centre	25582	Park Avenue Medical Centre	**GP Centre**	FK8 2AU	7846

	Park Terrace Medical Practice	25506	Park Terrace Medical Practice	**The GP and Minor Injury Service**	FK8 2AU	7072
	The Whins Medical Practice	25031	Clackmannanshire Community Healthcare Centre	**Hallpark Road**	FK10 3JQ	7024
	Tillicoultry Medical Practice	25544	Tillicoultry Medical Practice	**Park Street**	FK13 6AG	8333
	Tor Medical Group	25991	Tor Medical Group	**Carbrook Drive**	FK7 8DW	3145
	Viewfield Medical Practice	25737	Viewfield Medical Practice	**The GP and Minor Injury Service**	FK8 2AU	9723
Falkirk	**Antonine Medical Practice**	25192	Antonine Medical Practice	**Larbert Road**	FK4 1ED	5051
	Ark Medical Practice	25277	Ark Medical Practice	**9 Booth Place**	FK1 1BA	2567
	Bo'ness Road Medical Practice	25332	Bo'ness Road Medical Practice	**33 Bo'ness Road**	FK3 8AN	8222
	Bonnybank Medical Practice	25205	Bonnybank Medical Practice	**Bonnybridge Health Centre**	FK4 1ED	8369
	Braesview Medical Group	25455	Braesview Medical Group	**Meadowbank Health Centre**	FK2 0XF	9846
	Camelon Medical Practice	25313	Camelon Medical Practice	**3 Baird Street**	FK1 4PP	8176
	Carron Medical Centre	25652	Carron Medical Centre	**Ronades Road**	FK2 7TA	3980
	Carronbank Medical Practice	25188	Carronbank Medical Practice	**Denny Health Centre**	FK6 6GD	10272
	Denny Cross Medical Centre	25173	Denny Cross Medical Centre	**1 Duke Street**	FK6 6DB	5196
	Forthview Practice	25070	Forthview Practice	**Health Centre**	EH51 0DQ	4427
	Graeme Medical Centre	25309	Graeme Medical Centre	**1 Western Avenue**	FK2 7HR	5635
	Kinglass Medical Practice	25099	Kinglass Medical Practice	**Kinglass Centre**	EH51 9UE	3473
	Meeks Road Surgery	25281	Meeks Road Surgery	**10 Meeks Road**	FK2 7ES	10673
	Ochilview Practice	25671	Ochilview Practice	**Stenhousemuir Health Centre**	FK5 3BB	5898
	Parkhill Medical Practice	25460	Parkhill Medical Practice	**Meadowbank Health Centre**	FK2 0XF	12011
	Parkview Practice	25402	Parkview Practice	**Stenhousemuir Health Centre**	FK5 3BB	4954
	Polmont Park Medical Practice	25441	Polmont Park Medical Practice	**Meadowbank Health Centre**	FK2 0XF	7620
	Slamannan Medical Practice	25474	Slamannan Medical Practice	**Bank Street**	FK1 3EZ	2035
	Stenhouse Practice	25597	Stenhouse Practice	**Stenhousemuir Health Centre**	FK5 3BB	3101
	The Richmond Practice	25084	The Richmond Practice	**The Richmond Practice**	EH51 0DQ	8376
	Tryst Medical Centre	25648	Tryst Medical Centre	**431 King Street**	FK5 4HT	6198
	Viewpoint Medical Practice	25390	Viewpoint Medical Practice	**Stenhousemuir Health Centre**	FK5 3BB	6258

	Wallace Medical Centre	25262	Wallace Medical Centre	**254 Thornhill Road**	FK2 7AZ	7926
	Westburn Medical Practice	25883	Westburn Medical Practice	**Falkirk Community Hospital**	FK1 5SU	4561
					Total	**322972**

*Forth Medical Group includes: Kersiebank Grangemouth, Bannockburn and Hallpark Alloa

APPENDIX B: BOARD UPDATE PRIMARY CARE IMPROVEMENT PLAN – DECEMBER 2021

Primary Care Improvement Plan Implementation and Learning

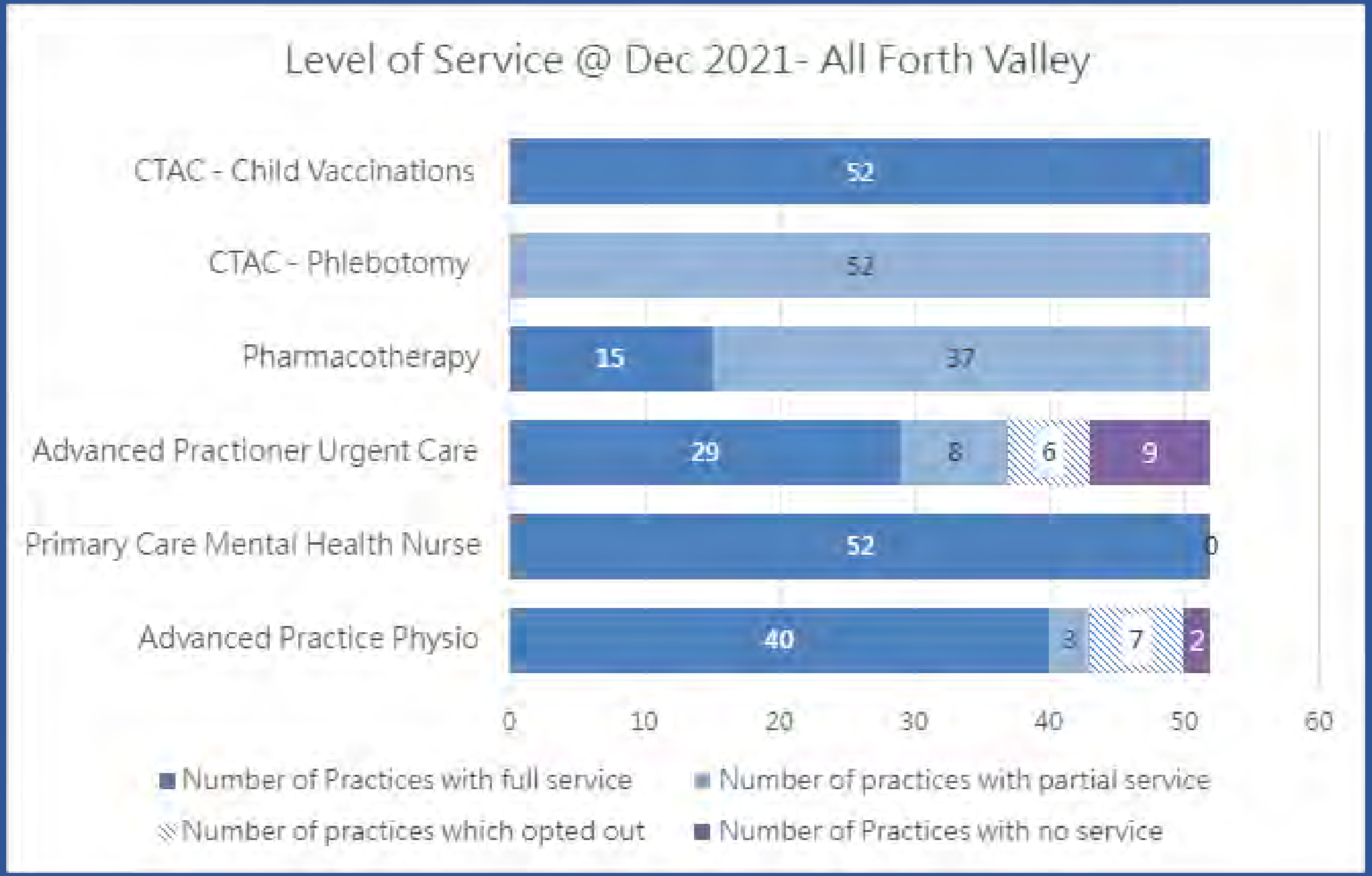
2018-2021

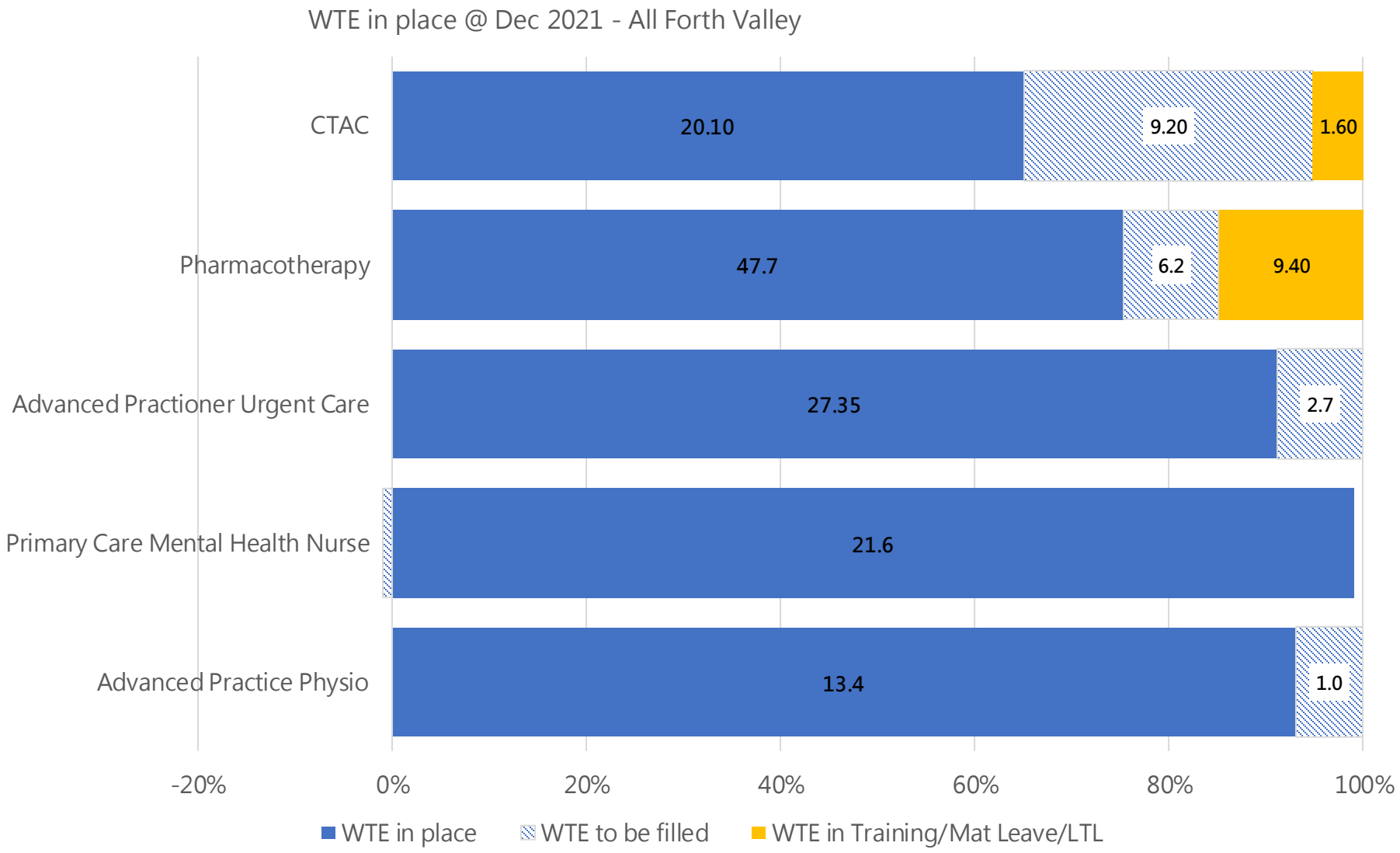
Lesley Middlemiss, Primary Care Improvement Programme Manager

6 Priorities over 4 years

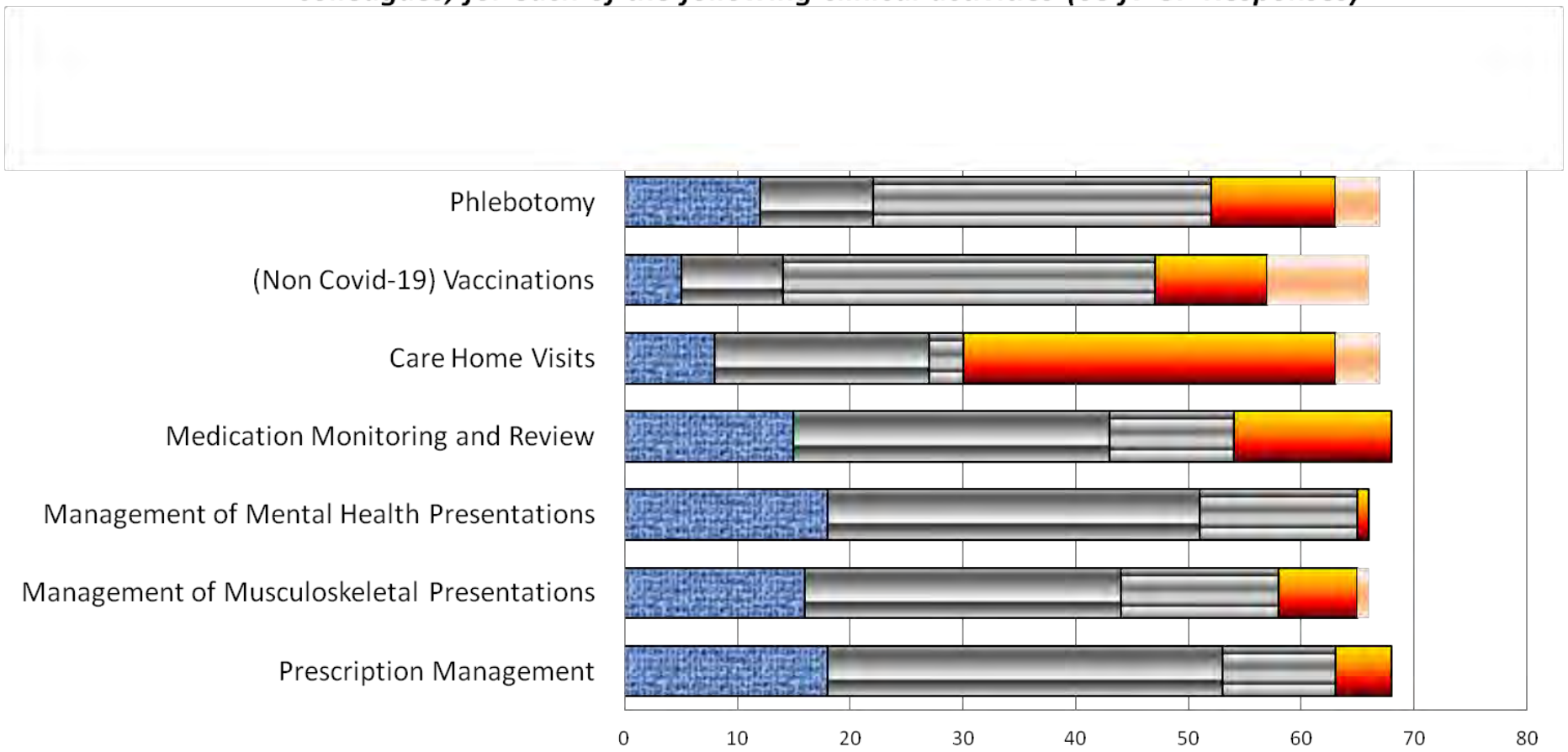
- Pharmacotherapy
- Vaccinations
- Community Treatment and Care
- Urgent Care
- Additional Professional Roles
- Community Link Workers

- **197 WTE New Staff**
- **New Roles**
- **New Teams**


Level of Service @ Dec 2021- All Forth Valley
CTAC - Child Vaccinations
52
CTAC - Phlebotomy
52
Pharmacotherapy
15
37
Advanced Practioner Urgent Care
29
8
6
9
Primary Care Mental Health Nurse
52
0
Advanced Practice Physio
40
3
7
2
0
10
20
30
40
50
60
Number of Practices with full service
Number of practices with partial service
Number of practices which opted out
Number of Practices with no service


WTE in place @ Dec 2021 - All Forth Valley
CTAC
Pharmacotherapy
Advanced Practioner Urgent Care
Primary Care Mental Health Nurse
Advanced Practice Physio
20.10
9.20
1.60
47.7
6.2
9.40
27.35
2.7
21.6
13.4
1.0
-20%
0%
20%
40%
60%
80%
100%
WTE in place
WTE to be filled
WTE in Training/Mat Leave/LTL

Are the additional staff helping to ease your workload, or the workload of your colleagues, for each of the following clinical activities (68 fv GP Responses)



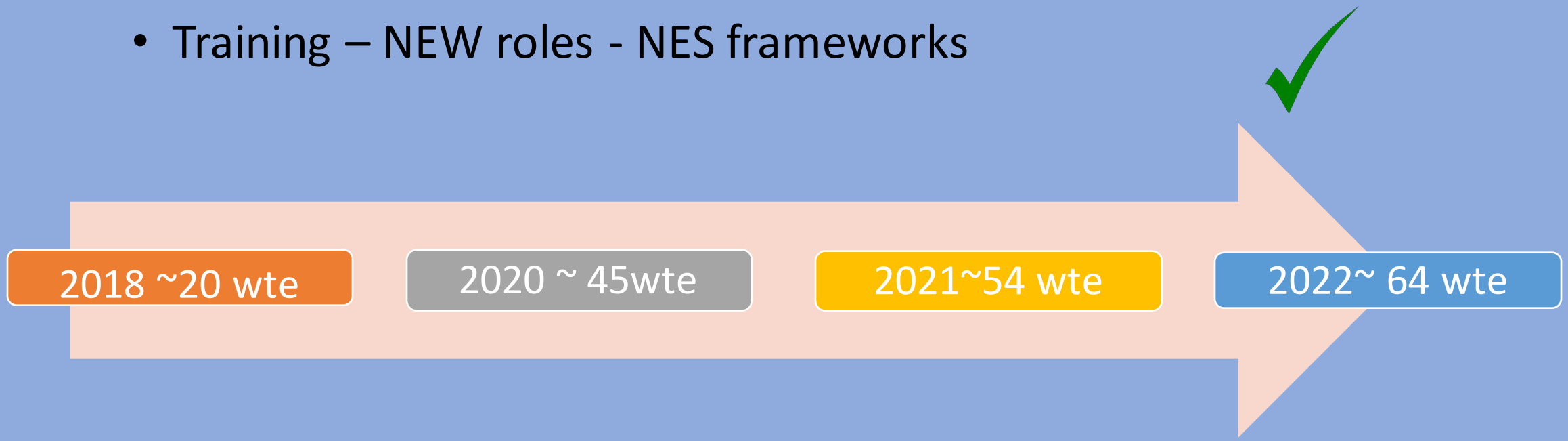
Pharmacotherapy

Building the bridge while walking on it

Clare Colligan, Lead Pharmacist, Primary Care, NHS Forth Valley

What do we need to build the bridge?

- People
  - Recruitment - successful
  - “Gaffers” – time for leadership and service development
  - Different Skills – Pharmacists / Technicians / Pharmacy Support Workers
  - Training – NEW roles - NES frameworks



What else do we need?

Timescale – by April 2022

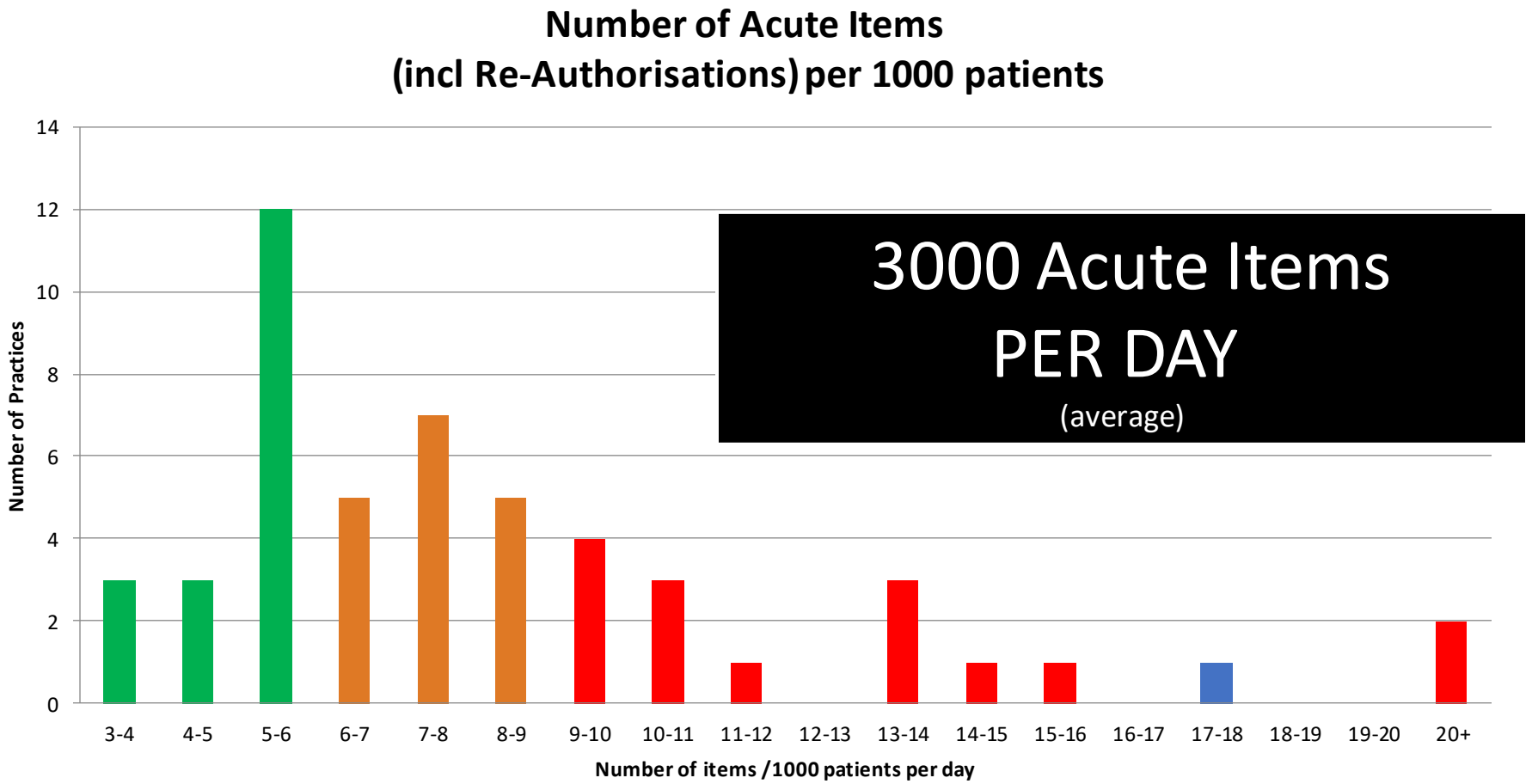
How many bricks? (TASKS)

What “weight” does the bridge need to carry

How many builders (staff) are required?

Is every bridge the same size?

What is the size of the bridge and what weight does it need to carry? Variation – Acute Requests



Data from manual count - March 21

How can we address this?

Whole System Working – launched Nov 21

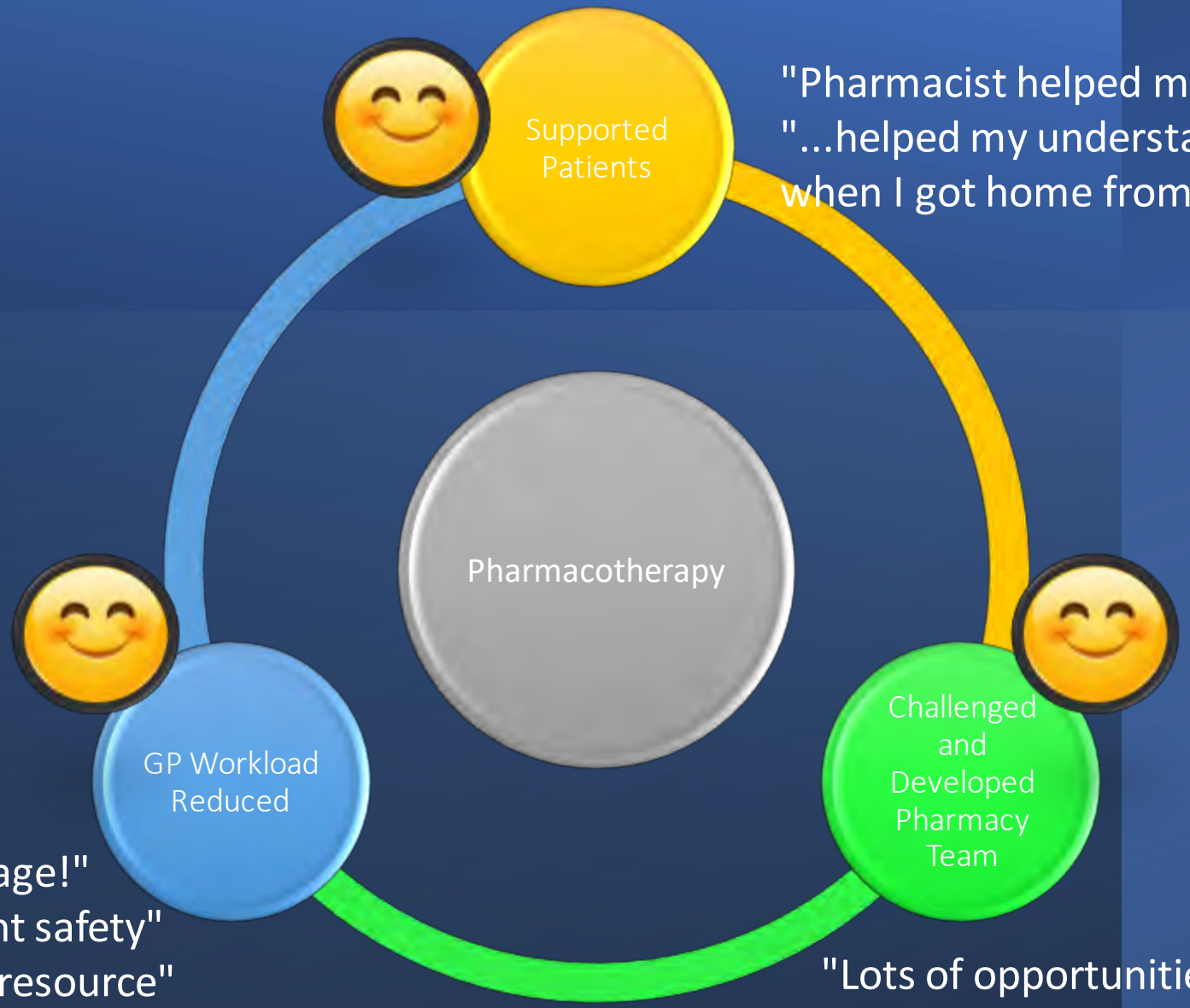
50 practices engaged

Review prescribing processes to streamline requests

Aim-> Reduce variation in acute requests and ↑Serial Prescribing

Ultimate Goal

Reduce	Reduce GP workload • Acute requests / Changes to medications on discharge / outpatient consultation
Manage	Manage HIGH RISK medications • Safe systems, appropriate recall
Support	Support patients on multiple medications / complex regimes • Polypharmacy reviews • Specialist clinics e.g pain, diabetes



"Pharmacist helped my hip pain"
"...helped my understand my medicines when I got home from hospital"

"Saved my marriage!"
"Improved patient safety"
"Knowledgeable resource"

"Lots of opportunities to develop"
"I feel a valued member of the team"

Christina Haining Lead Advanced Nurse Practitioner

ADVANCED PRACTITIONERS: NURSING AND PARAMEDIC PRACTITIONERS

Primary Care Improvement Plan 2018-2021

- By 2021, in collaboration with NHS Boards there will be a sustainable advance practitioner provision in all HSCP areas, based on appropriate local service design. These practitioners will be available to assess and treat urgent or unscheduled care presentations and home visits within an agreed local model or system of care.

How have we achieved this?

Currently **31** Advanced practitioners

in **41** practices, 6 of whom are in training

Provision of around 1200 appointments per week

Ongoing training of advanced nurses/paramedics

Further funding to recruit Senior ANPs

Provision of advanced practice modules appropriate to the role: Advanced Clinical Assessment Course, Non Medical Prescribing Course and Diagnosis & Decision Making in Primary Care

Collaboration with MDT, GPs, PMs

When I started in the role of ANP Trainee I knew I had a lot of transferable skills but I also knew I had a lot to learn. Working between 2 surgeries was difficult as both had different ways of working. One already had established ANP's that they employed and had a clear vision of what they expected from them. In Wallace I found it easier as they had never had an ANP so had no pure conceived ideas. In a way we were learning the role together. I felt supported by the GP's whilst encouraged to push my limits and learn more. The support I received from the lead ANP was outstanding. She would observe me in surgery and encourage my learning, encouraging my autonomy and always ensuring safe practice. The surgery have 5 GP's who all have very different characters and ways of working but they have adapted to my role and appreciate the contribution I make to the practice. Moving forward now that I have completed the training I have regular clinical supervision sessions with my identified link GP to further progress my learning.

Lorna Wells ANP

Brian Turner GP

I'm not sure what I really expected. I think I was hoping for the type of personality that Lorna has that can cope with our type of patients. I hoped that we would have significant amounts of our urgent patients dealt with by the ANP and not requiring GP input but obviously having the on call GP there for advice when needed. That has worked well. I don't think we ever really noticed/treated Lorna as a trainee as her experience in previous job really helped her. I think/hope she'd agree that we have been as supportive to her and always here when she needs us.

Our experience with having an ANP has been excellent. It has reduced our urgent workload and allowed us more time to spend on our complex routine patients and indeed the admin side of our job. Lorna has been an excellent addition to our team.

Challenges

- Local and national shortages of ANPs/AP
- Difficult to recruit to rural posts
- Resistance of practices to take on board a trainee ANP or Paramedic
- Staff withdrawing from posts or not applying due to salary
- Covid-19

Workforce Planning Then Vs Now

- March 2020 ANP & APs were pivotal in the setting up, organisation & staffing of the Covid assessment centre at Kersiebank then at SCH & CHART Team.

- Huge shift – shortage workforce & right skillset, interruption of training

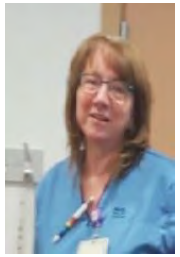
Class of 2021!

Urgent Care: Sharon Oswald; FV Advanced Practice Lead
Our PCIP Care Home Team, December 2021

Clackmannan

Pat 0.5 WTE ANP

Hazel 1.0 WTE Trainee ANP



Stirling

Claire 1.0 WTE ANP

UNIVERSITY of STIRLING

Falkirk

Carol 1.0 WTE ANP

Amanda 1.0 WTE Trainee ANP

Liaison Nurses to ANPs...

CLACKMANNANSHIRE CARE HOMES

Total Beds Covered = 382

PCIP ANP = 1.5 WTE (approx 250 beds per ANP)

NO GAPS

FALKIRK CARE HOMES NOT YET COVERED

Uncovered Nursing Home Beds= 325

Uncovered Residential Beds= 161

Total= 486

Total Beds Covered= 405 (Nursing Home Beds)

PCIP ANP: 2 WTE (approx 200 beds per ANP)

Falkirk Health and Social Care Partnership

NHS Forth Valley

STIRLING CARE HOMES NOT YET COVERED

Uncovered Nursing Home Beds= 100

Uncovered Residential Beds= 164

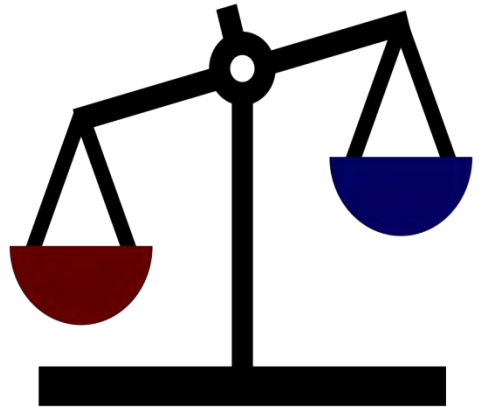
Total Beds Uncovered= 264

Total Beds Covered= 282 (Nursing Home Beds)

PCIP ANP = 1 WTE (approx 280 beds per ANP)

Clackmannanshire & Stirling Health & Social Care Partnership

"We Care" NHS Forth Valley



CLINICAL CHART

Background

- In April 2020 a dedicated multi-professional and multi-agency team called CHART (Care Home Assessment and Response Team) was implemented to support our care homes.

- The clinical CHART team was initially formed of different professionals that included GPs, palliative care specialist nurses and Advanced Nurse / Paramedic Practitioners to support care homes through the first wave of the pandemic. In the summer 2020, the deployed staff returned to their substantive posts.

- Unfortunately, in October 2020 the second wave of the pandemic saw our care homes return to a high risk and vulnerable position. The CHART team at that time was supported by the Advanced Practice workforce, often as overtime on days off and AL until some funding was released for temporary ANPs.

- The clinical CHART team actively visited some of the sickest people who were affected by COVID19 and kept anxious families updated. The team were involved in making difficult decisions about whether residents required admission to hospital and provided palliative and end of life care for those dying from the effects of the virus. The ANPs also supported the OOH teams for all non-COVID care home work at weekends and PHs.

FEEDBACK

Care Home staff feedback

" I felt fully supported and encouraged by the Clinical CHART team, staff were like guardian angels who have made my job more manageable, I am so grateful for the help the team have provided"

"CHART support was pro-active, flexible and helpful in applying the requirements of covid-19 management to a small care home. The team were good at coming and giving us advice to keep our residents safe. And if they didn't know they would find out for us."

"The group performed to a higher and more detailed level than I would have anticipated."

GP Feedback

"A great resource during the pandemic - as we needed a dedicated and resourced team with the knowledge and skills to support vulnerable people living in care homes."

Feedback from an ANP shielding at home

"It was nice to be involved in the team meetings in the morning and updated on how things were in general in the community during covid. I enjoyed being part of the team and feeling I was still able to contribute despite shielding at home."

Present Day & the Future??

No substantive funding was secured to continue CHART and the service ceased in July 2021, the temporary funded ANPs were aligned to substantive posts in H@H

In November 2021 COVID funding was secured for 2.6 WTE ANPs until March 2022

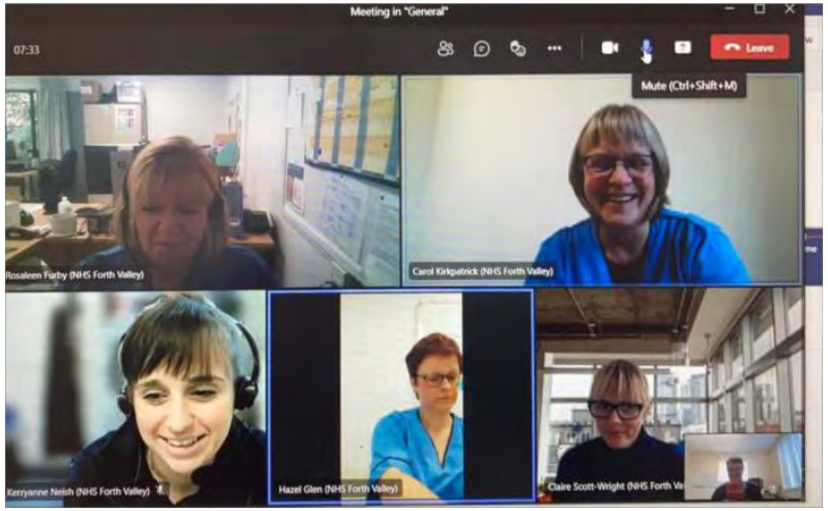
Sep. 2021

July 2021

Nov. 2021

In September 2021 our care homes had another outbreak of COVID-19 with no contingency for a clinical response team.

Ad-hoc ANP cover is again provided by those working additional hours



Advanced Physiotherapy Practitioners (APPs) in Primary Care

Cameron Marr
Advanced Physiotherapy Practitioner and Clinical Lead

APP service currently serves 44/51 GP Practices in FV (7 Practices opted out of an APP service)

First Health Board in Scotland to fully implement an APP service based in each GP Practice.

Based on a 1:20,000 wte per Practice population.

25 APPs/16wte

APP Service Vision & Aims

Vision:

- Be effective, compassionate and innovative in the delivery of high quality patient care by the right person, in the right place, first time.

Aims:

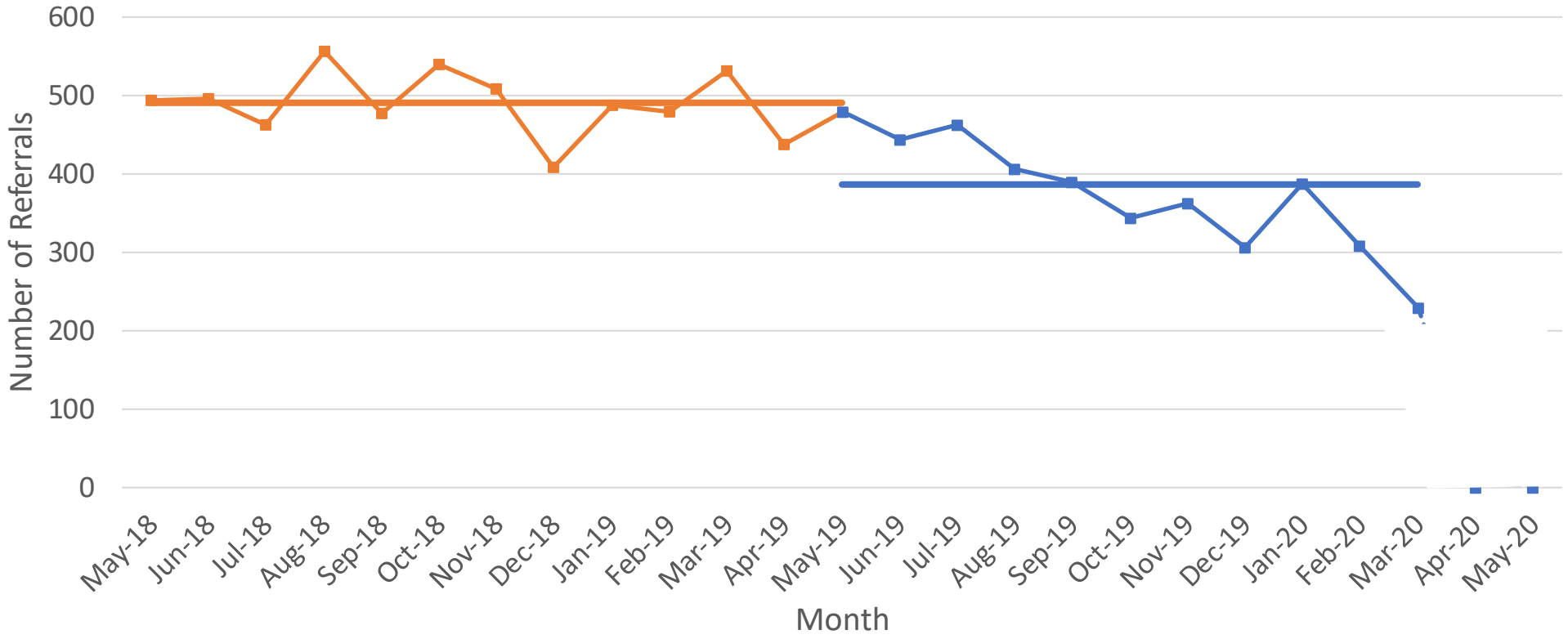
- Relieve pressure on GP workload by successfully managing MSK patients in Primary Care.
- Positively impact and measure concurrent benefits to the MSK and Orthopaedic services and improve collaborative working.

Service Summary – Impact on GP Workload

- Approx 3000 appointments available per month.
- Virtual consultations 40% & Face to Face consultations 60%
- Service fill rate is approx 98% (DNA rate 8%)
- >90% patients are managed solely within Primary Care
- Onward referral rate MSK Physio 7% & Ortho 2%
- 761 Steroid Injections in 2020 = refund £38,000 to Practices
- 885 X-rays ordered & 21 MRI in 2020

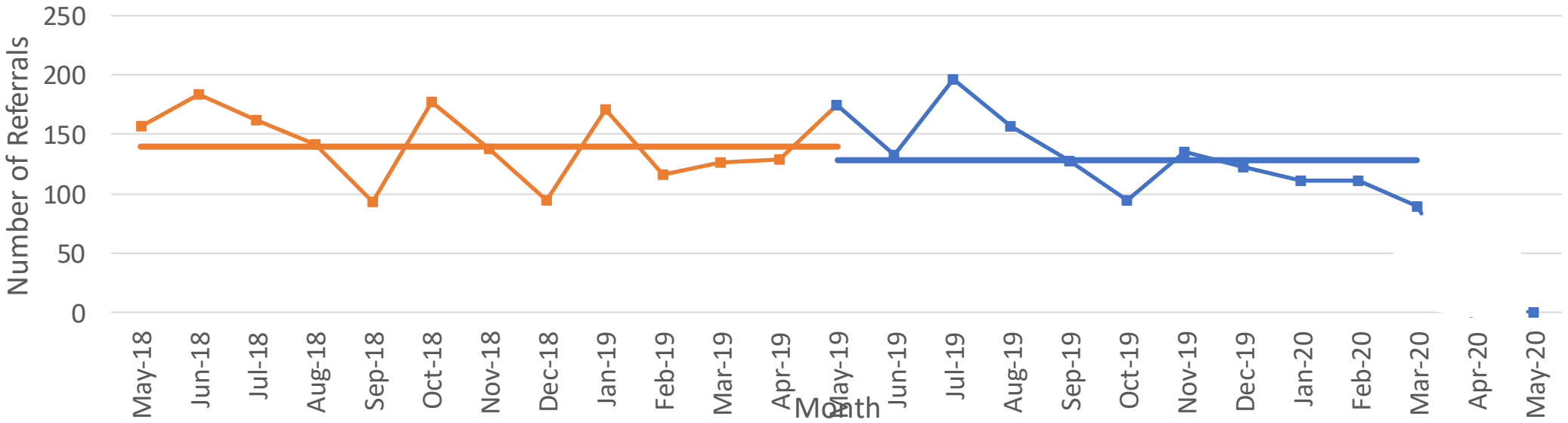
Benefits to the MSK Physio Service

- **21% reduction** from Practices with an APP service versus **13% reduction** from clusters with no APP service – a difference of 8% and amounts to approximately **1248 saved referrals per year.**



Benefits to Forth Valley Orthopaedic Service

- 761 Steroid injections offers a saving of £141,000 if these were completed by Orthopaedic Consultants.
- **9% decrease** in referral rates with Practices with an APP service whereas Practices without an APP service saw a **13% increase** in referral rates. This amounts to approximately **360 saved referrals per year.**



The Primary Care Mental Health Nursing Service Aim:

Stacey McIntosh
Team Lead

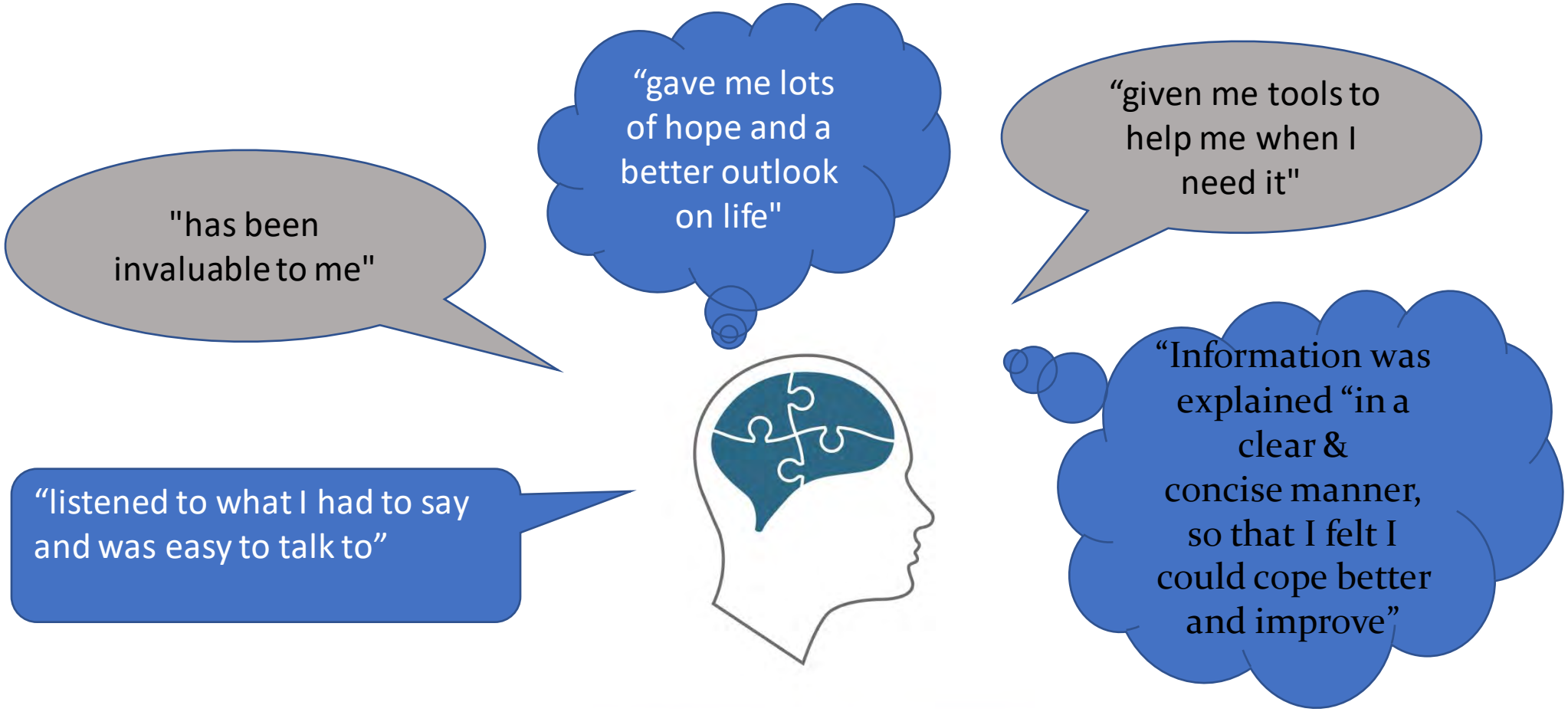
- To provide direct access to expert assessment and early intervention for patients with mild to moderate mental health difficulties within all 51 general practices in Forth Valley.

- To enable GPs to focus on more complex care by providing more than 4000 appointments per month to help manage the primary care mental health workload.

Positive for patients:

The PCMHN Service is seeing the right people at the right time:

- **96% of patients felt they saw the right person for their issue.**
- **86% of patients felt that they were seen as soon as they needed.**



Positive for Mental Health Nurses:

- **87%** of staff feel they have sufficient support to do their job well and would recommend the team as a good one to be part of.
- **100%** of staff would recommend a consult to their friends and family.

- Each member of staff is embedded in up to 4 GP practices.
- Staff have access to 1:1 managerial supervision every 4-6 weeks.
- Staff are able to engage in peer support sessions at regular intervals.
- All staff are being supported to complete a non-medical prescribing qualification, which allows more robust and efficient care for patients.

The PCMHN Staff Voice:

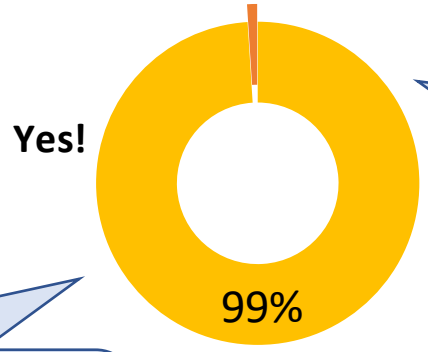
“A lot of appreciation from patients at a difficult time is encouraging".

Data collected over 1 week, with 13 respondents.

Positive for General Practice:

- The PCMHN Service now offers approx 4,172 appts per month (average).
- Approximately 80% of PCMHN appointments are attended.
- Referral back to GP care was less than 2.5%.

Is the PCMHN service valued?



Joint working between the GP and PCMHN is "very helpful"

The PCMHN "goes above and beyond to offer the best care" and is "very approachable and extremely helpful"

The PCMHN Service is "invaluable to us as a practice" and "takes pressure off GPs"

Data collected over 2 weeks, with 95 respondents.

The PCMHN Service Now:

All 51 practices have full service in place.

We have successfully recruited a full team of 24.7 WTE staff.

Whilst we don't have resource for covering absence, we now have a flex post which offers some resilience to any gaps created by vacancy or long-term leave.

Two thirds of PCMHN staff have now been supported through the non-medical prescribing course, and training will be ongoing for the remaining third.

Good understanding of the service and outcomes from three cycles of service evaluation.

Joint working and future plans:

- Community link workers, currently only in Falkirk, have a supportive working relationship with PCMHNs, and have worked jointly to provide positive outcomes for patients.

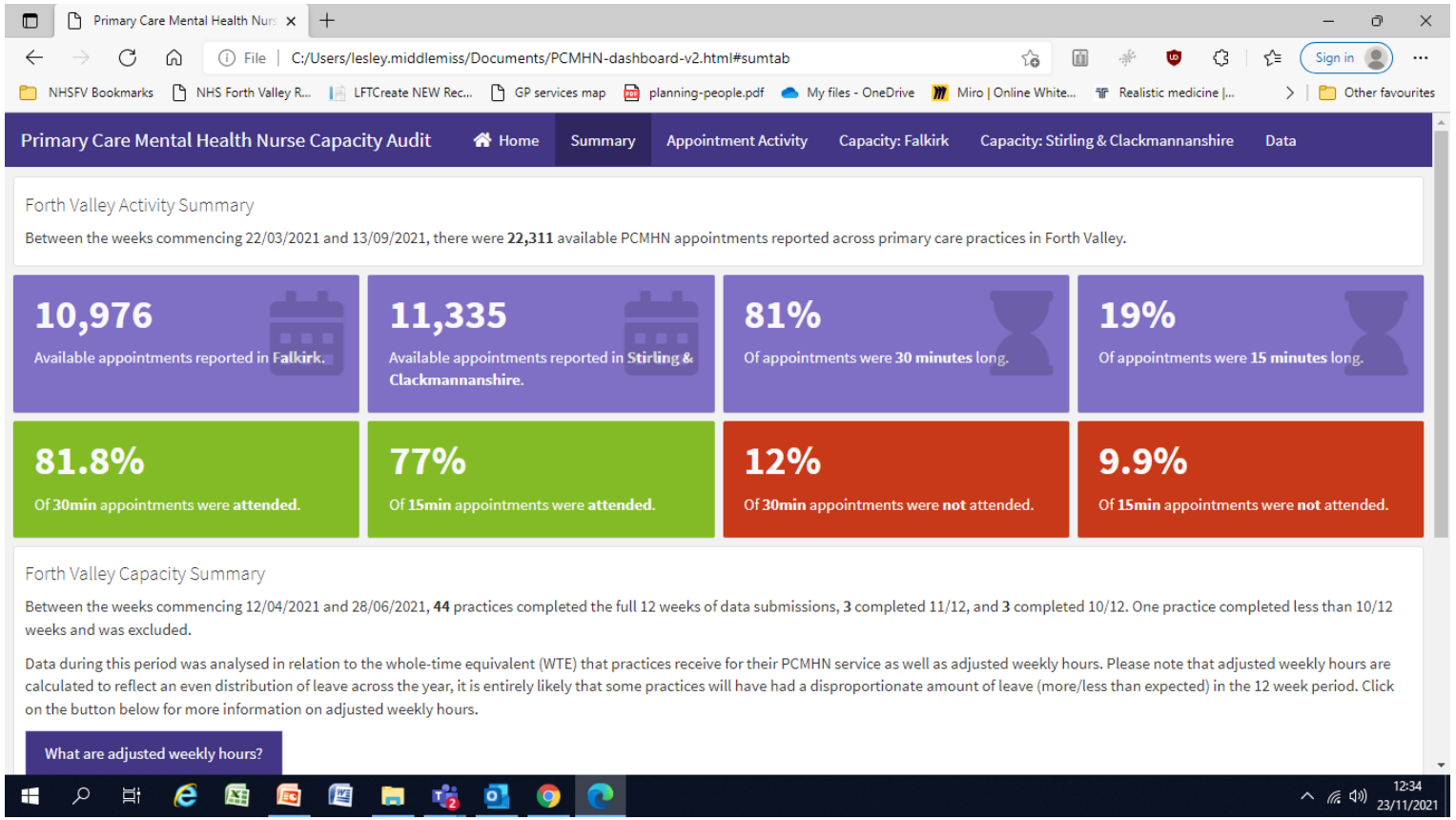
"Here all GPs feel the CLW is an asset to the practice"

"Our CLW has expedited numerous supports for clients, and has made an amazing contribution to care"

"The PCMHN having rapid access to such a resource has been invaluable"

- With support of funding from CAMHS the PCMHN service is completing a test of change for 12-18 year olds.

The Future: Continuous Improvement



Community treatment and care

Phlebotomy service

Kim Aitchison, Team Lead

CTAC in Forth Valley

Whilst recognising that CTAC encompasses treatment room, new phlebtomy and monitoring services. Our development service refers specifically to phlebotomy and chronic disease monitoring.

Treatment room services within FV have been well established and under direction of community nursing services.

CTAC (phlebotomy)has been introduced with the aim of transferring around 23-25000 blood samples per month from general practice workload. We estimate this to equate to 12,000 appointments

Where are we now?

Falkirk

- 11 Staff in post 8.9 wte (band 3, 1.5 wte band 2, 7.4 wte)
- Covers 24/25 practices
- Combination of hub model and within GP practices
- NEW hub developed at FCH

Clacks and Stirling

13 staff in post -12.07 wte (band 3 wte -2.0 ,band 2- 10.7wte)

- Covers 18/26 practices **
- Combination of hub model and working within GP practices

**Rural Practices are retaining phlebotomy provision

Capacity

Falkirk currently offers 5180 appointments per month

Clacks and Stirling currently offers 4380 appointments per month

Teaching self administration of hydroxocobalamin for Vitamin B12 deficiency

- Clacks and Stirling HSCP had almost 4000 patients prescribed hydroxocobalamin .
- Transfer of all administration was under CTAC services .
- This now accounted for approx 16000 appointments per year
- Due to covid restrictions we encouraged patients to self administer as administration potentially would have been delayed or not given due to staff / self isolation
- A test of change with SCV saw 50 % of patients able to be self manage .
- This has continued to all other areas within Clacks and Stirling

Plan for 2022/2023

Complete recruitment and build to full service of phlebotomy and Chronic Disease Monitoring.

Expansion of services within established clinics to offer a fuller service with negotiation with other services which may determinately impacted by expansion .

Underpinnings and Enablers:

Kathy O'Neil

Premises

Quality Improvement

Collaboration

Remote IT solutions

Workforce development & Service Design

Primary Care Initial Agreement: Service Options

01

- Urgent on day care and urgent mental health
- Long term continuous care
- Reception services

02

Opportunity to share these GMS resources on multi-practices sites:

- PCIP Team
- Phlebotomy/ Treatment room
- Community Nursing
- Group Consult

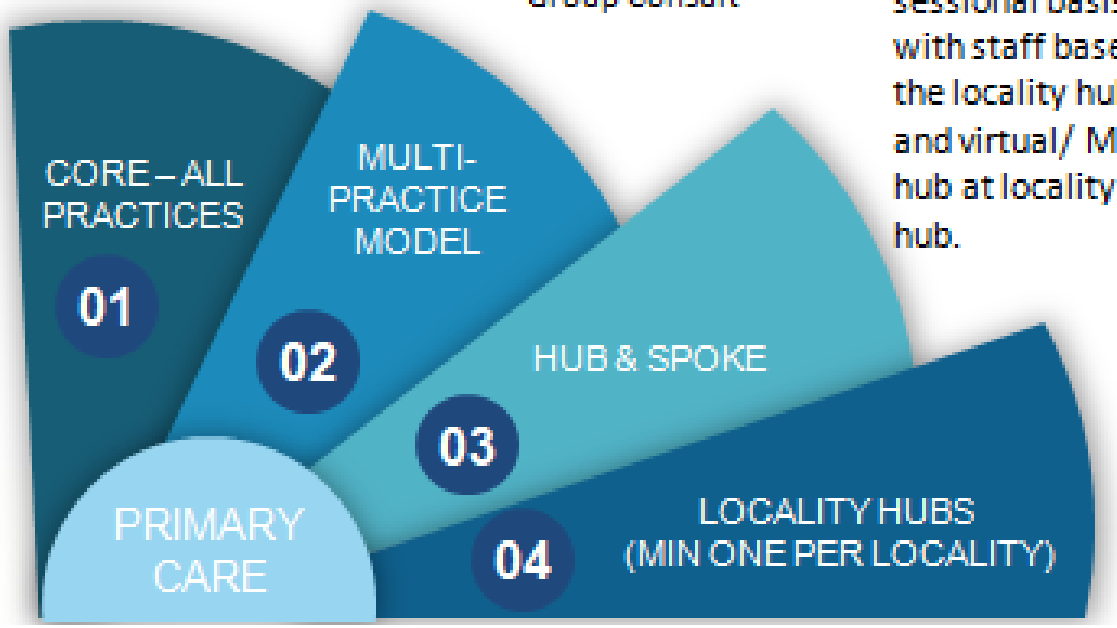
03

Where standalone practice and not within a locality hub, these services would be provided on a sessional basis with staff based at the locality hub and virtual/ MDT hub at locality hub.

04

Community Hub supporting multiple practices and geographical communities. (May or may not align with a multi practice site).

- Hub Base for PCIP staff teams (pharmacotherapy remote team / phlebotomy and treatment rooms / Immunisations)
- Virtual consulting & MDT suite
- Range of health board / HSCP delivered services including:
  - Midwife
  - AHP MSK Podiatry and Physio
  - Community Nursing Hub / school nursing
  - Health Visitors
  - Care Home team
  - Hospital @ Home
  - Psychological services, SMS, CAMH
- Alignment with other HSCP community services (social work, AHPs, Intermediate care)
- Alignment with interface / secondary care outpatient services



APPENDIX C:ASSET AND PROPERTY MANAGEMENT INFORMATION

Ownership	Practice Name	CR/GP	patients	m2	CR/Clinician	patients	m2	R/Clinici	patients	m2	Condition	Suitability	Utilisation	Quality	Low	Medium	Significant	High	Low	Medium	Significant	High
1	Slamannan	2.33	3.69	279	1.27	2.035	58.58	2	4	279	B	B	F	B	£0	£0	£3,822	£0	£36,760	£0	£0	£0
1	Polmont Park (Meadowbank)				1.78	1.374																
1	Dr Whitelaw (Meadowbank)				5.23	0.693																
1	Braesview (Meadowbank)				1.35	0.921																
1	Steven Brown (Meadowbank)				3.00	1.047																
1	Meadowbank Health Centre	1.42	1.00	2,070				1	1	2,070	B	B	F	B	£0	£71,523	£0	£0	£406,390	£0	£0	£0
1	Shieldhill Clinic - Branch Surgery (Braesview), Shieldhill										C	B	F	C	£0	£0	£19,106	£0	£44,122	£59,468	£7,000	£0
2	Avonbridge Clinic - Branch surgery (Dr Whitelaw)										C	B	U	C	£8,592	£0	£1,070	£0	£2,646	£1,771	£0	£0
5	Tryst Medical Centre, Stenhousemuir	1.50	0.95		0.95	0.938					B	B	F	B	£20,384	£10,319	£0	£0	£7,694	£587	£15,086	£0
4	Parkview Practice (Stenhousemuir)	2.09	1.24		1.27	1.08	204.00	2	1		B	B	F	B	£0	£0	£0	£0	£3,323	£0	£0	£0
4	Stenhouse Practice (Stenhousemuir)	2.09	1.24		0.80	1.24	248.00	2	1		B	B	F	B	£0	£0	£0	£0	£3,323	£0	£0	£0
4	Ochilview Practice (Stenhousemuir)	2.09	1.24		1.10	1.14	242.00	2	1		B	B	F	B	£0	£0	£0	£0	£3,323	£0	£0	£0
4	Viewpoint Practice (Stenhousemuir)	2.09	1.24		1.19	1.11	295.00	2	1		B	B	F	B	£0	£0	£0	£0	£3,323	£0	£0	£0
	Stenhousemuir - HB accommodation																					
1	Bonnybridge Health Centre (Antonine)	1.75	1.04	979	0.92	0.80	133.30	2	1	979	B	C	F	C	£0	£0	£0	£0	£348,856	£0	£0	£0
5	Bonnybridge & Banknock				2.11	1.55	143.43				C	B	F	C		£38,690	£10,236	£0	£8,708	£865	£456	£0
2	Carronbank Medical Practice	1.22	1.24		1.96	2.16	281.95	1	1		B	B	O	B	£0	£0	£0	£0	£12,461	£0	£0	£0
	Carronbank- HB accommodation																					
7	Denny Cross Medical Centre, Denny	1.50	1.11		1.30	1.33					C	B	F	B	£19,132	£12,681	£4,004	£0	£5,761	£5,924	£0	£0
	Richmond, Boness Health Centre				1.11	1.31	169.08															
1	Forth View, Bo'ness Health Centre				1.75	1.59	128.92															
	Boness Health Centre - Health Board	1.80	1.44	1,246				2	1	1,246	C	B	F	C	£0	£38,925	£0	£0	£455,833	£0	£0	£0
2	Kinglass, Bo'ness	2.00	1.87		1.89	1.82		2	2		B	B	F	B	£0	£0	£0	£0	£3,727	£0	£0	£0
1	Kersiebank Medical Practice, Grangemouth			1,198	0.84	1.36	360.39			1,198	C	B	F	C	£0	£43,800	£15,032	£0	£483,555	£0	£0	£0
	Kersiebank - HB accommodation																					
5	Boness Road, Grangemouth	1.29	0.87		1.01	0.95					B	B	O	B	£0	£14,502	£0	£0	£0	£26,568	£0	£0
8	Wallace Medical Centre, Falkirk	1.75	0.90		0.64	1.13					B	B	F	B	£17,884	£0	£0	£0	£0	£456	£2,962	£0
5	Ark Medical Practice, Falkirk				1.50	1.25					B	B	F	B	£1,558	£0	£0	£0	£1,650	£0	£0	£0
5	Meeks Road Surgery	1.00	0.76		0.77	0.96					C	B	F	B	£7,916	£0	£0	£0	£11,716	£353	£0	£0
5	Graeme Medical Centre. Falkirk	1.17	1.23		1.34	1.20					C	B	F	B	£0	£0	£0	£0	£24,786	£27,787	£6,719	£0
5	Camelon Medical Practice, 3 Baird Street	1.00	0.72	444	1.24	1.06		1	1	444	B	B	F	B	£17,833	£126,089	£29,308	£0	£10,922	£9,526	£8,655	£0
7	Carron Medical Centre	1.00	1.03		1.05	1.20					B	B	F	B	£8,945	£0	£0	£0	£81	£0	£0	£0
1	Westburn Medical Practice FCH (Falkirk)	4.00	1.74		2.57	1.95		4	2		B	B	F	B	£0	£0	£0	£0	£7,141	£0	£0	£0

Note: Estate information relates to building; where multiple practices occupy the same building the information is displayed against the premise only. No information on registrations for branch practices

			2015 PAMS data			2018 calcuated data			2019 PAMS data							Backlog Maintenance (year 0)				Impending costs (years 1-5)			
	Ownership	Practice Name	CR/GP	CR/1000 patients	Floor area m2	CR/Clinician	CR/1000 patients	Floor area m2	t/Clinici	CR/1000 patients	Floor are m2	Physical Condition	Functional Suitability	Space Utilisation	Quality	Low	Medium	Significant	High	Low	Medium	Significant	High
20	5	Viewfield Medical Centre, Stirling Care Village				1.11	1.12	56.04				C	C	F	B	£44,955	£0	£22,122	£0	£8,116	£5,121	£0	£0
20	5	Park Avenue Medical Practrce , Stirling Care Village	0.86	0.75		1.77	1.02					C	B	F	B	£48,709	£6,880	£357	£0	£6,180	£0	£0	£0
20	5	Park Terrace, Stirling Care Village				1.76	1.26	80.51				B	B	O	B	£8,869	£0	£0	£0	£2,261	£4,586	£2,854	£0
20		Health Board - Stirling Care Village																					
21	5	Allan Park, Stirling	0.80	1.30		1.23	1.08					B	B	O	B	£0	£24,579	£0	£0	£0	£922	£0	£0
22	7	Wallace Medical Practice, Stirling	1.00	1.02		1.22	1.73					B	B	F	B	£5,165	£0	£0	£0	£2,769	£0	£0	£0
23	1	Orchard House HC, Striling	1.33	0.91	451	0.91	1.18	199.70	1	1	451	C	B	F	C	£0	£26,679	£7,175	£0	£220,896	£0	£0	£0
24	1	Bannockburn HC	2.00	1.43	159	0.91	1.78	372.28	2	1	432	C	B	F	C	£12,738	£90,146	£3,057	£0	£59,715	£6,620	£0	£0
24		Plean - Branch (Bannockburn)							2	1	159	C	B	F	C		£76,401	£29,495					
25	1	The Clinic Fallin, Fallin	1.50	1.00	265	0.80	0.63	199.50	2	1	265	B	B	F	C	£0	£0	£0	£0	£105,211	£8,999	£0	£3,000
25	1	The Clinic, Cowie Branch Surgery			150	1.18					150	C	B	F	C	£15,285	£39,487	£23,715	£0	£77,639	£34,000	£0	£0
25		Airth,			151	5.00																	
26	1	Killearn HC	1.00	0.95	288	2.50	1.81	96.00	1	1	288	B	B	F	B	£0	£0	£20,212	£0	£113,798	£5,175	£0	£0
27	6	Edenkiln Suregry, Strathblane	1.00	83.00		2.44	2.07					B	B	F	B	£5,208	£4,940	£0	£0	£675	£0	£488	£0
28	1	Balfron HC, Balfron	1.33	1.47	342	1.71	2.38	97.42	1.33	1.47	342	B	B	F	B	£0	£49,573	£13,254	£0	£30,534	£0	£0	£0
29	5	Aberfoyle Medical Centre	2.00	1.75		4.49	1.67					B	B	U	B	£0	£1,078	£0	£0	£0	£14,235	£0	£0
29	2	Buchlyvie Medical Centre - Branch Aberfoyle	2.00	1.62		2.63	#DIV/0!	210.00	2	2		B	B	F	B	£559	£0	£0	£0	£9,489	£0	£0	£0
30	5	**Kippen Surgery**	1.00	1.49								C	B	F	B	£5,065	£3,153	£84	£0	£300	£0	£2,488	£0
31	1	Drymen Health Centre			106	1.18	1.34	107.34			106	B	B	F	B	£0	£0	£10,107	£0	£35,990	£0	£0	£0
32	1	Bridge of Allan HC	0.80	0.60	589	1.20	1.60	151.23	1	1	589	B	B	F	B	£0	£30,797	£0	£0	£55,112	£1,000	£0	£0
33	1	Doune HC	1.67	1.29	267	1.63	2.23	135.47	2	1	267	C	C	F	C	£21,417	£3,945	£20,182		£85,933	£0	£0	£0
33	1	Thornhill Clinic - Branch Surgery for Doune HC			63						63	B	B	U	B	£0	£6,737	£1,274	£0	£3,864	£0	£0	£0
34	5	Airthrey Park, Stirling	-	-		1.51	0.61					B	B	O	B	£0	£15,175	£0	£0	£0	£13,649	£0	£0
35		Bracklinn Room (Callander)																					
35		Leny Room (Callander)																					
35	1	Callander Health Centre	1.20	1.38				1.20	1			B	B	F	B	£0	£0	£0	£0	£64,450	£0	£0	£0
36	1	Dunblane HC, Dunblane	0.71	0.49	685	1.03	1.64	312.61	1	0	685	B	B	O	B	£0	£24,345	£12,792	£0	£254,288	£0	£0	£0
37	5	Laggan Leigheas, Killin	1.50	1.90		1.81	2.58					B	B	O	B	£0	£0	£0	£0	£12,681	£5,733	£0	£0
38	1	Dollar HC	1.75	1.47	400	1.54	1.76	129.00	2	1	400	B	B	F	B	£1,274		£19,936	£0	£132,622	£0	£0	£0
39	5	Tillicoultry Medical Practice, Tillicoultry	0.57	0.51		0.91	1.59					B	B	F	B	£16,953	£0	£0	£0	£2,470	£0	£0	£0
40	6	Alva Medical Practice	1.08	0.96		1.20	1.01	58.00				C	B	F	B	£4,520	£8,320	£7,978	£0	£0	£0	£7,421	£0
40	1	Tullibody HC - Branch Surgery, (Alva)	1.08	2.10					1	2		C	B	F	C	£0	£41,721	£12,564	£0	£71,584	£0	£0	£0
41	1	Clackmannan HC , Clackmannan	0.50	0.55	387	0.86	0.88		1	1	387	B	B	F	B	£24,201	£58,572	£5,095	£0	£145,928	£0	£0	£0
42	3	V25972 Hallpark Med Practice 2C (Stirling)	1.25	0.77		1.46	1.70	432.40	1	1		B	B	F	B	£0	£0	£0	£0	£0	£0	£0	£0
42	3	Alloa HC - Sime	1.25	0.77		1.20	0.94	425.80	1	1		B	B	F	B	£0	£0	£0	£0	£0	£0	£0	£0
42	3	Alloa HC - The Whins (Borland)	1.25	0.77		1.16	1.10	388.40	1	1		B	B	F	B	£0	£0	£0	£0	£0	£0	£0	£0

APPENDIX D: BENEFITS REGISTER

ID	Benefit Description	Who Benefits?	Investment Objective	Who is responsible?	Dependencies	Support needed	Assessment (How will this be assessed?)	How will this be measured?	Baseline Measure (What info do we have now?)	Person Centred	Safe	Effective quality of care	Health of population	Value and sustainability	Prioritisation (RAG) status	Target date (when will this benefit be realised?)	How will the benefit be realised? (how will we know we have succeeded?)
e.g. 1	*e.g. Supporting people in looking after and improving their own health and wellbeing*	*e.g. Public/patients*	*e.g. Meet user requirements*	*e.g. SRO*	*e.g. Dependent upon public/patients taking positive steps following service improvement*	*e.g. Promotion of self-care linked to service improvement*	*Quantitatively via QOI*	*The proportion of adults within 'a place' who assess their health as good or very good*	*e.g. 74%*	*Y*	*Y*	*Y*	*Y*	*Y*	*5*	*01/03/2021*	*e.g. reaching target, feedback*
PC PIA	Ensure equity of access and positive experience to primary health and care services improving the service capacity and reducing restricted lists	public patients	Increase in space available within primary care facilities; reducing number of GP owned premises		Capital funding & successful business case process	Business case process	Quantitatively via GP lists	Number of restricted lists			Y	Y	Y	Y		on completion of programme	reduced / no restricted lists
PC PIA	Increase multi-disciplinary primary care workforce to appropriate level for practice population to enable timely access for patients, focusing on prevention, independence and self-care	public patients	Increase space within Hub premises to facilitate efficient, effective PCIP delivery model.		Revenue funding; available workforce	Recruitment & retention strategy, developing optimum workforce models	Quantitatively via workforce	total wte in primary care		Y	Y	Y	Y	Y		on completion of programme	additional workforce available in all areas
PC PIA	Deliver the requirements within the new GMS contract. To ensure sustainability of general practice and provide high quality care in the community	public patients staff	Increase in space available within primary care facilities; reducing number of GP owned premises		Capital funding & successful business case process	Recruitment & retention strategy, developing optimum workforce models	Qualitatively via quality measure; Quantitatively via number via GP contract	Number of practices able to offer full GMS contract. Quality measures tbc		Y		Y	Y	Y		on completion of programme	Feedback
PC PIA	Improve the quality and physical condition of the healthcare estate (SAFR), improving performance against 6 facet survey – NHS Estate code	public patients staff NHS FV	Provide modern flexible fit for purpose facilities responsive to changing demand profile		Capital funding & successful business case process	Engagement through design development process	Quantitatively via 6 facet	6 facet return info			Y	Y		Y		on completion of programme	improved 6 facet rating
PC PIA	Improves design quality in support of increased quality of care and value for money (QOI)	all building users	Provide modern flexible fit for purpose facilities responsive to changing demand profile		Responsive design team	Engagement through design development process	Quantitatively via SCART;; Qualitatively via patient and staff survey	SCART return; patient & staff feedback on quality of environment		Y	Y	Y		Y		on completion of programme	feedback, ratings
PC PIA	Supports attainment of service targets, Strategic Plans. E.g. early cancer detection, antenatal access, early years vaccination. Health & Wellbeing Outcomes	public patients staff	Increase space within Hub premises to facilitate efficient, effective PCIP delivery model.		Capital funding & successful business case process; revenue funding & workforce availability	Optimum use of additional capacity created	Quantitatively via targets achieved/improved rating	Delivery against key targets		Y	Y	Y	Y	Y		post completion of programme	improved against targets
PC PIA	Increased efficiency of workforce, enable integrated working through creation of "Hub" facilities and co-location of services in cognisance of the principles of "Place" and locality planning	public patients staff organisation	Provide opportunity to co-locate and share accommodation within localities		Continued joint working with HSCPs	Integrated planning, joining up with HSCPs, local authorities and 3rd sector	Quantitatively via number of co-located services	number of co-located services. Public feedback		Y	Y	Y	Y	Y		post completion of programme	availability of multiple services from key locations

APPENDIX E: RISK REGISTER

Ref	Risk raised by?	Date raised	Risk Category	Risk Description	Baseline Likelihood	Baseline Impact	Baseline Overall Risk Score	Mitigation	Risk Owner (SRO)	Likelihood	Impact	Overall Risk Score	Review notes	Review Decision (e.g. transfer, tolerate, terminate, treat)	Last Review Date	Next review date	Further mitigatory action to mitigate?	Further mitigatory action Owner	Further mitigatory action Target Date	Overall Risk status
PCPIA	PMO	19-Aug-21	Governance / Communication / Project Plan	Interdependencies with FCH Masterplan - inability to deliver project to plan	3	3	9	Joint project plan to manage interdependencies Convening of joint programme board to engage with senior leadership, governance structure Scheduling joint cross check event	KON	2	3	6	04/11/2021 - to be assessed after cross check event 01/12/2021 - further work undertaken to identify interdependencies, cross check event has taken place. Consider delay with Falkirk central work. Benefit to Falkirk practices in terms of capital funding but may not be top priority.	Tolerate	19/08/2021 28/09/21 21/10/21 01/12/21	15-Jan-21	Reviewed. Cross Check event planned November 2021. No further minigating action.			Open
PCPIA	PMO	19-Aug-21	Stakeholder engagement / adverse impact on project delivery (Internal &Or External	Unable to secure developer contributions to allow for varation in demand i.e. not utilisting space to 100% capacity	3	2	6	Robust case for change (evidence based) Lessons Learned from previous similar developments	KON	2	1	2	01/12/21 - no change, keep developers up to date post approval.	Tolerate	19/08/2021 28/09/21 21/10/21 01/12/21	15-Jan-21	Consistent and continuous engagement with three local authorities. Regular meetings to raise and address concerns. Positive discussions with developers w/c 18/11	MF		Open
PCPIA	PMO	19-Aug-21	Compliance / Health & Safety / Infection Control	Legislative changes pending and impact to project requirements (being able to deliver all requirements) - external	4	3	12	Keeping abreast of pending changes from Scottish Government/HFS/GP Contract.	KON/SW	3	3	9	01/12/21 - to be reassessed after meeting with NHS Assure	Tolerate	19/08/2021 28/09/21 21/10/21 01/12/21	15-Jan-21	NHS Assure review. Presenting to GP sub committee to determine early impacts. Early engagement with NHS Assure - pick up with Iain Storrar (MM to arrange meeting)	Project Team / Kathy O'Neill		Open
PCPIA	PMO	19-Aug-21	Clarity of understanding of brief / objectives / scope creep	failing to take cognisance of interoperability, integration of IT systems to make best use of space to deliver service model	3	4	12	eHealth Representative on project team baseline requirements to be established	KON	3	4	12	01/12/21 - Establish eHealth sub-group at OBC stage. No change.	Tolerate	19/08/2021 28/09/21 21/10/21 01/12/21	15-Jan-21	Representative from eHealth on Project Team.	Kevin Edwards / Jonathan Proctor		Open
PCPIA	PMO	19-Aug-21	Clarity of understanding of brief / objectives / scope creep	Project fails to address space contraints and will impact on delivery of GMS contract and recruitment and retention/ working environment	4	4	16	Project to consider GMS contract of delivery model Business as usual risk register to implement solutions	KON/SW	3	4	12	04/11/21Service areas to consider local solutions to supplement the longer term fix that this project will potentially put in place 01/12/21 - schedules received. Reduced score	Tolerate	19/08/2021 28/09/21 21/10/21 01/12/21	15-Jan-21	Discussions with locality GP			Open
PCPIA	PMO	19-Aug-21	Governance / Communication / Project Plan	Unable to respond to future policy or strategic changes (Internal)	3	3	9	Cross check event	KON/SW	3	3	9	21/10/2021Consider wider engagement Oversight Board establishment 01/12/21 - no change	Tolerate	19/08/2021 28/09/21 21/10/21 01/12/21	15-Jan-21	Joint programme board to review once established. Ensure contingency and flexibility of approach Ongoing feedback from workshops			Open
PCPIA	PMO	19-Aug-21	Stakeholder engagement / adverse impact on project delivery (Internal &Or External	Fail to identify appropriate stakeholders	3	4	12	Input from project team in identifying stakeholders Launch event to identify any outstanding stakeholders Presentation to SLT	KON	2	3	6	01/12/21 - further request to engage with strategic planning groups. Patient engagement needs some further consideration	Treat	19/08/2021 28/09/21 21/10/21 01/12/21	15-Jan-21	Engagement with GP sub committee and practice managers through comms and engagement plan. Ongoing review of stakeholders as part of workshops, including patient/public representatives Meet with GP locality leads and locality managers Patient engagement strategy required			Open
PCPIA	PMO	19-Aug-21	Stakeholder engagement / adverse impact on project delivery (Internal &Or External	Right level of stakeholder engagement and failure to engage	4	4	16	Launch event to give better understanding Briefing paper prepared to confirm expectations Understanding the benefits of being involved Exec leadership/support Communications Plan/messaging GP Sub Committee Comms & Engagement Plan	KON	2	3	6	Further forums identified and approached - GP trainees Project team involvement to be reinforced - roles and responsibilities 01/12/21 - further engagement to engage with strategic planning groups.	Treat	19/08/2021 28/09/21 21/10/21 01/12/21	15-Jan-21	Further engagement required going forwards Developing comms for sharing - exec summary of IA.			Open
PCPIA	PMO	19-Aug-21	Stakeholder engagement / adverse impact on project delivery (Internal &Or External	Unable to get consensus as stakeholders may have contradictory plans/aspirations	3	4	12	Early engagement Strategic direction Management of process Evidence base/objective Communications Plan/messaging Following SG process for capital investment (SCIM) Early engagement GP sub-committee Patient engagment workshop	KON	2	3	6	21/10/21 Engagement with GP Sub committee Enagement with partnership representatives 01/12/21 Convening of programme board Locality meetings have taken place, working towards concensus. Reduced score.	Tolerate	19/08/2021 21/10/21 01/12/21	15-Jan-21				Open
PCPIA	PMO	19-Aug-21	Governance / Communication / Project Plan	Failure to deliver project plan within the agreed timescales	3	3	9	Detailed project planning Early engagement setting out at the beginning Virtual forum	KON	3	2	6	21/10/21 Assessment of progress and timescales agreed for next steps Backward mapping of key decision points	Treat	19/08/2021 21/10/21 01/12/21	15-Jan-21	Mapping to be undertaken of governance groups/dates to determine timeline. SLT end of January 2022, Board meeting thereafter or P and R to be confirmed. Aim for P and R 1/3/22, and Board following for sign off (end March). Dates required for CIG (end March/April).			Open
PCPIA	PMO	19-Aug-21	Clarity of understanding of brief / objectives / scope creep	Stakeholders unable to identify with future models of care	3	4	12	Early engagement Strategic direction Management of process Evidence base/objective Communications Plan/messaging Early engagement GP sub-committee	KON	2	3	6	21/10/21 3 Workshops have taken place Visual diagram required to communicate propsed model 01/12/21 - no change	Tolerate	19/08/2021 21/10/21 01/12/21	15-Jan-21				Open
PCPIA	PMO	19-Aug-21	Governance / Communication / Project Plan	Unable to get corporate agreement with model of care/how services will be delivered - strategic fit	3	4	12	Clear Governance structure Early engagement with SLT Continuous involvement of SLT Knowledge base on project team National direction Mapping process	KON	2	4	8	Establisment of programme board engagement with HSCPs to be undertaken 01/12/21 - no change	Tolerate	19/08/2021 21/10/21 01/12/21	15-Jan-21				Open
PCPIA	PMO	19-Aug-21	Clarity of understanding of brief / objectives / scope creep	Being too ambitious - scope of the programme unable to be delivered	3	4	12	Stakeholder expectation management through launch event and workshops and wider comms Launch event - messaging Follow SCIM process and clear Governance route	KON	3	3	9	Unable to mitigate at present due to stage of project 01/12/21 - no change.	Tolerate	19/08/2021 21/10/21 01/12/21	15-Jan-21				Open
PCPIA	PMO	19-Aug-21	Stakeholder engagement / adverse impact on project delivery (Internal &Or External	Risk of stakeholders unable to engage due to time constraints - capacity to attend and to be able to deliver work	4	4	16	Detailed project planning - quantify input Expectations of capacity Senior support/coverage/early engagement with SLT	KON	3	3	9	Review of stakeholder engagement and gaps identified and acted on Evidence of stakeholder involvement through workshops, project team and GP sub-committee Engagement with partnerships required 01/12/21 - score reduced.	Treat	19/08/2021 21/10/21 01/12/21	15-Jan-21				Open

APPENDIX F: OPTION ASSESSMENT

Service / care model	Flow – activity levels	Likely Contact per episode	Virtual / face to face (travel?)	Current availability of service to facilitate User Availability	Scale to ensure optimal availability to patients	Importance of Co-ordination of care	Importance of Continuity of care	Comment / option scoping
Urgent on day care / duty service Urgent on day mental health	High	Low (1)	50/50	All practices,	Full time	moderate	low	High volumes, high telephone consult rate, requires sustainable workforce – smaller practices less resilience - Collaborative Hub?
Complex/ undifferentiated	moderate	recurring	20/80	All practices daily	Full time	high	High	GP dependent, co-ordination and continuity important – CORE GP
Long term conditions continuous care	moderate	recurring		All practices daily	Full time	moderate	High	Continuity / co-ordination important, team based, GPN – GP - stay local
Family planning / contraceptive / sexual health	moderate	Low	20/80	Limited dependent on GPN schedule	Full time	Low	Lows	Potential to hub – increase scale, flexibility for patients, infrequent

Service / care model	Flow – activity levels	Likely Contact per episode	Virtual / face to face (travel?)	Current availability of service to facilitate User Availability	Scale to ensure optimal availability to patients	Importance of Co-ordination of care	Importance of Continuity of care	Comment / option scoping
Public health screening (e.g. Smear)	low	Low (1)	0/100	Limited dependent on GPN schedule	Full time	low	low	Potential to hub this kind of work – increased scale = increased flexibility for patients – infrequent need – less issue with travel - community Hub (CTAC)
Mild / moderate mental health	mod	Low (2-3)	50/50	All practices general consult	Full time	Medium	medium	Co-ordinated between local practices where feasible -
Vaccination	Low	Low	0/100	becoming more hub based	Full time	low	low	Community Hub - Vaccination centre model
Treatment Room	Medium	Medium –high	1/100	Hub / spoke over M-F	Full time	med	med	Locality hub and spoke model in place just now – any patient to any centre

Service / care model	Flow – activity levels	Likely Contact per episode	Virtual / face to face (travel?)	Current availability of service to facilitate User Availability	Scale to ensure optimal availability to patients	Importance of Co-ordination of care	Importance of Continuity of care	Comment / option scoping
CTAC (Phlebotomy)	High	Low	0/100	Hub and spoke – availability dependent on practice size	Full time	low	low	Locality Hub / spoke (?80/20)
Pharmacotherapy	high	Low	10/90	daily	Full time	medium	medium	Requires a degree of local presence supported by remote hub (hub and spoke)
APP	mod	Low (1)	30/70	All practices general consults	Full time	medium	low	Co-ordinated or locality
Link Workers	low	3-5	50/50		person dependent	med	med	Community based / virtual team?
MSK physio		Low (1-3)	20/80	Full week with choice of location	Full week	low	low	Locality / community Hub

Service / care model	Flow – activity levels	Likely Contact per episode	Virtual / face to face (travel?)	Current availability of service to facilitate User Availability	Scale to ensure optimal availability to patients	Importance of Co-ordination of care	Importance of Continuity of care	Comment / option scoping
MSK Podiatry	low	Medium	20/80	?	Full week	low	med	Locality / Community Hub
Psychological services	low	medium	?	limited	Full week	med	med	Locality / community hub
Health Visitor co-ordination	community	recurring	80/20	Full week	Full flex	med	high	Virtual team member? Tech supported?
District Nurse Co-ordination	community	recurring	90/10	7 day	Full flex	med	high	Virtual team member? Tech supported?

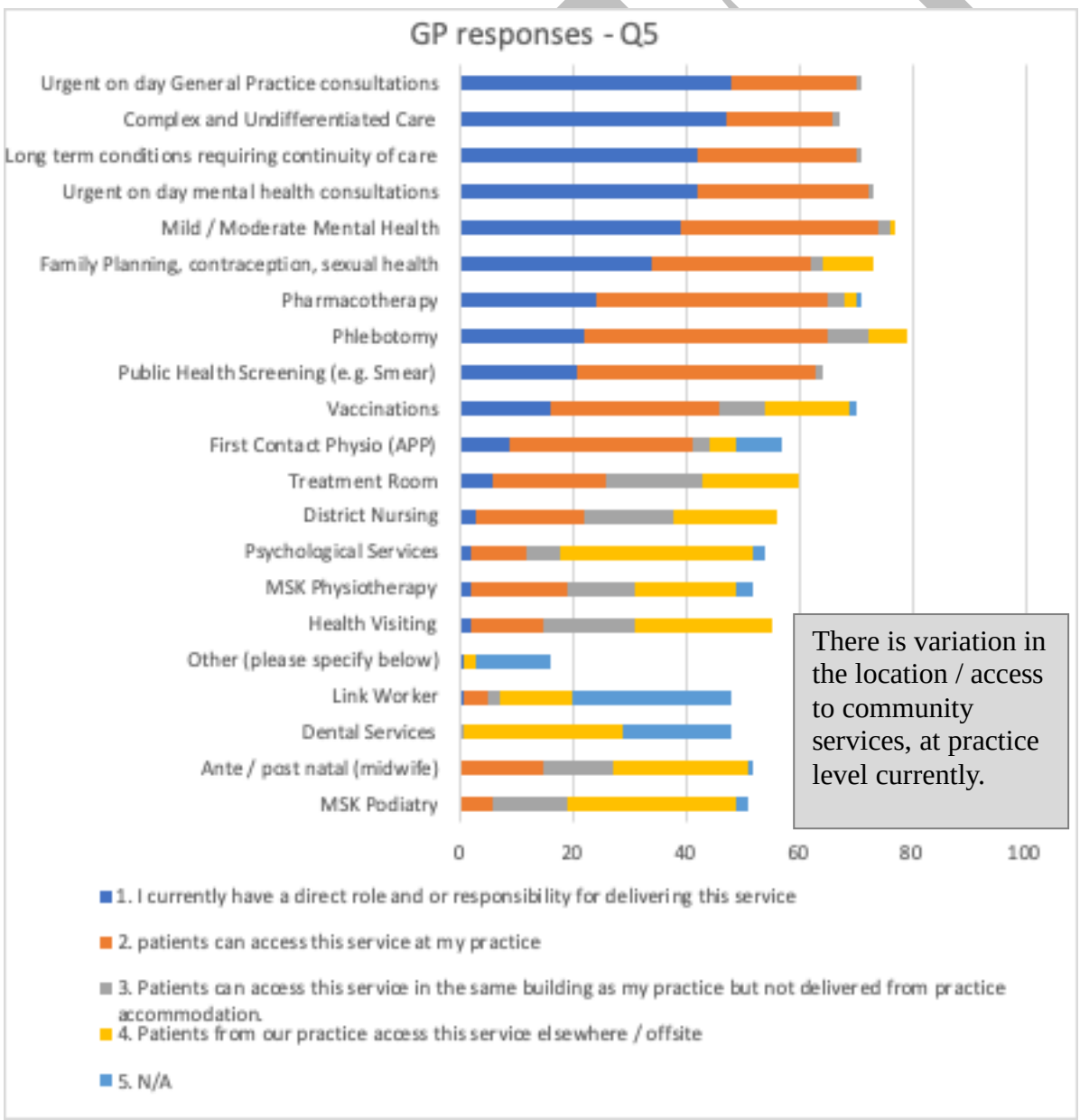
APPENDIX G: GP SURVEY

Questions 1-4 in the survey were used to establish the location, size, ownership model etc of the participating GPs and their practices as reference data for interpreting the survey. Data is provided for 50 respondents to the survey.

The core content of the survey questions and responses is shown below:

Q5. The services below are a list of both GMS and other "primary care" services currently provided to patients by general practice teams or to patients by health and care service teams with close links to general practice teams. Please consider each of the following services and tick all answers that apply from your perspective. (options 2,3,4 are from GP team perspective)

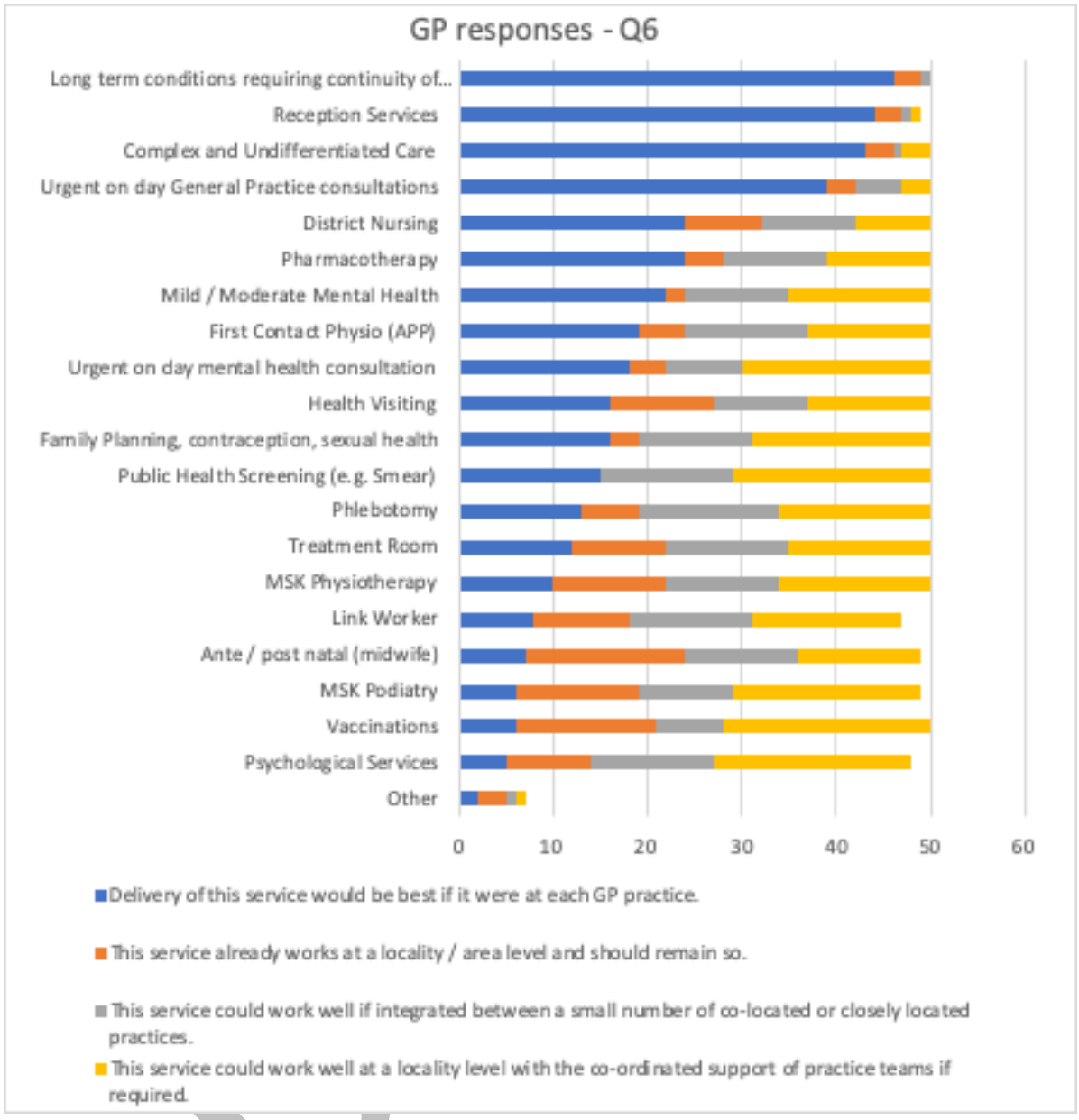
Number of respondents: 50, selected answers: 1265



There is variation in the location / access to community services, at practice level currently.

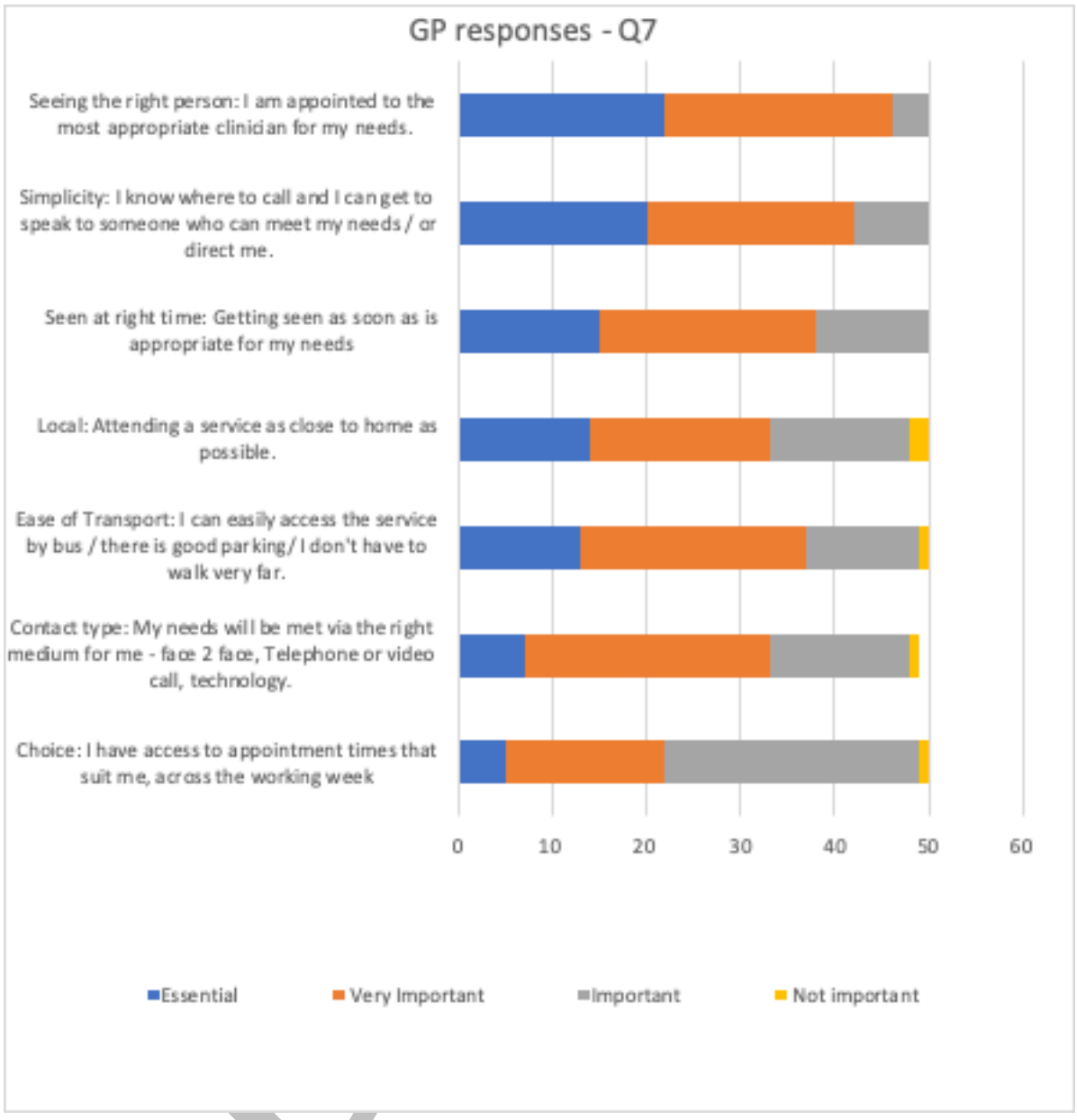
Q6. The 4 scenarios below describe different options for delivering GMS and non-GMS services. Please tick one for each suggested service.

Number of respondents: 50

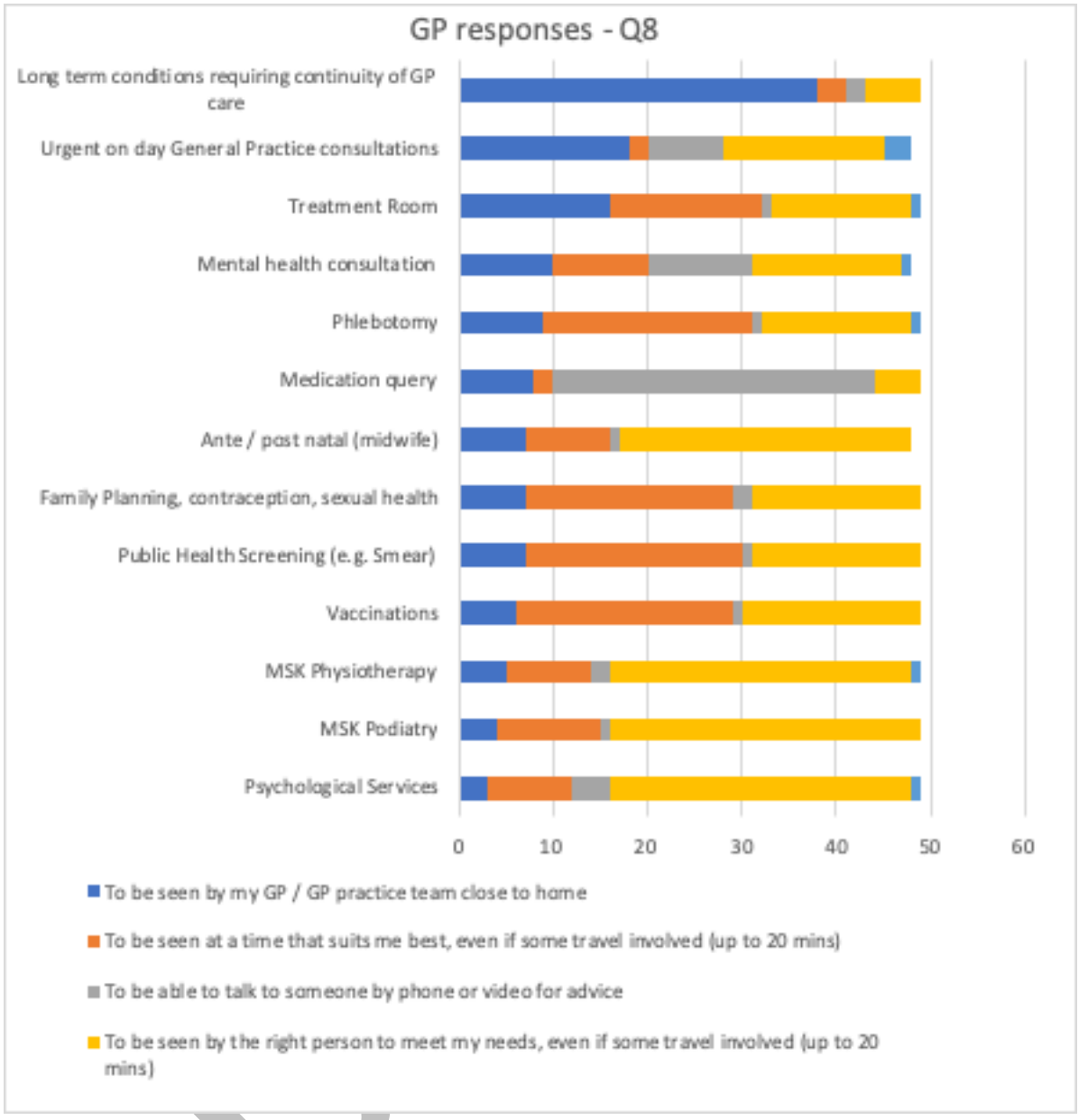


Q7. Services should be Accessible: in order to help us generate service user design questions, please consider the following: How important are the following to you when accessing primary care services?

Number of respondents: 50



Q8. Not all healthcare services can be provided in all health centres. What is the most important to you of the following when seeking healthcare support?
Number of respondents: 49



9. If the development of integrated locality hubs were an option, what other health, care or other services do you think should be provided or located in this type of model?
Number of respondents: 18

A Wordle graphic has been created to illustrate the range and number of responses given. Please note: Items in larger text were cited more frequently than those with smaller text.

APPENDIX H: AEDET

Functionality

		Weight	Score	Notes
A.01	The prime functional requirements of the brief are satisfied	1	3	
A.02	The design facilitates the care model	2	2	
A.03	Overall the design is capable of handling the projected throughput	2	1	
A.04	Work flows and logistics are arranged optimally	1	3	
A.05	The design is sufficiently flexible to respond to clinical /service change and to enable expansion	2	1	
A.06	Where possible spaces are standardised and flexible in use patterns	1	3	
A.07	The design facilitates both security and supervision	2	2	
A.08	The design facilitates health promotion and equality for staff, patients and local community	1	2	
A.09	The design is sufficiently adaptatable to external changes e.g. Climate, Technology	1	2	
A.10	The benchmarks in the Design Statement in relation to building USE are met	0		

	Access	Weight	Score	Notes
B.01	There is good access from available public transport including any on-site roads	1	3	
B.02	There is adequate parking for visitors/ staff cars/ disabled people	1	3	
B.03	The approach and access for ambulances is appropriately provided	1	3	
B.04	Service vehicle circulation is well considered and does not inappropriately impact on users and staff	1	3	
B.05	Pedestrian access is obvious, pleasant and suitable for wheelchair/ disabled/ impaired sight patients	1	3	
B.06	Outdoor spaces wherever appropriate are usable, with safe lighting indicating paths, ramps, steps etc.	1	2	
B.07	Active travel is encouraged and connections to local green routes and spaces enhanced	2	2	
B.08	Car parking and drop-off should not visually dominate entrances or green routes	1	3	
B.09	The benchmarks in the Design Statement in relation to building ACCESS are met	0		

	Space	Weight	Score	Notes
C.01	The design achieves appropriate space standards	2	0	
C.02	The ratio of usable space to total area is good	1	3	
C.03	The circulation distances travelled by staff, patients and visitors is minimised by the layout	2	3	
C.04	Any necessary isolation and segregation of spaces is achieved	1	2	
C.05	The design maximises opportunities for space to encourage informal social interaction & wellbeing	1	3	
C.06	There is adequate storage space	1	1	
C.07	The grounds provided spaces for informal/ formal therapeutic health activities	2	2	
C.08	The relationships between internal spaces and the outdoor environment work well	1	3	
C.09	The benchmarks in the Design Statement in relation to building SPACE are met	0		

Build Quality

	Performance	Weight	Score	Notes
D.01	The building and grounds are easy to operate	1	2	
D.02	The building and grounds are easy to clean and maintain	2	3	
D.03	The building and grounds have appropriately durable finishes and components	1	3	
D.04	The building and grounds will weather and age well	1	3	
D.05	Access to daylight, views of nature and outdoor space are robustly detailed	1	2	
D.06	The design maximises the opportunities for sustainability e.g. waste reduction and biodiversity	2	2	
D.07	The design minimises maintenance and simplifies this where it will be required	2	3	
D.08	The benchmarks in the Design Statement in relation to PERFORMANCE are met	0		

	Engineering	Weight	Score	Notes
E.01	The engineering systems are well designed, flexible and efficient in use	2	3	
E.02	The engineering systems exploit any benefits from standardisation and prefabrication where relevant	1	3	
E.03	The engineering systems are energy efficient	2	2	
E.04	There are emergency backup systems that are designed to minimise disruption	2	4	
E.05	During construction disruption to essential services is minimised	1	0	
E.06	During maintenance disruption to essential healthcare services is minimised	1	3	
E.07	The design layout contributes to efficient zoning and energy use reduction	1	3	

	Construction	Weight	Score	Notes
F.01	If phased planning and construction are necessary the various stages are well organised	0		
F.02	Temporary construction work is minimised	0		
F.03	The impact of the building process on continuing healthcare provision is minimised	0		
F.04	The building and grounds can be readily maintained	0		
F.05	The construction is robust	0		
F.06	Construction allows easy access to engineering systems for maintenance, replacement & expansion	0		
F.07	The construction exploits opportunities from standardisation and prefabrication where relevant	0		
F.08	The construction maximises the opportunities for sustainability e.g. waste and traffic reduction	0		
F.09	The construction contributes to being a good neighbour	0		
F.10	Infection control risks for options, design and construction recorded/ minimised using HAI Scribe	0		

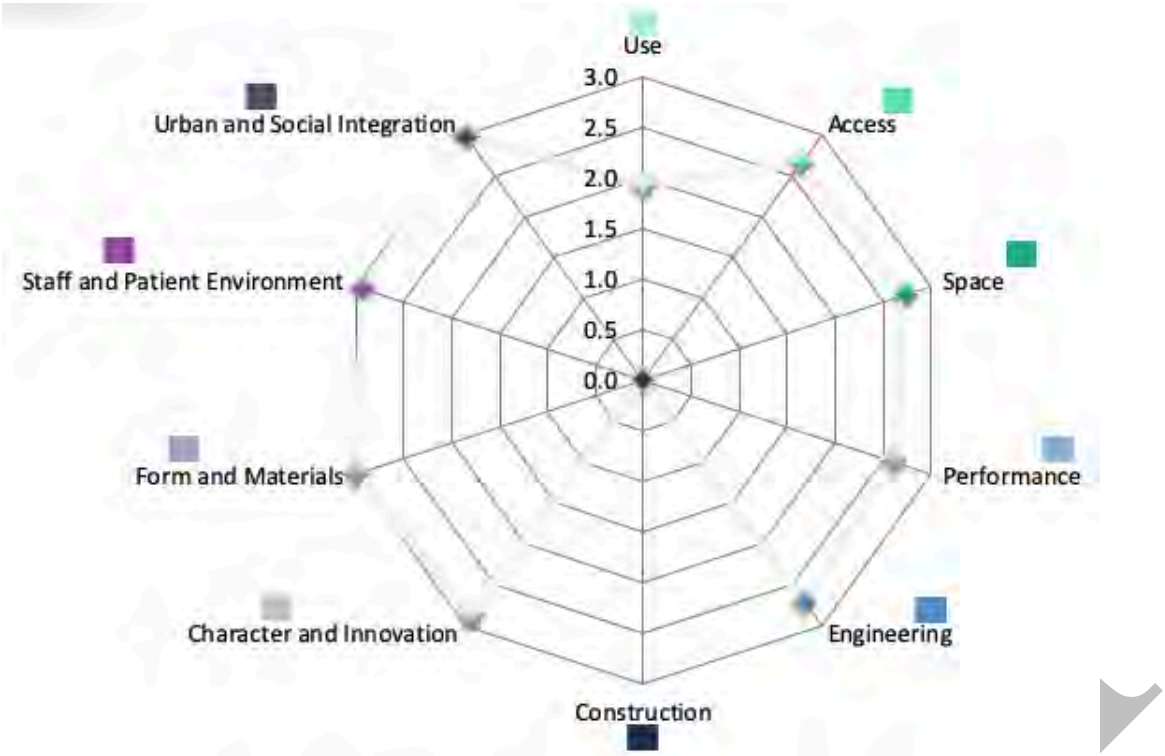
Impact

	[illegible]	Weight	Score	Note
G.01	There are clear ideas behind the design of the building and grounds	1	3	
G.02	The building and grounds are interesting to look at and move around in	1	3	
G.03	The building, grounds and arts design contribute to the local setting	2	3	
G.04	The design appropriately expresses the values of the NHS	1	2	
G.05	The project is likely to influence future designs	1	5	
G.06	The design provides a clear strategy for future adaptation and expansion	2	2	
G.07	The building, grounds and arts design contribute to well being and a sustainable therapeutic strategy	2	3	
G.08	The benchmarks in the Design Statement in relation to CHARACTER & INNOVATION are met	0		

	Town and Materials	Weight	Score	Note
H.01	The design has a human scale and feels welcoming	2	3	
H.02	The design contributes to local microclimate, maximising sunlight and shelter from prevailing winds	1	3	
H.03	Entrances are obvious and logical in relation to likely points of arrival on site	2	3	
H.04	The external materials and detailing appear to be of high quality and are maintainable	1	3	
H.05	The external colours and textures seem appropriate and attractive for the local setting	1	3	
H.06	The design maximises the site opportunities and enhances a sense of place	2	3	
H.07	The benchmarks in the Design Statement in relation to FORM & MATERIALS are met	0		

	Staff and Patient Environment	Weight	Score	Note
I.01	The design reflects the dignity of patients and allows for appropriate levels of privacy	2	0	
I.02	The design maximises the opportunities for daylight/ views of green natural landscape or elements	1	3	
I.03	The design maximises the opportunities for access to usable outdoor space	1	3	
I.04	There are high levels of both comfort and control of comfort	2	3	
I.05	The design is clearly understandable and wayfinding is intuitive	1	3	
I.06	The interior of the building is attractive in appearance	1	2	
I.07	There are good bath/ toilet and other facilities for patients	2	3	
I.08	There are good facilities for staff with convenient places to work and relax without being on demand	2	2	
I.09	There are good opportunities for staff, patients, visitors to use outdoors to recuperate/ relax	1	3	
I.10	The benchmarks in the Design Statement in relation to STAFF & PATIENT ENVIRONMENTare met	0		

	Urban and Social Integration	Weight	Score	Note
J.01	The height, volume and skyline of the building relate well to the surrounding environment	1	3	
J.02	The facility contributes positively to its locality	2	3	
J.03	The hard and soft landscape contribute positively to the locality	1	3	
J.04	The overall design contributes positively to neighbourhood and is sensitive to passers-by	2	3	
J.05	There is a clear vision behind the design, its setting and outdoor spaces	1	3	
J.06	The benchmarks in the Design Statement in relation to INTEGRATION are met	0		



		Benchmark
	Use	1.9
	Access	2.7
	Space	2.7
	Performance	2.6
	Engineering	2.7
	Construction	0.0
	Character and Innovation	2.9
	Form and Materials	3.0
	Staff and Patient Environment	2.9
	Urban and Social Integration	3.0

Weighting	=	Target
2	=>	5 - 6
1	>	3 - 4
0	<	3

Forth Valley Primary Care Programme – Exemplar Facility: SCIM DESIGN STATEMENT – Draft V1.5

Introduction

The Design Statement developed is in support of the Programme Initial Agreement for Primary Care within NHS Forth Valley. It is intended to set the key principles for all facilities and will be updated for each specific project as part of the Outline and Full Business Case stages.
The objectives the projects within the Forth Valley Care Programme seek to achieve are outlined in the Initial Agreement, namely:

- *Additional workforce is required to deliver the new GMS contract. Furthermore, future solutions need to recognise that future generations of GPs are less likely to wish to own their own premises.*
  Objective 1: Increase in space available within primary care facilities; reducing number of GP owned premises
- *The future model of care requires the development of locality hubs to maximise the use of the new workforce from PCIP*
  Objective 2: Increase space within Hub premises to facilitate efficient, effective PCIP delivery model
- *Seek to deliver timely access to care across primary care within NHS FV. Addressing areas of significant new housing.*
  Objective 3: Provide modern flexible fit for purpose facilities responsive to changing demand profile
- *New model of care includes increased group delivery and adoption of new digital delivery models.*
  Objective 4: Provide modern technologies, flexible room used
- *Seek to implement Place making principles, support delivery of 20-minute neighbourhoods, support delivery of secondary care digital models*.
  Objective 5: Provide opportunity to co-locate and share accommodation within localities

To achieve these objectives the completed development must have the attributes described below. These experiences are expected for all people irrespective of physical, sensory or cognitive impairments. Although the experiences below are split by different user groups due to their different needs, this should not be read that each experience must be met through providing separate spaces. Where different groups' needs are compatible or can be accommodated in the same space at different times, the spaces for these experiences should be provided for together.

The following outlines the vision for the facility, including at the Appendix a list (initial and non-exhaustive) of applicable design guidance.

1 Non-Negotiables for Patients (all Service Users)

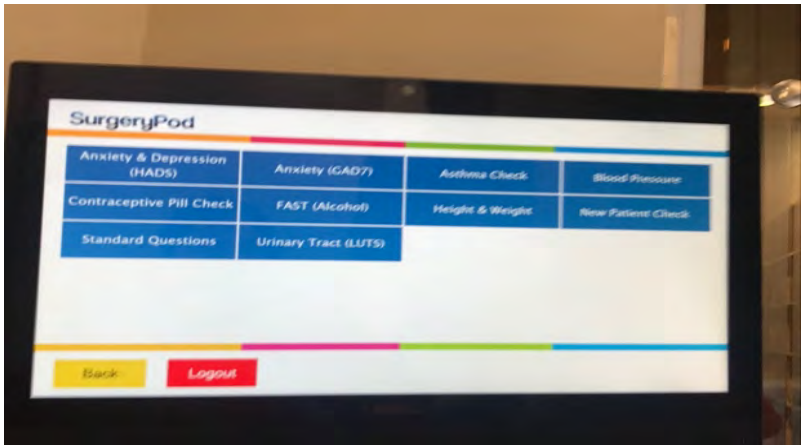
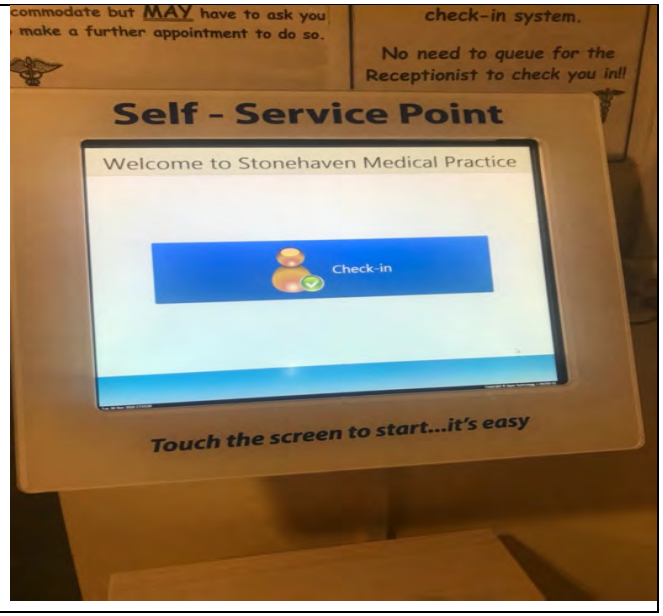
Agreed Non-Negotiable Investment Objective	Benchmark Standard – The criteria to be met and/or some views of what success might look like
1.1 Site Layout Getting to and from the facility must be easy and reliable, safe and	• Facilities should be easily accessible and close to / within communities. • Wherever possible development should be accessible by public transport and walking, and if necessary, by car. • Development should be well connected to main roads, clearly signposted from roads, walkways and cycle paths.

pleasant during the daylight and darkness. The location of the facility must enable choice of how to get there. It should allow flexibility to meet potential expansion over services over time.	• Good public transport and road links, and adequate provision for pedestrians and cyclists, are required promoting wellbeing and health and green travel options. • Bus stop(s) not more than (5-10) minutes away from the main entrance(s). • Drop off points close to the main entrance(s) but not obscuring them, with parking as close as possible but not dominating the site. • Provision of shelter, secure storage for bikes, and where required charging for e-bikes, e-scooters, within 25 metres of entrance, attractively designed to encourage use. • Pedestrian routes and parking to have good lighting and visibility during hours of darkness to provide a safe environment for patients accessing / leaving / the building and to be sheltered from the wind by use of building or landscape planting/features. • Parking provision to be sufficient in number and appropriate in location, with sufficient provision for electrical vehicle charging points as agreed for each locality / facility. • Where possible consideration of up to 25% expansion space to be provided on site to allow for potential future of the facility / expansion over time 

1.2 Building Approach / First Impressions The facility should not feel 'out of place' in its setting, but familiar and comfortable for patients with the landscape (paving, plants, vehicle areas) an integral part of public routes. It should have a professional but not overly harsh feel. The entrance(s) must be obvious from arrival routes.	• Need to ensure DDA compliance including wheelchair accessibility (disabled parking next to main entrance) appropriately designed, barrier-free paths, main entrance wide and accommodating with automatic doors. • Intergenerational / sight / child / dementia friendly signage and loop system for hearing impaired. • Build in a one-way flow, ability to close down parts of the building and segregate patients if required (eg. 'red / green' pathways) . 

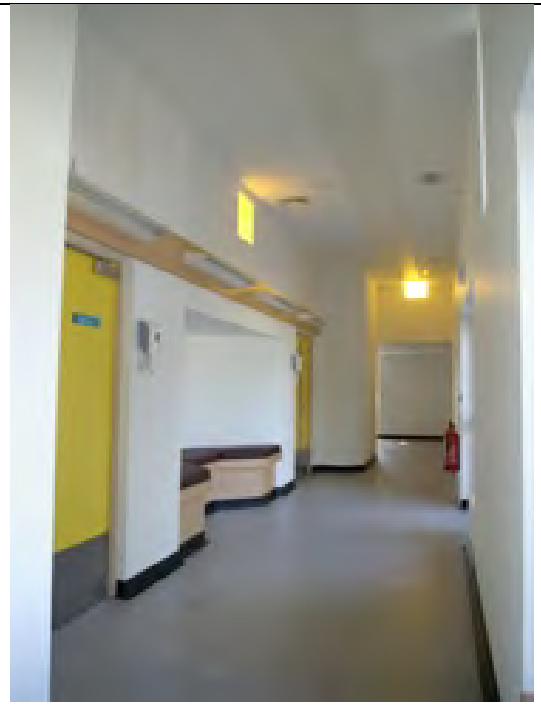
1.3 Arrival / Reception Reception must set the tone for the onward patient journey, be accessible and welcoming. On entering, there must be a direct view to a single 'place' to check in irrespective of the service being accessed, though individuals' personal needs and preferences must be accommodated at check-in.	• Initial arrival / reception space should be bright and welcoming. It should have a range of areas / heights / volumes to allow personal choice (physical and acoustic) in environment. • From this space you should be able to see and get direct access to external spaces used for rest, exercise and activity to encourage people to engage in these. • Reception facilities offering the choice of face-to-face and electronic check in. Patients should only have to check in once, and be given options of where to go to wait for their appointments, with reliable information provided in real-time. • Where needed designs should allow for multiple GPs to maintain their identity and for their patients to be able to identify with this within a single/shared reception and waiting area for the practices. • Reception areas should allow for confidential discussion when required – if necessary separate rooms/areas should be provided for this. • The design should protect confidentiality between staff and public areas – eg. offset reception with sight of the waiting area, not facing reception desk. • Provision to be made for patients to be received and called to their appointments in the most appropriate manner. • Design to be inclusive and take account of specific requirements, eg. wheelchair user interface at reception desks, induction loop provision, dementia friendly. • Reception, WCs and refreshments within 25 metres of entrance, all visible from point of entry. • Bookable, meeting/activity rooms accessed directly off entrance area for training/in-reach/3rd sector/community use.

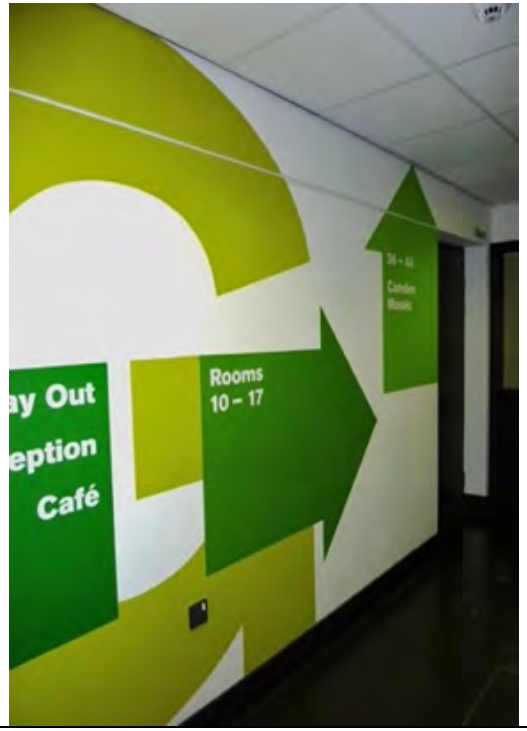

Reception

	 SurgeryPod Anxiety & Depression (HADS) Anxiety (GAD7) Asthma Check Blood Pressure Contraceptive Pill Check FAST (Alcohol) Height & Weight New Patient Check Standard Questions Urinary Tract (LUTS) Back Logout	 commodate but MAY have to ask you make a further appointment to do so. check-in system. No need to queue for the Receptionist to check you in!! Self - Service Point Welcome to Stonehaven Medical Practice Check-in Touch the screen to start...it's easy

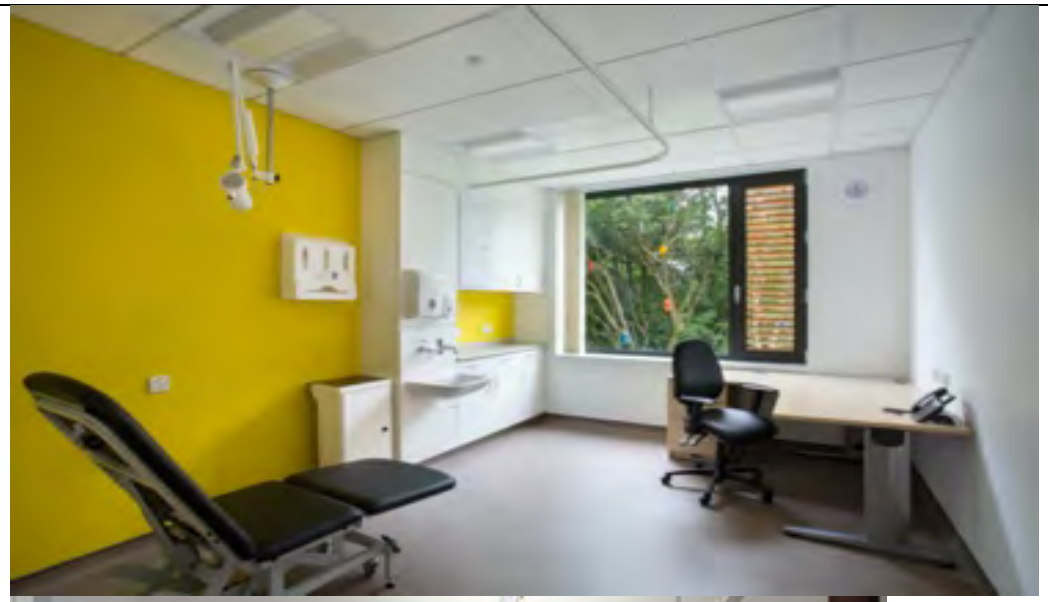

Waiting Room
Consulting Rooms

1.4 Waiting Areas Booking and patient planning systems should reduce waiting times, but where patients will wait waiting area (including any immediately accessible external areas) must be flexible to cater for the different needs of patients, considering age and personal preferences, a pleasant place providing: • opportunities for social interaction and support, and areas of a more private nature, • positive distractions – something interesting to look at and a place for children to play, • facilities to deal with patient needs (toilet, refreshments, support spaces) • clear connection to staff for assistance and call to appointments.	• Use of technology and video noticeboards to provide up to date health information (with closed captions) and access to support, patient call system, access to remote check-ins; video link to waiting areas, and alert by message / update of time-frames. • A variety of comfortable and accessible seating options with appropriate distancing (e.g. 1metre), arranged in groups to allow some personal choice and perception of privacy, and these groups should have space for wheelchair users and buggies as part of the group. • Outside sheltered space where people can wait prior to entering the building. To aid flow and minimise numbers inside the building. • Good sound attenuation / acoustics to provide audio separation from private conversations. The ability to play background music/radio. • Access to food/refreshments for longer waits. • Toilets and space to support breastfeeding adjacent (max 25 metre) and location visible from waiting areas. • Good natural light and positive, age-appropriate distractions to be provided such as views and access to outside sheltered areas, internal/external artwork to alleviate stress, and internal and external children's play area for supervised play within sight of spaces where people may wait for more extended periods of time. • Charging points and access to WiFi. • Flexibility in layout to allow visiting services including promotion of third sector



1.5 Circulation and Wayfinding Patient's routes around the facility must be short (particularly routes from waiting to consulting/treatment), pleasant and clear. The route from consulting/treatment must not put patients immediately 'on show' but allow a moment to compose themselves.	• Minimum number of entrances and reception points / minimise large cohorts of people. • Where needed, stairs and lifts to be visually obvious – make use of stairs an attractive option for use through design/location/prominence. • Reception/sub-reception areas should be easy to locate. • Where corridors are longer by necessity, alcove seating areas along the way to provide resting opportunities should be provided. • Good use of natural light, ventilation (openable windows), views / links to external spaces for orientation. • Good use of colour/finishes to distinguish service locations and assist wayfinding • Need to ensure DDA compliance including wheelchair accessibility – appropriately designed corridor and doors. • Dementia friendly design and layout. • Flexibility to adopt one-way systems if required. • Ability to access one consulting room without cross over with other patient groups e.g. red flow area • Allow flexibility for option of patients to be called to consulting room or collected by GP from waiting area. 

	
1.6 Clinical and Treatment Rooms The design and location of consulting and treatment rooms must provide good daylight while retaining adequate visual and audio privacy. Spaces must promote open and trusting interactions, helping patients take in information and maintain dignity.	• Natural light and views to be provided without compromising privacy. • Good use of colour and artwork to promote a calming environment. • Good sound attenuation to waiting and public areas. • Refer HFS Repeatable Rooms documentation for recommended room layout – guidance to be implemented as much as possible. • Avoid barriers for good communication- options to view information provided by consultant (eg. moveable monitor/screen). • Desk position with clinician and patient should be optimised • Examination couches should not be placed opposite the door – positioned to allow examination from one side. • There must be a space to gather yourself again after the consultation before stepping out into 'public'. • Consideration of alternative exit from clinical area. • Provide flexibility in spaces for variety of treatment and options for different types of environment (including virtual consultations).



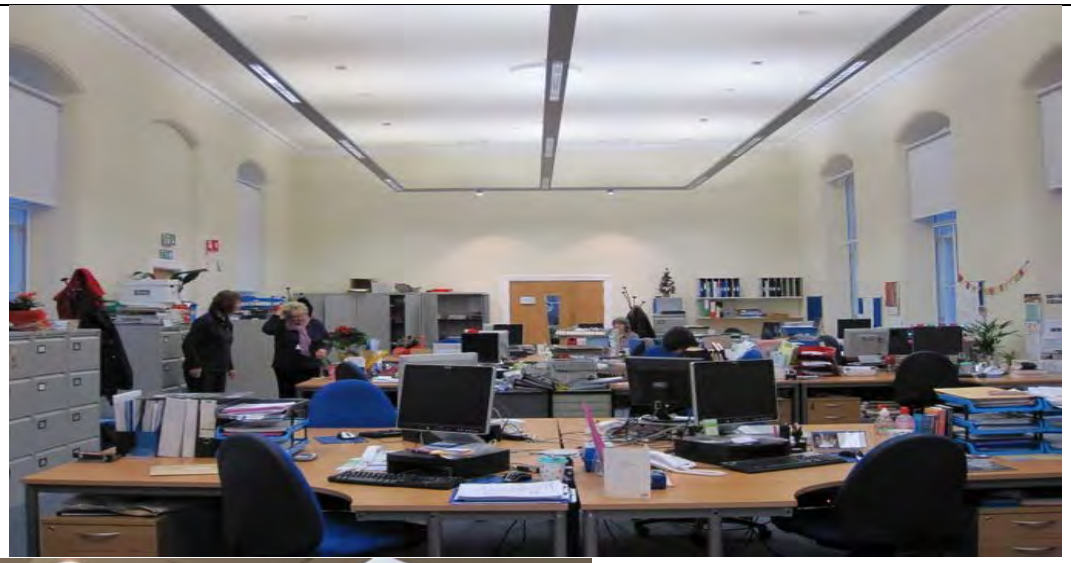
2 Non-Negotiables for Staff

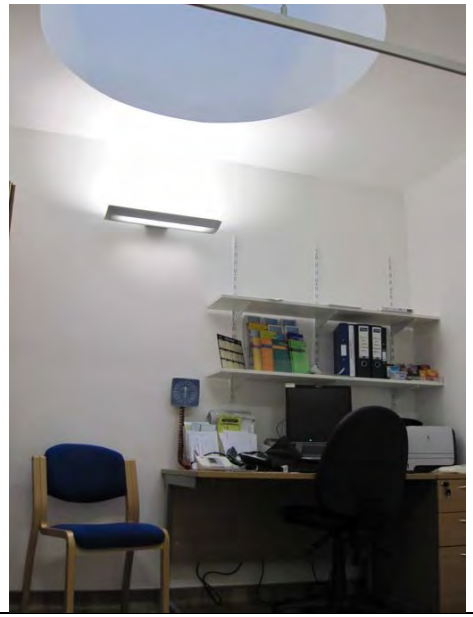
Agreed Non-Negotiable Investment Objective	Benchmark Standard – The criteria to be met and/or some views of what success might look like
2.1 Site Layout The layout of the site must provide: safe and reliable access for staff based there and visiting) in daylight and darkness in a manner that supports green travel where possible.	• Ability to lock-off areas of the building and exit securely in a well-lit area to provide staff safe and reliable access, particularly for greater extent of lone-working model • Volume of staff parking necessitated and defined on a site-by-site basis particular to each facility • Dedicated staff parking a portion of which for staff visiting or on call must be provided conveniently to a discrete entrance, with easy route for those handling large items of equipment etc. • Secure and adequate facilities for bikes, e-bikes, e-scooters close to the entrance, attractively designed to encourage use of green travel options. • Provide ability for staff to get to/from staff areas / rooms without having to go via the patient waiting area • Where designs require there is potential for GP practices and support staff to be located at first floor level, with appropriate access provided. • Routes all staff must allow them to 'check in' on entry
2.2 Wellbeing There must be a place staff to be able to rest, socialise and make food/refreshments convenient to work areas, to encourage use by all staff.	• Attractive dedicated and accessible staff space, placed away from public view to all staff to be 'off duty' and relax. • Space / lockers provided to store personal belongings • Changing and showering areas and provision to dry wet clothes desirable to support active travel. • An external area should also be provided to ensure staff have the opportunity for respite and exercise – a breath of fresh air in their day.

	 
2.3 Supporting Relationships and Training	• Flexibility for rooms to support visiting services and cater for their specific requirements. • Flexible and agile space(s) for group learning and accessing IT based education material should be provided. This should be designed and located so that it can be used (on its own and in conjunction with other spaces) for

The facility must support the education and continuing development of staff.	other purposes, including support for visiting services, community groups and the public for events and to support access to information and support. •  
2.4 Staff Working Environments The layout of the facility must promote team working across all service providers.	• Flexible and agile working spaces within hubs, efficient and effective for a variety of work environments including blended approach • Where possible scope for adaptable spaces that can be converted (made bigger / smaller) as required. • Like functions (non-clinical and clinical like administrative space or consulting rooms) should be provided together to improving training and communication • Consider potential for flexibility in uses over ground / first floor, eg. consultation rooms located on upper floors. • Staff routes around the facility to be shared, not separate, allowing impromptu meetings and conversations • The layout of activities and routes, including where there is separation between floors, should enable effective communication between all members of staff and make it easier to talk to a colleague face to face than to send e-mails.



	 
2.5 Facilities Management The management and transfer of materials and waste, and the maintenance of the facility must not impact the nature of patient areas or staff rest areas.	• Bin/recycle stores and delivery entrance placed out of sight of main public routes and spaces. • Consideration must be given to all internal finishes from a cleaning and maintenance perspective. • Facility to be easy to clean and service without impacting on patient areas, or staff rest areas, visually or with noise. • Material flows should be separated from public flows. • Sufficient goods distributed storage. (Corridors should not be used for storage) • Goods delivery areas including storage facilities to be accessible without implications on Patients. • Plant areas should be accessible without impacting on function of facility. • Vehicle service routes to be placed away from public and clinical areas to minimise noise impact and disruption. (Deliveries can arrive during the night so this needs to be taken into consideration). • Secure Service Yard sufficiently sized with no unauthorised access.

3 Non-Negotiables for Visitors/Family/Carers/Dependents

The needs of these people will be largely met by the objectives above, only additional criteria are noted below

Agreed Non-Negotiable Investment Objective	Benchmark Standard – The criteria to be met and/or some views of what success might look like
3.1 Site Layout and Availability The routes to and from the facility must be clear, safe and intuitive for visitor access, including access requirements during out of hours.	Benchmarks for Visitors should be indistinguishable from those for Patients identified in in 1.2 & 1.3 above.  


Waiting Room
Consulting Rooms

3.2 Welfare and Wellbeing The needs of carers / parents / dependents should be catered for equally as service users. They should have access to a pleasant space to wait, with positive distractions, and feel supported in their own needs and wellbeing.	Benchmarks for Visitors should be indistinguishable from those for Patients identified in in 1.3 & 1.4 above. In addition, the facility must also provide; • Suitable toilet and facilities for use by visitors • Visitors should have access to WiFi, phone charging points etc. • Spaces to relax, including access to external areas with shelter for fresh air and to sit quietly and green spaces for walks and to allow visitors 'a breath of fresh air'. • Access to refreshment/catering facilities near the main entrance. • Layout of reception desk / height needs to offer security whilst not providing a barrier. • Information points for carers.
3.3 Support Spaces The layout of public areas (consult/treatment/meeting/waiting) must provide flexibility in use for visiting services and for additional activities such as health promotion, support groups, fundraising.	• Flexible space for use by 3rd Sector organisations to provide information and offer support for family, friends and carers. Preferably located near Reception so it is visible and accessible upon arrival. • Bookable consulting and treatment rooms provided alongside rooms intended for GP use and served from the same reception/circulation. • Meeting rooms/education areas and waiting areas designed to be used individually and as a suite for special events and out of hours activities

The current Health Facility Scotland (HSF) index of guidance has been reviewed for project applicability and relevance. The **Appendix** which follows summarises those which projects within this programme of investment will require to meet.

4 Alignment of Investment with Policy

(NB: this section has been written on the presumption of a new-build solution and is to be revised should service redesign – and the above described characteristics - be realised through reconfiguration of the existing estate).

Agreed Non-Negotiable Investment Objective	Benchmark Standard – The criteria to be met and/or some views of what success might look like
4.1 The design of the facility must contribute to the wider regeneration of the area in terms of village/townscape, links and contribution to the local economy	• The development must take cognisance of the surrounding area and foster good relationships with neighbours – ensuring that traffic impacts during construction and operations are minimised and that sufficient parking is provided on-site to prevent on-street parking becoming a nuisance. • This will be completed at Outline Business Stage for each specific project
4.2 The facility must be adaptable in the longer term and identify how services could be expanded on the site should demographic changes / increase demand in the immediate locality.	• Ability to accommodate additional services, workforce and facilitate greater links with partnership services. Wider range of services offered within primary care setting. • Ability to meet future demand e.g. new housing and new residents within NHS Forth Valley; no lists operating closed status
4.3 The facility should be designed to be sustainable in its development, use, adaptation and decommissioning.	• Facility must current net zero carbon and sustainability requirements and compliance with DL(2021)38, utilising the Sustainable Design and Construction (SDaC) Guide (SHTN 02-01).
4.4 The facility should, internally and in the approaches, be designed to be Equality Act compliant and accessible.	• Compliance with the Equality Act and relevant design guidance, NHS specific and applicable to buildings in general, Building Regulations, BS etc.

The above have been developed and agreed through the involvement of the following stakeholders:

Janette Fraser, Head of Planning
Lesley Middlemiss, PCIP Programme Manager
Morag Farquhar, Associate Director of Facilities & Infrastructure - Asset Management
Laura Byrne, Associate Director Primary Care Pharmacy
Jessie Anne Malcolm, Communications
David Reid, GP Meadowbank
David Herron, HSCP Lead GP Falkirk/GP Meadowbank
Amanda Grieg, Practice Manager – Graeme Medical Practice
Kara Connor, PCIP Service Lead, Mental Health, Falkirk
Morag McKellar; Associate Director Allied Health Professional
Helen MaGuire, Public / Patient Representative
Charlene Condecco, Disability Advisor
Annette McInnes, Disability Advisor
Cameron Marr, PCIP Service Lead, Advance Practice Physio
Darline Reekie, District Nursing Lead, Falkirk
Louise McCallum, Primary Care Manager
Jillian Taylor, Vaccination/Health Visiting

5 Self Assessment Process

Decision Point	Authority of Decision	Additional skills or other perspectives	How the above criteria will be considered at this stage and / or valued in the decision	Information needed to allow evaluation
Outline Business Case development	Programme Board, HSCP; NHS Board	NHS Assure	Ability of design proposal to meet brief	Concept design Site appraisal
Completion of brief to go to market	Programme Board, HSCP; NHS Board	Technical advisors NHS Assure	Updated Design Statement project specific within brief	Early engagement with Hubco
Selection of Delivery / Design Team	Programme Board, HSCP; NHS Board,	Technical advisor external to design team to be appointed	Selection process per hubco method statements to be applied, with quality and cost considerations, to ensure that the best design team for the development is chosen from the hubco Supply Chain. Designers will have already been through a qualification process to become part of the Supply Chain. 'Participants' will be involved in the selection process for the project and can influence the outcome including, if necessary, nomination of other designers for consideration (providing they meet the standards set by hubco).	Previous experience/ examples of the designers' work on similar commissions. Interview process to include presentation/ questions regarding design approach and potential to fulfil the set criteria. As it is unlikely that previous experience will be an exact match for the proposed project, careful consideration will require to be given to the quality criteria set.
Selection of early design concept from options delivered	Programme Board, HSCP; NHS Board	Comment to be sought from NDAP	AEDET or other assessment of options to determine whether they meet the criteria	Proposals developed toStage C with sufficient detail to allow distinction between the main uses of the building(s) including circulation and external space. Elevations/3D visuals
Approval of design proposals to be submitted to planning authority	Programme Board, HSCP; NHS Board		AEDET or other assessment of the proposals to determine whether they meet the criteria	Selected design to Stage D with elevations etc.
Approval of detailed design proposals to allow construction	Programme Board, HSCP; NHS Board		AEDET or other assessment of the proposals to determine whether they meet the criteria	Design developed to at least Stage E with agreed specification.

APPENDIX J: CURRENT HEALTHCARE GUIDANCE

The current HFS index of guidance has been reviewed for project applicability and relevance. The table below summarises those which projects within this programme of investment will require to meet. This list is not exhaustive and will be reviewed and updated as part of the Outline Business Case process to include any revised or amended guidance to ensure up to date and relevance.

Project applicability	Reference ID	NHS Scotland Facility Guidance Title (web version) current at sourced date above	Date Published
3 - Highest	HBN 00-01	Core guidance - General design for healthcare buildings (HBN 00-01)	Oct-14
3 - Highest	HBN 00-07	Core guidance - Planning for a resilient healthcare estate (HBN 00-07)	Oct-14
3 - Highest	SHFN 30 Part A	HAI-SCRIBE Manual information for project teams (SHFN 30 Part A)	Oct-14
3 - Highest	SHFN 30 Part B	HAI-SCRIBE Implementation strategy and assessment process (SHFN 30 Part B)	Oct-14
3 - Highest	SHFN 30 Part C	HAI-SCRIBE questionsets and checklists (SHFN 30 Part C)	Jan-15
3 - Highest	SHTM 00	Best practice guidance for healthcare engineering policies and principles (SHTM 00)	Feb-13
3 - Highest	SHPN 36 part 1	General Medical Practice Premises in Scotland (SHPN 36 part 1)	Jul-06
2 - Normal	HBN 00-02	Core elements - Sanitary spaces (HBN 00-02)	Mar-17
2 - Normal	HBN 00-03	Core guidance - Clinical and clinical support spaces (HBN 00-03)	Oct-14
2 - Normal	HBN 00-04	Core Guidance - Circulation and communication spaces (HBN 00-04)	Oct-14
2 - Normal	HBN 08-02	Dementia-friendly Health and Social Care Environments (HBN 08-02)	Aug-16
2 - Normal	HTM 65	Wayfinding -effective wayfinding and signing for healthcare facilities (HTM 65)	Aug-16
2 - Normal	SFPN 00-01	Fire safety - A model management structure (SFPN 00-01)	Apr-04
2 - Normal	SFPN 6	Fire safety - Prevention and control of deliberate fire-raising in healthcare premises (SFPN 6)	Dec-07
2 - Normal	SHFN 02	Access - Audit survey toolkit for disabled people in healthcare premises (SHFN 02)	Sept-07
2 - Normal	SHFN 03	Access - checklist for people with dementia in healthcare premises (SHFN 03)	Oct-07
2 - Normal	SHFN 03-04	Security Lockdown - Controlling movement and access in healthcare facilities (SHFN 03-04)	Mar-20
2 - Normal	SHFN 14	Access - Disability (SHFN 14)	Sept-00
2 - Normal	SHFN 20	Access - audits of primary healthcare facilities (SHFN 20)	Sept-00
2 - Normal	SHTM 03-01 Part A	Ventilation for Healthcare - Design and validation (SHTM 03-01 Part A)	Feb-14
2 - Normal	SHTM 03-01 Part B	Ventilation for Healthcare - Operational and verification (SHTM 03-01 Part B)	Oct-11
2 - Normal	SHTM 04-01 Part A	Water safety for healthcare- Design installation and testing (SHTM 04-01 Part A)	Jul-14
2 - Normal	SHTM 04-01 Part B	Water safety for healthcare- Operational management (SHTM 04-01 Part B)	Jul-14
2 - Normal	SHTM 04-01 Part C	Water safety for healthcare- TVC Testing Protocol (SHTM 04-01 Part C)	Feb-14
2 - Normal	SHTM 04-01 Part D	Water safety for healthcare- Disinfection of domestic water systems (SHTM 04-01 Part D)	Aug-11
2 - Normal	SHTM 04-01 Part E	Water safety for healthcare- Alternative materials and filtration (SHTM 04-01 Part E)	Aug-15

2 - Normal	SHTM 04-01 Part F	Water safety for healthcare- Chloramination of water supplies (SHTM 04-01 Part F)	Dec-11
2 - Normal	SHTM 04-01 Part G	Water safety for healthcare- Operational procedures and exemplar (SHTM 04-01 Part G)	Jul-15
2 - Normal	SHTM 04-02 Part A	Water safety for emerging technologies - Solar domestic hot water heating (SHTM 04-02 Part A)	Jul-15
2 - Normal	SHTM 04-02 Part B	Water safety for emerging technologies - Rainwater harvesting (SHTM 04-02 Part B)	Jul-15
2 - Normal	SHTM 04-02 Part C	Water safety for emerging technologies - Grey water recovery (SHTM 04-02 Part C)	Jul-15
2 - Normal	SHTM 06-01 Part A	Electrical services supply and distribution: Design considerations (SHTM 06-01 Part A)	Jul-15
2 - Normal	SHTM 06-01 Part B	Electrical services supply and distribution: Operational management (SHTM 06-01 Part B)	Jul-15
2 - Normal	SHTM 06-02	Electrical safety guidance for Low Voltage systems (SHTM 06-02)	Jul-15
2 - Normal	SHTM 06-03	Electrical safety guidance for High Voltage systems (SHTM 06-03)	Jul-15
2 - Normal	SHTM 07-03	Transport management and car parking (SHTM 07-03)	Jan-08
2 - Normal	SHTM 07-04	Transport - NHSScotland Travel Plan Guidance (SHTM 07-04)	Sept-07
2 - Normal	SHTM 08-01	Specialist Services: Acoustics (SHTM 08-01)	Jul-15
2 - Normal	SHTM 08-02	Specialist Services - Lifts (SHTM 08-02)	Jul-15
2 - Normal	SHTM 08-05 Part A	Building Management Systems: Overview and Management (SHTM 08-05 Part A)	Apr-12
2 - Normal	SHTM 08-05 Part B	Building Management Systems: Design Considerations (SHTM 08-05 Part B)	Apr-12
2 - Normal	SHTM 08-05 Part C	Building Management Systems: Validation and Verification (SHTM 08-05 Part C)	Apr-12
2 - Normal	SHTM 08-05 Part D	Building Management Systems: Operational Management (SHTM 08-05 Part D)	Apr-12
2 - Normal	SHTM 08-07	Confined Spaces policies procedures and guidance (SHTM 08-07)	Feb-15
2 - Normal	SHTM 08-08	Pressure Systems: Policies and Guidance (SHTM 08-08)	Jul-14
2 - Normal	SHTM 2035 Part 1	Mains signaling - Overview and management (SHTM 2035 Part 1)	Jun-01
2 - Normal	SHTM 2035 Part 2	Mains signalling - Design considerations (SHTM 2035 Part 2)	Jun-01
2 - Normal	SHTM 2035 Part 3	Mains signalling - Validation and verification / operation (SHTM 2035 Part 3)	Jun-01
2 - Normal	SHTM 54	Building component series -User manual (SHTM 54)	Dec-06
2 - Normal	SHTM 55	Building component series -Windows (SHTM 55)	Dec-06
2 - Normal	SHTM 56	Building component series - Partitions (SHTM 56)	Dec-06
2 - Normal	SHTM 57	Building component series - Internal glazing (SHTM 57)	Dec-06
2 - Normal	SHTM 58	Building component series - Internal doorsets (SHTM 58)	Dec-06
2 - Normal	SHTM 59	Building component series - Ironmongery (SHTM 59)	Dec-06
2 - Normal	SHTM 60	Building Component Series - Ceilings (SHTM 60)	Oct-09
2 - Normal	SHTM 61	Building component series - Flooring (SHTM 61)	Jul-09
2 - Normal	SHTM 61 app 1a	Building component series - Flooring - matrix example xls (SHTM 61 app 1a)	Jul-09
2 - Normal	SHTM 62	Building component series - Demountable storage systems (SHTM 62)	Dec-06
2 - Normal	SHTM 63	Building component series - Fitted storage systems (SHTM 63)	Dec-06
2 - Normal	SHTM 67	Building component series - Laboratory storage systems (SHTM 67)	Dec-06
2 - Normal	SHTM 69	Building component series - Protection (SHTM 69)	Dec-06
2 - Normal	SHTM 81 part 1	Fire safety - Precautions in new healthcare premises (SHTM 81 part 1)	Jul-09

2 - Normal	SHTM 81 part 2	Fire safety - Fire engineering of healthcare premises (SHTM 81 part 2)	Jul-09
2 - Normal	SHTM 81 part 3	Fire safety - Atria in healthcare premises (SHTM 81 part 3)	Apr-13
2 - Normal	SHTM 82	Fire safety - alarm and detection systems (SHTM 82)	Apr-13
2 - Normal	SHTM 83	Fire safety - General fire precautions in healthcare premises (SHTM 83)	Apr-04
2 - Normal	SHTM 83 Part 2	Fire Safety - Fire safety training (SHTM 83 Part 2)	Jul-17
2 - Normal	SHTM 84	Fire safety - Risk assessment in residential care premises (SHTM 84)	Apr-03
2 - Normal	SHTM 85	Fire safety - Precautions in existing healthcare premises (SHTM 85)	Dec-07
2 - Normal	SHTM 86	Fire safety - Risk assessment (SHTM 86)	Jun-13
2 - Normal	SHTM 87	Fire safety - Textiles and furniture (SHTM 87)	Aug-09
2 - Normal	SHTN 02-00	Sustainable Development Strategy (SHTN 02-00)	Feb-12
2 - Normal	SHTN 02-02	Sustainable - EV Charging Infrastructure (SHTN 02-02)	Dec-20
2 - Normal	SHTN 3	Waste management - Segregation Chart (SHTN 3)	Nov-13
2 - Normal	SHTN 3 Part A	Waste management - Summary of requirements - best practice overview (SHTN 3 Part A)	Feb-15
2 - Normal	SHTN 3 Part B	Waste management - Policy template (SHTN 3 Part B)	Feb-15
2 - Normal	SHTN 3 Part C	Waste management - Compendium of regulatory requirements (SHTN 3 Part C)	Feb-15
2 - Normal	SHTN 3 Part D	Waste management - Guidance and example text for waste procedures (SHTN 3 Part D)	Feb-15
1 - Low	HBN 14-02	Medicines storage in clinical areas (HBN 14-02)	Sept-21

APPENDIX K:ROLES & RESPONSIBILITIES OF PROJECT TEAM

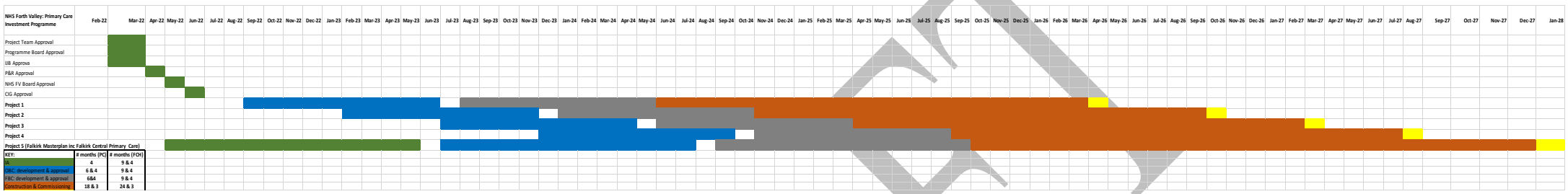
Project Group Roles and Responsibilities			
	Project Role	**Responsible person**	**Project responsibilities overview**
Senior Responsible Officer		Cathie Cowan	Chair of FCH Masterplan & PC / PIA Programme Board. Accountable for the success of the programme and enabling the organisation to exploit the new environment and opportunities arising from the programme.
Project Core Group	Project Director	Kathy O'Neill (General Manager Primary Care & Mental Health Directorate)	Ultimate responsibility for the project and 'owns' the Business Case throughout the life of the project. Primary contact for all decision making associated with the project and responsible for overall management of the project including liaising with the sponsor; coordinating and leading the project board; overseeing project implementation, financial and administrative oversight and monitoring and evaluation of the project. Approves the project structure to deliver the agreed aims and objectives and ensures adequate resources are made available to deliver the project within agreed costs and timescales. Links directly to the NHS Board /HSCP's/IJB's/Voluntary Sector, Project Board, and all external organisations (SFT, Scottish Government).
	Subject matter expert-Pharmacy	Laura Byrne (Associate Director of Pharmacy-Primary care & Community)	Subject matter experts (SME's) (Pharmacy) Responsible for representation of primary care and community pharmacy related matters and providing professional advice to the project. Providing pharmacy related leadership and advice to the project.
	Subject matter expert-Primary Care General Practice	Scott Williams (Deputy Medical Director-Primary Care)	Subject matter experts (SME's) (Clinical) Responsible for representation of clinical matters and providing professional advice to the project. Providing clinical leadership and advice to the project.
	Subject matter experts-GP leads	David Herron Teresa Cannavina David Reid James King Jonathan Turner Scott Henderson Sarah Boddington Jill Carmichael	Subject matter experts (SME's) (Clinical) Responsible for representation of clinical matters within their locality and providing professional advice to the project.
	Subject matter expert-Finance Lead	Steven Kirkwood (Senior finance manager)	Subject matter expert (SME) (Financial planning and management) Participates as a member of the Project group and manages and monitors the allocation of funding to the project in conjunction with the NHS appointed Project Manager. Monitor's expenditure and provides regular reports to the Project Director and SRO. Links effectively with the finance and service managers in the operational areas affected by the project and ensure that revenue budgets are co-ordinated and aligned consistent with the project programme.

			Supports the Workforce planning process and costs the agreed workforce changes.
	Subject matter expert-Estates & Infrastructure Lead (Associate Director of Facilities & Infrastructure)	Morag Farquhar (Associate Director of Facilities & Infrastructure)	Subject matter expert (SME) (Infrastructure, Estates & Capital Planning) Provides expertise in design development, contract, procurement, stakeholder, and procurement management and assists the SRO with project governance and commercial acumen. Supports the delivery of the project through provision of expert advice on all aspects of the built environment including links to lead advisors; legal advisors; authorising engineers (Water, medical gases etc.); health and safety; fire officers; compliance, estate's & engineering managers, telecoms, energy, and transport experts, as required, to facilitate and inform the project. Supervision of NHS appointed technical advisors.
	Subject matter expert-eHealth & ICTLead	Kevin Edwards (ICT support manager)	Subject matter expert (SME). (eHealth & ICT) Supports the delivery of the project through provision of expert advice and resource to support the eHealth and ICT needs of the project. Assists throughout the business case, commission, design, and construction phases to ensure proposals are fit for purpose and align with organisational objectives and to ensure resource is available as the project requires it to prevent delays. Supports the service change, identifies opportunities and challenges to provide a robust, reliable technical infrastructure and good standard of support.
	Subject matter expert-Improvement-Primary Care	Lesley Middlemiss (Improvement Programme Manager Primary Care)	Subject matter expert (SME). (Improvement) Supports the delivery of the project through provision of expert advice and resource to support the improvement needs of the project. Assists throughout the business case process to ensure proposals are fit for purpose and align with organisational objectives. Supports the service change and identifies opportunities and challenges to help ensure an informed solution
	Subject matter pert- nursing	Elaine Kettings (Head of person centred care)	Subject matter expert (SME) (Nursing) Supports the delivery of the project through provision of expert advice and ensure sufficient resource to meet the organisational objectives related to nursing to deliver unscheduled care. Provide nursing staff governance expertise and leadership. Supports service change, identifies opportunities and challenges. Responsible to communicating project progress within their speciality. Provide nursing clinical governance expertise and leadership.
	Subject matter expert – Planning	Janette Fraser (Head of Planning)	Subject matter expert (SMEs) (Planning) Responsible for representation of planning and providing professional advice to the project. Providing planning related leadership and advice to the project. Supports the service change, identifies opportunities and challenges to meet the future health and care needs of the Forth Valley population.

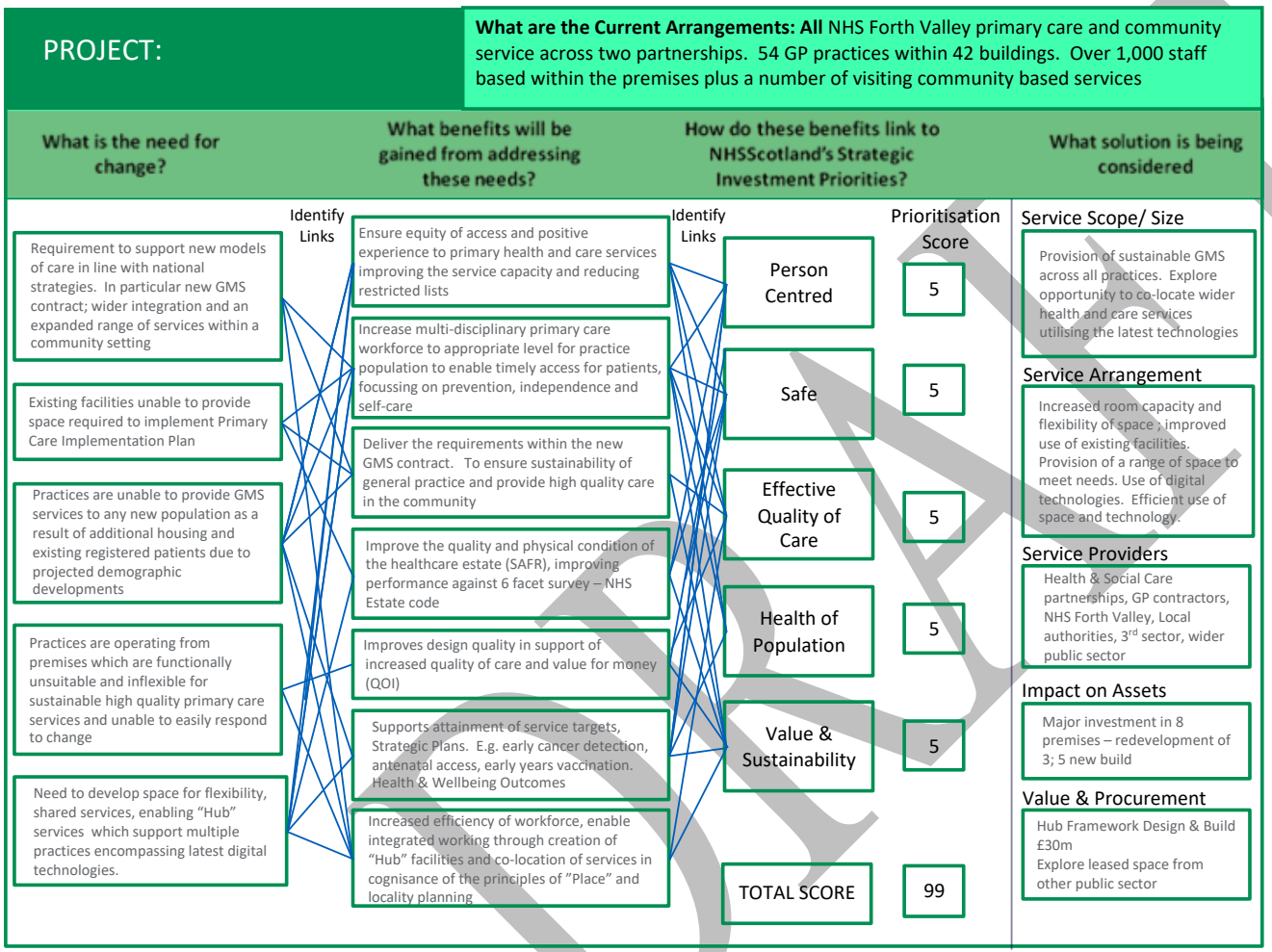
	Subject matter expert – Communication & Engagement	Elsbeth Campbell (Head of NHS FV Communications) Paul Surgenor (Communications Lead, HSCP)	Subject matter expert (SMEs) (Communication and Engagement) Responsible for representation of NHS Forth Valley Communications Department and providing professional advice to the project in terms of communication and patient/public engagement. Providing communications and patient/public engagement related leadership and advice to the project. Responsible for liaising with deputy to keep abreast of progress and support on strategic direction for the Communications and Engagement plan.
		Jessie-Anne Malcolm (Deputy to NHS FV Head of Communications)	Responsible for leading in initial stages for preparatory work and keeping the Head of Communications updated. Responsible for representation of NHS Forth Valley Communications Department and providing professional advice to the project in terms of patient/public engagement.
	Subject matter expert (HSCPs)	Gail Woodcock (Falkirk) Bob Barr (Clacks/Stirling)	
	Capital Build Project Manager - NHS	To be appointed	Overall responsibility (in conjunction with the external technical advisor (Buchan & Associates) for the successful initiation, planning, design, execution, monitoring, controlling and closure of the project. Responsible (in conjunction with the external technical advisor) for the day-to-day management of the project including managing the scope, schedule, finance, risk, quality, and resources). Management and co-ordination of the project team and the day-to-day contact for the project team. Liaison with external advisors (HFS/SG), Project Board leads; clinical leads and the technical advisors to ensure an effective framework is in place to deliver the project. Monitoring progress against the project plan; reporting variances and providing progress reports to the Project Board. In conjunction with the Project Director maintaining the project Risk Register and issue log and communicating, escalating accordingly. Raising issue/exception reports to the Project Director as soon as there are concerns that the tolerances set by the NHS Programme Board are liable to be exceeded.
	Project co-ordination /management support	Val Arbuckle / Debbie MacLeod / Maggie MacKinnon (CPMO)	Responsible for the coordination and contribution to a range of activities in support of the project. Responsible for establishing governance structure. Supporting the Project Manager and Project Team in the co-ordination, planning, and control of the project. Ensuring the agreed project management methods, standards and processes are maintained throughout the project lifecycle. Assisting the Project Manager in the production and maintenance of project plans. Developing and maintaining the project library, filing, recording, and reporting systems. Advise and assist project team members in the application of project procedures, disciplines and recording and reporting standards.
NHS Appointed technical advisors			

Buchan + Associates	Technical advisor (Healthcare Planner)	Karen Pirrie (Associate Director)	

APPENDIX L: PROGRAMME PLAN



APPENDIX M: STRATEGIC ASSESSMENT (2019)



APPENDIX N: Prioritisation Exercise Summary PAPER

10th May 2022

PURPOSE: to support the Programme Initial Agreement (PIA) of investment in primary care across NHS Forth Valley a prioritisation exercise was undertaken to evaluate the priority of locality based Outline Business Case to be taken forward. An initial prioritisation exercise was undertaken as part of the Services & Premises review in 2019; this has been updated to reflect latest data and information from the development of the PIA. This paper provides the summary of results.

Approach to prioritise

The prioritisation of locality based investments adopted best practice investment appraisal methodology in the form of a quantifiable assessment. The following steps were undertaken:

- Determine criteria to assess each investment area – ensuring each criterion can be objectively measured
- Rank the importance of each criterion
- Apply a weighted paired assessment to determine the weight for each criterion
- Rank each criterion based on total locality score – e.g. locality with biggest shortfall in space ranked 1st etc.
- Apply weights to ranking to obtain overall weighted rank

Criteria

The following criteria were developed and information gathered to assess each locality's score. The basis for the total locality score is shown below

Table 1: Criteria

Criteria	Source	Basis of total locality score
Population	October 2021 practice populations	Total of all practice population within locality
Additional space required	Total shortfall in space by practice based on the Initial assessment from 2019 Premises report; updated to take into account additional space from minor investment programme of work	Total additional space required within the locality
Workforce sustainability	Original assessment based on 2019 Practice Sustainability tool; unable to update however review impact if this criterion excluded	Weighted sustainability score for each practice; weighted on population size.
New Population	Total housing plans; as referenced within the PIA	Total new houses within the locality
Estate Metrics	Combination of estate factors from Property & Asset Management Strategy 2019	Total score across all facets; where A given score of 1; B=2 etc.
Need	Assessment of deprivation, need, prevalence of disease using NRAC prescribing index for excess costs	Weighted sustainability score for each practice; weighted on population size.

Assess Localities against each criteria

The combined locality score for each criteria was then ranked with highest score awarded rank 1. Noting there was no identified capital investment within Rural Stirling locality; therefore excluded from the final ranking. Falkirk Central locality has been included in the analysis below however; the capital investment in primary care within this locality will be taken forward as part of the Falkirk Community Hospital Master planning project

Table 2:Criteria score

Criteria/ Locality rank	Clackmannanshire Locality	Stirling city with the eastern villages, Bridge of Allan & Dunblane Locality	Falkirk East Locality	Falkirk West Locality	Falkirk Central Locality
Population	3	1	2	4	5
Additional space required	2	1	2	5	2
Workforce sustainability	1	2	4	5	3
New Population	5	1	3	2	4
Estate Metrics	4	1	2	3	5
Need	2	5	4	3	1

Rank & Weight of Criteria

Each of the criteria was ranked in importance and a weighted pairs exercise carried out to determine the overall weight. This was undertaken as part of the original premises work and the same rank and weight used for this prioritisation exercise. The final rank and weight is shown below:

Table 3: Rank & Weight

Criteria	Rank	Weight
Locality population	6	10.7%
Additional space required	1	23.6%
Workforce sustainability	4	16.1%
New population	3	17.0%
Estate Metrics	2	21.2%
Need	5	11.3%

The weights above were used to derive a final overall ranking of the localities based on all criteria; summarised in the table below;

Table 4: Final Ranking

Rank	Applying weighted criteria
1	**Stirling city with the eastern villages, Bridge of Allan & Dunblane Locality**
2	**Falkirk East Locality**
3	**Clackmannanshire Locality**
4	**Falkirk Central Locality**
5	**Falkirk West Locality**

By way of sensitivity testing two test were undertaken with the impact on ranking shown below:

- an equal weighting of criteria; results in no change to ranking but Falkirk East and Clackmannanshire localities 2nd equal;
- excluding workforce sustainability criteria as unable to update from 2019; results in no change to ranking but Falkirk West and Falkirk Central localities are 4th equal.

Conclusion

Based on the evaluation the prioritisation of locality based Outline Business Cases indicates the first as locality as Stirling city with the eastern villages, Bridge of Allan & Dunblane, followed by Falkirk East, Clackmannanshire, then Falkirk West with Falkirk Central addressed as part of the Falkirk Community Master plan project.

Clackmannanshire & Stirling
Health & Social Care
Partnership

Falkirk
Health and Social Care
Partnership

NHS
Forth Valley

Primary Care Programme Initial Agreement

***Improving GP Services for all**: ensuring all GP practices have adequate capacity to deliver core general medical services with access to extended community services within 'fit for purpose' premises; responsive to current and changing practice populations.*

NHS Forth Valley

17th May 2022

Glossary

AEDET	Achieving Excellence Design Evaluation Toolkit
ACP	Anticipatory Care Plans
AHP	Allied Health Professionals
ANP	Advanced Practice Nurse
APP	Advanced Practice Physiotherapist
BREEAM	Building Research Establishment's Environmental Assessment Method
CAMHS	Child & Adolescent Mental Health Service
CCHC	Clackmannanshire Community Healthcare Centre
CHART	Care Home Assessment & Response Team
CIG	Capital Investment Group
CPMO	Corporate Portfolio Management Office
CTAC	Community Treatment & Care
CVS	Community & Voluntary Services
EQUIA	Equity Impact Assessment
FCH	Falkirk Community Hospital
FV	Forth Valley
GP	General Practitioner
GPN	General Practice Nurse
GMS	General Medical Services
GROW	Growth in Resilience & Opportunities for Wellbeing
HEAT	Health Improvement, Efficiency, Access &Treatment
HFS	Health Facilities Scotland
HIS	Health Improvement Scotland
HSCP	Health & Social Care Partnership
IA	Initial Agreement
ICT	Information Communications Technology
IJB	Integration Joint Board
IM&T	Information Management & Technology
ISD	Information Service Division
IT	Information Technology
LMC	Local Medical Committee
MHWPC	Mental Health & Wellbeing Primary Care
MDT	Multi-disciplinary Team
MSK	Musculoskeletal
NDAP	NHS Scotland Design Assessment Process
NRS	National Records of Scotland
OBC	Outline Business Case
PAMS	Property & Asset Management Strategy
PCIP	Primary Care Improvement Plan
PCMHN	Primary Care Mental Health Nurse
PIA	Programme Initial Agreement
P&R	Performance & Resources
QALYs	Quality Adjusted Life Years
QOI	Quality Outcome Indicators
RCGP	Royal College of General Practitioners
SAFR	NHS Scotland Assets and Facilities Report
SCIM	Scottish Capital Investment Manual
SG	Scottish Government
SGPC	Scottish General Practitioners Committee
SME	Subject Matter Expert
SMS	Substance Misuse Services
SRO	Senior Responsible Officer
VTP	Vaccination Transformation Programme
WTE	Whole Time Equivalent

Contents:

1 EXECUTIVE SUMMARY

1.1.1 This Initial Agreement sets out proposals for a major programme of investment to redesign and improve access to GP and primary care services across Forth Valley. It describes the strong and compelling case for change, preferred service model and highlights the many benefits for local patients, staff and communities across the area.

1.1.2 These proposals, which have been developed in partnership with local health and care staff, voluntary organisations and service user and carer representatives, build on the work undertaken as part of the premises and services review in 2019. This identified a number of priority areas which required investment to address insufficient capacity and/ or inadequate healthcare facilities to meet current and future needs. They will also support the delivery of a number of key local and national plans including NHS Forth Valley's Primary Care Improvement Plan, Healthcare Strategy, the strategic plans of our two Health and Social Care Partnerships (HSCPs) and the E-health strategy. In addition, it will help achieve the goals set out in the Scottish Government's National Clinical Strategy which states "effective primary care, with universal coverage, can significantly improve the outcomes for patients, and deliver the most cost-effective healthcare system" as well as ensure we are able to deliver the ambitious commitments and changes set out in the new General Medical Services contract.

1.2 Development of the Programme Initial Agreement (PIA)

1.2.1 The development of the PIA has been undertaken jointly with Falkirk and Clackmannanshire and, Stirling Health and Social Care Partners, 3rd sector, user and carer engagement as well as regular updates to the GP sub-committee.

1.2.2 The PIA sets out the overarching proposition for future and on-going investment to deliver the strategic aims and ambitions of the Programme, which may be delivered as a series of discrete projects.

1.2.3 It builds on the work undertaken as part of the Premises & Services Review in 2019 which identified priority areas for investment to address need in relation to insufficient capacity and inadequate facilities. This work has now been taken forward within the PIA in addition to establishing the investment required to implement the preferred service model.

1.3 The Need for Change

Recruitment and retention

1.3.1 Forth Valley currently has fewer whole time equivalent (WTE) GPs compared to the Scottish average (5.7 vs 6.4 per 10K - BMJ 2019) and a population which is experiencing more rapid change than the rest of Scotland - both in population increase and demographic shift. It is therefore vital that we create innovative and sustainable ways of delivering GP and primary care services which meet the current and future needs of our rising population and improve the recruitment and retention of GPs and other healthcare professionals who now form part of the wider primary care teams. GP sustainability is a significant corporate risk for NHS Forth Valley and without significant investment in primary care services and premises, along with changes to the way these services are delivered, this risk is unlikely to reduce.

Access to local services

1.3.2 Some GP practices have challenges recruiting to posts and/ or providing suitable accommodation and facilities for additional staff. As a result, many are unable to routinely

accept new patients, which means some patients may have to travel further to access local services.

1.3.3 If improvements to existing primary care facilities are not made, NHS Forth Valley will not be able to realise the benefits from the Primary Care Improvement Plan (PCIP). This includes the ability to fully implement the introduction of more than 200 additional healthcare professionals whose roles are already making a positive impact on GP workload, and help to reduce pressure on hospital services.

1.3.4 For example, GP Practices which have access to advanced practice physiotherapists have seen a reduction in orthopaedic referrals and those with mental health nurses have been able to prevent the need for referrals to community mental health teams.

1.3.5 The roll out of these services also means patients have direct access to expert advice and treatment at an earlier stage, which prevents their problems from becoming more severe and requiring more intensive and costly treatment. In addition, it reduces pressure on GPs and frees up more of their time to support patients with more complex health conditions.

1.3.6 However, due to size, condition and layout constraints, many local GP Practices are unable to accommodate all of the additional new healthcare roles which could make a real difference to local patients and GP workload.

Rising demand

1.3.7 Significant housing development within NHS Forth Valley (up to 12,000 new homes with many more planned over the next few years) combined with the significant growth in the number of local residents aged over 65 from 1-in-6 currently to 1-in-4 by 2035 means that the existing GP premises and workforce are unable to meet current and future demand for local healthcare services.

1.3.8 This, in turn, means some local practices may be unable to deliver the full range of core and expanded services as set out in the General Medical Service (GMS) contract leading to rising unmet need, growing health inequalities, poorer health outcomes and rising demand for acute care.

IT and infrastructure

1.3.9 Inadequate healthcare facilities, including buildings in poor physical condition, lack of space to expand and poor IT infrastructure means many GP Practices may be unable to implement new digital developments for both staff and patients, or support the delivery of modern healthcare services which patients expect.

1.3.10 Restrictions in size, layout and capacity mean that many GP Practices are unable to maximise the benefits of health and care integration or develop health and care shared services. An inability to accommodate wider multi-disciplinary teams or social care colleagues means many of the benefits of joint working are not achievable and this can result in more limited and fragmented services for local patients.

1.4 The Proposed Way Forward

1.4.1 There are currently 50 GP practices within 45 buildings, with over 1,000 staff based in the premises plus a number of visiting community-based services. A full list can be found in **Appendix A**.

1.4.2 In order to achieve the transformational changes set out in the new GMS contact, we need to significantly modify the way existing services are delivered and developed, and invest in

improved healthcare facilities and technology which can accommodate the staff and services required now and in the future.

1.4.3 The success of other strategic investments such as Forth Valley Royal Hospital and Forth Valley's community hospitals is dependent on financing services in primary care across Forth Valley to help deliver these as close to home as possible, reducing pressure on the Emergency Department and preventing hospital admissions.

1.4.4 A three-stage approach was undertaken to identify the preferred service solution. This considered alternative service arrangements and **how services** could be best delivered. This considered the different ways in which the workforce and space could best be used as well as opportunities to share staffing resources or collocate the primary care workforce across practices. For example, sharing accommodation for multiple practice locations and sharing sessions use across areas.

1.4.5 Work was then undertaken to identify **what service** delivery model is most appropriate for each service provided within GP Practices. For example, which services need to be provided by each individual practice and which could be shared between practices.

1.4.6 The final stage involved identifying **where** each service would be provided and the specific requirements of each locality within NHS Forth Valley. This considered need, deprivation, rurality, the overall geography of the locality and included engagement with lead GPs, managers and patient representatives from each locality.

1.4.7 Underpinning the proposed service model is the expansion of **"hub" based models** of care, where services for some practices are provided within larger premises. For example, podiatry services have moved to delivering the majority of clinical sessions in a smaller number of locations but with a larger number of sessions provided to increase capacity for patients. There are wider opportunities for premises hosting multiple GP Practices, where health board services can be offered to the total population served by the premises rather than those served by individual practices.

Benefits

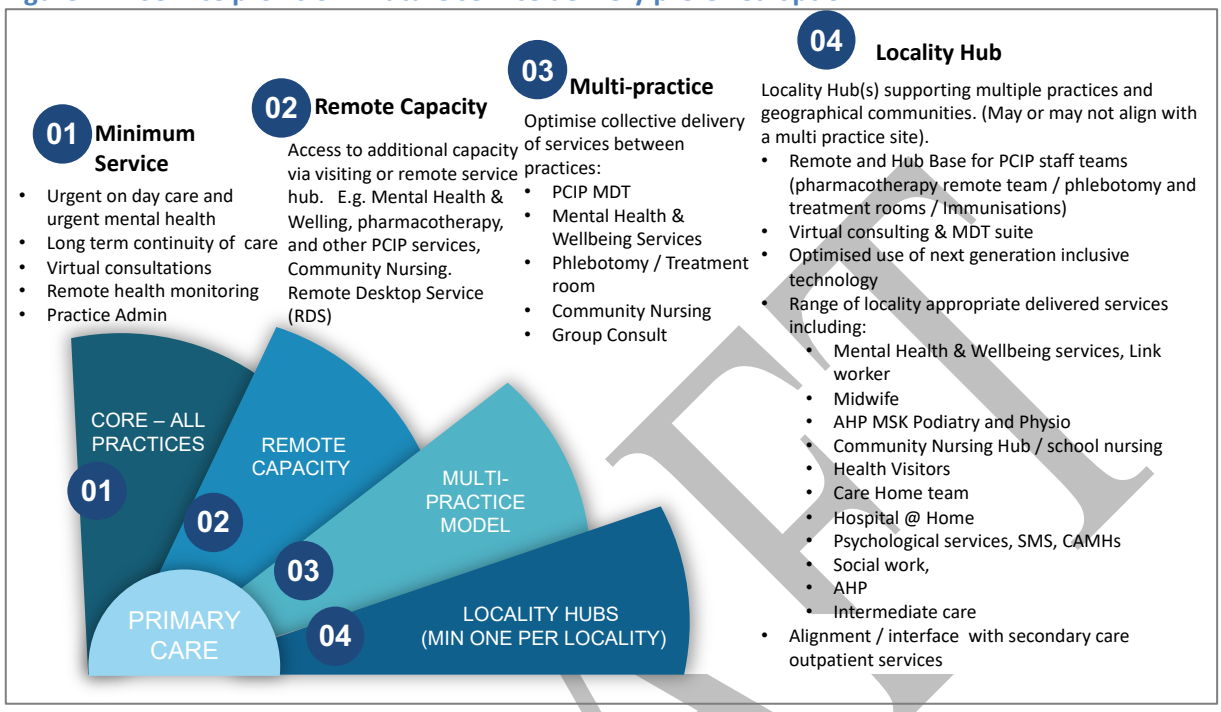
1.4.8 The benefits of the proposed changes are many and wide-ranging. They will not only improve patient care but will also increase staff recruitment and support the delivery of more modern, cost-effective services.

- Improved access to a wider range of services
- Ability to meet current and future demand
- Reduced waiting times for mental health advice and physiotherapy
- Reduced health inequalities
- Improved health outcomes and increase in overall population health
- Increased staff recruitment and retention
- Improved patient experience
- Reduced pressure on secondary care – fewer specialist referrals and Emergency Department attendances
- Ability to deliver aims and objectives of local and national policies
- Improved working environment
- More joined up and integrated working across health and social care increasing the range of wider community benefits
- Improved information sharing
- Increased training, learning and development opportunities for local staff
- Improved economies of scale
- Reduced costs associated with increased referrals and unmet need

Preferred Service Delivery Option

1.4.9 The diagram below summarises the future service delivery option for each service; how each service would be provided within the future model :

Figure 1-1: Service provision – future service delivery preferred option



1.4.10 Further details on the specific options are outlined below:

1. **Do Minimum**: all practices would continue to provide the following elements of service:
   - Urgent on the day care;
   - Long term continuity of care; and
   - Practice administration services.
2. **Remote Capacity**: individual practices would continue to provide core services as per "do minimum" but would have, in addition, a range of visiting and remote services delivered from the locality hub.
3. **Multi-practice**: individual practices would continue to provide core services as per "do minimum". The health board delivered services, including primary care improvement plan staff, would be optimised to collectively deliver to the total population. This would increase access and make best use of all available resources to the total population served by all practices. For example, this could mean increased access to advanced practice physiotherapy through sharing of the sessional allowance between all practices.
4. **Locality Hub**: a key base within localities delivering core services to all practices plus a wide range of primary and community-based services to the wider catchment population.

1.4.11 The implementation of the proposed service model within localities considered population need; deprivation and access and generally aligns to areas of the greatest need.

1.4.12 The table below sets out the specific impact of the proposed service model by locality including the proposed investment required to deliver the preferred model.

Figure 1-2: Impact of Proposed Service Option – by locality

Locality Summary	Proposed Configuration	Benefits	Investment Impact
 **Falkirk Central Locality** • 7 GP practices • 43,000 population • 71% Practice owned premises • All practice lists have an "open but full' status and they are currently not routinely accepting new patients. • Over 1,000 additional new houses are planned. • Most practices are unable to accommodate additional professional roles.	• Locality hub with up to 4 practices. All other practices benefit from additional capacity via remote and visiting services. • The use and function of the current Camelon Health Centre to be included in the Falkirk primary care master planning process.	• Meet additional capacity requirements for new GMS contract across all practices. • Reduce number of practice owned premises. • Improved locality services. • Meets demand from new housing.	• Redevelopment of up to four practices into a multi-practice locality hub. • Reprovision of, and improved locality services from, a single hub. • This project will be taken forward within the Falkirk Community Hospital Master planning project.
 **Falkirk West Locality** • 9 GP practices • 54,000 population • 22% Practice owned premises • 55% of practice lists have an "open but full' status and they are currently not routinely accepting new patients. • Over 1,100 additional new houses are planned • Most practices are unable to accommodate additional professional roles.	• Locality hubs to take account of the geography of the locality. • Review and facilitate effective service delivery between the existing Stenhousemuir multi-practice hub and a second hub in the Denny / Bonnybridge cluster.	• Investment to enable full provision of GMS services. • Releases space in Stenhousemuir to facilitate efficient provision of full GMS care. • Meets demand from new housing. • Addresses significant infrastructure challenges.	• Creates second locality hub for the Denny / Bonnybridge population. • Addresses an existing multi-primary care investment priority in Bonnybridge.
 **Falkirk East Locality** • 9 GP practices • 65,000 population • 11% Practice owned premises • 44% of practice lists have an "open but full' status and they are currently not routinely accepting new patients. • Over 2,600 additional new houses are planned. • Most practices are unable to accommodate additional professional roles and services.	• Hub locality services across Grangemouth and Bo'ness • Refocus Meadowbank HC as a multi-practice site to create space for expanded GP services. • Re-providing locality non-GMS services within the locality hub. • Meadowbank catchment also likely to use Falkirk Central locality services.	• Improve access to GMS services. • Meet additional capacity requirements for new GMS contract. • Potential to improve services limited by poor building quality and include a shift of practice-owned premises to HB ownership. • Meets demand from new housing	• Investment to hub locality services across Grangemouth and Bo'ness • Optimised links with Falkirk central hub.

Locality Summary	Proposed Configuration	Benefits	Investment Impact
Stirling city with the eastern villages, Bridge of Allan & Dunblane Locality  • 11 GP practices; wide geographical spread over urban and rural settings. • Over 72,000 population. • 18% Practice owned premises. • 44% of practice lists have an "open but full' status and they are currently not routinely accepting new patients. • Over 6,000 additional new houses are planned. • A number of practices are unable to accommodate the additional professional roles and services.	• Locality hubs – addressing the spread of population and, in particular, supporting areas of high deprivation in the East and West of Stirling city. • Optimise Stirling Health & Care Village supplemented by improving the existing Orchard House hub service. • Development of a new hub and extended GP practice within eastern villages.	• Improve services limited by poor building quality and include a shift of practice owned premises to HB ownership. • Meet the additional capacity requirements for new GMS contract within a number of practices. • Addresses premises with significant infrastructure challenges. • Meets demand from new housing.	• Optimise the existing primary Stirling Health and Care Village hub through provision of share service capacity within an east and west Stirling hub. • Optimised links with Stirling Care Village central hub. • Addresses an existing primary care investment priority in Cowie.
Clackmannanshire Locality  • 7 practices; wide geographical spread over urban and rural settings. • 58,000 population. • 28% Practice owned premises. • 28% of practice lists have an "open but full' status and currently they are not routinely accepting new patients. • Over 1,000 additional new houses are planned. • Most practices are unable to accommodate additional professional roles and services.	• Locality hubs addressing the spread of population • Improving service delivery and alignment between the existing CCHC and a hub servicing the Hillfoots villages (Menstrie, Alva, Tillicoultry, Dollar & Muckhart).	• Reprovision of, and improved, locality services between the existing CCHC and a new Hillfoots hub. • Potential to improve services limited by poor building quality • Includes a shift of practice owned premises to HB ownership. • Meets demand from new housing.	• Investment creates a 2nd hub within the Hillfoots villages. • Investment addresses demand created by additional housing.
Rural Stirling Locality • 10 practices; wide geographical spread over urban and rural settings. • 26,000 population. • 33% Practice owned premises. • All practice lists are open. 	• Application of the model will align with the existing provision in local villages and communities with opportunities to improve access. • Requirement to be more novel than a locality-based model.	• Increased access to the multi-disciplinary team across practices within the locality. • Use of remote technology solutions to enable inter-practice access to services over the working week.	• No infrastructure investment required. • Investment in appropriate technology to enable access to inter-practice services.

1.4.13 The PIA development has focussed on the service model options; the specific locations of locality hubs and investments will be appraised and evaluated as part of the Outline Business Cases which follow.

1.4.14 The indicative costs are summarised below; this includes capital and revenue.

Figure 1-3: Indicative costs

Locality	Cost		Whole Life		Estimated Net Present Cost
	Capital	Recurring Revenue	Capital	Recurring Revenue	
Do Nothing	**1,874**	**382.7**	**1,874**	**11,863**	**8,973**
Falkirk West Locality	9,206	112.9	9,206	3,453	
Falkirk East Locality	10,501	128.8	10,501	3,740	
Stirling city with the eastern villages, Bridge of Allan & Dunblane Locality	13,725	168.4	13,725	4,588	
Clackmannanshire Locality	13.069	160.3	13.069	4,873	
Total	**46,501**	**570.5**	**46,501**	**16,654**	
Optimism Bias	9,300	-	9,300	-	
Internal Costs	2,936	-	2,936	-	
Total include Optimism bias	**58,737**	**570.5**	**58,737**	**16,654**	**56,387**

1.5 The Outline Commercial Case

1.5.1 The Commercial Case assesses the possible procurement routes which are available for a project. NHS Forth Valley has been consulting with Scottish Government on the procurement and finance model which will be used; this will be factored into the process as we move towards the Outline Business Case stage. It is anticipated that the programme of investment will be taken forward through the Hub procurement route.

1.6 Financial Case

1.6.1 The table below sets out the capital and revenue affordability to NHS Forth Valley.

Figure 1-4: Capital & Revenue Affordability - £000

Cost	£000
Capital costs	**58,737**
Recurring Revenue costs	234
Depreciation	1,448
Total revenue costs	***1,682***
Current released costs	(441)
Net Revenue impact	**1,241**

1.6.2 There is likely to be an opportunity to seek developer contributions in relation to areas of significant housing developments. To date there has been early engagement and this will continue as part of the Outline Business Case process; this will quantify the level of contribution in proportion to the additional capacity required to support the new housing.

1.7 Management Case

1.7.1 A Programme Board has been established, chaired by NHS Forth Valley's Chief Executive, who is also the programme's Senior Responsible Officer (SRO).

1.7.2 The work will be taken forward with the Project Board team supported by a number of sub-groups.

1.7.3 The high-level timeline below sets out the approval process for the PIA and subsequent business cases to support the full implementation of the programme of investment.

Figure 1-5: Project Plan

Stage	Task	Assumed time	Indicative Date
Programme Initial Agreement Approvals Process	Project Team Approval	4 months	February 2022
	Programme Board Approval		22nd April 2022
	Falkirk Integration Joint Board		10th June 2022
	Clacks & Stirling Integration Joint Board		29th June 2022
	NHS Forth Valley Performance & Resources		26th April 2022
	NHS Forth Valley Board		31st May 2022
	Capital Investment Group		Submission 18th May 2022 for 29th June 2022 meeting
Outline Business Case Development & approval	Project 1	6 months each; 4 month approval	September 2022 - June 2023
	Project 2		February 2023 - November 2023
	Project 3		July 2023 - April 2024
	Project 4		December 2023 - September 2024
Full Business Case Development & approvals	Project 1	6 months each; 4 month approval	August 2023 - May2024
	Project 2		January 2024 - October 2024
	Project 3		June 2024 - March 2025
	Project 4		November 2024 - August 2025
Construction & commissioning	Project 1	18 months build; 3 months commissioning	June 2024 - April 2026
	Project 2		November 2024 - September 2026
	Project 3		April 2025 - February 2027
	Project 4		September 2025 - July 2027
Operational	Project 1	1 month from commissioning	May 2026
	Project 2		October 2026
	Project 3		March 2027
	Project 4		August 2027

1.8 Is this proposal still important?

1.8.1 This document sets out the overarching Programme of investment within Primary Care across NHS Forth Valley. It is a key enabler of the full delivery of the new GMS contract and the Primary Care Improvement Plan.

1.8.2 In taking forward the Outline Business Case it is anticipated this will take the form of locality-based business cases; totalling four. No capital investment was identified within rural Stirling locality and the Falkirk Central locality requirements will be addressed within the Falkirk Masterplanning project. This will maximise the linkages between services and integration with locality-based planning principles. Links are already initiated in some areas regarding the potential for collaborative investment in line with place based principles.

1.8.3 A prioritisation exercise has been carried out to determine the order of locality based Outline Business Case (described in **Appendix N**). This considered a number of measurable criteria and resulted in the following proposed programme.

1. Stirling city with the eastern villages, Bridge of Allan & Dunblane Locality
2. Falkirk East Locality
3. Clackmannanshire Locality
4. Falkirk West Locality

2 PURPOSE

2.1.1 The main purpose of this Initial Agreement (IA) is to deliver, "*increased access everywhere*" ensuring all GP practices have adequate space to deliver core and extended primary care services within 'fit for purpose' premises; responsive to current and changing practice populations.

2.1.2 This document will confirm the need for investment in primary care services across NHS Forth Valley. This follows the submission of the Strategic Assessment in 2019 from NHS Forth Valley Primary Care services across two partnerships; Falkirk and Clackmannanshire, and Stirling Health and Social Care Partnerships (HSCP)s. Further work has now been undertaken in relation to the next stage of the capital investment lifecycle; the development of the Initial Agreement (IA) in line with the Scottish Capital Investment Manual (SCIM) process.

2.1.3 NHS Forth Valley are taking a different approach, and in consultation with members of the Capital Investment Group have proceeded with a Programme Initial Agreement (PIA). This sets out the programme of investment within primary care services across the two partnerships. This details the overarching proposition for future and on-going investment to deliver the strategic aims and ambitions within primary care.

2.1.4 The PIA culminates in the prioritisation of the individual project OBCs under this Programme IA and the next steps which will be required to progress through the next phase of the SCIM cycle.

2.1.5 The PIA will meet the needs of the 2018 General Medical Services (GMS)contract, NHS Forth Valley Primary Care Improvement Plan (PCIP) 2018-2021, and E-health strategy in alignment with the Property and Asset Management Strategy (PAMS) and a number of national strategic drivers for change, it will demonstrate that this is a good thing to do. The HSCPs are committed to delivering on the new GMS contract and PCIP and implementation is well underway, however, challenges are being faced in fully completing the implementation due to the limitations of the existing estate. This PIA will demonstrate how the need to facilitate the full implementation of the PCIP, to fully leverage the benefits this offers, combined with other key drivers are compelling NHS Forth Valley to undertake more service redesign, and prioritise investment in primary care facilities.

2.1.6 It will do this by responding as appropriate to the following questions:

- What is the strategic background to the proposal?
- Why is this proposal a good thing to do?
- What is the preferred strategic/ service solution?
- Is the organisation ready to proceed with the proposal?
- Is this proposal still important?

STRATEGIC CASE

3 WHAT IS THE STRATEGIC BACKGROUND TO THE PROPOSAL?

3.1.1 The following section of the PIA will outline:

- Who is affected
- Links to NHS Scotland's Strategic priorities
- Links to other policies and strategies
- Influence of external factors

3.2 Who is affected by the proposal?

3.2.1 The diagram below outlines the stakeholder groups affected. The table which follows summarises the engagement and confirmed support:

Figure 3-1: Who is affected by the proposal?

Stakeholder Group:	Engagement that has taken place	Confirmed support for the proposal
Forth Valley: General Practice population	User /care/ public representatives within workshops: Investment Objectives, Benefits, Achieving Excellence Design Evaluation Toolkit (AEDET), Design Statement, Option development and within locality based option impact meetings. Significant user/carer/public representatives at the Cross Check Event. The purpose of this session was for all clinical services within both this project and the Falkirk Master planning project to describe their proposed future model of care. This allowed all attendees to gain an understanding of the proposals, the likely impact highlighting any issues for their service. At the programme IA limited general public engagement until specific projects are taken forward and local requirements are fully established.	*"As a service user, I have welcomed the opportunity to participate in this project as change is needed to support care closer to home and to encourage better wellbeing within the community. I support wholeheartedly the proposed model for Primary Care and commend all those who have been involved in its preparation for their efforts and commitment" – service user A.* *"Respect shown to our opinions and contributions on what affects those who live in Forth Valley and use its Health and Social Care Services" – service user B.* *"I was very pleased to be invited to participate in this process as the representative for carers and have found the process to be very thorough and inclusive. The assessment of the need for change and the proposals for an alternative way of working have been well researched and provide a model of future care that is likely to be of benefit to those working in Primary Care and to those who receive care" – service user C.* *"I am a service user living in Forth Valley area in the City of Stirling. At all stages of this Masterplan I have*

		been consulted about what the process was, and any questions and concerns were answered clearly and honestly" – service user D.
NHS Forth Valley: Falkirk and Clackmannanshire & Stirling HSCP	Frequent updates provided to both HSCPs. Project team includes both HSCP GP leads and representation from all PCIP staff groups; District Nursing; Pharmacy; Finance Estates and Staff side representatives. Representation within workshops: AEDET; Design Statement; Cross check All Locality managers attended Locality impact meetings. Finance sub-group includes both Chief Finance officers.	The Programme Board are asked to approve the PIA on 22nd April 2022. Strategic Planning Groups endorsed the proposed clinical model - 15th December 2021 (C&S HSCP; 16th December 2021 (Falkirk). As part of the approvals process both Integrated Joint Boards will approve the PIA in May/June 2022.
Independent GP contractors and employed staff	Involvement in all aspects of the PIA development including all workshops. Specific GP input to project team. Regular and frequent update to GP sub-committee and Practice Managers' forum throughout development. Locality lead GPs part of project team and played an active role in workshops to develop the PIA. Survey issued to all practice-based staff – both GP and wider health board teams. Presentation to trainee GPs.	*The GP sub have been engaged throughout development of the Programme Initial Agreement and support the direct of travel. They will continue to be involved throughout the locality based OBCs as part of the next phase of the work.*
Acute and community interface services	Wide engagement with a range of acute and community-based teams, including focussed discussions with District Nursing leads and the AHP Outpatient Manager.	Clinical model and locality-based impact endorsed as part of locality-based discussions.
Healthcare Improvement Scotland	Healthcare Improvement Scotland (HIS) have been informed of the impact of any proposed service change on patient care. Copies of the Communications Plan and Equality Impact Assessment have been shared.	Healthcare Improvement Scotland – Community Engagement confirmed by email on 4th May 2022 that the engagement to date appears to meet the requirement of guidance.

3.3 How does the proposal respond to NHS Scotland's strategic priorities?

3.3.1 The National Clinical Strategy for Scotland, published in 2016, sets out the importance of primary care and how clinical services need to change to provide sustainable health and social care services. It notes that,

"effective primary care, with universal coverage, can significantly improve outcomes for patients, and deliver the most cost-effective healthcare system" and signalled a transformation in primary care. The strategy goes on to comment that "increased investment in primary care will ensure the sustainability of secondary care services by allowing an increasingly elderly population with multi-morbidity to be treated more appropriately in primary care". The strategy also describes the rationale for an increased diversion of resources to primary and community care. Stronger primary care across Scotland should and will be delivered by increasingly multidisciplinary teams, with stronger integration (and where possible, co-location) with local authority (social) services, as well as independent and third sector providers. "

3.3.2 We will build a greater capacity in primary care, centred around practices, by enhancing the recruitment of doctors to general practice and by increasing the adaptation of technological solutions to increase access and improve decision making. There will be a range of extended, professional roles within primary care, such as Advanced Nurse Practitioners, Pharmacists and Allied Health Professionals. This will provide the range of skills needed to meet the changing and complex needs of communities.

3.3.3 NHS Scotland's strategic investment priorities are aligned to the Quality Strategy

- Person centred
- Safe
- Effective quality of care
- Health of population
- Value and sustainability

3.3.4 To ensure that we are responding to the core strategic investment priorities, we will monitor the effectiveness of our new ways of working based on the following table.

Figure 3-2: Responding to NHS Scotland's Strategic Investment Priorities

NHSScotland Strategic Investment Priority:	How the proposal responds to this priority	As measured by:
Person Centred	• Enable speedy access to modernised and integrated Primary Care and Community Health and Social Care Services. • Improve access to primary care services that are person centred, safe and clinically effective. • Self-management of Long-term Conditions will increase the proportion of people with intensive needs being cared for at home.	• Improved GP Access – 48-hour access/ advance booking • Full implementation of the new General Medical Services contract • Reduced hospital bed days within key long-term conditions; • Levels of homecare provision • Increased primary care contacts from multi-disciplinary teams

Safe	• Working will support holistic care and anticipatory approaches. • Improved quality of the estate will be easier to clean and support Patient Safety Programme.	• Implementation of the new General Medical Services contract • Number of Anticipatory Care Plans (ACPs) in place • Reduced Healthcare Acquired Infections
Effective Quality of Care	• Creation of locality-based hubs will improve communication across health and care teams; enhancing team-working and maximising the additional resources within Primary Care Improvement Plan. • Enhancing community wellbeing opportunities; maximising opportunities to integrate and co-locate a wider range of community based services within locality hubs	• Increase in number of sessions of healthcare delivered within primary care from wider multi-disciplinary teams • Increase in number of services provided at locality hubs
Health of Population	• Service users will benefit from a wider range of primary care services available and opportunities to increase the level of services in primary care; helping to support fewer unscheduled care admissions.	• Unscheduled care admissions from primary care • Reduction in referral to secondary care through increased primary care provision e.g. Advance Practice Physio
Value & Sustainability	• Operating out of modern fit for purpose buildings will be more energy efficient which will reduce the carbon footprint. • Delivering a safe high-quality physical environment for service users and staff – visible investment in the health of NHS FV residents sends a message that we value their health and that they should too. • Staff working agilely will be equipped with the latest technology, allowing them access to the same information they would have in the office but now electronically from patient's home or whilst agile.	• Carbon emissions • Take up rates for health improvement services • Staff surveys • Proportion of staff working agile • Reduction in number of desk spaces

3.4 What strategies does this proposal directly respond to, and how?

3.4.1 NHS Forth Valley's Healthcare strategy 2016-2021 identified ten key priorities, articulated in 6 clear statements which are represented in the following vision

Figure 3-3: Statements showing 10 key priorities

3.4.2 With the increasing demand on services, resources and budgets comes the need to reshape the way we support people in our communities to allow them to look after themselves and have the knowledge that health and social care services are there when needed. These services include hospitals, GPs, community nurses, occupational therapists, physiotherapists, podiatrists, speech therapists, social workers, housing officers, care homes, care providers and unpaid Carers, voluntary and charitable organisations.

Figure 3-4: National, Regional and Local Strategies

Policy	Key Themes	Impact
HSCP Strategic Plans 2019-22	Commitment to improving outcomes for people living in the HSCP area. Delivery of this transformation is through the implementation of the Primary Care Improvement Plan (PCIP). Redesign of key organisational processes that release GP time for care; enhance and extend primary care workforce capacity and capability, including how we sustain urgent and out of hours primary care and work with colleagues from secondary care; and strengthen the interface between primary care and localities so that we fully understand and make best use of the assets of our local communities and Third sector partners.	Sustainable shift of workload and responsibilities from GPs to release capacity for their Expert Medical Generalist role are: • Vaccination Transformation Programme • Community Treatment and Care Services • Pharmacotherapy Services • Urgent Care (advanced practitioners) • Additional Professional Roles • Community Link Workers
NHS Recovery Plan, August 2021	£1 billion of targeted investment over the next 5 years to increase NHS capacity, deliver reforms in the delivery of care, and get everyone the treatment they need as quickly as possible. Focus on all parts of the pathway including primary and community-based care. Including: • funding for 1,000 additional staff in Primary care mental health • increase the GP workforce by 800 by 2026 • 225 new advanced musculoskeletal practitioners by 2024/25	Further increase in the workforce within primary and community based care, all of whom require facilities from which to deliver health and care services.

	• By April 2022, we are aiming to have Board-delivered pharmacy and nursing support in all 925 of Scotland's General Practices or direct additional support to Practices where this is not the case • Increase in community pharmacy funding Overall an increase in primary care spending of at least 25% by the end of this parliament. Establish a community pharmacy hospital discharge and medicines reconciliation service and investment in developing new digital solutions such as ePrescribing and eDispensing.	
National Code of Practice for GP Premises	The Scottish Government recognises that there is pressure on the sustainability of general practice which is linked to liabilities arising from GP contractors' premises. Around two-thirds of GP premises are either owned by GPs or leased by them from third parties. GP contractors receive financial assistance from their Health Boards towards the cost of these premises. In recent years, there has been an increase in the number of GP contractors who have asked their Health Boards to help with liabilities connected to their premises. This Code of Practice sets out the Scottish Government's plan to facilitate the shift to a model which does not entail GPs providing their practice premises.	Opportunity in the implementation of the proposed model of care to address a number of the GP owned premises within NHS Forth Valley. This would assist in GP sustainability challenges; making it easier to recruit new GP partners without premises ownership obligations.
Scotland's Digital Health & Care Strategy	The people of Scotland expect technology and information systems to be part of how health and care services are delivered. Digital technology is the area of greatest change in society, and of potential transformation for health and social care.	There is an opportunity to ensure digital delivery models are at the core of the emerging service model. Maximising the opportunity and harnessing lessons learned during the pandemic.

3.4.3 A number of other recent publications offer insight into how primary care services should be shaped going forwards, ensuring high-quality care matched to the current and future needs of the population:

Figure 3-5: Summary of relevant Reports and Publications for reference

Publication	Key Themes	Impact
Place Standard & 20 minute neighbourhood	20 minute neighbourhoods are a concept of urban development that has ascended rapidly in the minds of policymakers, politicians and the general public across the world because of Covid-19. Supports a move toward to a sustainable, resilient and inclusive recovery. This includes an accelerated progress to a zero-carbon economy, increased resilience to risk, and creation of fair, healthy and prosperous communities. In addition, this will support Forth Valley as an Anchor Institution.	This programme presents an opportunity to implement place making principles and co-location and integration of services to support 20-minute neighbourhoods.
Planning Guidance for Mental Health and Wellbeing in Primary Care Services; January 2022	Mental Health & Wellbeing in Primary Care (MHWPC) should be established within a group of GP practices (cluster/locality) and should be multi-agency. Every GP practice should have access to a Community Link Worker. MHWPC services can be either fully embedded in practice teams and employed by the practice or aligned whereby employed by the health board to a group of GP practices or alternatively a hybrid model of both embedded and aligned.	This programme will offer increased options for delivering MHWPC services at all practices across NHS Forth Valley

Fit for the Future: a Vision for General Practice July 2021	Developed by the Royal College of General Practitioners, this report sets out the vision for the future of General Practice in the UK. It explores 6 key enablers which the report concludes are essential to the realisation of the vision: Funding, Workforce, Modernised premises, Training and Education, Digital Technology and Research and Innovation.	This programme explores many of the same themes in the local context as drivers for change and enablers for future service delivery, demonstrating alignment with the core themes.
General practice COVID-19 recovery: the future role of remote consultations & patient triage May 2021	In this report by the Royal College of General Practitioners (RCGP), they explore how remote and digitally enabled patient care have been important elements of general practice for some time, but how they were rapidly expanded at the outset of the pandemic. The paper sets out the challenges which the RCGP believe need to be addressed to ensure GPs and practice teams can continue to provide high-quality patient care as we look towards a 'new normal', building upon the benefits that have emerged from technology advances and new ways of working during the pandemic, while ensuring that relational care and health inequalities do not suffer in the longer-term. The RCGP conclude that this will only be possible with further evaluation, action and government investment around systems of triage, mixed models of patient consultation, process optimisation and supporting technology.	This programme has included reflections locally on learning from the COVID-19 pandemic, systems and technology used in primary care and how these can be optimised as a key part of the provision of services going forward.
Innovative models of general practice June 2018	This publication from the King's Fund in 2018 concludes that delivering person-centred and holistic care requires general practice to be at the heart of the development of new models of care and integrated care systems across the NHS. It makes recommendations to be taken forward by those working in General practice, System Leaders and Commissioners as well as National Policy Makers. Themes include: improving access and co-designing services with patients, leveraging a wider set of skills from an MDT, investing in supporting technology, engaging with third sector, and general workforce development.	The key themes highlighted are picked up in other publications referenced here and are reflected in our analysis as part of this programme of work.

3.5 What external factors are influencing this proposal

3.5.1 The national policy context has a critical influence on the development of health and care services in Forth Valley. While not intended to be exhaustive, the following list identifies some of the key national policies that have influenced the current proposals

- Health and Social Care Delivery Plan (2016)
- NHS Recovery Plan 2021-2026
- 2020 Vision "Achieving sustainable quality in Scotland's healthcare"
- Chief Medical Officer's Annual Report "Realistic Medicine"
- Reshaping Care for Older People: A Programme for Change
- New GMS Contract
- Self-Directed Support Act
- Digital Health and Care Strategy
- Carers (Scotland) Act 2016
- Renewing Scotland's Public Services
- National Clinical Strategy
- Getting it Right for Every Child
- Hidden Harm
- Changing Lives

- Delivering for Health and associated guidance
- Better Health, Better Care
- Health and Homelessness Standards
- Equality Legislation
- Improving Health in Scotland: the Challenge
- Respect and Responsibility – the national sexual health strategy.
- Equally Well – report of the ministerial task force on health inequalities
- Community planning and community justice agendas.

3.5.2 Each of these policies seeks to improve the health and social care service response to the people of Scotland. It is worth highlighting the key messages in some of these policies.

3.5.3 The Health and Social Care Delivery Plan (2016) sets out the Government's programme to further enhance health and social care services. Working so that the people of Scotland can live longer, healthier lives at home or in a homely setting and that we develop a health and social care system that

- is integrated;
- focuses on prevention, anticipation and supported self-management;
- will make day-case treatment the norm, where hospital treatment is required and cannot be provided in a community setting;
- focuses on care being provided to the highest standards of quality and safety, whatever the setting, with the person at the centre of all decisions; and
- ensures that people get back into their home or community environment as soon as appropriate, with minimal risk of re-admission.

The Delivery Plan focuses on three areas referred to as the 'triple aim':

- Improving the quality of care for people by targeting investment at improving services, which will be organised and delivered to provide the best, most effective support for all ('better care').
- Improving everyone's health and wellbeing by promoting and supporting healthier lives from the earliest years, reducing health inequalities and adopting an approach based on anticipation, prevention and self-management ('better health').
- Increasing the value from, and financial sustainability of, care by making the most effective use of the resources that are available and the most efficient and consistent delivery, ensuring that the balance of resource is spent where it achieves the most and focusing on prevention and early intervention ('better value').

3.5.4 In summary this policy context provides the following key drivers for the current project:

- Improving equitable access to services through the availability of a wider range of services in community settings. It will increasingly be possible to provide safe and effective services closer to people's homes and this will benefit people who use the services by improving access. The demand for locally based services will grow and this will mean using facilities and staff in an imaginative way to expand capacity to meet this demand.
- People's expectations about the services they receive and where and when they receive them will continue to be demanding, and striving to meet these expectations will remain a policy priority.
- The creation of sustainable and flexible services and facilities that can absorb rising expectations and demand, especially to meet needs for increased programmed care for chronic disease.
- Breaking down of the barriers between primary and secondary care, and health and social care organisations and professions, through a whole-system approach to planning and delivering services. Nurses, allied health professionals and social care professionals, in particular, will

continue to develop their roles in providing care in the context of extended primary care and community teams.

- Working more effectively and efficiently across the public and third sector to join up service provision to achieve better outcomes for the public.
- The high priority attached to the improvement of people's health and improvement of community services. Significant and sustained improvements in health and well-being are achieved through supported self-care and services and facilities are needed to motivate people to look after themselves and to help them to do this.
- Tackling health and social inequalities as a result of poverty and/ or discrimination because of people's ethnicity, disability, gender or sexual orientation.
- Good partnerships with staff, based on involvement and support to provide new, flexible and effective ways of working.
- The use of advances in information and communications technology generally to benefit service users and reduce the professional isolation of its staff. Medical, information and communications technology will continue to improve and create opportunities for improving local access, especially to diagnostic services.

4 WHY IS THIS PROPOSAL A GOOD THING TO DO?

4.1.1 This section will set out the following;

- Current arrangements
- Need for change
- Investment objectives
- Design quality objectives
- Benefits realisation plan
- Risk management strategy

4.2 Current Arrangements

NHS Forth Valley

4.2.1 As one of 14 territorial Health Boards in Scotland, NHS Forth Valley is responsible for the monitoring, protection and the improvement of the population's health and wellbeing and for the delivery of frontline healthcare services.

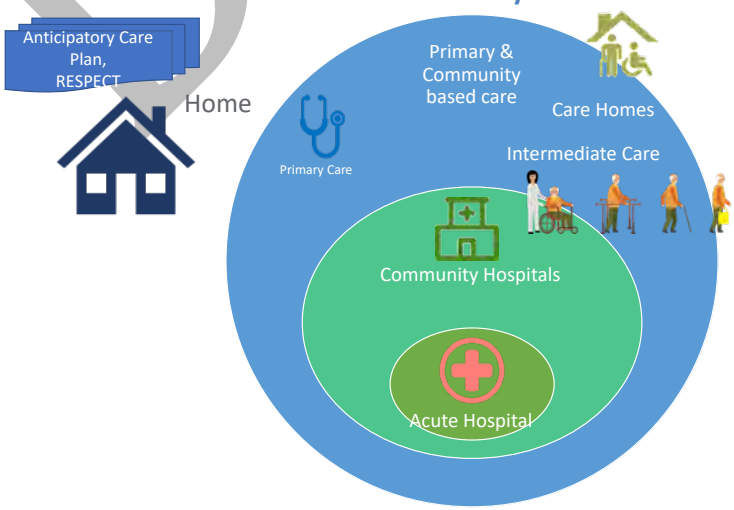
4.2.2 The Board serves a population of around 300,000 in a diverse geographical area which covers the heart of Scotland.

4.2.3 The Board employs around 8,000 staff, hosts one acute hospital - Forth Valley Royal Hospital in Larbert- and is supported by a network of four community hospitals, over 50 health centres, day centres providing care and support for patients with mental illness and learning disabilities and a wide range of community-based services.

Figure 4-1: Map showing Forth Valley location in Scotland

4.2.4 The diagram below summarises the components of health and care services within NHS Forth Valley with further information on each provided below including the role of primary and community care within each:

Figure 4-2: Health & Care Services within NHS Forth Valley



- **Home**: this includes a wide range of health and care services (mainly primary and community care) delivered in citizens' own homes, both visiting and on a virtual basis.
- **Primary Care**: 50 individual GP practices providing a range of health, care and wellbeing services to their population. A number of which are provided from larger multi-practice facilities integrated with a range of health board and partnership services.
- **Hospital @ Home**: short-term, targeted intervention that provides a level of acute hospital care in an individual's own home, that is equivalent to that provided within a hospital. Its main purpose is to prevent hospital admission where it is safe to do so. Multi-disciplinary team care including GPs.
- **Intermediate Care**: short-term (6-week) rehabilitation-/ reablement-focussed interventions. It provides both "step-up" care from home and also "step-down" care from an acute episode. Care provided by AHP, social care and portfolio GP team.
- **Community Hospital:** 4 community hospital sites providing longer term rehabilitation and specialised dementia care.
- **Care Home:** circa 2,000 beds providing the majority of long-term residential and nursing care with some specialist placement. Some short-term and respite care is also provided. Residents supported by primary and community care teams including the CHART (Care Home Assessment & Response Team).
- **Acute Services**: 1 acute hospital; circa 860 beds/day spaces. Mental health acute inpatient beds. Primary and community services support unscheduled admissions direct to Assessment unit and facilitate discharge through provision of ongoing care post discharge. Providing range of planned care including diagnostic services, outpatient and ambulatory care and planned procedures referred by primary care.

Health & Social Care Partnerships

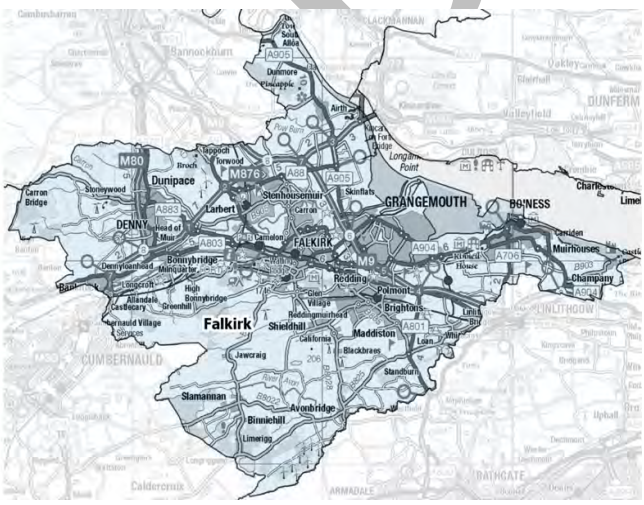
4.2.5 Within Forth Valley, the two Integrated Joint Boards have delegated responsibility for planning and resourcing of adult social care services, adult primary care and community health services, mental health services and some hospital services.

4.2.6 The Board works closely with the two Integrated Joint Boards (Falkirk, and Stirling and Clackmannanshire) who, for the above range of delegated services, are responsible for planning and resourcing health and care to improve quality and outcomes for their populations.

Falkirk HSCP (data based on 2019 data from NRS Council area profiles)

4.2.7 The Falkirk HSCP has been developed jointly by NHS Forth Valley and Falkirk Council and includes representation from all organisations and third Sector representatives, service users and carers.

Figure 4-3: Falkirk Council area covered



- estimated population of 160,340, increase of 2.5% since the 2011 census and projected to rise each year to 2041;
- 29,769 hectares and hosted 72,672 households in 2019;
- 1460 births in 2019, with a life expectancy from birth of 77.3 years for males and 80.5 years for females (compared to Scottish averages of 77.2 and 81.1 years respectively);
- Unemployment (2018) was 2.6% compared to 4.3% on average for Scotland; and
- SIMD 2020 database indicates that there are 35 small areas that fall into the 20% most deprived areas of Scotland (6,976 data zones in total).

Clackmannanshire and Stirling HSCP (data based on 2019 data from NRS Council area profiles)

4.2.8 The Clackmannanshire and Stirling HSCP has been developed jointly by NHS Forth Valley and Clackmannanshire Council and Stirling Council and includes representation from all organisations and third Sector representatives, service users and carers.

Figure 4-4: Stirling council area covered

- estimated population of 94,210;
- 218,600 hectares and hosted 23,890 households in 2019: Two adult households are the most common in Stirling at 33%;
- 737 births in 2019, with a life expectancy from birth of 78.3 years for males and 82.6 years for females in the Stirling council area (compared to Scottish averages of 77.2 and 81.1 years respectively);
- Unemployment (2018) was 2.6% compared to 4.3% on average for Scotland; and
- SIMD 2020 database indicates that there are 15 small areas that fall into the 20% most deprived areas of Scotland (6,976 data zones in total).

Figure 4-5: Clackmannanshire council area covered

- estimated population of 51,540
- 15,900 hectares and hosted 23,890 households in 2019 - one and two adult households most common in Clackmannanshire at 33%.
- 414 births in 2019, with a life expectancy from birth of 76.6 years for males and 80.7 years for females (compared to Scottish averages of 77.2 and 81.1 years respectively)
- Unemployment (2018) was 2.6% compared to 4.3% on average for Scotland; and
- SIMD 2020 database indicates that there are 18 small areas that fall into the 20% most deprived areas of Scotland (6,976 data zones in total).

4.2.9 Further information sourced from the Scottish Index of Multiple Deprivation 2020 provides the following insight into the population areas of the 3 local authorities, which make up the two HSCPs. Where a standardised ratio is referenced, this should be considered in the context of the Scotland average value as **100** for a population with the same age and sex profile.

Figure 4-6: Summary of relevant Key indicators from SIMD 2020

Key indicators from SIMD 2020	Clackmannan-shire	Stirling	Falkirk	ALL Scotland
Total population (based on 2017 NRS small area population estimates)	51,450	94,000	102,271	5.42m
% of Total Population of working age	62.9%	64.7%	63.9%	64.4%
Percentage of people who are employment deprived	11.5%	7.1%	9.5%	9.6%
Percentage of people who are income deprived	14.0%	8.9%	11.7%	12.3%
Average drive time to a GP surgery in minutes	3.2 minutes	3.6 minutes	3.2 minutes	3.6 minutes
Public transport travel time to a GP surgery in minutes	9.7 minutes	11.2 minutes	9.6 minutes	10.5 minutes

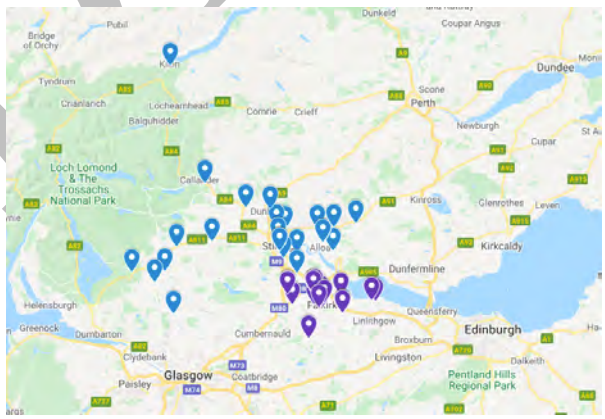
Health-related statistics	Clackmannan-shire	Stirling	Falkirk	ALL Scotland
Comparative Illness Factor: standardised ratio	107.6	81.9	101.7	100
Hospital stays related to alcohol misuse: standardised ratio	79.7	61.5	79	100
Hospital stays related to drug misuse: standardised ratio	87.2	77.6	79.9	100
Standardised mortality ratio	101.1	91.0	97.8	100
Proportion of population being prescribed drugs for anxiety, depression or psychosis	21.9%	16.9%	20.4%	19.1%
Proportion of live singleton births of low birth weight	7.2%	6.9%	4.9%	5.2%
Emergency stays in hospital: standardised ratio	91.4%	83%	98.5%	100

Primary Care Service

4.2.10 There are currently 50 GP practices within 45 buildings with over 1,000 staff based in the premises, plus a number of visiting community-based services.

4.2.11 The map below shows the locations of primary care premises across NHS Forth Valley, covered by the two partnerships of Falkirk HSCP (purple) and Clackmannanshire and Stirling HSCP (blue).

Figure 4-7:Map of primary care premises locations



4.2.12 Based on estimated practice population size figures obtained from ISD, published April 2021, over 322,000[1] residents are covered by these primary care practices, with 167,000 of these in Clackmannanshire and Stirling HSCP, and 154,000 in Falkirk HSCP. See **Appendix A** for more detailed breakdowns of populations served by practice location.

Service Arrangements

4.2.13 There are a wide range of services/ multi-disciplinary teams within/ aligned to primary care. These include a range of "core" services available in all practices and a number of extended/ additional services available in larger premises.

4.2.14 The existing service arrangements vary practice by practice. All core services are likely to be provided from all practices. Health Visitors and District nurses may be based separately from the practice to whose patients they provide services. A significant proportion of their contacts are domiciliary.

4.2.15 The additional services are provided within fewer locations; however, access is provided to all patients. The table below sets out the range of services within each grouping:

Figure 4-8: Services available to support service delivery

Core Services	Additional Services
GP consultations	Midwives
Practice Nurse	Health Visitors
Advance Practice Nurse	District Nurses
PCIP roles: Primary Care Mental Health Nurses; Advanced Practice Physiotherapy; Advanced Practice Nurse (ANP) supporting urgent care; Pharmacotherapy; Phlebotomy; Community Treatment & Care (CTAC); Vaccinations	Visiting Mental Health clinics e.g. Community Mental Health Team, Child & Adolescent Mental Health, Community Alcohol & Drug Services
Chronic Disease management clinics	Family planning
GP Trainees (not provided in all practices circa 35-45 within NHS Forth Valley at various stages)	AHP services: MSK Physiotherapy, Podiatry, Speech& Language, Dietetics etc
Screening	Counselling service
	Link worker
	Social work
	Psychological services including Cognitive Behavioural Therapy
	Visiting consultant clinics e.g. Dermatology

Service Providers

4.2.16 The main providers of primary care services are Independent general Practitioners; supported by a multi-disciplinary practice, this includes a number of other agencies:

- NHS Forth Valley
- Falkirk, Stirling and Clackmannanshire Councils
- NHS 24
- 3rd sector
- Volunteers
- Private Care Home providers
- Portfolio GPs
- Hospice service
- Community pharmacy
- Optometry

[1] Total primary care registrations are larger than the recorded NHS Forth Valley population due to cross-boundary patients registering with GPs within NHS Forth Valley.

- Dentists

4.2.17 Based on the April 2021 GP practice contact lists, 50 practices are located across Falkirk and Stirling and Clackmannanshire HSCPs. Practices by locality are as follows:

Figure 4-9: Current Practices

Locality	Practice
Rural Stirling Locality	• Aberfoyle & Buchlyvie Medical Centres • Balfron Health Centre • Callander Medical Practice • Doune Health Centre • Drymen Health Centre • Edenkiln Surgery, Strathblane • Killearn Health Centre • Killin Medical Practice • Kippen Surgery
Stirling city with the eastern villages, Bridge of Allan & Dunblane Locality	• Airthrey Park Medical Centre • Allan Park Medical Practice, Stirling • Bridge Of Allan Health Centre • Dunblane Medical Practice • Fallin, Cowie & Airth Health Centre (one practice delivered from 3 sites) • Forth Medical Group*, Bannockburn • Orchard House Health Centre, Stirling • Stirling Care Village Practices: Park Avenue Medical Centre; Park Terrace Medical Practice & Viewfield Medical Practice • Tor Medical Group, Plean
Clackmannanshire Locality	• Alva Medical Practice (branch Tullibody) • Clackmannan & Kincardine Medical Practice • Dollar Health Centre • Clackmannanshire Community Healthcare Centre Practices: Dr Sime and Partners, The Whins Medical Practice, & Forth Medical Group - Hallpark Medical Practice, Alloa* • Tillicoultry Medical Practice
Falkirk Central Locality	• Ark Medical Practice, Falkirk • Camelon Medical Practice • Carron Medical Centre, Falkirk • Graeme Medical Centre, Falkirk • Meeks Road Surgery, Falkirk • Wallace Medical Centre, Falkirk • Westburn Medical Practice, Falkirk Community Hospital site
Falkirk East Locality	• Bo'ness Road Medical Practice, Grangemouth • Forth Medical Group, Kersiebank, Grangemouth* • Bo'ness Community Hospital site practices: Forthview Practice, & The Richmond Practice • Kinglass Medical Practice, Bo'ness • Meadowbank Health Centre practices: Braesview Medical Group, Parkhill Medical Practice & Polmont Park Medical Practice, • Slamannan Medical Practice
Falkirk West Locality	• Bonnybridge Health Centre practices: Antonine Medical Practice & Bonnybank • Carronbank Medical Practice, Denny • Denny Cross Medical Centre, Denny • Stenhousemuir Health Centre practices: Ochilview Practice, Parkview Practice, Stenhouse Practice & Viewpoint Medical Practice • Tryst Medical Centre, Larbert

*one practice at three locations across NHS Forth Valley

4.2.18 Practices have been classified as small, medium or large based on the populations they serve using the following practice sizes. The distribution by locality is shown in the chart:

Figure 4-10: Practice size

Practice population	Size designation
0-6000	Small
6001-12,500	Medium
12,501+	Large

of practice sizes by locality designations

Figure 4-11: Distribution

Current workforce

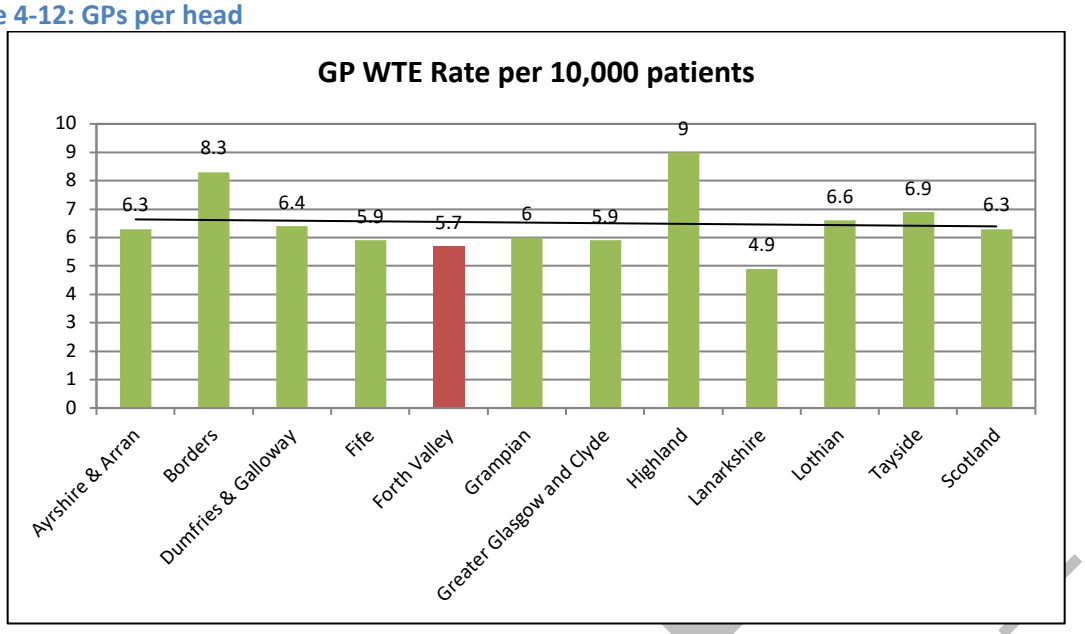
4.2.19 The key results from the latest Primary Care Workforce survey carried out in 2017[2] indicate the following:

- On average, across NHS Forth Valley, there are 1,666 people for every 1 Whole Time Equivalent (WTE) GP.
- The vacancy rate % reported by practices in NHS Forth Valley was 6.4%, equivalent to 13,4 WTEs or 107 vacant sessions per week.
- 48% of GP vacancies arising in 2017 were filled within NHS Forth Valley during 2017, lower than the Scotland average of 59%.
- Across NHS Forth Valley in 2017, the Reported locum/ Sessional "WTE" as a % of total GP "WTE" input to practices was 6.5%.
- The proportion of locum/sessional GP sessions worked by regular locum (%) was reported as 19% - the lowest in Scotland in 2017, excluding the Western Isles

[2] Latest survey 2017; no update available since

4.2.20 More recent information from Public Health Scotland shows the number of GPs per 10,000 patients across Scotland as outlined below. This indicates Forth Valley has fewer WTE GPs per 10,000 patients than average in Scotland with only NHS Lanarkshire lower:

Figure 4-12: GPs per head



4.3 What is the need for change?

4.3.1 There are various reasons why a need for change can be driving forward an investment proposal; including overcoming a problem with the existing arrangements, responding to a driver for change, or presenting an opportunity to improve outcomes when compared to existing arrangements.

4.3.2 A full list of the main issues causing the need for change is provided below, much of which is a direct response to problems with the existing arrangements described earlier. The summary table at the end describes the effect it is having (or likely to have) if nothing is done about it, and an explanation of why action needs to be taken now and through this proposal.

4.3.3 To provide evidence in support of each driver of change a specific practice case study will be presented demonstrating the particular area of need.

Address GP sustainability, recruitment and retention of expanded primary care teams

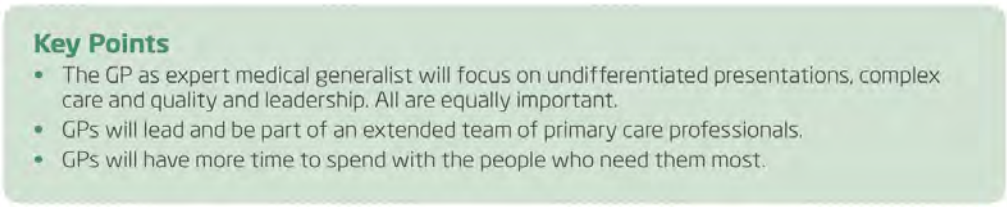
4.3.4 GP sustainability is currently the highest corporate risk for NHS Forth Valley. Without investment in primary care services and premises this risk profile is unlikely to change.

4.3.5 Within NHS Forth Valley 46% of practices have a "Open but List Full" status: this means they are not routinely accepting patients (as at 1st December 2021). This data is collected quarterly and demonstrates a growing number of "Open but List Full" statuses with 38% recorded in March 2021. Once on this status it can take some time for practices to start accepting new patients.

4.3.6 Fundamental to addressing GP sustainability is the full implementation of the new GMS contract and the ability to meet the Code of Practice.

4.3.7 The new contract aims to support the development of the Expert Medical Generalist role for GPs, with a shift over time of workload and responsibilities to enable this.

Figure 4-13: Key points on the GP as the expert medical generalist from the GMS contract 2018



4.3.8 There is an emphasis on appropriately scoping a "Manageable Workload" for GPs, identifying key types activity which can be safely delivered by other staff groups with appropriate skills and training. The emphasis will shift from delivery of primary care services by GPs and Practice nurses, to delivery by a more varied and broader multi-disciplinary team. This shift in activity should enable a more manageable workload for GPs and in turn improve and address overall sustainability.

Figure 4-14: Key points on GP Manageable Workload from the GMS contract 2018

4.3.9 Many of these changes were due to have been implemented by 2021, but there has been recognition that some areas require additional focus and investment to facilitate these changes taking full effect.

4.3.10 The responsibility for provision of Community Treatment and Care Services has been transitioning from GPs to HSCPs from 2018-2021. These services should be commissioned by HSCPs, and delivered in collaboration with NHS Boards that will employ and manage appropriate nursing and healthcare assistant staff.

4.3.11 Community treatment and care (CTAC) services include many non-GP services that patients may need, including (but not limited to):

- management of minor injuries and dressings
- phlebotomy
- ear syringing
- suture removal
- chronic disease monitoring and related data collection.

4.3.12 The GMS contract notes the requirements on the HSCPs to develop Primary Care Improvement Plans, and that NHS Boards with HSCPs will develop clear arrangements to deliver the commitments in respect of the new Scottish GMS contract. These arrangements include key areas of service redesign to be agreed with the local GP Subcommittee of the Area Medical Committee and the Local Medical Committee (LMC).

4.3.13 The National Code of Practice for GP premises published in 2017 sets out the Scottish Government's plan to facilitate the shift to a model which does not entail GPs providing their practice premises. This will facilitate the gradual shift over the next 20-25 years from GP

premises ownership to Health Boards. This includes commitment to use the primary care estate better and to identify priorities for investment.

4.3.14 Around 30% (13) premises in Forth Valley are owned by the practices and under the code of practice would be shifting ownership by 2043.

4.3.15 Investment in primary care services and premises will enable capacity to reduce the GP workload, resulting in improved sustainability. In addition, the opportunity to expedite the implementation of the Code of Practice, shifting ownership of premises from GP to Health Boards should improve recruitment of new GPs to NHS Forth Valley.

4.3.16 This need for change can be demonstrated in the case study below:

Figure 4-15: Case Study 1: Address GP sustainability, recruitment and retention of expanded primary care teams

Practice A; a large urban practice, over 10,000 patients registered; currently within premises owned by partner GPs. Current challenges faced in support of this driver for change:

- Current "open but full" status; not routinely accepting new patients and has been this status for over a year.
- Average list size per GP in excess of 1,800 (well above average within NHS Forth Valley 1,666 and aim of 1,500). However, the practice has employed additional ANPs to provide further clinical capacity.
- Unable to recruit new GP partners due to premises ownership obligations and could result in practice sustainability issues in the future - especially when current partners retire.
- In areas with new housing planned (circa 1000 homes).
- Unable to deliver full PCIP services resulting in additional patient travel out with the practice to Falkirk Community Hospital. Currently some PCIP staff are delivering phone consultations only and when covid restrictions allow more face- to-face consultations the practice would not have clinical space for this.
- Current premises unable to be extended, there are not enough clinical rooms. A few of the clinical rooms are not ideal, being small or with difficult access.

Unable to maximise the benefits from the Primary Care Improvement Plan (PCIP) including the ability to fully implement new roles and therefore unable to reduce demand for secondary care

4.3.17 NHS Forth Valley published their Primary Care Improvement Plan (PCIP) in 2018 which set out the plan to transform the way Primary Care services for the population of Forth Valley are provided. It included a vision for enhanced and expanded multi-disciplinary teams, made up of a variety of professionals, contributing unique skills towards person-centred care and support that improves outcomes for individuals and local communities.

4.3.18 The ambitions are to realise the six outcomes for Primary Care:

- We are more informed and empowered when using primary care
- Our Primary care services better contribute to improving population health
- Our experience of primary care is enhanced
- Our primary care workforce is expanded, more integrated and better coordinated with community and secondary care
- Our primary care infrastructure – physical and digital – is improved
- Primary care better addresses health inequalities

4.3.19 To achieve these outcomes, a fundamental shift in the relationship between citizens and professionals is required so that individuals, families and local communities are empowered to have more control over their health and care, and are enabled and supported to live well.

4.3.20 PCIP sets out a number of changes to the services and workforce within primary care. The table below summarises the impact at an overall NHS Forth Valley level.

Figure 4-16: Impact of PCIP key changes at NHS Forth Valley level

Service/ Role	Description of change
Vaccination Transformation Programme (VTP)	Board delivered vaccination programme – hub -spoke model within each locality
Community Treatment & Care Services (CTAC)	Board delivered Treatment room services including centralised phlebotomy service hub-spoke model within each locality.
Pharmacotherapy Services	1 Pharmacy team member for every 5,000 population. Includes: technician, support worker, pharmacist.
Primary Care Mental Health Nurses (PCMHN)	1 PCMHN per 15,000 (overall some practices higher rate).
Advanced Practice Physiotherapists (APP)	1 APP per 20,000 population (potentially 1 per 10,000 in some Practices).
Urgent Care - Advanced Nurse Practitioners (ANP)	1 ANP per 11,000 population (could increase and is in addition to practice ANPs).
Community Link Workers	8 Link Workers across Forth Valley focusing on key areas of need/ most deprived communities.

4.3.21 On full implementation this will represent an additional circa 200 WTE. The latest workforce tracker information for PCIP is summarised below:

Figure 4-17: PCIP WTE by profession and HSCP as at March 2022

	Advance Practice Physio	Primary Care Mental Health Nurse	Advance Practice Nurse	Pharmacotherapy	Phlebotomy	Others*	Total
Falkirk	7.5	10.7	15.0	28.3	15.6	13	90.1
Clacks & Stirling	6.9	10.7	12.9	24.9	15.3	13	83.7
Total	**14.4**	**21.4**	**27.9**	**63.2**	**30.9**	**26**	**173.8**

*Vaccination, Community Links Workers & care home ANPs

4.3.22 The Primary Care Improvement Plan was launched in 2018, with the ambition to realise the six outcomes for Primary Care by 2021. Good progress has been made by tri-partite partners in implementing the recommendations of this plan, and facilitating the availability of the supporting staff roles required to deliver the agreed local priorities of a safe, effective, affordable and sustainable shift of workload and responsibilities from GPs to release capacity for their Expert Medical Generalist role.

4.3.23 Across the system, as these roles have been developed and trained staff appointed, challenges have been faced by primary care in leveraging the benefits of these models to increase GP capacity. It is imperative that the structural changes required to make optimal use of these new staff roles is prioritised to realise the full benefits of this new model of care, strengthening our capacity for prevention, anticipatory care, enablement and self-management.

4.3.24 To support the creation of new roles, appointing additional members of staff as part of the primary care MDT with a breadth of skill and experience available to help manage the

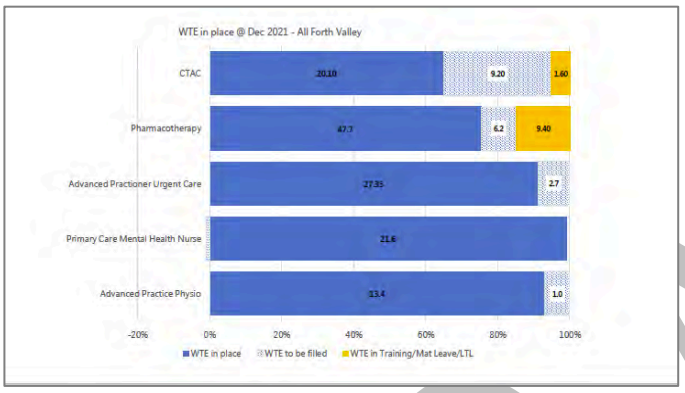
workload traditionally delivered by GPs, it is equally imperative that the appropriate environments and sufficient physical capacity is provided to accommodate them.

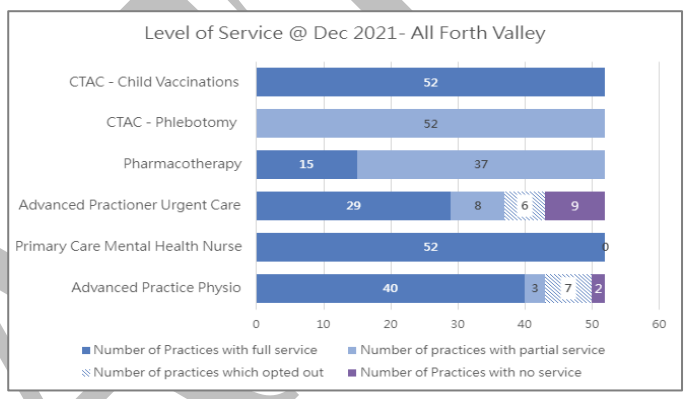
4.3.25 CTAC centres have been introduced in a number of locations across NHS Forth Valley geography, but examples show that there could be better co-ordination and shared visibility of resources.

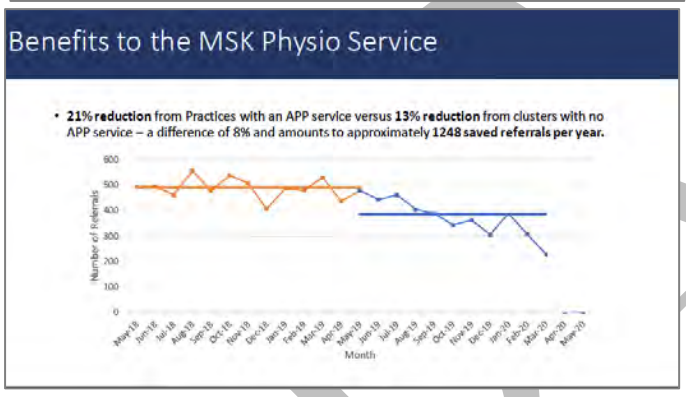
4.3.26 While great progress has been made in identifying, training and recruiting new members of staff to our primary care delivery teams to support this aim, constraints in physical infrastructure and capacity are limiting the extent to which the plan can be fully implemented.

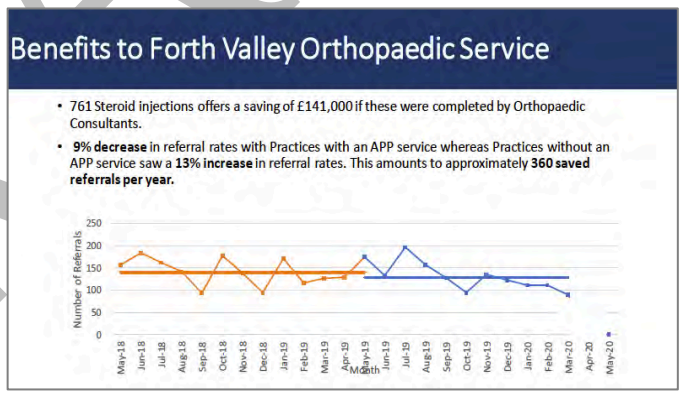
4.3.27 Significant progress has been made in implementing the Primary Care Improvement Plan with 141,000 additional consults provided. **Appendix B** provides a copy of the latest Board update on PCIP; a number of key charts have been extracted and shown below:

Figure 4-18: PCIP Progress (December 2021)









Supporting shift from acute to community-based models

4.3.28 There are a number of new models of care within secondary/ acute care services which require capacity within primary/ community-based care to implement. This includes Hospital at Home, Outpatient Parenteral Antimicrobial Therapy (OPAT) services for managing infections and Community Respiratory pathways. These services allow patients to be treated in their own home and to receive the relevant treatment without admission to hospital.

4.3.29 The following case studies help demonstrate this ambition.

Figure 4-19: Diabetic Outpatient Future Service Model Case Study

Proposal:	The future service model for Diabetic service is to deliver asynchronous outpatient screening appointments.
Requirement:	Fundamental to this shift in model is the ability to capture information within primary and community care which in turn would be asynchronously reviewed by secondary care clinicians. Vision is for three community-based hubs at each community hospital site, co-located with primary care services with potential to share phlebotomy services.
Benefit:	There are circa 19,000 patients across NHS Forth Valley who would benefit from this model; reducing travel and time in clinic. Increase capacity within secondary care.

Figure 4-20: Integrated Phlebotomy Service

Proposal:	Opportunity to maximise the phlebotomy service within primary care as part of CTAC to expand to include secondary care demand.
Requirement:	Integration of IT systems, additional phlebotomy within community care; flexible use of staffing across acute and community care to maximise resources.
Benefit:	Reducing travel and time in clinic. Increase capacity within secondary care.

4.3.30 This need for change can be demonstrated in the case study below:

Figure 4-21: Case Study 2: Unable to maximise the benefits from the Primary Care Improvement Plan (PCIP) including the ability to fully implement new roles and therefore unable to reduce demand for secondary care

A multi-practice site serving circa 30,000 patients registered. Current challenges faced in support of this driver for change:

- All practices operating "open but full" status; not routinely accepting new patients
- In areas with new housing planned (circa 2600 homes)
- Unable to offer Vaccination or Community Treatment & Care Services within the locality; patients required to travel to Falkirk Community Hospital site.
- Practices unable to receive full allocation of ANP resource due to room shortage
- Pharmacotherapy service delivered from reception area therefore unable to deliver tier 2 service and patient facing consultations due to room shortages. .

Unable to meet current and future demand for core and expanded primary care services as part of new General Medical Service (GMS) contract

4.3.31 The population served by NHS Forth Valley is growing and more people are living longer. As a result, demand for health services is increasing year-on-year. The population of Forth Valley is changing more significantly than the Scottish average and is expected to grow substantially over the next 15 years. This will result in unmet need through significant population growth and new housing with potential to increase the demand for acute care in absence of sufficient primary care resource.

Figure 4-22: Projected impact of demographic change in NHS Forth Valley

4.3.32 Despite many improvements, there are still major health inequalities across our local communities which need to be addressed. Growing numbers of people are also developing preventable health conditions linked to alcohol, smoking and being overweight. All of this presents a huge challenge to the NHS and our healthcare services need to adapt to meet these challenges.

4.3.33 The Board recognised in their Healthcare Strategy Shaping the Future 2016-2021, that the NHS needs to work with partners, community organisations and the voluntary sector to deliver more care and support in people's homes, GP practices and health centres to help reduce emergency hospital admissions. Furthermore, there is a commitment to improve overall population health and address inequalities in access health and care services.

Additional Housing

4.3.34 There are significant housing development plans across all three local authority areas within NHS Forth Valley. The table below summaries the total number of housing units planned based on the most recent discussions with local authorities and highlights the key practices impacted.

Figure 4-23: Latest Planned Housing Developments

Local Authority	Total units	Locality	Practices impacted
Clackmannanshire	500 500	Clackmannanshire	Dollar Alva
Stirling	3700 1100 1130	Stirling – eastern villages	Tor, Plean Bannockburn Cowie, Fallin
Falkirk	1113 1700 970 1147	Falkirk Central Falkirk – East Falkirk – East Falkirk – West	Falkirk town practices Meadowbank practices Bo'ness practices Denny & Bonnybridge practices

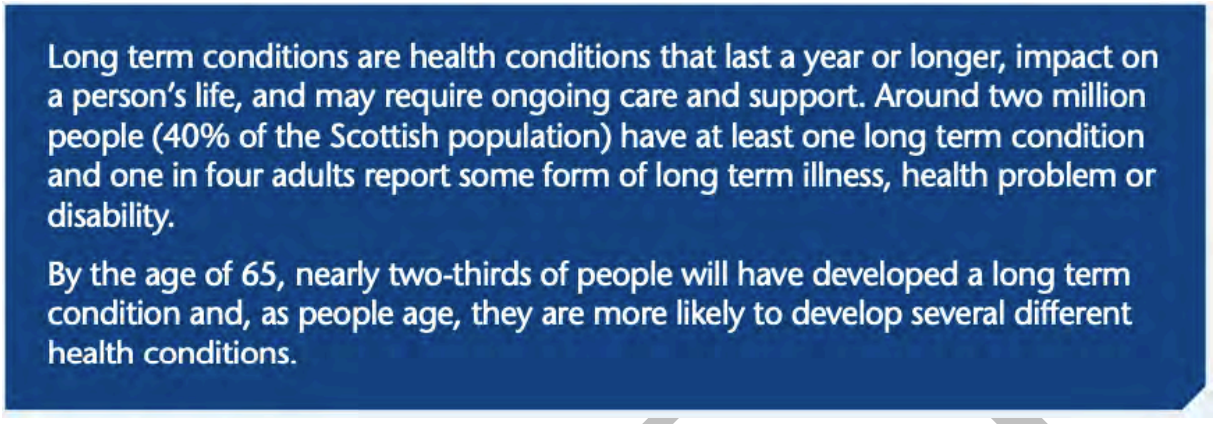
Rising demand for long-term care

4.3.35 Whilst the population is increasingly healthy and more people are living to an older age, the number of people living with one or more long-term conditions is also increasing rapidly. Future models should help people focus on positive well-being, preventing disease and complications, anticipating care needs and self-management tailored to their needs.

4.3.36 The human costs and the economic burden of managing long-term conditions for health and social care are profound, as 60% of all deaths are attributable to long-term conditions and

they account for 80% of all GP consultations. Coupled with the opportunities afforded by the new GMS contract, the demographic drivers outlined above and the advancement of supporting technology systems in managing Long-term conditions, this is a key area of change driving the need for transformation.

Figure 4-24: Excerpt from NHS Forth Valley Healthcare Strategy, referencing long-term conditions



Demand & Capacity

4.3.37 The table below sets out current and future demand and capacity estimates; based on the target PCIP rates per 1000 population and using a rate of 1 GP per 1,500 registrations (current rate 1 per 1,666 noted need for reduced workload to improve sustainability):

Figure 4-25: Demand & Capacity

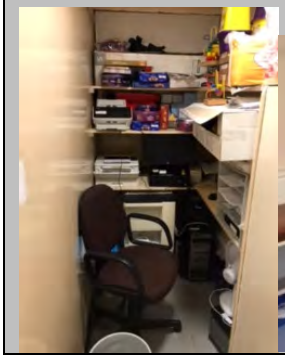
Workforce	Registrations per 1wte	Total wte required – current population (322k)	Current wte	Current gap	Future wte – projected population (331k)	Impact demographic	Projected gap from current
GP	1,500	214.7	193	(21.7)	221.0	6.3	(28.0)
Pharmacotherapy Services	5,000	64.4	61.5	(2.9)	66.3	1.9	(4.8)
Primary Care Mental Health Nurses (PCMHN)	15,000	21.5	18.6	(2.9)	22.1	0.6	(3.5)
Advanced Practice Physiotherapists (APP)	20,0000	16.1	10.1	(6.0)	16.1	0.5	(6.5)
Urgent Care - Advanced Nurse Practitioners (ANP)	11,000	29.3	30.8	1.5	30.1	0.9	0.7
Community Link Workers	n/a targeted practices	8	8	-	8.3	0.2	(0.2)
Total		**353.9**	**322.3**	**(31.6)**	**364.4**	**10.4**	**(42.4)**

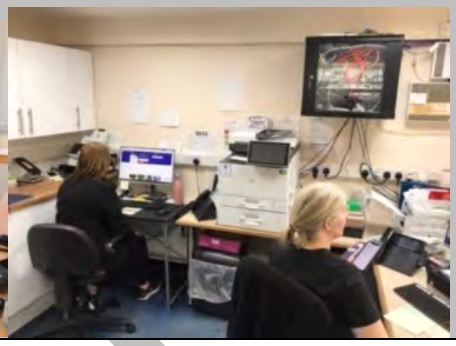
4.3.38 The table above suggests current gap of circa 32 wtes; rising to 42wte by 2041.

Figure 4-26: Case Study 3: Unable to meet current and future demand for core and expanded primary care services as part of new General Medical Service (GMS) contract

Practice B; a small practice within area of deprivation with over 3,500 patients registered. Current challenges faced in support of this driver for change:

- Unable to accommodate all additional roles within new GMS contract
- Significant additional housing; over 6000 new homes; potential for up to 10,000 new residents
- Existing premises consist of 3 consulting rooms within modular temporary structure and unable to extend to support the significant increase in practice population as a result of the new homes.
- Unable to expand the clinical team and range of services offered due to space shortages
- Virtual consults undertaken from cupboard (see photo)
- Pharmacotherapy service delivered from reception area therefore unable to deliver tier 2 service and patient facing consultations due to room shortages





Inadequate facilities including building and IT infrastructure; unable to fully implement digital models due to IT infrastructure

4.3.39 The Property and Maintenance Survey (PAMS) report was updated as part of the Primary Care premises review work in 2018 to establish the condition and environmental suitability of the various locations delivering primary care services. A full table of the findings can be found in **Appendix C**. The survey assessed the accommodation of all practices and premises locations. Ratings were applied at practice level as differences were noted between the accommodation of different practices within a single location.

4.3.40 Three aspects are measured on an A-D rating scale, namely Physical condition, functional suitability and Quality. Space utilisation is measured using E, U,F & O (Empty, Underutilised, Full and Overcrowded respectively). The following table gives an indication of the meanings of those ratings as applied to each aspect

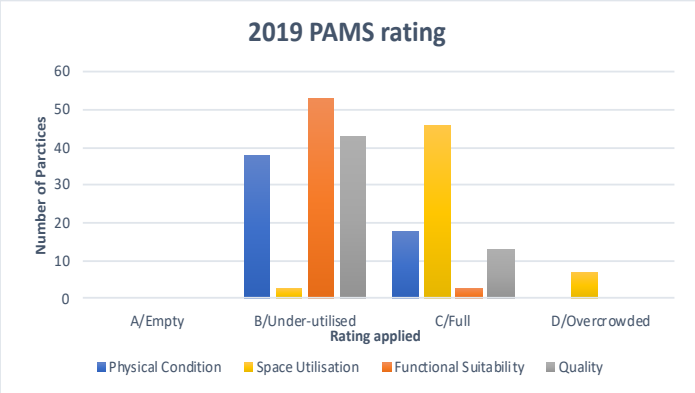
Figure 4-27: Rating scale for PAMS assessment

Rating	Physical Condition	Space Utilisation	Functional suitability	Quality
A/E	Excellent, as new expected to perform as intended over its expected lifespan.	E=Empty/underutilised at all times	Very satisfactory, meet all modern health care requirements	Excellent Quality
B/U	Satisfactory condition, minor deterioration	U= Underutilised, could be significantly increased	Satisfactory, meets standards of time with minor change	Satisfactory, general improvements required

C/F	Poor condition, evidence major defect operational but in need of major repair	F= Fully utilised, satisfactory level	Not satisfactory, doesn't meet minimal healthcare requirements significant change required	Less than satisfactory quality with investment needed
D/O	Unacceptable condition, non-operational/about to fail replacement necessary	O= Overcrowded, overloaded and facilities stretched	Unacceptable in present layout, doesn't meet health care requirements major change needed	Poor quality, significant investment needed

4.3.41 The overview of how practices were rated on these aspects is shown below:

Figure 4-28: How Practices were rated in 2019



4.3.42 The majority of premises were rated B for physical condition, functional suitability and quality. The majority are full in terms of capacity utilisation, with 12.5% rated as "overcrowded". A copy of the latest PAMS for all premises is shown in **Appendix C.**

4.3.43 The most recent Property and Asset Management Strategy (PAMS) identified over a third of premises requiring improvement in physical condition with over £1.4M of backlog maintenance identified across the estate.

4.3.44 A number of facilities do not meet modern building guidelines on minimum size, and practice feedback indicates that activities are restricted in certain spaces due to inadequate space to accommodate appropriate equipment and furnishings. Many practices have identified single spaces as being expected to cover multiple functions, without the appropriate flexibility in configuration or capacity in the time schedule to adequately accommodate all of these at an optimal and sustainable level.

4.3.45 As part of the Primary Care Services & Premises review in 2019 a number of practices were identified as priority for investment as outlined in the table below. This assessment was based on their ability to provide the capacity required for PCIP, impact of new housing and building infrastructure:

Figure 4-29: Primary Care Services & Premises Review Prioritisation

	Falkirk Hub *	Meadowbank	Tor, Plean	Cowie	Dollar	Alva	Bonnybridge	Kersiebank**
Weighted Rank	**4.0**	**4.2**	**3.9**	**3.5**	**6.2**	**3.6**	**4.1**	**3.**
Final Rank	**5**	**7**	**3=**	**1**	**8**	**2**	**6**	**3=**

Notes:

* the data for a Falkirk Hub assumes a potential of 50% of the combined Falkirk Town metrics as potential for some of Falkirk town practices to relocate.

** Kersiebank data includes Bo'ness Road as potential to include this practice as part of premise wide major investment.

Supporting NHS Forth Valley Property Strategy

4.3.46 NHS Forth Valley has had significant investment in new facilities over the last 10-15 years including a new acute hospital and two community health and care developments. The

remaining areas of poor building infrastructure relate to Falkirk community hospital site and associated primary care developments.

4.3.47 A new Falkirk health and care facility including expanded and enhanced primary and community care services will be addressed through the Falkirk master planning project; governed by a joint Programme Board.

4.3.48 The programme of primary care investment proposed through this business case process will provide the underpinning infrastructure and capacity to deliver future models of care closer to home, within community and care settings reducing the need for acute care.

Learning from the COVID-19 pandemic

4.3.49 The Covid – 19 pandemic has required significant changes to how staff work, and in the ways that clinical services are delivered in primary care and across NHS Forth Valley. The need for facility reconfiguration to create a safer working environment has underlined the importance of ensuring that staff across NHS Forth Valley have a clear understanding of the lessons learned from working during a pandemic situation, to ensure that the final design of primary care services has the resilience to manage similar situations in future and respond to ongoing changes in service delivery models.

4.3.50 A number of the impacts associated with the future provision of primary care services driven by COVID-19 include:

- There are a number of unintended consequences including increased mental health needs and the impact of long-term covid.
- Future model of service delivery will require a balance of face to face and virtual consultations. This impacts on the type of room requirement and staff based in primary care facilities;
- Use of technology to support greater elements of care at home e.g. self-monitoring of long-term conditions. This will require primary and community-based services to support ongoing review and management of individuals through providing access to diagnostics and data gathering (e.g. phlebotomy) to support asynchronous secondary care consultation
- Application of technologies to change how individuals wait prior to appointments with remainder when "next in queue" and minimising waiting within primary care traditional waiting areas and individuals opting to wait in cars, outside rather than inside. This will impact on the space required for waiting areas.
- Increased specification to meet living with COVID implications including physical distancing, increased ventilation and ability to facilitate one-way flow within buildings.

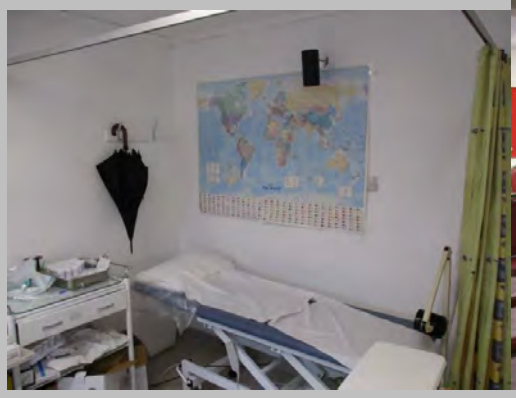
Figure 4-30: Case Study 4: Inadequate facilities including building and IT infrastructure; unable to fully implement digital models due to IT infrastructure

Practice D, a small practice with around 3,000 patients registered. Current challenges faced in support of this driver for change:

- Current premises rated "C" for Physical Condition; "*poor condition, evidence major defect operational but in need of major repair"* and "C:" for Quality: "*not satisfactory, doesn't meet minimal healthcare requirements- significant change required"*
- Specific comments on the function of current facilities:
  - Average rooms size smaller than best practice
  - Insufficient toilets (one unisex staff and one unisex patient)
  - Inadequate storage
  - Waiting space overcrowded; close proximity to reception
  - Corridors narrow and restrictive
  - Heating and ventilation inadequate
  - Treatment room requires folding couch due to small size (see photo); room size significantly smaller than required

- Acoustic privacy within consulting rooms poor due to wall construction






- Current premises unable to be modified - past useful life.

Unable to maximise benefits of integration, supporting flexibility of use, shared services

Current service models do not always offer person-centred care

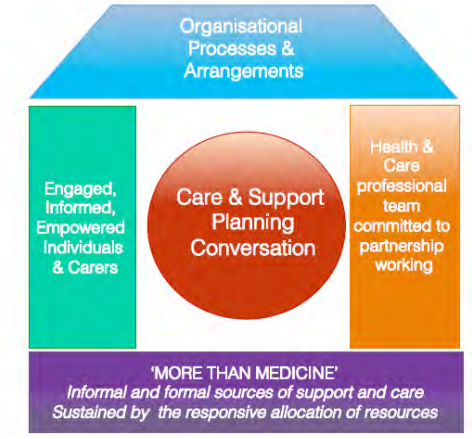
4.3.51 How we engage with those that use our services is changing. Realistic medicine puts the person receiving health and social care at the centre of decisions made about their care. It encourages health and care workers to find out what matters most to the person so that the care of their condition fits their needs and situation. This is supported the "*What matters to you*?" initiative http://www.whatmatterstoyou.scot/ and other approaches used within the Person-Centred Health and Care Programme.

4.3.52 Realistic medicine recognises that a one-size-fits-all approach to health and social care is not the most effective path for the person receiving the services. Realistic medicine is not just about doctors. 'Medicine' includes all professionals who use their skills and knowledge to help people maintain health and to prevent and treat illness. This includes, for example, nursing, pharmacy, occupational therapy, physiotherapy and social work.

4.3.53 Realistic medicine encourages shared decision-making about people's care. It is about moving away from a 'professionals know best' culture. This means the professional should understand what matters to the person and what they want to achieve. People receiving the services are encouraged to ask questions about their condition and the options for their treatment and care. Professionals should explain the options available and the benefits and risks of these procedures. They should also discuss the option of doing nothing and what effects this could have. People should be given enough information and time to make an

informed decision. It is also worth remembering that Doctors generally choose less treatment for themselves than they provide for their patients.

Figure 4-31: House of Care framework



"We need to change the outdated 'doctor knows best' culture to one where both parties can combine their expertise and be more comfortable in sharing the power and responsibility of decision-making. It requires system and organisational change to promote the required attitudes, roles and skills. Such system change is articulated in models such as the ***House of Care****, which provides a useful representation of the components, all of which are required, to place collaborative, relational decision making and planning at the heart of our system."*

Chief Medical Officer's Annual Report 2014-15 REALISTIC MEDICINE

4.3.54 The House of Care is a standard Framework which facilitates the development of a new and improved relationship between patients, unpaid carers and staff. Person-centred care is care that is responsive to individual personal preferences, needs and values, while assuring that patients' values guide all clinical decisions. A person-centred culture places the quality of patient care and patients' experiences, at the centre of the healthcare services which are provided to them.

4.3.55 Current health and social care service models do not always support person-centred care, for example, there is a lack of co-produced service models and lack of choice of service options available.

4.3.56 Communication, both amongst services and with the people who use them, also presents opportunities for improvement; Services not knowing what other services are involved with the person and/ or failing to communicate effectively or co-ordinate with the person are still common place.

4.3.57 There is an opportunity as part of the primary care programme of investment to integrate a wider range of health and care services; including bases for peripatetic staff and domiciliary services such as Hospital @ home and home care.

Focus on citizen wellness rather than patient illness

4.3.58 The changing role of primary care, with an increased emphasis on prevention and self-management and with care planned and delivered by a broader multi-disciplinary health and social care team, should support people to achieve the maximum level of health and wellbeing they can, whilst encouraging independence.

4.3.59 Supported self-management can delay the progression or exacerbation of illness and aims to maintain people in a state of optimum health and independence for as long as possible. A personalised approach to care, shared decision making and patient empowerment, would, for example, provide the person with a summary of their consultation. It can also support a staged approach to anticipatory care planning. This means that as soon as the condition begins to worsen, the person knows how to take immediate action, preventing avoidable deterioration and the need for more intensive treatment or hospitalisation.

4.3.60 Self-Directed Support has a very similar approach to Realistic medicine, from a Social Care perspective. The Social Care (Self-directed Support) (Scotland) Act 2013 places a duty on local authority social work departments to offer people who are eligible for social care a range of choices over how they receive their social care and support. Self-directed Support allows

people, their carers and their families to make informed choices on what their support looks like and how it is delivered, making it possible to meet agreed personal outcomes.

4.3.61 Increased mobility of services, and a greater shift in treatment and care to a home situation has been proven to improve patient health outcomes. This will enable NHS Forth Valley to shift its focus from illness to wellness.

Advancements in Digital Health capabilities

'Digital technology is key to transforming health and social care services so that care can become more person centred' Scottish Government, Health and Social Care Delivery Plan

4.3.62 Digital technology plays an ever-increasing role in all of our lives, whether or not we want it to and no matter how much, or little we engage with it. There are opportunities to use technology to make our services more effective and efficient, whilst that journey has been ongoing for some, for others it has barely started. For people who use our services, many expect to be able to use technology to access services, monitor their own health or self-manage their long-term condition, to find readily accessible information about available services online or to help them maintain their independence.

4.3.63 The technology landscape supporting health and care in Forth Valley today remains embedded inside individual organisational domains. Whilst good work exists inside the partner organisations there are no joined up services stretching across organisational boundaries or allowing citizens to interact digitally in ways they have come to expect in other areas of their life. The establishment of IJBs has introduced new and sometimes transformative working practices but this is not yet underpinned by scalable digital capabilities.

4.3.64 There is an opportunity to leverage the emerging technologies in digital health and system integration to empower citizens to better manage their health and wellbeing, to create a virtual by default approach, and to empower and develop our staff. This is a paradigm shift. The technology in use across Forth Valley meets the needs of the organisations in the way in which the services are configured today, it does not deliver against our national strategies or vision. IT systems in the future should be able to be used seamlessly by practices, social care and patients so that Anticipatory Care Plans (ACPs) and information can be updated by multiple agencies to provide a genuine real-time record.

4.3.65 Recent developments in technology can enable NHS Forth Valley to change the business culture and service delivery approaches e.g. accelerating and embedding digital monitoring technology to increase capacity of services that can be delivered in a person's home. Making use of digital services in a more agile and effective way, supporting GPs and extended primary care teams, and expanding service innovation to do more within the home, avoiding unnecessary conveyances.

Placemaking & 20 Minute Neighbourhoods

4.3.66 A planning concept and urban growth model known as the 20-minute neighbourhood, has gained significant traction across the world as a means of supporting this recovery, spurred on in part by the outcomes of the Covid-19 pandemic. In Scotland, 20-minute neighbourhoods have made their way into policy and political spheres with inclusion within the Programme for Government 2020-21 and explicit mention in the recently published National Planning Framework 4 Position Statement. Whilst their definition is not universally agreed upon, the basic premise is a model of urban development that creates neighbourhoods where daily services can be accessed within a 20-minute walk. The aim of such neighbourhoods is to regenerate urban centres, enhance social cohesion, improving

health outcomes and support the move towards carbon net-zero targets through reducing unsustainable travel.

4.3.67 An array of interventions needs considering to support the implementation of 20-minute neighbourhoods including active travel interventions, public realm and greenspace enhancements, traffic reduction methods, service provision and considerations of densification. Whilst 20-minute neighbourhood type interventions are recent in their deployment, there is a growing body of evidence supporting such interventions.

4.3.68 Poverty and inequality remain the biggest and most important challenge to Scotland's health, as the majority of health differences find their root cause in differences in wealth and income. Healthy Male Life Expectancy at birth in the 10% most deprived areas in Scotland is 43.9 years, 26.0 years lower than in the least deprived areas (69.8 years). Healthy Female Life Expectancy at birth is 49.9 years in the most deprived areas, 22.2 years lower than in the least deprived areas (72.0 years). This is preventable. A key opportunity the primary care programme offers is to plan to address the extent to which primary care services can be made as accessible as possible to those living in our most deprived communities and equalities groups, to improve health and reduce disease. A significant challenge for those living in poverty being the cost of transport to access services.

4.3.69 NHS Forth Valley are an Anchor Institution, this supports their ongoing role within communities as part of community health and wealth building project GROW (Growth in Resilience & Opportunities for Wellbeing).

4.3.70 Consideration will be given as to what services could be co-located to support the delivery of this concept. There will be ongoing engagement with a range of partner organisations throughout the planning process to seek to maximise the opportunities for wider community benefits.

Figure 4-32: Case Study 5: Unable to maximise benefits of integration, supporting flexibility of use, shared services

There is the opportunity to co-locate and wider integrate a number of practices within a locality serving over 20,000 patients. Current challenges faced in support of this driver for change:

- Difficulties enabling "Expert Generalist" GP role as defined in the contract; result in less opportunity to fully integrate and support those of most need
- Unable to extend the range of wider health and care services within the locality unless taken forward separately missing opportunities for increased flexibility of use and wider integration of services.
- Unable to deliver increased wellbeing services due to insufficient space / inappropriate space and investment within e-health required
- Lack of inter-operability of health and social care systems resulting in duplication and lost opportunities to integrate services
- Missing focal point of health, care and wellbeing services within locality; disjointed and fragmented and opportunity to better used combined resources

Summary of the Need for Change

4.3.71 The table below summarises the need for change:

Figure 4-33 :Summary of the need for change

What is the cause of the need for change?	What effect is it having, or likely to have, on the organisation?	Why action now:
GP sustainability is currently the highest corporate risk for NHS Forth Valley. Address GP	Unable to meet demand for core GMS services due to workforce shortages.	Ensure patients seen in the appropriate setting; insufficient access to primary care will impact on the demand for

sustainability, recruitment and retention of expanded primary care teams.	Unable to fully deliver the new GMS contract Requirement to hire spaces (cost constraint) for vaccination programmes Recruitment and retention issues associated with GP owned facilities	acute unscheduled care and Emergency Department attendances. More people & space required in primary care. Insufficient space to see patients and meet expectations for in person consults. Progressive withdrawal of services. GP sustainability and avoid "burn out"
Unable to maximise the benefits from the Primary Care Improvement Plan (PCIP) including the ability to fully implement new roles and therefore unable to reduce demand for secondary care	Unable to provide all PCIP services in all areas and therefore unable to obtain full benefits of these roles. Increase in space required for wider primary care team Unable to move to more efficient Hub models Unable to address all Quality dimensions – timely, efficient, effective	Failure to fully implement the new services therefore unable to deliver full benefits including reduced referrals to secondary care. Fully realise benefit of staff groups employed to support new GMS contract Unable to use resources in most efficient way Enable the wider opportunities PCIP – level 2 pharmacy, wider AHP services
Unable to meet current and future demand for core and expanded primary care services as part of new General Medical Service (GMS) contract.	Increase in the number of restricted lists. Patients unable to register with local GP. Patients unable to get timely access to primary care services which in turn will increase ED attendances. Unable to meet post-pandemic impact e.g. long covid, waiting times, growing aging/ complex patient group Unable to make sustainable improvements within population health	Ensure sufficient capacity in place within primary and community care to reduce unscheduled care attendances and pressures on acute care sector. Unable to deliver "Care closer to home" Ensure future flexibility
Inadequate facilities including building and IT infrastructure	Unable to offer group, MDT meeting spaces; lost capacity to clinical services Limited flexibility Inadequate IT capacity to support virtual models Improve recruitment & retention,	Difficulties retaining staff if can't accommodate Increasing financial burden of inadequate facilities Promote attractiveness of NHS FV to live and work in Enable the adoption of future models of care which facilitate greater level of care in community and non-acute setting.
Unable to maximise benefits of integration, supporting flexibility of use, shared services	Lack space limiting integration Unable to meet increase in community-based services Lack of knowledge and information of range of health and social care services available with localities. Unable to gain wider community benefits	Benefits of integrated services unable to be achieved. Increased workforce and costs in already overstretched health and care services Support locality planning, Place making principles and 20-minute neighbourhoods. Improved communications, information and awareness of services enabling citizens to make informed choices about how their health and wellbeing can be supported and optimised.

4.4 What is the organisation seeking to achieve?

4.4.1 Through stakeholder engagement workshops the following Investment Objectives have been identified as a response to the identified need for change:

Figure 4-34: Investment Objectives

What effect is it having, or likely to have, on the organisation?	What needs to be achieved to overcome this need? (Investment Objectives)
Unable to meet demand for core GMS services due to workforce shortages. Unable to fully deliver the new GMS contract Requirement to hire spaces (cost constraint) for vaccination programmes Recruitment and retentions issues associated with GP owned facilities	Additional workforce is required to deliver the new GMS contract. Furthermore, future solutions need to recognise that future generations of GPs are less likely to wish to own their own premises. **Objective 1: Our primary care workforce is expanded, more integrated and better coordinated with community and secondary care**
Unable to provide all PCIP services in all areas and therefore unable to obtain full benefits of these roles. Increase in space required for wider primary care team Unable to move to more efficient Hub models Unable to address all Quality dimensions – timely, efficient, effective	The future model of care requires the development of locality hubs to maximise the use of the new workforce from PCIP. Equity of access to all services within all localities based on need not space available. **Objective 2: Our Primary care services better contribute to improving population health and better address health inequalities**
Increase in the number of restricted lists. Patients unable to register with local GP. Patients unable to get timely access to primary care services which in turn will increase ED attendances. Unable to meet post-pandemic impact e.g. long covid, waiting times, growing aging/ complex patient group	Seek to deliver timely access to care across primary care within NHS FV. Addressing areas of significant new housing. Our experience of primary care is enhanced. **Objective 3: Provide modern flexible fit for purpose facilities responsive to changing demand profile**
Unable to offer group, MDT meeting spaces; lost capacity to clinical services Limited flexibility Inadequate IT capacity to support virtual models Improve recruitment & retention,	New model of care includes increased group delivery and adoption of new digital delivery models. **Objective 4: Our primary care infrastructure – physical and digital – is improved**
Lack space limiting integration Unable to meet increase in community-based services	Seek to implement Place making principles, support delivery of 20-minute neighbourhoods, support delivery of secondary care digital models. **Objective 5: We are more informed and empowered when using primary care**

4.5 What measurable benefits will be gained from this proposal?

4.5.1 By addressing the need for change a number of measurable benefits have been identified and a benefits register established for the project. The key benefits are summarised below, with a copy of the benefits register within **Appendix D.**

Figure 4-35 : Measurable Benefits

Category	Benefits
Patients	Ability to access timely, appropriate and relevant health and care services within community setting.
	Ensure equity of access and positive experience to primary health and care services improving the service capacity and reducing restricted lists
	Increase multi-disciplinary primary care workforce to appropriate level for practice population to enable timely access for patients, focusing on prevention, independence and self-care

	Improve the quality and physical condition of the healthcare estate (SAFR), improving performance against 6 facet survey – NHS Estate code
Workforce	Deliver the requirements within the new GMS contract. To ensure sustainability of general practice and provide high-quality care in the community
	Increased efficiency of workforce, enable integrated working through creation of "Hub" facilities and co-location of services in cognisance of the principles of "Place" and locality planning
	Ability to increase the range of services available to citizens as part of multi-disciplinary team enabling GPs to provide the "expert generalist" role.
	Increase the ability to train GPs and other primary care practitioners
Health & Care System	Improves design quality in support of increased quality of care and value for money (QOI)
	Supports attainment of service targets, Strategic Plans. E.g. early cancer detection, antenatal access, early years vaccination. Health & Wellbeing Outcomes
	Support the urgent care model; meeting the most appropriate needs within community / non-acute setting.

Patient and Citizen Benefits

4.5.2 There are clear benefits to patients accessing services within the newly proposed model, and more widely, of benefit to local citizens not classed as patients.

4.5.3 Citizens will have access to a broader range of services and clinicians with the specific expertise they require, available on a more frequent basis within their locality area.

4.5.4 Citizens will begin to recognise the different clinical groups who work together as part of their MDT and feel the benefit of more specialised care, accessing the right care professional and seeing results more quickly.

4.5.5 Access to GPs where this is required will become easier, with more available capacity as the expert medical generalists, while other specialists forming part of the MDT specialise in their own areas of care.

4.5.6 Patients will be able to access more service provided in their own home, through the hospital at home model, avoiding the need for them to be admitted to hospital.

4.5.7 Citizens will have access to a broad range of wellness and health promotion services, available locally, often within the less clinical environments of leisure facilities and community assets. This can increase the appeal and reduce the anxiety often associated with historically accessing medicalised services in clinical settings.

4.5.8 Whilst there will be specific premises and practices directly impacted by the investment there will be wider benefits to a number of other practices as this will provide the opportunity to align services based on need not space.

Wider Socio-Economic Benefits

4.5.9 In addition to the benefits identified above which relate to the investment objectives, it is anticipated that the Primary Care programme will deliver a wider range of indirect social and economic benefits for the population of NHS Forth Valley. These arise from a number sources but are predominantly focussed on the benefits arising from improvements in population health – this means that not only will Forth Valley residents lead longer lives but their quality

of life will be enhanced relative to a situation in which NHS Forth Valley does not undertake any level of primary care transformational change.

4.5.10 The economic and societal benefits associated with the life years gained as a result of the programme can by quantified by using the concept of Quality Adjusted Life Years (QALYs). Further analysis would be undertaken within each project at Outline Business Case stage.

4.6 What risks could undermine these benefits?

4.6.1 A number of risks have been identified and a detailed risk register established for the project. These have been assessed and formal risk review process established supported by the Corporate Portfolio Service Office (CPMO). The key risks are summarised below, with a copy of the risk register within **Appendix E.**

Figure 4-36: Risks

Risks
Interdependencies with FCH Masterplan - inability to deliver project to plan
Unable to secure developer contributions to allow for variation in demand i.e. not utilising space to 100% capacity
Legislative changes pending and impact to project requirements (being able to deliver all requirements) - external
Failing to take cognisance of interoperability, integration of IT systems to make best use of space to deliver service model
Space constraints impact on delivery of GMS contract
Space constraints impact recruitment and retention/ working environment
Unable to respond to future policy or strategic changes (Internal)
Identifying appropriate stakeholders
Right level of stakeholder engagement and failure to engage
Unable to get consensus as stakeholders may have contradictory plans/aspirations
Risk of over run of the programme due to timings over summer holidays etc
Stakeholders unable to identify with future models of care
Unable to get corporate agreement with model of care/how services will be delivered - strategic fit
Being too ambitious - scope of the programme of investment
Risk of stakeholders being able to engage due to time constraints - capacity to attend and to be able to deliver work

4.7 Are there any constraints or dependencies?

4.7.1 The following constraints and dependencies have been identified:

Constraints

- Improvements must be delivered with the available capital and revenue funding
- Compliance with all current health guidance
- The availability of workforce may impact on the future delivery model adopted
- Business case process including build and commission

Dependencies

- There is a dependency on adopting new working models e.g. shared and owned spaces
- There is a dependency with the Falkirk Community Master planning project specifically within the Falkirk central locality
- The adoption of new models of care is dependent on the delivery of the Digital strategy.

ECONOMIC CASE

5 WHAT IS THE PREFERRED STRATEGIC/ SERVICE SOLUTION?

5.1.1 This section will include the following:

- Do Nothing/Minimum Option
- Service Change Proposals
- Developing and assessing the long list of proposed solutions
- Impact of Proposed Service Option
- Indicative Costs
- Design Quality Objectives

5.2 Do Nothing

5.2.1 The table below sets out the do-nothing option; how primary care services across NHS Forth Valley are currently delivered.

Figure 5-1: Do Nothing/ Minimum Option

Strategic Scope of Option:	Do Nothing
Service provision:	Existing 50 GP practices across NHS Forth Valley.
Service arrangements:	All care remains at an individual practice level. Some practices host all services, others utilise Hub locations and/ or other primary care facilities. Some practices are unable to host all services due to space constraints.
Service provider and workforce arrangements:	Core GMS services plus the allocation of PCIP staff and NHS board services.
Supporting assets:	28 NHS owned and 15 practice owned premises, a number of which would remain unfit for purpose.
Public and service user expectations:	Access to a range of primary care services in a timely manner. Inequity of service provision due to insufficient capacity.

5.3 Service Change Proposals

5.3.1 The development of service change proposals is driven by the identified drivers for change and a requirement to provide a wider range of primary care and community-based services that are equitable and accessible to Forth Valley residents.

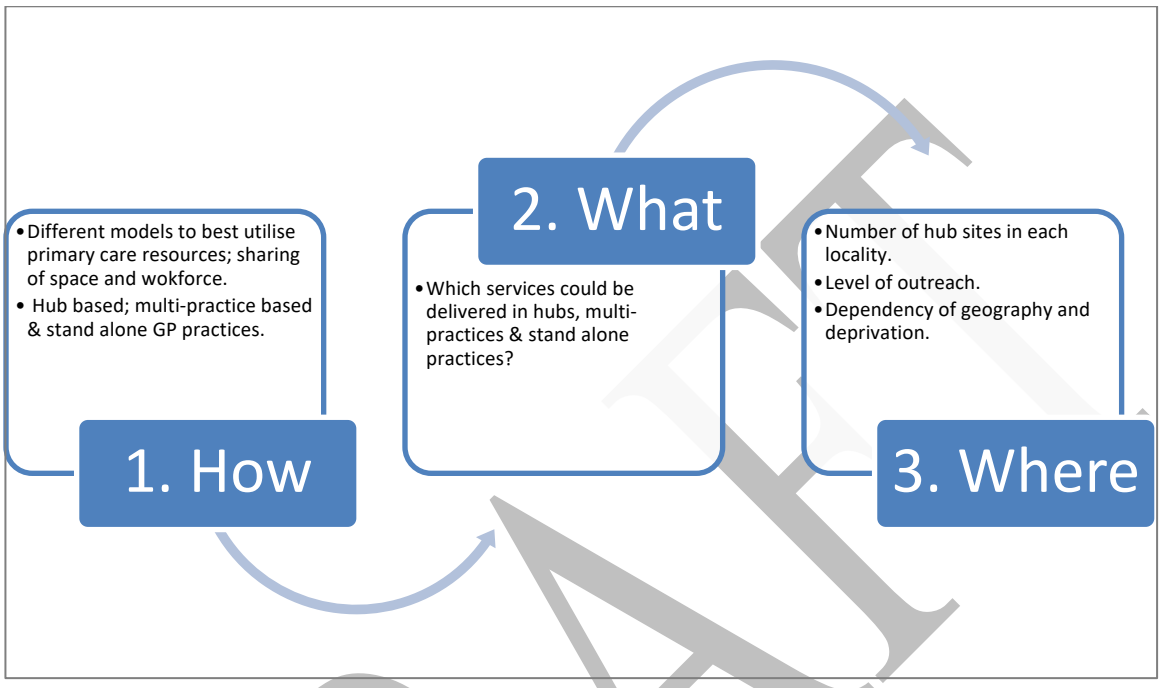
5.3.2 The proposals are multi-faceted, including the range and way in which each service is delivered and the resultant impact within each practice and locality. Furthermore, as a programme approach is being undertaken there are different considerations for each population base. The board has sought to explore a number of service delivery models to inform the option development process from traditional to radical. These focus on the level of service which could be delivered from locality hubs and local practices. The extent to which different service models can be applied in each area is dependent on a range of factors including:

- Ease of access to travel across the locality;
- Deprivation and areas of need;
- Total population served, including impact of rural areas; and
- Mix of contact mediums used within each service e.g. level of remote versus face-to-face interactions.

5.4 Developing and assessing the long list of proposed solution

5.4.1 In developing the long list of proposed service solutions, a three staged approach was adopted as set out in the diagram below. This was undertaken by the project team, shared and validated with the GP sub-committee and wider staff forums (e.g. District Nursing Leads, PCIP Teams and the AHP Manager).

Figure 5-2: Option Development Stages



1. Considering alternative service arrangements - "*how*" services could be delivered:
   - This evaluated the potential for change to the way services are provided. The opportunity to look at sharing and co-locating primary care workforce across practices e.g. sharing of accommodation within multiple practice locations and sharing session use across areas.
2. Identifying "*what*" service delivery model is most applicable for each service within primary care:
   - Having identified at stage 1 the different ways in which the workforce and space could be used, this stage determined which model was most appropriate for each service e.g. urgent care, complex, undifferentiated and long-term continuity of care remain as per the current model, provided by each individual practice whereas PCIP services could be shared between practices.
3. Finally identifying "*where*" each element of service would be provided and the impact that this would have within each locality.
   - Having established how each service would be delivered, the final stage involved identifying the specific requirements of each locality within NHS Forth Valley. This considered deprivation, need, rurality, overall geography and the spread of the locality. Engagement with locality lead GPs, locality managers and patient representatives from each locality was undertaken.

Alternative options for "how" primary care services could be delivered

5.4.2 The alternative delivery options were based on the following attributes:

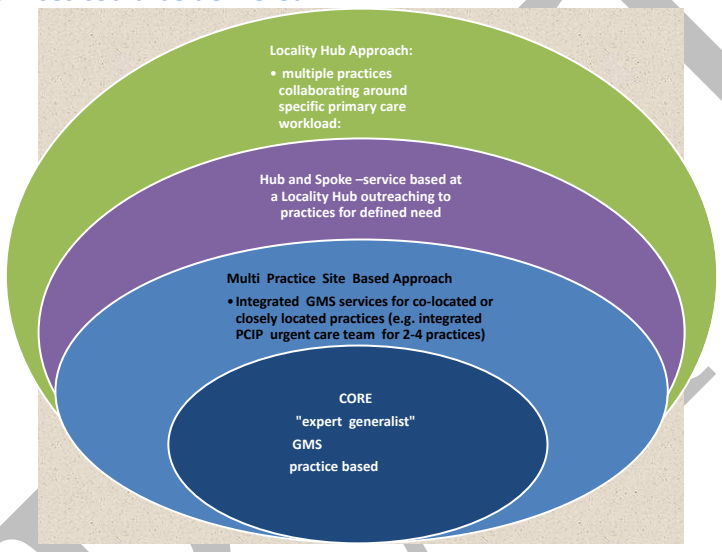
- An ambition to focus on wellness, wellbeing and supporting the needs of citizens rather than designing a system to treat illness.

- Health promotion and self-management are key components of service offerings e.g. accessing community-based assets such as leisure facilities.
- Person centred primary care – access not just in terms of location, but consideration of service availability, contact medium, specialisation, right person at the right time and travel implications.
- Co-ordinated care – adopting the principles of "tell their story once".
- Complexity of care – multi-morbidities.
- Continuity of care – between patient and healthcare professional, adopting a consistent approach to individualise care.

5.4.3 The alternative ways of delivering services were developed by the project team and shared for comment and feedback with both GP sub-committee and PCIP service groups.

5.4.4 The resultant options are summarised in the diagram below:

Figure 5-3: "How" services could be delivered



5.4.5 These models range in scope as outlined below:

- Do Minimum – access to core GMS services within each practice.
- Remote capacity –individual practices would continue to provide core services as per "do minimum" but would have, in addition, a range of visiting and remote services delivered from the locality hub.
- Multi-practice site-based approach – expert generalist provided within each practice with a shared resource model for other elements of multi-disciplinary team.
- Locality Hub approach – multiple practices collaborating on workload and shared resources at a locality level; providing access to a wider range of health and social care services.

5.4.6 To assist in the evaluation of the options, an assessment of the advantages, disadvantages against the identified investment objectives was undertaken, this is outlined below:

Figure 5-4: Option Assessment – Service Arrangement

	Do Nothing: As existing arrangements	Do Minimum	Remote Capacity	Integrated multi-practice model	Locality Hub
Advantages Strengths & Opportunities	• Access maintained • No change to patient expectations	• Increased availability of non – GMS services • Release space in practice for GMS team • Would provide increased capacity for services • Would improve the range of additional services • Likely to improve some of the building infrastructure • Potential for increased integration, but at a minimal number of locations	• Increased availability of space in spoke sites for GMS • May increase workforce resilience • Increased access to a range of primary care services • Increased f51flexibility and use of workforce and space • Increased capacity for services • Improve range of additional services • Likely to improve some of the building infrastructure • Potential for increased integration	• Increased flexible use of workforce and space • Increased availability of non-GMS services • Increased resilience in workforce model/availability of services • An ability to redistribute space in line with service need • Increased capacity for services • Improve range of additional services • Likely to improve some of the building infrastructure • Potential for increased integration	• Increased flexible use of workforce and space • Increased availability of non-GMS services • Increased resilience in workforce model and availability of services • Redistribute space in line with service need • Increased capacity for services • Improve range of additional services • Likely to improve some of the building infrastructure • Support locality planning and locality-based models
Disadvantages Weaknesses & Threats	• Does not address current sustainability issues • Unable to fully implement PCIP • Inefficient workforce • Does not meet current and projected demand for services • A number of inadequate and unsuitable facilities • Unable to maximise benefits of integration • Diseconomies of scale • Does not meet Code of Practice	• Increased patient travel and potentially reduces physical access to services • Unlikely to improve GP sustainability; may increase risk as significant change in service provision • Potential for loss of link with GMS team and wider multi-disciplinary team in primary care • Potential loss of income to GPs	• Increased need for space in hub site • Potential issues in securing space for visiting services from Hub • Potential loss of GP income • Potential loss of link with GMS team and wider multi-disciplinary team in primary care in non-multi-practice/ Hub sites	• Potential impact to perception of what is available • Potential for increased travel • Potential loss of GP income • Potential loss of link with GMS team and wider multi-disciplinary team in primary care in non-multi-practice sites	• Potential impact to perception of what is available • Potential for increased travel • Increased need for space in hub site • Potential loss of GP income

	Do Nothing	Remote Capacity	Integrated multi-practice model	Locality Hub	Do Minimum
	Does it meet the Investment Objectives (Fully, Partially, No, n/a)?				
Our primary care workforce is expanded, more integrated and better coordinated with community and secondary care	✗	✓	✓	✓	✓
Our Primary care services better contribute to improving population health and better addresses health inequalities	✗	?	✓	✓	✓
Provide modern flexible fit for purpose facilities responsive to changing demand profile	✗	✗	✓	✓	✓
Our primary care infrastructure – physical and digital – is improved	✗	?	✓	✓	✓
We are more informed and empowered when using primary care within localities	✗	?	✓	✓	✓
Are the indicative costs likely to present value for money and be affordable? (Yes, maybe/ unknown, no)					
Vfm & Affordability	✗	?	?	?	?
Preferred/ Possible/ Rejected	Rejected	Possible	Possible	Possible	Possible

5.4.7 The assessment of the service arrangements identified a range of possible service delivery options. These were then taken forward into the next stage to consider which is most appropriate for each service.

Identify "what" service delivery model is most applicable for each service within primary care.

5.4.8 In determining the optimum service delivery model for each service within primary care the following attributes were identified and assessed for each service:

Figure 5-5: Service provision attributes

Attribute	Assessment basis
The activity levels (what is the most common reason for primary care consultation	• High - Moderate - Low
Likely contact per episode	• Low - Medium - High - Recurring
Contact medium – virtual versus face-to-face	• Likely percentage split
Current availability to meet user requirements	• Week days - sessional limited - 7 days
Target availability to meet use requirements	• Flexible - 7 days
Co-ordination of care	• Low - Medium - High
Continuity of care	• Low - Medium - High

5.4.9 Each of these attributes were assessed for each element of primary care provision grouped into:

- GMS Services: Urgent on the day, Urgent mental health, Complex undifferentiated, Long-term conditions, Screening and Family planning;
- PCIP services: Mild and moderate mental health, vaccination, CTAC, Pharmacotherapy, APP and link worker; and
- Health Board and partnership services: MSK Physio & Podiatry, Psychological services, Health visiting, District Nurse, Midwifery, Drug services. Potential new and expanded services e.g. Occupational Therapy, additional AHP services, home care teams and an increase in group delivered sessions.

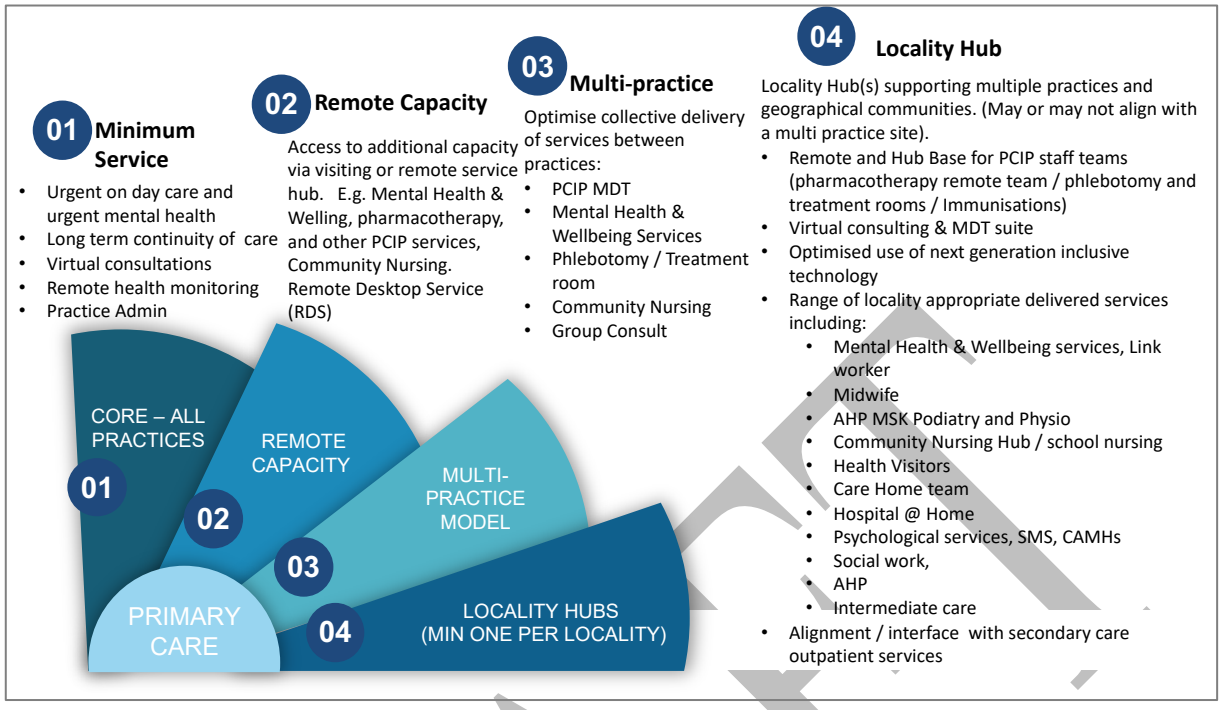
5.4.10 The assessment for each service is shown at **Appendix F.**

5.4.11 To support the options development process, a survey was issued to primary care staff to assess the appetite and opportunity for alternative service options. In total 73 responded, including 49 GPs. The outputs are shown at **Appendix G,** in summary this suggested:

- Practice services: long-term conditions, complex/undifferentiated; urgent care and reception;
- Integrated practices working together: pharmacotherapy, Advanced Practice Physiotherapist, District Nurse, phlebotomy and mental health; and
- Locality services: screening, family planning/women & children's, Treatment room, MSK, Psychological and vaccinations.

5.4.12 Using the assessment and triangulating this with feedback from a survey issued to primary care staff, an assessment of the service delivery options was developed and is summarised below:

Figure 5-6: Service provision – future service delivery preferred option



5.4.13 The impact of the proposed service delivery option would provide the following elements of service in all practices:

- Urgent on day care and urgent mental health;
- Long-term continuity of care;
- Virtual consultations;
- Remote health monitoring; and
- Practice administration.

5.4.14 There would be the opportunity within multi-practice sites to have shared spaces for:

- PCIP Team: Link worker, Advance Practice Physio, Pharmacotherapy and Primary Care Mental Health nurse;
- Phlebotomy and Treatment room;
- Community Nursing; and
- Group therapy rooms.

5.4.15 Where delivered in a standalone practice and not within a locality hub these services would be provided on a sessional basis with staff based at the locality hub and a virtual/ MDT hub at the locality hub.

5.4.16 Creation of a minimum of one locality hub within each locality, including the following services:

- Co-located multi-site GP practices where possible;
- Base for PCIP staff teams;
- Virtual consulting & MDT suite;
- A range of Health Board & HSCP delivered services including:
  - Midwifery
  - AHP MSK Podiatry and Physiotherapy
  - Community Nursing Hub/ school nursing
  - Health Visitor
  - Care Home team

- Hospital @ Home
- Psychological services, Substance Misuse Services and CAMHs

- Alignment with other HSCP community services (social work, AHPs, Intermediate Care); and
- Alignment / interface with secondary care outpatients services.

5.4.17 Having identified the delivery option for each service the final stage undertaken was to assess for each locality the number of locality hubs, multi-practice sites and hub and spoke practices. Given a programme approach is being undertaken this will vary for each location to consider how best to meet need within the population served.

Finally, identify "where" each element of service would be provided and the impact within each locality

5.4.18 Within each locality the practices were mapped to the likely optimum service model option. This considered access, deprivation and scale of need against each of the identified needs for change. A focussed discussion with GP Locality leads, Locality managers and public representatives was undertaken to assess the most appropriate configuration for each locality.

5.4.19 The table below summarises the proposed implementation of the model within each locality and the impact of the investment; it also considers the investment priorities in relation to capacity and infrastructure. This was established by reviewing the proposed configuration at each locality against the capacity available, current infrastructure and existing priorities from the Primary Care Service and Estates review.

Figure 5-7: Impact of Proposed Service Option – by locality

Locality	Proposed Configuration	Investment Impact
Falkirk Central Locality	• Locality hub with up to 4 practices. All other practices benefit from additional capacity via remote and visiting services. • The use and function of the current Camelon health centre to be included in the Falkirk primary care master planning process.	• Redevelopment of up to four practices into a multi-practice locality hub. • Reprovision of and improved locality services from a single hub. • This project will be taken forward within Falkirk Community Hospital Master planning project.
Falkirk West Locality	• Locality hubs to meet geographical spread of the locality. • Review effective service delivery between the existing Stenhousemuir multi-practice hub and a second hub in the Denny / Bonnybridge cluster.	• Creates a second locality hub for the Denny / Bonnybridge population. • Addresses an existing multi-primary care investment priority in Bonnybridge.
Falkirk East Locality	• Hub locality services across Grangemouth and Bo'ness • Refocus Meadowbank Health Centre as a multi-practice site to create space for expanded GP services. • Re-providing locality non-GMS services within the locality hub. • Meadowbank catchment is also likely to use Falkirk Central locality services.	• investment to hub locality services across Grangemouth and Bo'ness • Optimised links with Falkirk Central Hub.
Stirling city with the eastern villages, Bridge of Allan & Dunblane Locality	• Locality hubs - addressing the spread of population and, in particular, supporting areas of high deprivation in the East and West of Stirling city. • Optimise Stirling Health & Care Village supplemented by improving the existing Orchard House hub service and the development of a new hub and extended GP practice within Eastern villages.	• Optimise the existing primary Stirling Health and Care Village hub through provision of share service capacity within an east and west Stirling hub. • Address an existing primary care investment priority in Cowie.
Clackmannanshire Locality	• Locality hubs addressing the spread of population	• Investment to create 2nd hub within the hillfoots villages.

	• Improving service delivery and alignment between the existing CCHC and a hub servicing the hillfoots villages (Menstrie, Alva, Tillicoultry, Dollar & Muckhart).	• Investment to addresses areas of additional housing.
Rural Stirling Locality	• Application of the model will align with existing provision in local villages and communities with opportunities to improve access requiring to be more novel than a locality-based model.	• No infrastructure investment required. • Investment in appropriate technology to support access to inter-practice services.

5.4.20 The areas identified for investment are in line with the findings from the Place Based Planning Tool outputs in November 2021.

5.4.21 To develop the capital cost, a schedule of accommodation was established based on a number of key principles as set out below:

- Shared reception and waiting areas between practices and health board / HSCP services. Allowances are based on current guidance and waiting space per consulting rooms from Stirling Care Village;
- Accommodation requirements are based on rates per 1,000 for PCIP staff and assuming rate of 1 GP per 1,500 patients;
- Inclusion of a virtual consulting suite and GP admin areas to release clinical capacity for face-to-face consultations;
- Standard room sizes from current guidance;
- Inclusion of a multipurpose room and group consulting space;
- Shared staff facilities for all members of primary care team; and
- Agile-multi-disciplinary team touch down desk spaces.

5.5 Indicative Cost

Capital Costs

5.5.1 The table below sets out the indicative additional costs of the proposed service model. This is based on the following assumptions:

- Do nothing costs include backlog maintenance costs;
- The indicative schedule of accommodation within each locality sets out the likely level of new accommodation required to deliver the preferred service model (based on assumptions set out above);
- Capital costs are based on £5,000/m2 which is benchmarked on the most recent project delivered by East Central Hub within primary care. This rate includes all Development Costs including all hubco fees, Healthcare Planning, Design Team Fees, Construction Costs including Risk and overheads and profit;
- Allowance of 10% for group 2-4 equipment;
- Adjustment for Optimism Bias of 20%;
- Internal Resource costs of £2.9m2; assumed over the 7 year business case and development timeline; and
- An allowance of £750,000 for project management, business case development fees and commissioning costs.

Revenue Costs

5.5.2 The specific premises impacted will be developed and prioritised as part of developing the Outline Business Cases. The economic appraisal presented at this stage is based on the additional costs of the preferred option.

5.5.3 The recurring revenue impact is based on the additional costs net of the savings generated from accommodation vacated as part of the investment. The released Health Board property costs have been based on the recharges to GP and not the total cost incurred; which is higher.

5.5.4 The savings do not include released property costs directly paid by practices as this information is not available to NHS Forth Valley finance.

5.5.5 The future recurring revenue costs are based on the following assumptions:

- Overall cost movement from current cost is shown rather than total cost. At this stage the specific premises impacted are not identified;
- Rate for the following areas is based on the rates charged to GPs occupying NHS premises; uplifted to current price base as at December 2021[3]:
  - Heat, light & power - £21.06/m2
  - Domestic service - £23.44/m2
  - Internal maintenance - £15.08/m2
- Rates are based on an average cost per m2 - £15/m2

5.5.6 The capital and revenue costs associated with Falkirk Central investment will be addressed as part of the Falkirk Master planning project and therefore excluded from the analysis below.

Economic appraisal assumptions

5.5.7 The economic appraisal is based on the following assumptions

- Do nothing, based on current costs saved through investment and backlog maintenance;
- Programme of investment between 2025/26 to 2029/30;
- 30-year appraisal period;
- 3.5% discount rate; and
- No lifecycle costs included at this stage.

Figure 5-8: Indicative costs by Locality - £000

Locality	Cost		Whole Life		Estimated Net Present Cost
	Capital	Recurring Revenue	Capital	Recurring Revenue	
Do Nothing	**1,874**	**382.7**	**1,874**	**11,863**	**8,973**
Falkirk West Locality	9,206	112.9	9,206	3,453	
Falkirk East Locality	10,501	128.8	10,501	3,740	
Stirling city with the eastern villages, Bridge of Allan & Dunblane Locality	13,725	168.4	13,725	4,588	
Clackmannanshire Locality	13.069	160.3	13.069	4,873	
Total	**46,501**	**570.5**	**46,501**	**16,654**	
Optimism Bias	9,300	-	9,300	-	
Internal Costs	2,936	-	2,936	-	
Total include Optimism bias	**58,737**	**570.5**	**58,737**	**16,654**	**56,387**

[3] Further work will be undertaken to review the likely revenue costs to recognise current actual premises costs and likely inflationary pressures for utilities.

5.6 Design Quality Objective

5.6.1 On November 17th, 2021, an AEDET (Achieving Excellence Design Evaluation Toolkit) assessment of the existing primary care premises across NHS Forth Valley proposal was facilitated by Michael Cassells of Health Facilities Scotland. The workshop was attended by staff, management, clinicians and public representatives. The outcome of this was documented in an AEDET Assessment summary which is included at **Appendix H.**

5.6.2 There was a particular challenge in relation to the assessments on Build Quality and Impact given the programme IA and inclusion of all current primary care facilities. As a result, a number of areas scored "3", this reflected a variety of premises and associated quality and impact within each, some would score higher, whilst others lower. It is anticipated a review would take place as part of the project level Outline Business Case when specific locations and sites are known. **Appendix C** provides the latest PAMS information and concurs with the sites which scored lowest.

5.6.3 The assessment highlighted the areas where the existing buildings work well:

- In relation to space standards;
- Emergency back-up; and
- Privacy and dignity of users.

5.6.4 There were a number of areas where the buildings were seen as being inadequate:

- Facilitating the care model;
- Ability to handle projected throughput;
- Flexibility to respond to changes in services;
- Security;
- Facilitating health promotion for staff, patients, local community;
- Lack of adaptability to external changes, such as climate change;
- Outdoor spaces;
- Active travel;
- Segregation of route;
- Insufficient storage; and
- Spaces for formal/information therapeutic health activities.

5.6.5 A workshop was undertaken on 19th November 2021 to develop a Design Statement for any new facility. This was facilitated by Steve Malone from Architecture & Design Scotland and was attended by broadly the same group of stakeholders who undertook the AEDET Assessment. The Design Statement is included at **Appendix I** and will form a key part of the briefing documentation to hub and its design team for any site options appraisal and the development of design proposals. The workshop highlighted the key aspects of any new design to be:

- Well located in communities, with good transport links, adequate car parking, good pedestrian and cycle access (including storage) supporting green travel and electric charging points;
- Considerate to intergenerational friendly signage and barrier free paths;
- Making good use of external space to support waiting (pre-entry and after entry) and for rest, exercise and staff downtime;
- Mindful that the location of receptions should be easily seen and respectful of privacy and dignity; should also promote the use of digital technologies to ease the waiting and check in process;
- Optimise way finding, good use of natural daylight, should be capable of adopting a one-way system if required;
- Create flexibility of treatment options for different types of clinical engagement;
- Easy for staff to move through the building avoiding public and waiting areas; and

- Supportive of staff wellbeing through the provision of green spaces for relaxation.

5.6.6 The current Health Facility Scotland (HSF) index of guidance has been reviewed for project applicability and relevance. **Appendix J** summarises those which projects within this programme of investment will require to meet.

COMMERCIAL, FINANCIAL AND MANAGEMENT CASES

6 IS THE ORGANISATION READY TO PROCEED WITH THE PROPOSAL?

6.1.1 This section will outline:

- Procurement strategy and timetable
- Affordability and financial consequences
- Governance and project management arrangements

6.2 Commercial Case

6.2.1 The Commercial Case assesses the possible procurement routes which are available for a project. NHS Forth Valley has been consulting with the Scottish Government on the procurement and finance model which will be used, this will be factored into the process as we move towards Outline Business Case stage. It is anticipated the programme of investment will be taken forward through the Hub procurement route.

6.3 Financial Case

6.3.1 The indicative financial costs are based on the following assumptions:

- Revenue costs within the economic appraisal notionally allocated to NHS/HSCP based on floor space occupied;
- Depreciation is based on 10 years for equipment and 50 years for buildings in line with NHS Forth Valley's capital costing principles;
- Cost impact is net of current depreciation saved; and
- Any impact of a minimum price guarantee given to any practices vacating practice owned premises is assumed within the optimum bias allowance.

6.3.2 The table below sets out the capital and revenue affordability of the preferred option to NHS Forth Valley; net of any recharge to GPs:

Figure 6-1:Capital & Revenue Affordability - £000

Cost	Health Board
Capital costs	**58,737**
Recurring Revenue costs	234
Depreciation	1,448
Total revenue costs	***1,682***
Current released costs	(441)
Net Revenue impact	**1,241**

6.3.3 As set out in section 5.5, the released Health Board property costs have been based on the recharges to General Practice and not the total cost incurred; this is higher, therefore understating the released costs. Further work will be undertaken as part of the specific outline business cases to determine current actual costs of the premises specifically impacted.

6.3.4 There is likely to be opportunity to seek developer contributions to capital costs in relation to areas of significant housing developments. To date there has been early engagement and

this will continue as part of the Outline Business Case process to quantify the level of contribution in proportion with the additional capacity required to support new housing.

6.4 Management Case

6.4.1 A programme board has been established to oversee the initiative, chaired by NHS Forth Valley's Chief Executive, who is also the programme's Senior Responsible Officer (SRO).

6.4.2 The programme board represents the wider interests of both the Primary Care Programme and the Falkirk Community Hospital site master planning work (out with the scope of this Initial Agreement, but with key relationships and interdependencies to this work) and it oversees the co-ordination of the development proposal.

- The programme board reports to the NHS Board and relevant Council Boards and IJBs and is designed to support the organisation and facilitation of the programme.

The Programme Board has the following duties:

- To be accountable for the success or failure of the programme;
- To provide unified direction to the Project Director/core project team;
- To provide the resources and authorise any funds required to progress the programme; and
- Decision making and approval of decision escalation to governance boards.

6.4.3 The Programme Board consists of the following key stakeholder:

Figure 6-2: Programme Board Membership

FCH/PIA PROGRAMME BOARD (requires reps from each group – council, IJB, NHS Board)	
Chief Executive (NHSFV) (SRO & Chair)	Cathie Cowan
Chief Officer Falkirk HSCP (Project Director FCH Masterplan / Chair of Project Group - or nominated delegate)	Patricia Cassidy
Chief Officer Clacks & Stirling HSCP – or nominated delegate	Anne Margaret Black
Deputy Medical Director Primary Care/ Co-chair PC PIA (NHSFV)	Scott Williams
General Manager, Primary Care, Mental Health & Prisons, NHS FV (Project Director PC PIA / Chair of Project Group – or nominated delegate)	Kathy O'Neill
Director of Facilities & Infrastructure / Digital & eHealth Lead (Senior Supplier) (NHSFV)	Jonathan Proctor
Director of Place, Falkirk Council	Malcolm Bennie
Director of Finance (NHSFV)	Scott Urquhart
Director of Human Resources (NHSFV)	Linda Donaldson
Director of Nursing (NHSFV)	Angela Wallace
Medical Director (NHSFV)	Andrew Murray
Director of Public Health & Strategic Planning (NHSFV)	Graham Foster
Employee Director (NHSFV)	Robert Clark
Director W,C&SH Services	Gillian Morton
Chief Finance Officer, Falkirk HSCP	Jillian Thomson
Chief Finance Officer, Clacks & Stirling HSCP	Ewan Murray
Equality Advisor, (NHSFV)	Charlene Condeco
CVS Falkirk	Beverley Francis
Administration Support	TBC

6.4.4 The programme board will represent the wider interests of both the Primary Care Programme and the Falkirk Community Hospital site master planning work (out with this scope).

6.4.5 While the programme board will provide strategic leadership and oversee delivery, a project team has been established to manage the day-to-day detailed information and tasks required to brief and deliver the project.

6.4.6 The project team is responsible for:

- co-ordination of the work streams necessary to deliver the project;
- agreeing project plans and timescales and reporting on progress;
- ensuring appropriate governance;
- providing assurance to the programme Board;
- collaborating to ensure effective delivery;
- providing regular updates on project progress; and
- highlighting any risks or emerging issues quickly.

6.4.7 It is the overarching role of the project team to support the development of a Programme Initial Agreement (PIA) in line with the Scottish Capital Investment Manual (SCIM), to seek agreement and identify a preferred way forward.

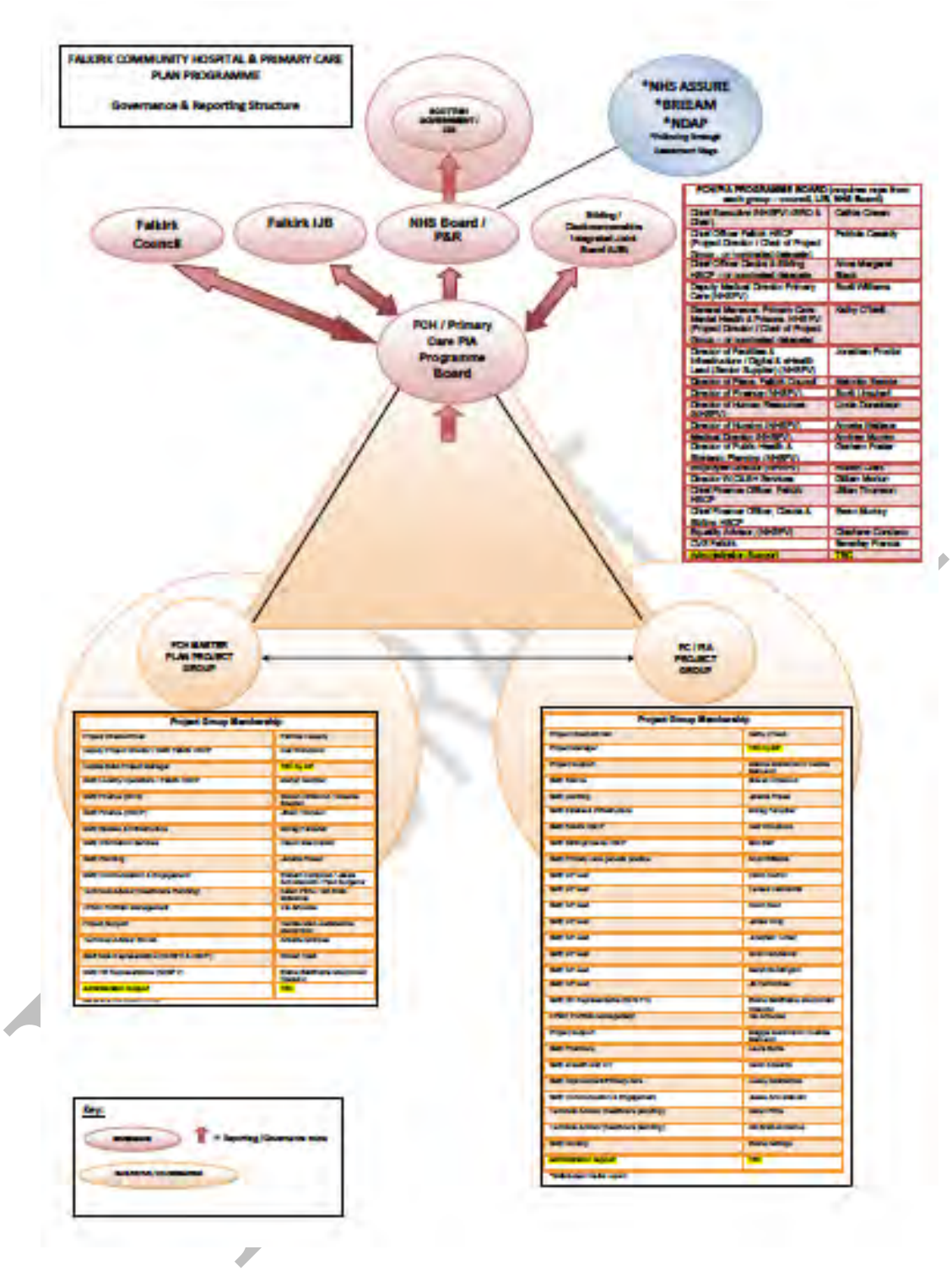
6.4.8 As the project develops, it will be supported by a project team which will be led by health care planning and technical planning/ capital project management. The Corporate Portfolio Management Office will provide support to the capital and health care planning project managers to establish and implement the programme/ project structure. It is noted that administration resources will need to be considered and agreed by the programme board to ensure the programme is fully co-ordinated and supported.

6.4.9 A series of subgroups will be established as required and identified in the Guide to Framework Scotland published by Health Facilities Scotland. These task teams will include Design User Group, Commercial, IM&T, Equipment, Commissioning and Public Involvement.

6.4.10 In relation to the appointment of the design team, this will be taken forward once there is an indication from the Scottish Government that funding will be made available to cover these costs.

6.4.11 The diagram below provides details of the proposed governance arrangements for both the Primary Care Programme and the Falkirk Community Hospital site master planning in Forth Valley which is progressing towards full implementation. The governance arrangements are joint between NHS Forth Valley and Falkirk Council and IJB, as well as involvement from Stirling and Clackmannanshire IJB. Approval will be obtained from each organisation at each stage of the development process.

Figure 6-3: Governance Arrangements



6.4.12 To support the organisation and facilitation of the programme. The Programme Board has the following duties:

- To be accountable for the success or failure of the programme;
- To provide unified direction to the Project Director/core project team;
- To provide the resources and authorise any funds required to progress the programme; and
- Decision making and approval of decision escalation to governance boards.

6.4.13 Co-ordination of the work streams necessary to deliver the project, agreeing project plans and timescales and reporting on progress; ensuring appropriate governance; providing assurance to the Programme Board; collaborating to ensure effective delivery; providing regular updates on project progress and highlighting any risks or emerging issues quickly.

6.4.14 When applicable, to support the development of a Programme Initial Agreement (PIA) in line with the Scottish Capital Investment Manual (SCIM) and to seek agreement and identify a preferred way forward.

6.4.15 The roles and responsibilities of project team as shown at **Appendix K.**

6.4.16 The latest project plan is shown below, with a detailed plan shown at **Appendix L.** Investment in Falkirk Central locality is assumed to be project 5; delivered as part of the of the Falkirk Community Hospital Masterplanning project.

Figure 6-4: Project Plan

Stage	Task	Assumed time	Indicative Date
Programme Initial Agreement Approvals Process	Project Team Approval	4 months	February 2022
	Programme Board Approval		22nd April 2022
	Falkirk Integration Joint Board		10th June 2022
	Clacks & Stirling Integration Joint Board		29th June 2022
	NHS Forth Valley Performance & Resources		26th April 2022
	NHS Forth Valley Board		31st May 2022
	Capital Investment Group		Submission 18th May 2022 for 29th June 2022 meeting
Outline Business Case Development & approval	Project 1	6 months each; 4-month approval. Project 5: Initial Agreement May-22 to May-24. OBC thereafter; assumed 12 months.	September 2022 –June 2023
	Project 2		February 2023-November 2023
	Project 3		July 2023-April 2024
	Project 4		December 2023-September 2024
	Project 5: Assumed Falkirk Central		July 2023-July 2024
Full Business Case Development & approvals	Project 1	6months each; 4 month approval. Project 5 assumed 9 months; 4 months approval	August 2023- May2024
	Project 2		January 2024-October 2024
	Project 3		June 2024-March 2025
	Project 4		November 2024-August 2025
	Project 5		August 2024-September 2025
Construction & commissioning	Project 1	18 months build; 3 months commissioning	June 2024 – April 2026
	Project 2		November 2024 - September 2026
	Project 3		April 2025 - February 2027
	Project 4		September 2025 – July 2027

	Project 5: Falkirk Central		**October 2025-December 2027**
Operational	**Project 1**	**1 month from commissioning**	**May 2026**
	Project 2		**October 2026**
	Project 3		**March 2027**
	Project 4		**August 2027**
	Project 5: Falkirk Central		**January 2028**

6.4.17 The current programme plan assumes consecutive delivery at each stage, however, there may be an opportunity to run some elements concurrently. This will be reviewed as part the programme planning supporting the Outline Business Case delivery.

Addressing Code of Practice

6.4.18 The Code of Practice is one of the drivers for this programme of investment. This Code will see the shift in ownership from GP partners to the NHS over the next 25 years. As part of the Outline Business Case, when considering how the preferred service model will be delivered and the bearing on current premises, the implications of the Code of Practice for both practices directly impacted by this programme of investment and those which are not will be outlined. In addition, further information will be presented about how the full implications of the Code of Practice will be met within NHS Forth Valley.

7 CONCLUSION

7.1 Is this proposal still important?

7.1.1 This document has set out the overarching Programme of investment within Primary Care across NHS Forth Valley. It is a key enabler to the full delivery of the new GMS contract and the Primary Care Improvement Plan.

7.1.2 The delivery of this programme of investment; confirms the Strategic Assessment intent (shown at **Appendix M**).

7.1.3 In taking forward the Outline Business Case it is anticipated this will take the form of locality-based business cases; totalling four. No capital investment was identified within rural Stirling locality and the Falkirk Central locality requirements will be addressed within the Falkirk Masterplanning project. This will maximise the linkages between services and integration with locality-based planning principles. Links are already initiated in some areas regarding the potential for collaborative investment in line with place based principles.

7.1.4 A prioritisation exercise has been carried out to determine the order of locality based Outline Business Case (described in **Appendix N**). This considered a number of measurable criteria and resulted in the following proposed programme.

1. Stirling city with the eastern villages, Bridge of Allan & Dunblane Locality
2. Falkirk East Locality
3. Clackmannanshire Locality
4. Falkirk West Locality

FORTH VALLEY NHS BOARD
TUESDAY 31 MAY 2022

7.1 Healthcare Associated Infection Reporting Template
For Assurance

Executive Sponsor: Gillian Morton, HAI Executive Lead

Author: Mr Jonathan Horwood, Area Infection Control Manager

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.

Recommendation:
The NHS Board is asked to:
- **note** the HAIRT report
- **note** the performance in respect of the AOP Standards for SABs, DABs, CDIs & ECBs
- **note** the detailed activity in support of the prevention and control of Health Associated Infection

Key Issues to be Considered:
- Total SABS remain within control limits. There were two hospital acquired SABs in April.
- Total DABs remain within control limits. There were two hospital acquired DABs in April.
- Total CDIs remain within normal control limits. There was one hospital acquired CDI in April.
- Total ECBs remain within normal control limits. There were three hospital acquired ECBs in April.
- There have been no deaths with MRSA or *C.difficile* recorded on the death certificate.
- There was one breast surgical site infection in April.
- There was one outbreak reported in April.

Financial Implications
None

Workforce Implications
None

Risk Assessment
Work is on trajectory to reduce all reducible SABs, DABs, ECBs and CDI infections across NHSFV to meet both national and local standards/expectations.

Relevance to Strategic Priorities
AOP Standards in respect of SABs, ECBs, DABs & CDIs

- *Staph aureus* bacteraemia (SABs)
  There were 5 SABs this month. The AOP target has now been extended to March 2023
- Clostridioides difficile infection (CDIs)
- There was 1 CDI this month. The AOP target has now been extended to March 2023 Escherichia coli bacteraemias (ECBs)
- There were 11 ECBs this month. The AOP target has now been extended to March 2023 Device associated bacteraemias (DABs)
  There were 6 DABs this month. DABs remain within control limits.

Equality Declaration

The author can confirm that due regard has been given to the Equality Act 2010 and compliance with the three aims of the Equality Duty as part of the decision making process.

Further to an evaluation it is noted that:

- Paper is not relevant to Equality and Diversity

Consultation Process

Infection Prevention and Control Team

Healthcare Associated Infection Reporting Template (HAIRT)

April 2022

NHS Forth Valley

Infection Prevention & Control Team

HAI Summary

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.

SUMMARY FOR THIS MONTH

- COVID-19 inpatient numbers have remained relatively stable this month. There was one reported outbreak of Covid this month, Ward A12 FVRH.
- Extension to AOP targets to March 2023. The CNO has confirmed the extension of the AOP targets to March 2023 due to the additional pressures of the pandemic over the last two years. At a national level no targets have not been met.

Performance at a glance

	Total No of Cases	Month RAG status			
Staphylococcus aureus bacteraemia (SABs)	**5**				
Clostridioides difficile infection (CDIs)	**1**				
Escherichia coli Bacteraemia (ECB)	**11**				
Device associated bacteraemia (DABs)	**6**				
Hand Hygiene (SPSP)	**99%**				
National Cleaning compliance (Board wide)	**95%**				
National Estates compliance (Board wide)	**95%**				
Surgical Site Infection Surveillance (SSIS)	**1**				

Key infection control challenges (relating to performance)

<u>*Staph aureus* bacteraemia</u>

- There were two hospital acquired SABs this month.
- There were three healthcare acquired SABs this month.
- Total SAB case numbers remained within control limits this month.

<u>Device associated bacteraemia</u>

- There were two hospital acquired DABs this month.
- There were three healthcare acquired DABs this month.
- There was one nursing home acquired DAB this month.
- Total DAB case numbers remained within control limits this month.

<u>*E coli* bacteraemia</u>

- There were three hospital acquired ECBs this month.
- There were seven healthcare acquired ECBs this month.
- There was one nursing home acquired ECB this month.
- Total ECBs case remained within control limits this month.

<u>*Clostridioides difficile* infection</u>

- There was one hospital acquired CDI this month.
- CDI case numbers remain within control limits this month.

<u>Surgical site infection surveillance</u>

- There was one surgical site infections reported this month.

Key HAI related activities

- There were no MRSA or *C. difficile* recorded deaths reported this month.

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
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 ie 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

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. The target was a national reduction rather than a board specific reduction, however the latest target set for 2019-2022 are board specific, based on our current infection rates.

NHS Forth Valley's approach to SAB prevention and reduction

All *Staph aureus* bacteraemia are monitored and reported by the IPCT. Investigations to the cause of infection consist of examining the patients notes, microbiology, biochemistry and haematology reports to identify potential causes of the infection; from this, in most cases, a provisional cause is identified, however this is discussed further with the clinical team responsible for the management of the patient to assist further with the investigation. Any issues identified during the investigations, such as incomplete bundle completion etc is highlighted at this time and where appropriate an IR1 is reported. Once a conclusion has been agreed, the investigations are presented to the Infection Control Doctor/Microbiologist for approval. The investigation is concluded with the IPCT reporting their findings to the clinical team and management.

This data is entered into the IPCT database collated, analysed and reported on a monthly basis. The analysis of the data enables the IPCT to identify trends in particular sources of infections, such as Hickman line infections etc and identifying areas requiring further support. The data also influences the direction of the HAI annual workplan.

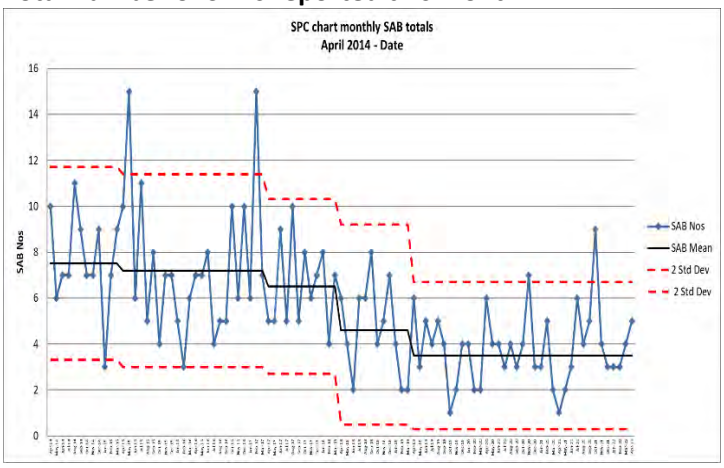
April 2022

Monthly Total	**5**
Hospital	2
Healthcare	3
Nursing Home	0

RAG Status *- Green denotes monthly case numbers are less than the mean monthly SAB totals. Amber denotes when monthly case numbers are above the mean monthly SAB totals but less than two standard deviations from the mean. Red denotes monthly case numbers are above two standard deviations from the monthly mean.*

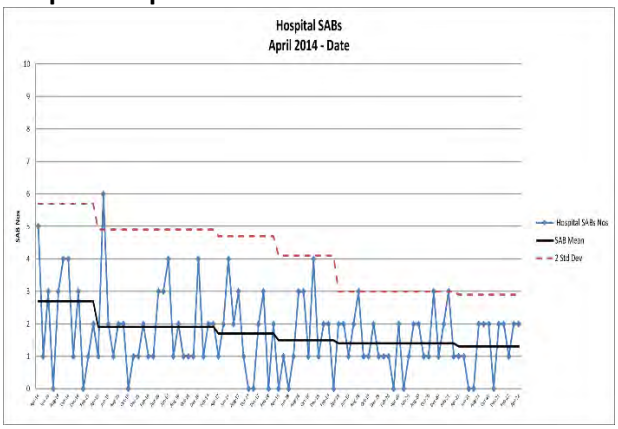
Staph aureus bacteraemia total - April 22 to date – 5

Total number of SABs reported this month



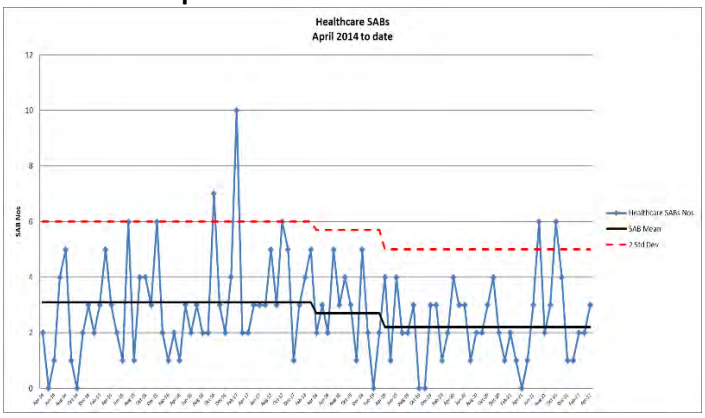
Comments: Case numbers remain within control limits this month. No concerns to raise.

Hospital Acquired SABs



Comments: Case numbers remain within control limits this month. The last 12 months has seen a very slight statistical improvement and is reflected in the above graph.

Healthcare Acquired SABs



Comments: Case numbers remain within control limits this month. No concerns to raise.

Breakdown

Source	No. of infections
Healthcare	**3**
Cellulitis	1
Ulcer	1
Wound	1
Hospital	**2**
PVC	
B21/22	1
Unknown	
No attributed ward	1
Grand Total	**5**

There were 534 blood cultures taken this month, of those there were in total 5 blood cultures that grew *Staph aureus*. This accounts for 0.9% of all blood cultures taken this month. There were two hospital acquired SABs this month, this accounts for 0.4% of all blood cultures.

There were two hospital SABs reported this month:

- Unknown - No source of infection identified. Blood cultures taken as part of seizure pathway.
- PVC - documentation incomplete prior to infection.

Directorate reports and graphs can be accessed using the following link:
https://staffnet.fv.scot.nhs.uk/infection-control/monthly-ward-reports/

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.

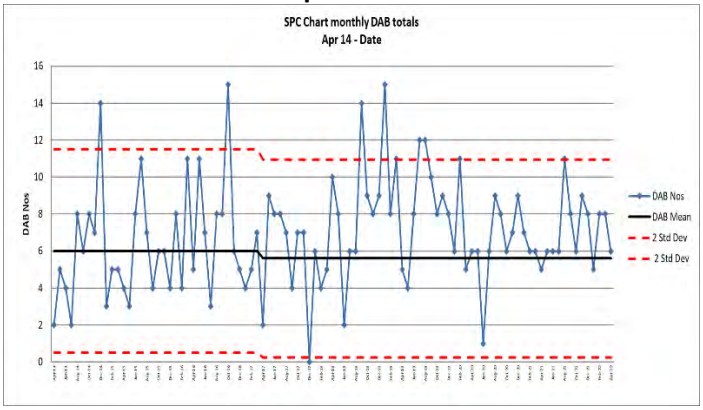
April 2022

Monthly Total	6
Hospital	2
Healthcare	3
Nursing Home	1

RAG Status *- Green denotes monthly case numbers are less than the mean monthly CDI totals. Amber denotes when monthly case numbers are above the monthly mean but less than two standard deviations from the monthly mean. Red denotes monthly case numbers are above two standard deviations from the monthly mean.*

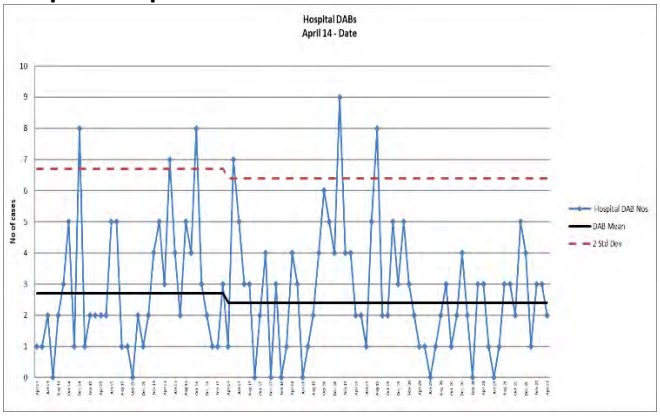
Device associated bacteraemia total – April 22 to date - 6

Total number of DABs reported this month



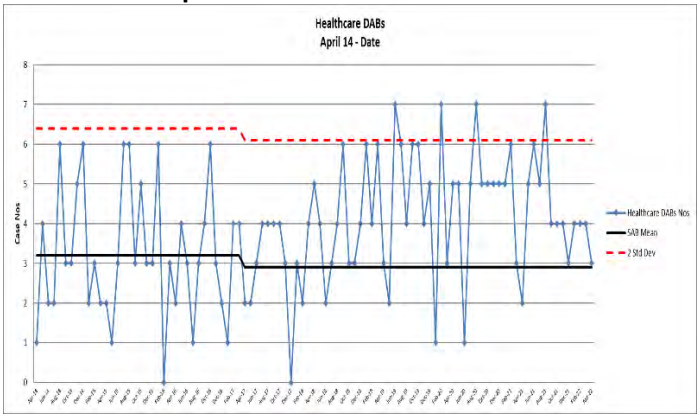
Comments:
Case numbers remain within control limits, no concerns to raise.

Hospital Acquired DABs



Comments:
Case numbers remain within control limits, no concerns to raise.

Healthcare Acquired DABs



Comments:
Case numbers remain within control limits, no concerns to raise.

Breakdown

Source	No. of infections
Healthcare	**3**
Urinary Catheter long term	3
Hospital	**2**
PVC	
B21/22	1
Urinary Catheter long term	
No attributed ward	1
Nursing home	**1**
Urinary Catheter long term	1
Grand Total	**6**

There were 534 blood cultures taken this month, of those there were in total 7 blood cultures that were associated with devices. This accounts for 1.1% of all blood cultures taken this month. There were two hospital acquired DABs this month, this accounts for 0.4% of all blood cultures taken this month.

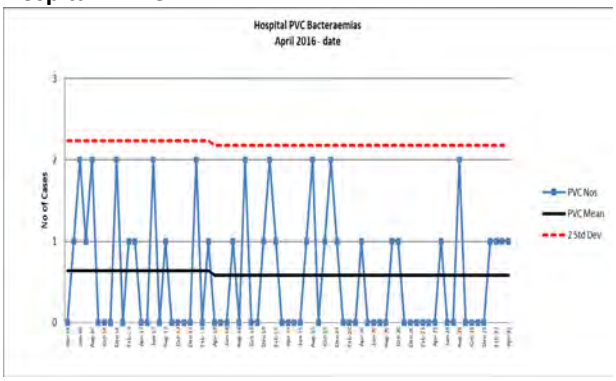
Hospital DABs

- UCLT - infection developed due to retention and urinary catheter insertion. No ward was attributed as documentation was fully completed prior to infection.
- PVC - documentation incomplete prior to infection.

Directorate reports and graphs can be accessed using the following link:
https://staffnet.fv.scot.nhs.uk/infection-control/monthly-ward-reports/

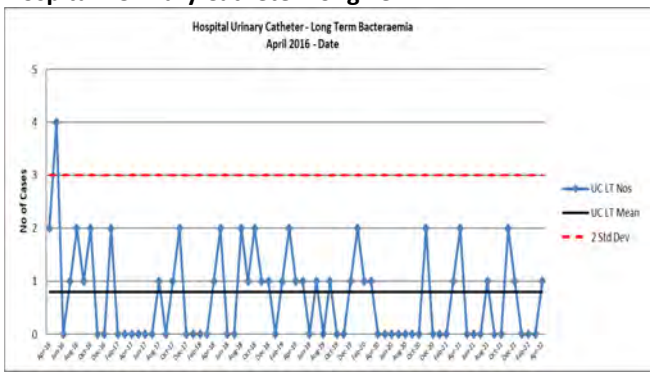
The graphs below provide an overview of the number of device associated bacteraemias, however, it doesn't provide sufficient detail of the individual device and whether the number of infections have exceeded control limits. Below are graphs relevant to the identified devices for this month.

Hospital – PVC



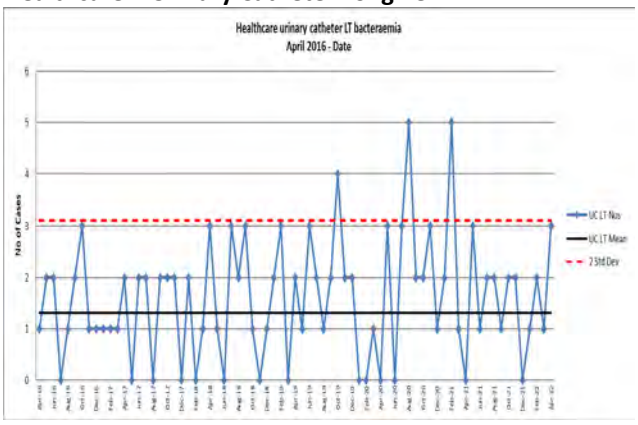
Comments: case numbers remain within control limits, no concerns to raise.

Hospital –Urinary Catheter Long Term



Comments: case numbers remain within control limits, no concerns to raise.

Healthcare – Urinary Catheter Long Term



Comments: case numbers remain within control limits, no concerns to raise.

Escherichia coli Bacteraemia (ECB)

NHS Forth Valley's approach to ECB prevention and reduction

E coli is one of the most predominant organism 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. As a result of this, the HAI Policy Unit has now included E coli as part of the AOP targets. 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.

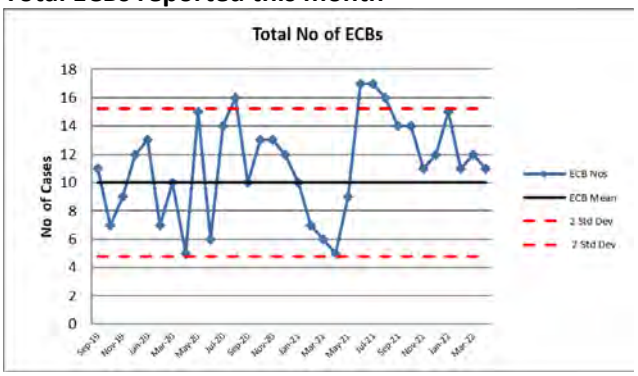
In NHS FV, device associated bacteraemias (DABs) surveillance has been ongoing since 2014 and have seen a reduction in urinary catheter bacteraemias over the years including Ecoli associated infections and will hope to continue to reduce so to achieve our target for 2022.

April 2022

Monthly Total	11
Hospital	3
Healthcare	7
Nursing Home	1

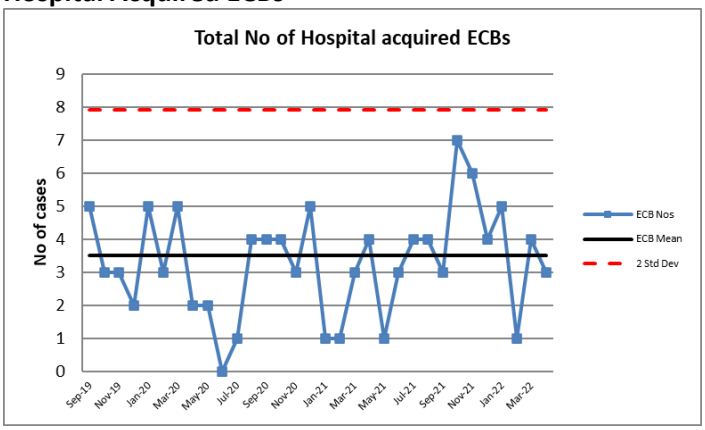
E coli bacteraemia infection total – April 22 to date - 11

Total ECBs reported this month



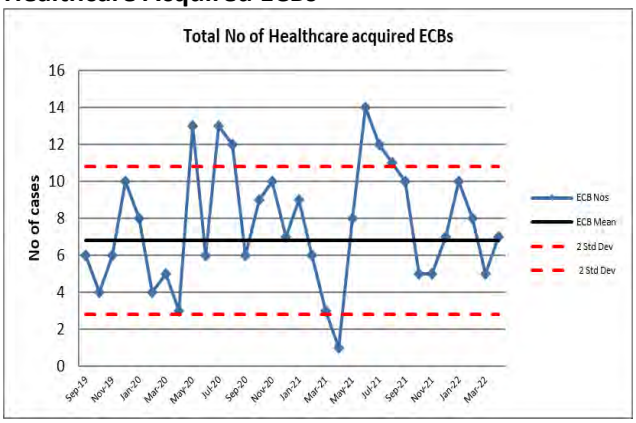
Comments: case numbers remain within control limits, no concerns to raise.

Hospital Acquired ECBs



Comments: case numbers remain within control limits, no concerns to raise.

Healthcare Acquired ECBs



Comments: case numbers remain within control limits, no concerns to raise.

Breakdown

Source	No. of infections
Healthcare	**7**
Biliary tract	1
Respiratory tract	1
Urinary Catheter long term	3
UTI	2
Hospital	**3**
Unknown	
No attributed ward	1
Urinary Catheter long term	
No attributed ward	1
Urinary Catheter short term	
No attributed ward	1
Nursing home	**1**
Urinary Catheter long term	**1**
Grand Total	**11**

There were 534 blood cultures taken this month, of those there were in total 11 blood cultures that grew *E. coli*. This accounts for 2.1% of all blood cultures taken this month. Hospital ECBs accounted for 0.6% of all blood cultures taken.

Hospital ECBs

- UCLT - infection developed due to retention and urinary catheter insertion. No ward was attributed as documentation was fully completed prior to infection.
- Unknown - no cause of infection identified.
- UCST - Developed urosepsis following TWOC. All documentation completed.

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. Similar to the SAB target, the new target set for 2019-2022 is based on Forth Valley's rate rather than an overall national rate.

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

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.

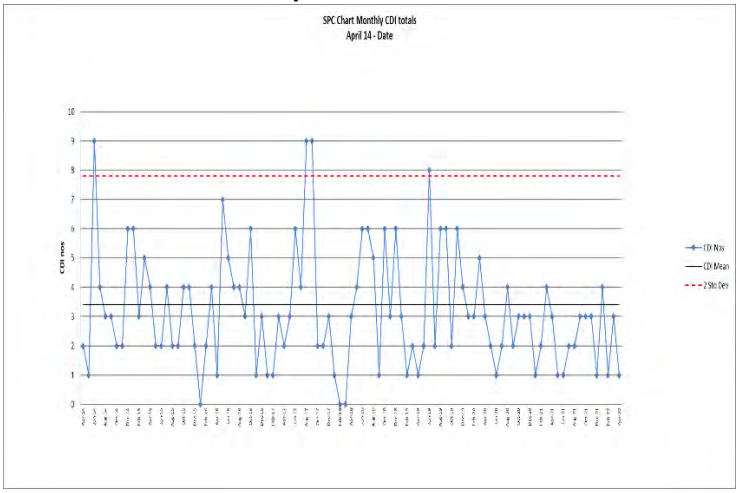
April 2022

Monthly Total	**1**
Hospital	1
Healthcare	0
Nursing Home	0

RAG Status *- Green denotes monthly case numbers are less than the mean monthly CDI totals. Amber denotes when monthly case numbers are above the monthly mean but less than two standard deviations from the monthly mean. Red denotes monthly case numbers are above two standard deviations from the monthly mean.*

Clostridioides difficile **infection total – April 22 to date – 1**

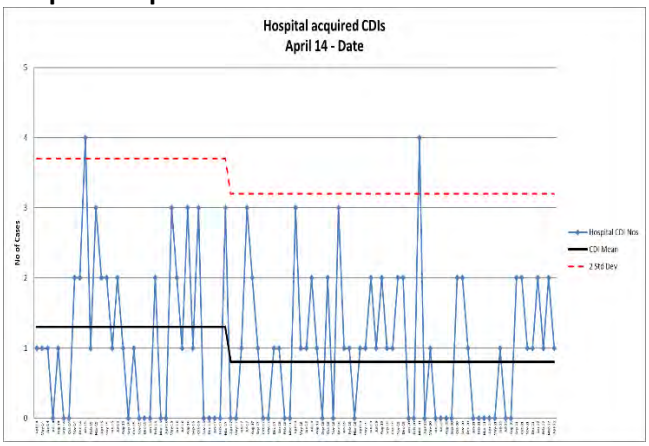
Total number of CDIs reported this month



Comments:

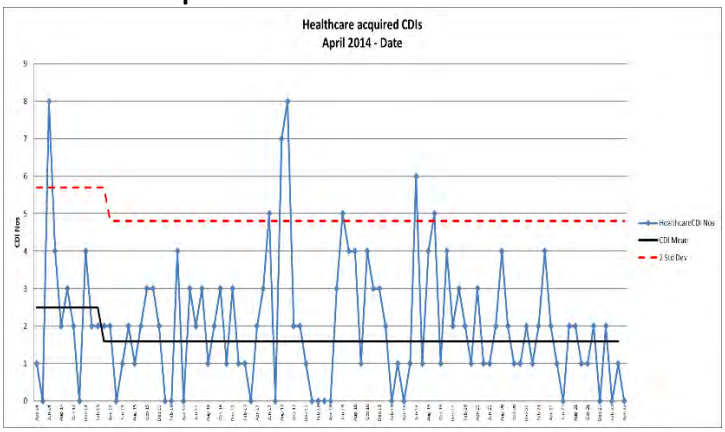
Case numbers remain within control limits, no concerns to raise.

Hospital Acquired CDIs



Comments:
Case numbers remain within control limits, no concerns to raise.

Healthcare Acquired CDIs



Comments:
Case numbers remain within control limits, no concerns to raise.

Breakdown

Source	No. of infections
Hospital	**1**
No attributed ward	
Grand Total	**1**

Hospital CDIs:

- No attributed ward – CDI developed following appropriate antimicrobial therapy.

Directorate reports and graphs can be accessed using the following link:
https://staffnet.fv.scot.nhs.uk/infection-control/monthly-ward-reports/

AOP TARGETS

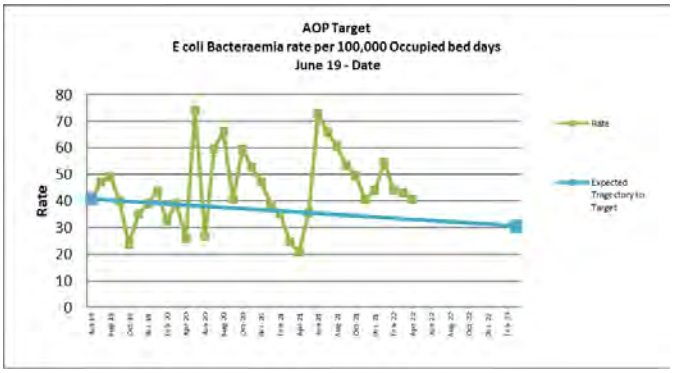
HAI AOP targets for 2019-2023

On the 10th October 2019, a letter was sent to all Health Board Chief Executives highlighting our new HAI targets. These targets are based on our (Forth Valley) current rates of infection and a percentage reduction has been set to be achieved by March 2022. This target is different from our previous targets and includes the reduction in hospital and healthcare acquired infections and does not include community acquired. Hospital and healthcare acquired infections are now classified as healthcare infections as it is perceived nationally that all hospital and healthcare infections are all reducible. For continuity, we will continue to report separately hospital and healthcare infections to maintain our quality and transparency in our data, however, the total number of infections will reflect on what we report nationally and in line with our set target. In addition to SABs and CDIs targets, *Escherichia coli* bacteraemia (ECB) is now included in our targets.

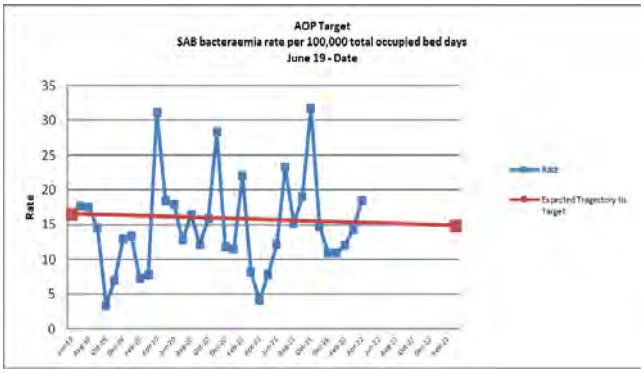
The table below highlights the targets for 2023 and the graphs below highlight progress towards these targets:

	2018/19 Rate (base line) per 100,000 total bed days	No of cases (per annum)	Reduction %	Date for reduction	Target rate per 100,000 total bed days	Target cases per annum
ECB	40.8	135	25	2023	30.6	101
SAB	16.6	55	10	2023	14.9	50
CDI	11.4	38	10	2023	10.3	34

AOP target progress to date



Comments: Infection rate has decreased this month



Comments: Infection rate has increased slightly this month.

Comments: Infection rate have decreased this month

Target Organism	Target Rate (per 100,000 total bed days)	Current Rate April 22 - date (per 100,000 total bed days)	Status
ECB	30.6	40.7	Above trajectory
SAB	14.9	18.5	On trajectory
CDI	10.3	3.7	On trajectory

Extension to AOP targets to March 2023

The CNO has confirmed the extension of the AOP targets to March 2023 due to the additional pressures of the pandemic over the last two years.

Surgical Site Infection Surveillance (SSIS)

Surgical site infection surveillance is the monitoring and detection of infections associated with a surgical procedure. In Forth Valley, the procedures include, hip arthroplasty, Caesarean section, abdominal hysterectomy, major vascular surgery, large bowel, knee arthroplasty and breast surgeries. We monitor patients for 30 days post surgery including any microbiological investigations from the ward/GP for potential infections and also hospital readmissions relating to their surgery. Any infection associated with a surgical procedure is reported nationally to enable board to board comparison. NHS Forth Valley infection rates are comparable to national infection rates.

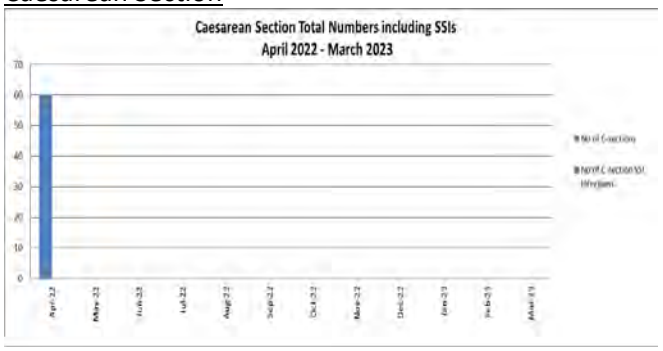
NHS Forth Valley's approach to SSI prevention and reduction

Surgical site infection criteria is determined using the European Centre for Disease Control (ECDC) definitions. Any infection identified is investigated fully and information gathered including the patients 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.

Breakdown

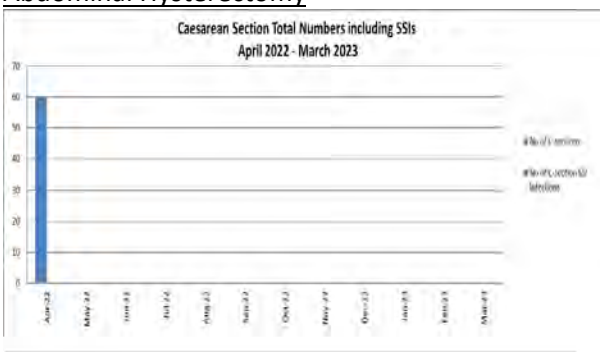
Procedure	Confirmed SSI
Abdominal Hysterectomy (v)	0
Breast Surgery (v)	1
Caesarean Section (m)	0
Knee Arthroplasty (v)	0
Hip Arthroplasty (m)	0
Major Vascular Surgery (m)	0
Large Bowel Surgery (m)	0

Caesarean Section



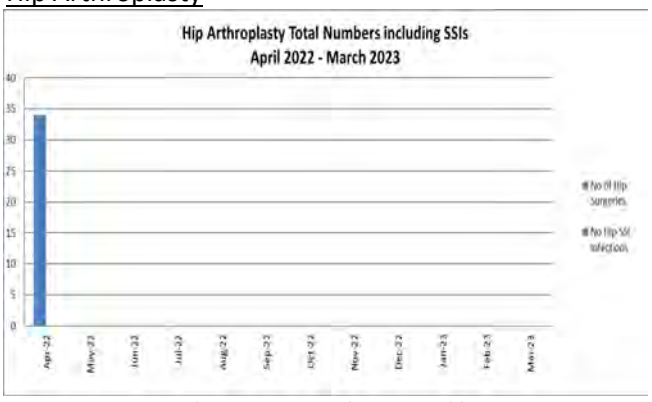
Comments: case numbers remain within control limits, no concerns to raise.

Abdominal Hysterectomy



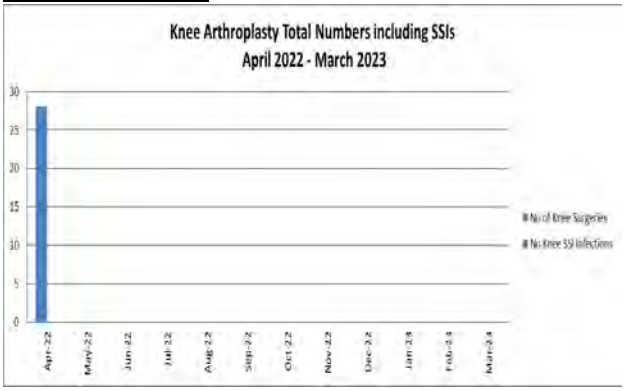
Comments: case numbers remain within control limits, no concerns to raise.

Hip Arthroplasty



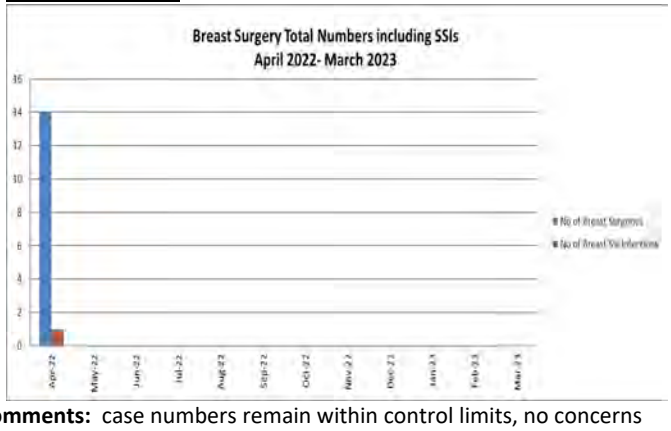
Comments: case numbers remain within control limits, no concerns to raise.

Knee Arthoplasty

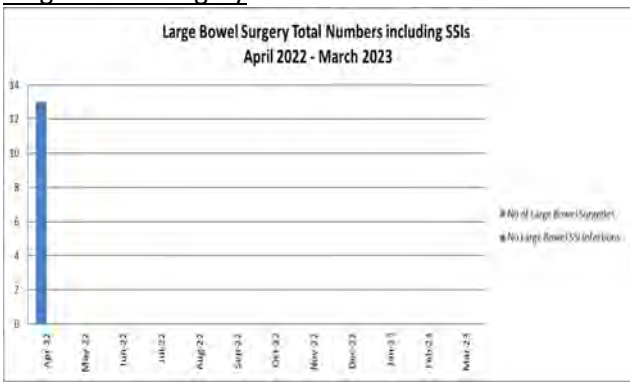


Comments: case numbers remain within control limits, no concerns to raise.

Breast Surgery



Comments: case numbers remain within control limits, no concerns to raise.

Large Bowel Surgery  **Comments:** case numbers remain within control limits, no concerns to raise.	National surveillance reporting has been suspended due to COVID-19. It is planned for national reporting to be reinstated in October 2022 following national review.

Meticillin resistant Staphylococcus aureus (MRSA) & Clostridioides difficile recorded deaths

The National Records of Scotland monitor and report on a variety of deaths recorded on the death certificate. Two organisms are monitored and reported, MRSA and *C. difficile*. Please click on the link below for further information:

https://www.nrscotland.gov.uk/statistics-and-data/statistics/statistics-by-theme/vital-events/deaths

This month, there were no C. difficile or MRSA recorded deaths reported this month.

SPSP Hand Hygiene Monitoring Compliance (%) Board wide

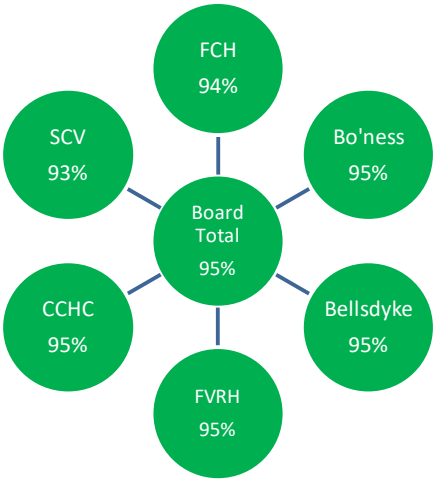
Data taken from TCAB (self reported by ward staff)

	May 2021	June 2021	July 2021	Aug 2021	Sept 2021	Oct 2021	Nov 2021	Dec 2021	Jan 2022	Feb 2022	Mar 2022	Apr 2021
Board Total	99	99	98	99	98	98	98	98	99	98	98	99

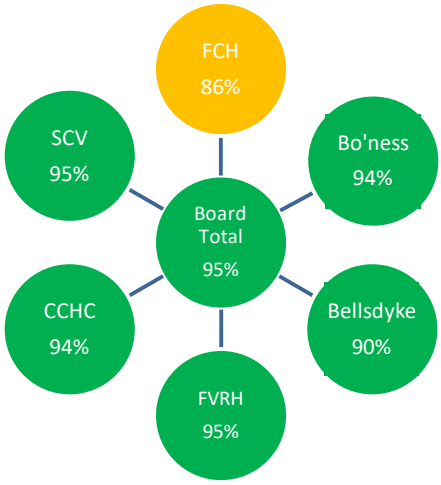
Estate and Cleaning Compliance (per hospital)

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.

Estates & Cleaning Scores January – March 2022 (next published report July 2022)



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

Bellsdyke Hospital & Falkirk Community Hospital Estate Scores

This quarter, the estate score from Bellsdyke Hospital has improved from last quarter to 90%. Falkirk Community Hospital has slightly decreased this quarter compared to the previous quarter of 89%. The remaining hospital sites have remained stable compared to the last quarter.

Ward Visit Programme

Below are table and graphs detailing the non-compliances identified during the ward visits.

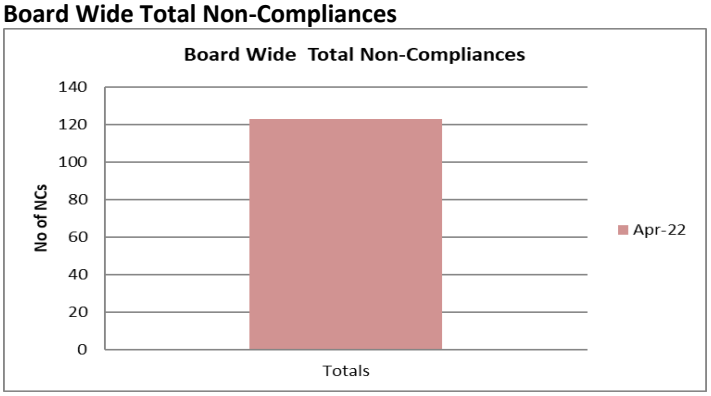
	Patient Placement	Hand Hygiene	PPE	Managing Patient Care Equipment	Control of the Environment	Safe Management of Linen	Safe Disposal of Waste	Totals
Acute Services	11	3	12	32	31	13	11	113
Primary Care & Mental Health Services	0	0	1	1	3	2	0	7
WC&SH Directorate	1	0	1	1	0	0	0	3
Totals	11	3	13	33	34	15	11	**123**

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.

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.

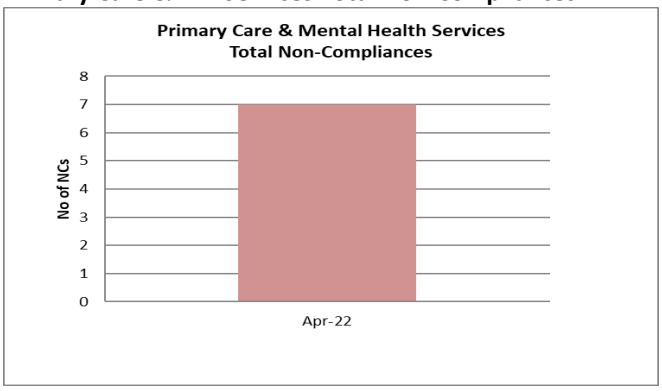
The predominant non-compliance reported this month was Control of the Environment category; non-compliances included area not free from clutter, area not well maintained and in good state of repair, inappropriate items in clinical area (i.e. staff belongings / coffee cups) and area does not appear to be clean. All non-compliances were highlighted to the nurse in charge at the time of audit and any equipment with cleanliness issues was rectified immediately. Other non-compliances such as Managing Patient Care Equipment, non-compliances included indicator tape /label missing, equipment visibly dirty, equipment dusty and items stored inappropriately.

Board Wide Total Non-Compliances

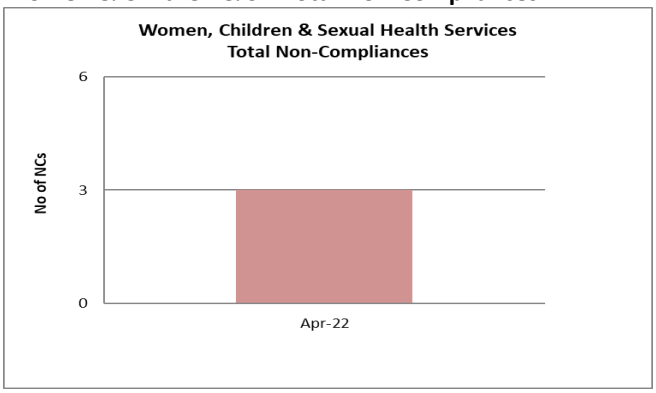


Acute Services Total Non-Compliances

Primary Care & MH Services Total Non-Compliances



Women & Children & SH Total Non-Compliances



Incidence / Outbreaks

All outbreaks are notified to Health Protection Scotland and Scottish Government (see below for further details).

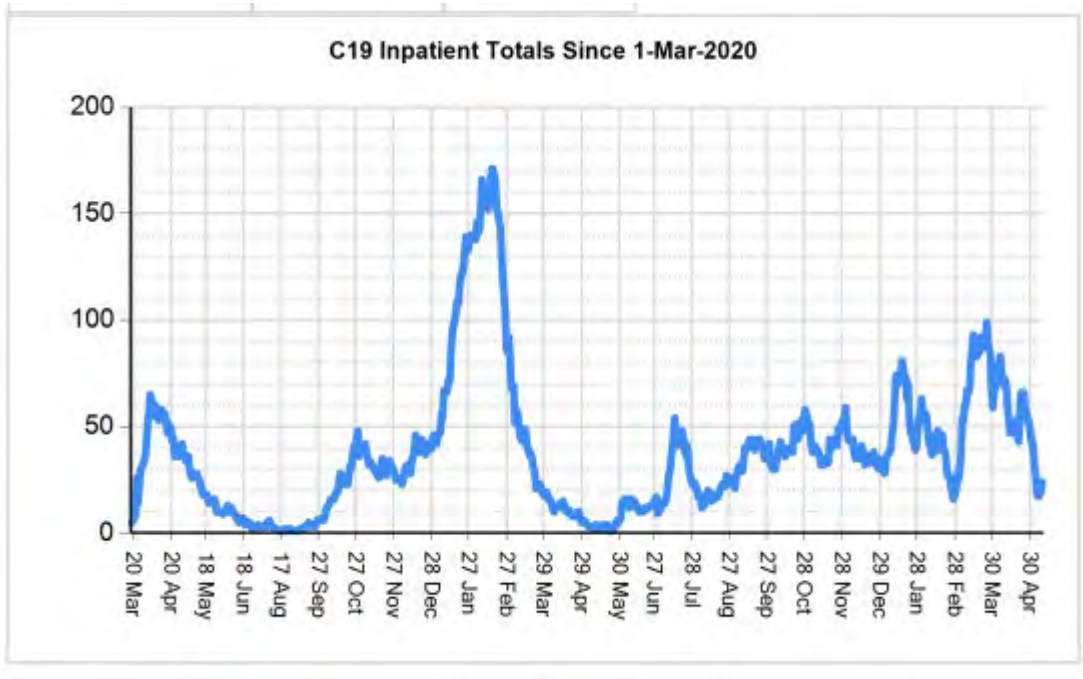
Healthcare Acquired Infection Incident Template (HAIIT)
The HAIIT is a tool used by boards to assess the impact of an incident or outbreak. The tool is a risk assessment and allows boards to rate the incident/outbreak as a red, amber, or green. The tool also directs boards whether to inform ARHAI Scotland/SG of the incident (if amber or red), release a media statement etc.

There was one COVID-19 outbreak reported this month:

Ward	No of patients affected
Ward A12 FVRH	16

Note: symptoms of patients affected during the outbreaks were generally very mild or had no symptoms at all

COVID-19
Covid-19 admissions and overall inpatient numbers in April have remained relatively stable throughout the month. See graph below of the inpatient case numbers.



On a weekly basis Health Protection Scotland publish infection figures based on electronic data submitted to them on the rate of COVID-19 infection that has been acquired during the patients hospital stay. This is calculated solely based on the time the patient was admitted to the hospital and the incubation period of COVID-19 (14 days). For example, if a patient stay has exceeded 14 days and became COVID-19 positive after day 14 then it is determined to be hospital acquired. Based on purely on admission times does not necessarily mean hospital acquired, however, these are the limitations of the data and the report. NHS Forth Valley's rate for hospital onset COVID is currently 0.3%.

Table 1: Number of COVID-19 cases, by onset status and NHS board: specimen dates up to 10 April 2022.[1,2,3,4]

NHS board	Total COVID-19 cases (n)	Non-hospital onset (n)	Indeterminate hospital onset cases (n)	Probable hospital onset cases (n)	Definite hospital onset cases (n)	Non-hospital onset (%)	Indeterminate hospital onset cases (%)	Probable hospital onset cases (%)	Definite hospital onset cases (%)
Ayrshire & Arran	132,830	1,851	268	431	883	1.4%	0.2%	0.3%	0.7%
Borders	30,676	194	57	56	141	0.6%	0.2%	0.2%	0.5%
Dumfries & Galloway	42,253	600	58	25	90	1.4%	0.1%	0.1%	0.2%
Fife	121,730	1,127	126	99	488	0.9%	0.1%	0.1%	0.4%
Forth Valley	109,422	1,405	155	128	371	1.3%	0.1%	0.1%	0.3%
Golden Jubilee	67	37	16	6	8	-	-	-	-
Grampian	170,024	1,232	148	146	467	0.7%	0.1%	0.1%	0.3%
Greater Glasgow & Clyde	442,761	4,867	1,015	1,057	2,575	1.1%	0.2%	0.2%	0.6%
Highland	87,698	615	56	42	187	0.7%	0.1%	0.0%	0.2%
Lanarkshire	260,892	1,788	507	499	983	0.7%	0.2%	0.2%	0.4%
Lothian	308,757	2,783	456	556	1,278	0.9%	0.1%	0.2%	0.4%
Orkney	4,919	27	1	1	5	0.5%	0.0%	0.0%	0.1%
Shetland	6,065	30	2	1	1	0.5%	0.0%	0.0%	0.0%
Tayside	130,984	1,789	222	266	602	1.4%	0.2%	0.2%	0.5%
Western Isles	6,999	43	3	5	14	0.6%	0.0%	0.1%	0.2%
Scotland	**1,856,077**	**18,388**	**3,090**	**3,318**	**8,093**	**1.0%**	**0.2%**	**0.2%**	**0.4%**

IPCT support to Care Homes

The Care Assurance Team is responsible for care homes in providing support, education and oversight. The Care Assurance Team assess nursing care to residents at care homes and provides advice and guidance to staff in minimising the risk of transmission of COVID-19. Two members of the IPCT now provide specialist expertise to the team and to care homes.

Over this last quarter formal outbreaks have fallen giving rise to the Care Assurance Team to provide a proactive supportive function in relation to general nursing care and infection prevention and control. The IPC Gold standard tool, a supportive document to enable care homes to main IPC standards is currently being rolled out across care homes.

New National IPC Standards

Following the consultation period of the new IPC Standards, the publication of the standards is expected in May 2022. The Care Inspectorate is anticipated to manage this rollout, however, the current IPC support within the Care Assurance Team will also provide advice and guidance to care homes going forward.

FORTH VALLEY NHS BOARD
TUESDAY 31 MAY 2022

7.2 Recovery & Performance Scorecard
For Assurance

Executive Sponsor: Mrs Cathie Cowan, Chief Executive

Author: Ms Kerry Mackenzie, Head of Policy & Performance; Claire Giddings, Corporate Performance Manager

---

Executive Summary

The overall approach to performance within NHS Forth Valley underlines the principle that performance management is integral to the delivery of quality improvement and core to sound management, governance, and accountability. The Recovery & Performance Scorecard is presented to provide the NHS Board with key performance information to support effective monitoring of system-wide performance.

Recommendation

The Forth Valley NHS Board is asked to:

- **note** the current key performance issues
- **note** the detail within the Recovery & Performance Scorecard

Key Issues to be Considered

The Recovery & Performance Scorecard considers our System-Wide Remobilisation Plan which sets out how we safely continue the resumption of services whilst taking account of the different ways in which we have been working during the pandemic and considers the ongoing impact as we move forward. Additionally, there is a focus on establishing more of a 'norm' going forward with the inclusion of monthly key performance measures.

The scorecard format has been developed to provides a comprehensive 'at a glance' view of measures. Work is on-going to ensure accuracy of data, that all the definitions and reporting periods remain appropriate and meaningful, and that suggested additions are included where possible. A further review will be scheduled later in the year.

The scorecard is circulated to the System Leadership Team (SLT) and the Non-Executive Directors of the Board on a weekly basis with a full monthly update presented to the NHS Board and Performance & Resources Committee.

Scorecard format

- Notes have been included describing the scorecard headings and providing definitions and detail in relation to the indicators and targets
- The scorecard is split by Recovery Measures, Key Performance Measures, and Response Measures with associated graphs/run charts where relevant
- The majority of Recovery and Response measures are reported on a weekly basis
- Key Performance Measures, which include the eight key standards that are most important to patients, are designed to support the overall recovery position and provide a month on month progress overview

- The eight key standards are: 12 week outpatient target, Diagnostics, 12 week treatment time guarantee, cancer targets, access to Psychological Therapies, access to Child & Adolescent Mental Health Services and Accident & Emergency 4-hour wait

- Where a Forth Valley wide measure is reported any areas of challenging performance within a specialty will be highlighted in the narrative
- Measures, Graphs and Key Performance Issues narrative are linked and should be viewed collectively
- Work is still being undertaken to establish detailed data in respect of clinic utilisation
- Work is on-going to include additional information in terms of the Scotland comparison where possible. This is being developed in the Pentana Risk Performance System and will be highlighted at the Performance & Resources Committee in June 2022

Key Performance Issues

- ***Unscheduled Care***

Overall compliance with the 4 hour target in April 2022 was 66.3%; Minor Injuries Unit 99.5%, Emergency Department 53.0%. A total of 2,313 patients waited longer than the 4 hour target across both the ED and Minor Injuries Unit (MIU); with 512 waits longer than eight hours and 93 waits longer than 12 hours. The main reason for patients waiting beyond 4 hours continues to be wait for first assessment with a cohort of 1,518 patients, an increase from 1416 in March. Note that this continues to be as a result of issues in relation to flow through the system and system-wide pressures.

- ***Scheduled Care***

At the end of April 2022, 60.8% of patients were waiting less than 12 weeks for a first appointment; this is better than the previous month. Activity against the agreed Remobilisation Plan trajectory highlights the cumulative position for Financial Year 2021/2022 as 97% compliance.

In April 2022, the number of inpatients/daycases waiting decreased to 3,859 from 3,921 with an increase in those waiting beyond 12 weeks to 1,860 from 1,649. Activity against the agreed Remobilisation Plan trajectory highlights the position for Financial Year 2021/2022 as 83% compliance.

At the end of April 2022: 2861 patients were waiting beyond 6 weeks for imaging with 54.6% compliance; 188 patients were waiting beyond 6 weeks for endoscopy with an improvement to 61.2% compliance.

Cancer target compliance in March 2022:

- 62-day target – 71.2% which is an improvement in performance from the February position of 70.1%.
- 31-day target – 99.1%

- **DNA**

The new outpatient DNA rate across acute services in April 2022 is noted as 8.3% which is an increase from the position in March of 7.9%. The return outpatient DNA rate across acute services in April 2022 was 6.1%.

- ***Psychological Therapies***

In April 2022, 66.1% of patients started treatment within 18 weeks of referral. This is a reduction from the previous month and the performance in April 2021 of 66.5%. The Remobilisation Plan trajectory of 60% was exceeded in March with current performance better than the plan. The provisional March position is 80.0% however this data is currently undergoing validation. A robust programme of work is in place to support improvements including engagement with the Scottish Government's Enhanced Support Programme.

- ***Child & Adolescent Mental Health Services***

In April 2022, 54.5% of patients started treatment within 18 weeks of referral. This is a reduction from 73.7% in March 2022 however an improvement from 51.8% in April 2021. The remobilisation plan trajectory of 45% was exceeded in March 2022 with current performance better than the plan.

A multi-level improvement plan is in place with NHS Forth Valley receiving a tailored programme of enhanced improvement support from the Scottish Government.

- ***Workforce***

The sickness absence target is 4.0% with NHS Forth Valley working towards a local milestone target of 4.5% agreed at the Staff Governance Committee. Absence remains above the target at 5.52% in March 2022. This is a slight improvement from 5.62% in March 2021 and 5.62% in February 2022.

The absence for Coronavirus reasons is noted as 5.02% in March 2022; an increase from 3.58% in March 2021 and 3.14% in February 2022.

- ***Delayed Discharges***

The April 2022 census position in relation to standard delays (excluding Code 9 and guardianship) is 81 delays; an increase from 61 in March. There was a total of 35 code 9 and guardianships with 2 infection codes noted. In addition, there were 4 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 March 2022 census was 1629, this is an increase from 1369 in March.

- ***Test & Protect***

Routine contact tracing ended on 30 April 2022.

Financial Implications

Financial implications and sustainability are being considered within the overall remobilisation agenda working closely with Scottish Government colleagues. The Finance Report is a standing item on the Performance & Resources Committee and Forth Valley NHS Board meeting agendas.

Financial Breakeven is detailed on the Strategic Risk Register as a Very High risk for NHS Forth Valley. As such it is reviewed and managed as a risk assigned to the Performance & Resources Committee.

- SRR.005: Financial Breakeven - If NHS Forth Valley financial plans are not aligned to strategic plans and external drivers of change, there is a risk that our cost base for our services over the medium to long term could exceed our future funding allocation, resulting in an inability to achieve and maintain financial sustainability, and a detrimental impact on current/future service provision.

Workforce Implications

Overarching workforce plan in place to support remobilisation plans along with a focus on staff health and wellbeing.

Risk Assessment

Covid-19 remobilisation is noted as a Strategic Risk and as such is considered through the Strategic Risk Register as a risk assigned to the Performance & Resources Committee.

- SRR.012: Covid-19 Remobilisation - If NHS Forth Valley does not deliver an effective re-mobilisation plan in response to Covid-19 there is a risk we fail to manage demand on services and miss opportunities for long term change / improvement.

Discussions are underway with regard to threading the Covid-19 Remobilisation Risk through all relevant Strategic Risks in support of establishing a ‘norm’ going forward. This will be presented in the Strategic Risk Register update to the Audit & Risk Committee in June 2022.

In terms of performance there are also direct links to SRR.002 Unscheduled Care and SRR.004 Scheduled Care. The Strategic Risk Register Update is a regular item at the Board Assurance Committees and the NHS Board.

Relevance to Strategic Priorities

Re-mobilise, Recover, Re-design: The Framework for NHS Scotland, published on 31 May 2020, continues to provide the over-arching context for our remobilisation planning, including the principles and objectives for safe and effective mobilisation.

The draft Remobilisation Plan version 4 was submitted to the Scottish Government along with a number of supporting documents on 7 October 2021. The purpose was to provide an opportunity to review and update our System-Wide Remobilisation Plan 3 to ensure that it continues to reflect the situation, six months into 2021/2022. John Burns, NHS Scotland Chief Operating Officer wrote to the Chief Executive on 19 November 201 highlighting that he was content for the Plan to be taken through local governance processes. The System-Wide Remobilisation Plan October 2021 to March 2022 was approved by the NHS Board on 30 November 2021 and published on the NHS Forth Valley website.

The updated plan informs on-going engagement with Scottish Government colleagues and service leads within NHS Forth Valley. Quarterly progress updates against the delivery of Remobilisation Plan 4 are being requested by the Scottish Government with the quarter 3 update to the end of December 2021 submitted as requested and per guidance received on 9 February 2022. The quarter 4 update was submitted on 29 April 2022.

Annual Delivery Plan (ADP) Guidance has been received by Scottish Government commissioning a one year plan to be submitted at the end of July 2022. The Plan will focus on a limited set of priorities for 2022/23 to enable the system and workforce to recover from the pressure experienced over the past two years. This will encompass a relatively high level narrative setting out our key priorities for recovery and transformation within this period, and how these contribute to national priorities, underpinned by a spreadsheet-based ADP. Guidance is anticipated in July providing an extended time frame for plans to be developed for 2023/24 to 2025/26.

Equality Declaration

The author can confirm that due regard has been given to the Equality Act 2010 and compliance with the three aims of the Equality Duty as part of the decision making process.

Further to an evaluation it is noted that:

- Paper is not relevant to Equality and Diversity

Consultation Process

The System-Wide Remobilisation Plan has been informed by our senior clinical and non-clinical decision makers in primary and community care, health and social care partnerships, acute hospital and support services, and their service specific mobilisation plans.

The Recovery Scorecard Short Life Working Group, led by the Medical Director, met on 23 August to review the scorecard. The revised Recovery & Performance Scorecard was endorsed by the Performance & Resources Committee.

A further review of the scorecard will be undertaken following completion of the Annual Delivery Plan 2022/2023 due to be submitted to the Scottish Government at the end of July 2022.

Appendices

Appendix 1: Recovery & Performance Scorecard

Scorecard Detail

Target Type	FV - Local target/measure set and agreed by NHS Forth Valley; SG_R - Target/measure set by Scottish Government in relation to remobilisation planning; 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 Position	Previous month, week or day dependent on frequency of monitoring
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

Indicator Definitions and Detail

Emergency Department Attendances Mental Health	Attendances at A&E with a cause of injury recorded as Intentional Self Harm
Emergency Department (ED)	Hospital department which typically provides a consultant-led, 24 hour service with full resuscitation facilities and designated accommodation for the reception of emergency patients.
Accident & Emergency (A&E)	Collectively the term Accident and Emergency (A&E) Services includes the following site types: Emergency Departments (EDs); Minor Injury Units (MIU); community A&Es or community casualty departments that are GP or nurse led; Trolleyed areas of an Assessment Unit
Unscheduled Care Definition	Unscheduled care (USC) is sometimes referred to as unplanned, urgent or emergency care, and is care which cannot be planned in advance. This can happen at any time, 24 hours a day, seven days a week.
ED Percentage Compliance	National standard for A&E waiting times is that new and unplanned return 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.
Number of ED Attendances	Number of ED attandances and a target of 'Reduction' is relevant in relation to capacity and flow.
Emergency Admissions	Admission to a hospital bed following an attendance at an A&E service. November 2021 - NHS Forth Valley has made changes to the measurement which is now in line with the national data sets. Previous definition was local interpretation.
Elective Target	Average weekly projection
New Outpatient Activity	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.
Diagnostics	Waiting times standard is that patients should be waiting no more than six weeks for one of the eight key diagnostic tests and investigations - Xray, Ultrasound, CT, MRI, Colonoscopy, Upper Endoscopy, Lower Endoscopy, Cystoscopy
Unavailability	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
Did Not Attend (DNA)	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.
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
Clinical Priority - P1, P2, P3, P4	Applicable to elective TTG patients as part of the implementation of COVID-19 Clinical Prioritisation Framework P1a - Procedure (for surgical patients) or admission (medical patients) needed within 24 hours P1b - Procedure (for surgical patients) or admission (medical patients) needed within 72 hours P2 - Clinical assessment determines procedure (for surgical patients) or admission (medical patients) required within 4 weeks P3 - Clinical assessment determines procedure (for surgical patients) or admission (medical patients) required within 12 weeks P4 - Clinical assessment determines procedure (for surgical patients) or admission (medical patients) may be safely scheduled after 12 weeks
Readmissions	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.
Psychological Therapy 18 week RTT	The 18 Weeks RTT is a whole journey waiting time standard from initial referral to the start of treatment. The standard has been determined by the Scottish Government and states that 90.0% of patients should have a completed pathway within 18 weeks.
Child & Adolescent Mental Health Services (CAMHS) 18 week RTT	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.
Bed Occupancy	The percentage occupancy is the percentage of average available staffed beds that were occupied by inpatients during the period.
Average Length of Stay	This is the mean length of stay (in days) experienced by inpatients in FVRH Acute wards, does not include MH or W&C.
Sickness Absence	Hours lost due to sickness absence / total hours available (%)
Absence for Covid-19 reasons	Coronavirus absences are recorded as Special Leave they are not included within the sickness absences figures. Therefore the absence for Covid-19 reasons is hours lost due to Covid-19/ total hours available (%)

Delayed Discharge	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
Bed Occupancy	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
Number of deaths death in hospital since start of outbreak	Cumulative number of deaths in hospital since the start of the outbreak
Number of deaths since start of outbreak - all locations	Weekly provisional figures on deaths registered where coronavirus (COVID-19) was mentioned on the death certificate in Scotland. Figures are based on date of registration. Week runs from Monday to Sunday. Locations include Care Home, Home/non-institution, Hospital, Other institution e.g prison
Hospital staff testing	The number of eligible staff tested in specilaist cancer wards.
Care Home Testing - Staff	Recording of the number of staff tested against the number of staff eligible and available for testing as a percentage – Only staff who are at work in the care home should be included and those staff who are not at work for any reason should be excluded from this number e.g. annual leave, sick leave, days off, self-isolating or working elsewhere.
Index Case	The first documented case in a group of related cases or potential cases.
Flu Vaccinations	The number carried out as a percentage of the eligible cohort. The target is described as the estimated take up rate as a percentage
COVID Vaccination Programme	The percentage of the number eligible for the vaccine vaccinated with 1st dose and 2nd dose

Key Performance Issues

Unscheduled Care

Overall compliance with the 4 hour target in April 2022 was 66.3%; Minor Injuries Unit 99.5%, Emergency Department 53.0%. A total of 2,313 patients waited longer than the 4 hour target across both the ED and Minor Injuries Unit (MIU); with 512 waits longer than eight hours and 93 waits longer than 12 hours. The main reason for patients waiting beyond 4 hours continues to be wait for first assessment with a cohort of 1,518 patients, an increase from 1416 in March. Note that this continues to be as a result of issues in relation to flow through the system and system-wide pressures. Wait for a Bed accounted for 368 patients waiting beyond 4 hours with Clinical Reasons accounting for 176 breaches.

The weekly position is detailed in the Recovery Measures with graph U1 & U2 highlighting the position over time in respect of ED attendance and compliance, noting an increasing trend in the number of attendances. 4,912 ED attendances were noted in April 2022 compared with 4,746 in April 2021. Recovery Graph U3 details the weekly position in terms of the number of patients seen out with the 4 hour waiting time standard noting fluctuating performance and a decrease in the last week. The most recent full week figures highlight compliance with the 4 hour ED standard as 54.0% and the overall Health Board position 68.1%. The position within ED remains challenging with continued variation in performance. Factors in relation to bed occupancy, length of stay, delayed discharges, and time of discharge continue to impact on flow through ED. Daily meetings are in place to review urgent actions required to improve the system capacity and flow. The focus on patient and staff safety continues.

A comprehensive Unscheduled Care Update was presented to the Performance & Resources Committee on 18 January 2022 led by the Medical Director. Background and context were provided in respect of the current position along with detail of the National unscheduled care workstreams of Redesign of Urgent Care, Interface and Discharge without Delay.

Also described was the programme of redesign being undertaken as part of NHS Forth Valley's plan to improve the unscheduled care performance through a series of three programmes; Access, Optimise Flow and Transfer. The programmes are aligned to key drivers and to an overarching vision of 'Transforming Our Care'. The Access programme will see the Emergency Department reviewed in its totality including pathways into and out of ED. Key 30, 60, 90 day actions are in place to support transformation.

A further update will be presented to the Performance & Resources Committee in October 2022.

Scheduled Care

The application of clinical prioritisation to support appropriate, timely and safe care continues.
-Priority level 1a: Procedure (for surgical patients) or admission (medical patients) needed within 24 hours
-Priority level 1b: Procedure (for surgical patients) or admission (medical patients) needed within 72
-Priority level 2: Clinical assessment determines procedure (for surgical patients) or admission (medical patients) required within 4 weeks
-Priority level 3: Clinical assessment determines procedure (for surgical patients) or admission (medical patients) required within 12 weeks
-Priority level 4: Clinical assessment determines procedure (for surgical patients) or admission (medical patients) may be safely scheduled after 12 weeks.

At the end of April 2022, the number of patients on the waiting list waiting for a first outpatient appointment decreased to 15,855 from 16,138 the previous month; of which 6,214 were waiting beyond 12 weeks. 60.8% of patients were waiting less than 12 weeks for a first appointment; an improvement from 59.2% the previous month. Activity against the agreed Remobilisation Plan trajectory highlights the position for financial year 2021/2022 as 97% compliance. Compliance against the plan for the month of April is 92%.

In April 2022, the number of inpatients/daycases waiting decreased to 3,859 from 3,921 with an increase in those waiting beyond 12 weeks to 1,860 from 1,649. Activity against the agreed Remobilisation Plan trajectory highlights the position for financial year 2021/2022 as 83% compliance. Compliance against the plan for the month of April is 77%. This is a reduction from 91% in March.

Diagnostics

Imaging

At the end of April 2022, 2861 patients were waiting beyond the 6 week standard for imaging which is 54.6% compliance and a deterioration from the previous month. Despite this position, activity against the agreed Remobilisation Plan trajectory highlights the cumulative position for financial year 2021/22 as 105% compliance. The position for April 2022 is 110% compliance. Patients continue to be seen on a priority basis with waiting lists actively monitored and managed. Following a significant increase in the numbers of imaging referrals, particularly for CT and Ultrasound, the department continues to work to increase activity and address the long waiters. Note that the waiting list has doubled in the period April 2021 to April 2022 from 3,109 to 6,305 patients waiting.

Endoscopy

At the end of April 2022, 188 patients were waiting beyond 6 weeks for endoscopy with 61.2% compliance and an improvement from the previous month. As with imaging services, activity against the agreed Remobilisation Plan trajectory is better than the plan with the cumulative position for financial year 2021/2022 as 109% compliance with the position in April 116% compliance against plan. The total number of patients waiting for endoscopy has reduced in April 2022 to 485 patients from 505 in March 2022 and 616 in April 2021.

Cancer

Urgent elective outpatient, daycase and inpatient services to support suspected cancer presentations continue with robust monitoring in place in relation to additions to the 62 day and 31 day cancer pathways. The number of patients being tracked on the 62-day cancer pathway is approximately 1348 patients of which 10% are confirmed cancer patients.

The March 2022 position is noted as:
- 62-day target – 71.2% which is an improvement in performance from the February position of 70.1%. The Scotland position is noted as 75.5%
- 31-day target – 99.1%. The Scotland position is 96.5%.

The position for the January to March 2022 quarter is that 72.2% of patients were treated within 62 days of referral with a suspicion of cancer. This is noted to be a decrease from the previous quarter. During the same period, 97.9% of patients were treated within 31 days of the decision to treat.

The Performance & Resources Committee received a Cancer Services Performance Update in March 2022 detailing the Clinical Governance Routes for Cancer Services and highlighting the Framework for Effective Cancer Management and how this would serve as a benchmarking tool for NHS Forth Valley. The team have agreed to provide a progress update to the Performance & Resources Committee in December 2022.

Unavailability

Monitoring of patient unavailability is an Audit Scotland recommendation and refers to the percentage of outpatient or inpatient/daycase unavailability as a proportion of the total waiting list size.
- Outpatient unavailability in April 2022 was 0.7% of the total waiting list
- Inpatient/daycase unavailability in April 2022 increased further to 9.6% from 8.4% in March 2022 and 5.1% in February 2022. The unavailability rate is less than 10% for all specialties except for OMFS 17.1%, Pain Management 14.3%, Paediatric Surgery 13.3%, Orthopaedics 10.9%, General Surgery Breast 10.5% and Ophthalmology 10.4%. Note that the number of patients unavailable in theses specialties is 5 or less with the exception of OMFS (26 patients), Ophthalmology (59 patients) and Orthopaedics (119 patients). This position is monitored on an ongoing basis. The Inpatient/daycase unavailability increase is due to an increase the unavailabilty reason of 'Clinician Advise - Medical'. This accounts for 50% of all unavailable patients in April.

Did Not Attend (DNA)

The new outpatient DNA rate across acute services in April 2022 is noted as 8.3% which is an increase from the position in March of 7.9%. The Scotland position in January is noted as 7.4%. Variation across specialties continues with rates ranging from 18.2% (6 patients in Pain Management) to 0%. The biggest impact in terms of the number of DNAs can be seen in Ophthalmology 12.9% (105 patients), Dermatology 9.4% (52 patients) and General Surgery 7.1% (62 patients).

The return outpatient DNA rate across acute services in April 2022 was 6.1%. There continues to be a high number of DNAs in Dermatology 101 patients (5,5%) and Ophthalmology with 225 patients (8.2%). There are also significant return outpatient DNAs in Orthopaedics and Pre Op.

Work continues in support of a reduction in the number of DNAs, including, centralisation of appointments to ensure a consistent approach to appointing; work to ensure a consistent application of the Access Policy; Outpatient Development Group established reviewing how we communicate with patients and work being undertaken to understand the reasons for non-attendance. Patient Focussed Booking which has not been in place since the implementation of Trakcare due to a system issue, is being reinstated across specialties and is anticipated to have a positive impact on the number of DNAs.

Psychological Therapies

In April 2022, 66.1% of patients started treatment within 18 weeks of referral. This is a slight reduction than the performance in April 2021 of 66.5%. and the expected reduction from the previous month. The Remobilisation Plan trajectory of 60% was exceeded in March with current performance better than the plan.

In the quarter ending December 2021 the published 18 week referral to treatment standard comparison is Scotland 84.4%; Forth Valley 64.1%.

As one of the Board areas receiving a programme of enhanced support, NHS Forth Valley submitted a comprehensive Psychological Therapies Improvement Plan to the Scottish Government. This provides details of improvement actions, anticipated trajectories and plans for use of the allocation from the Mental Health Recovery & Renewal Fund.

A full programme of improvement actions is in place and includes:
- Use of Netcall to complete a waiting list validation exercise.
- Introduction of Netcall appointment reminders by text.
- Introduction of online therapeutic groups.
- Mainstreaming of Near Me and telephone appointments as long-term options for patients.
- Development of the NHS Forth Valley public website mental health pages to include signposting and access to online packages.
- Continuation of the Primary Care Support Service established during covid, providing rapid access to short-term psychologically informed support.
- A visible focus on staff wellbeing, both because it is the right thing to do and because of the positive impact on recruitment and retention.

Further actions underway are described in the Remobilisation Plan 4 Delivery Plan Template Update.

An update in terms of Psychological Therapies was presented to the Performance & Resources Committee in April 2021 detailing key challenges and actions. A further update is scheduled for August 2022.

Child and Adolescent Mental Health Services (CAMHS)

In April 2022, 54.5% of patients started treatment within 18 weeks of referral. This is a reduction from the previous month however an improvement from 51.8% in March 2021. The remobilisation plan trajectory of 45% was exceeded in December 2021 with current performance better than the plan.

In the quarter ending December 2021 the published 18 week referral to treatment standard comparison is Scotland 70.3%; Forth Valley 57.7%.

Work continues to prioritise urgent referrals for children and young people who have experienced longer waits with the aim of clearing the waiting list backlog by 31 March 2023. The Performance & Resources Committee received a comprehensive update in October 2021 detailing the position in respect of referrals, waiting list and activity along with the complexities involved in the delivery of CAMHS. A further update is scheduled in June 2022.

The CAMHS waiting list at the end of April 2022 is noted as 533 and highlights a significant improvement from 646 at the end of January.

Choice and Partnership Approach (CAPA) went live at the end of January as planned, with the first phase of our nursing team starting their new CAPA job plan. This allowed 160 letters offering an initial choice appointment, being sent in January to our longest waits. An additional 120 choice appointment letters were sent in February, again to our longest waits. This significant 'choice appointment' activity is not reflected in the waiting list immediately but would be within 8 weeks of the initial choice appointment. The CAMHS leadership team, continue to progress CAPA job planning with all clinical staff.

NHS Forth Valley submitted an Improvement Plan to the Scottish Government in September 2021 detailing improvement actions and anticipated trajectories. The improvement work planned, and the implementation of CAPA will have an impact on RTT performance with a reduction in performance anticipated. This is a consequence of the need to tackle the waiting list based on prioritising those waiting longest. The measurement for the teams to determine performance will be the reduction in longest wait and reduction of waiting list.

Workforce

The sickness absence target is 4.0% with NHS Forth Valley working towards a local milestone target of 4.5% agreed at the Staff Governance Committee. Absence remains above the target at 5.52% in March 2022. This is a slight improvement from 5.62% in March 2021 and 5.62% in February 2022. The 12 month rolling average April 2021 to February 2022 is: NHS Forth Valley 6.15%; Scotland 5.69%.

Coronavirus absences are recorded as Special Leave and are not included within the sickness absences figures. The absence for Coronavirus reasons is noted as 5.02% in March 2022; an increase from 3.58% in March 2021 and 3.14% in February 2022.

Total absence for March 2022 is 10.54%, an increase from a total of 8.75% in February 2022.

The management of absence and the improvement of staff wellbeing remain key priorities for NHS Forth Valley. A multidisciplinary improvement programme is on-going along with the establishment of a partnership working group. Support is being provided to staff at work, to staff self-isolating, to staff within the shielding category and to enable home working.

Issues in relation to workforce continue to be examined and discussed at the quarterly Staff Governance Committee.

Delayed Discharges

The weekly delayed discharge position (all delays) is detailed in the recovery measure graph V3 under better value. This highlights the fluctuating position in respect of delays.

The April 2022 census position in relation to standard delays (excluding Code 9 and guardianship) is 81 delays; an increase from 61 in March. There was a total of 35 code 9 and guardianships with 2 infection codes noted. In addition, there were 4 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 March 2022 census was 1629, this is an increase from 1369 in March. Local authority breakdown is noted as Clackmannanshire 204, Falkirk 860, and Stirling 545. There were a further 18 bed days occupied by delayed discharges for local authorities' out with Forth Valley.

The reasons for delay (excluding code 9) are noted as:

Clackmannanshire
3 - awaiting care packages for home (1 patient over two weeks and 2 under two weeks)
4 – awaiting move to Care Home (2 patients over two weeks and 2 under two weeks)
1 – awaiting Specialist Care Home (1 over two weeks)
1 – awaiting interim move for SDS planning (1 under two weeks)

Stirling
8 – allocated and assessment commenced (7 patients over two weeks and 1 under two weeks)
2 - await move to Care Home (2 patients over two weeks)
8 - awaiting care packages for home (1 patient over two weeks and 7 under two weeks)
6 – awaiting social work allocation (1 patient over 2 weeks and 5 under two weeks)

Falkirk
11 - awaiting move to care homes (5 patients are over two weeks and 6 under two weeks)
14 - awaiting care packages for home (6 patients over two weeks and 8 under two weeks)
18 - allocated and assessment commenced (6 patients over two weeks and 12 under two weeks)
4 - awaiting allocation and assessment (4 under two weeks)
1 – awaiting housing, care arrangements or adaptations (1 over two weeks)

Significant focus remains on the delayed discharge position to support flow of patients through Forth Valley Royal Hospital and the community sites. Work is continuing in partnership, including third sector, to ensure appropriate care and to support timely discharge with care in the community, community intermediate care and community hospital facilities a high priority.

Detail of the Health & Social Care Partnership Recovery Planning was presented to the Performance & Resources Committee in January 2022. Actions in place include enabling the right short term support at home through responsive community care and support, coordination of community support with less duplication and a more efficient support model, care home multi agency working, interim placements to care homes and third sector link worker based on the acute site. A number of further supporting actions continue to be developed.

Test & Protect

Routine contact tracing ended on 30 April 2022.
Note the continued downward trend in terms of case numbers with 865 in the week commencing 25 April 2022.

Week beginning	Individual Cases (PHS)
4 April 2022	2565
11 April 2022	1872
18 April 2022	1315
25 April 2022	865

A high level of compliance continues with care home testing:
- Care home testing 88.7%
- Staff testing was discontinued from April 2022

Covid-19 Vaccination

The Covid-19 vaccination programme continues in line with Scottish Government guidance and Joint Committee on Vaccination and Immunisation (JCVI) recommendations. The programme continues to be delivered along with the Covid-19 booster programme taking account of guidance received.

The JCVI advise a spring dose of the coronavirus (COVID-19) vaccine for:
- adults aged 75 years and over (or will turn 75 by 30 June 2022)
- residents in care homes for older adults
- individuals aged 12 years and over who have a weakened immune system

and this is being offered about 6 months after the last coronavirus vaccine.

A full vaccination programme update was presented to the Performance & Resources Committee in January 2022 detailing progress with the Vaccination Transformation Programme, the Covid vaccination programme and uptake rates

KEY RECOVERY MEASURES

BETTER CARE

REF	Target Type	FREQUENCY	MEASURE	DATE	TARGET	CURRENT POSITION	PREVIOUS POSITION	RUN CHART	DIRECTION OF TRAVEL
UNSCHEDULED CARE				Week commencing					
U1	SG_R	Weekly	ED percentage compliance against 4 hour access target	16-May-22	95%	54.0%	54.9%	✓	▼
U2	SG_R	Weekly	Number of ED Attendances	16-May-22	Reduction	1235	1218	✓	▼
U3	SG_R	Weekly	Number that waited >4 hours in ED	16-May-22	Reduction	568	549	✓	▼
U4	SG_R	Weekly	Minor Injuries Unit percentage compliance against 4 hour target	16-May-22	98%	99.6%	99.6%	✓	▲
U5	SG_R	Weekly	Number of Minor Injuries Unit Attendances	16-May-22	-	554	535	✓	-
U6	SG_R	Weekly	Number of Emergency Admissions	16-May-22	707	685	667	✓	▼
SCHEDULED CARE									
Outpatients									
S1	SG_R	Weekly	New Outpatient Referrals Received	16-May-22	-	1617	1489	✓	▼
S2	SG_R	Weekly	New Outpatient Activity (number of patients)	16-May-22	1164	1414	1320	✓	▲
Diagnostics									
S3	SG_R	Weekly	Elective Colonoscopy Activity (number of patients)	16-May-22	61	25	31	✓	▼
S4	SG_R	Weekly	Elective Sigmoidoscopy Activity (number of patients)	16-May-22	**2**	7	4	✓	▲
S5	SG_R	Weekly	Elective Upper Endoscopy Activity (number of patients)	16-May-22	34	41	30	✓	▲
S6	SG_R	Weekly	Elective Cystoscopy Activity (number of patients)	16-May-22	2	10	11	✓	▼
Inpatients & Day cases									
S7	SG_R	Weekly	Inpatient/Daycase Activity (number of patients)	16-May-22	181	224	215	✓	▲
S8	SG_R	Monthly	Inpatient/Daycase Activity (number of patients)	30-Apr-22	-	765	840	-	▼
TTG Clinical Prioritisation									
	SG_R	Monthly	Clinical Priority 1a - surgery or admission within 24 hours/ 1b - within 72 hours	30-Apr-22	-	4	2	-	-
	SG_R	Monthly	Clinical Priority 2 - surgery or admission within 4 weeks)		-	188	210	-	-
	SG_R	Monthly	Clinical Priority 3 - surgery or admission within 12 weeks		-	258	278	-	-
	SG_R	Monthly	Clinical Priority 4 - surgery or admission may safely be scheduled after 12 weeks)		-	312	350	-	-

BETTER WORKFORCE

REF		FREQUENCY	MEASURE	DATE	TARGET	CURRENT POSITION	PREVIOUS POSITION	RUN CHART	DIRECTION OF TRAVEL
W1	FV	Weekly	FVRH - percentage staff absence related to COVID-19	26-May-22	Reduction	0.4%	0.3%	✓	▼

BETTER VALUE

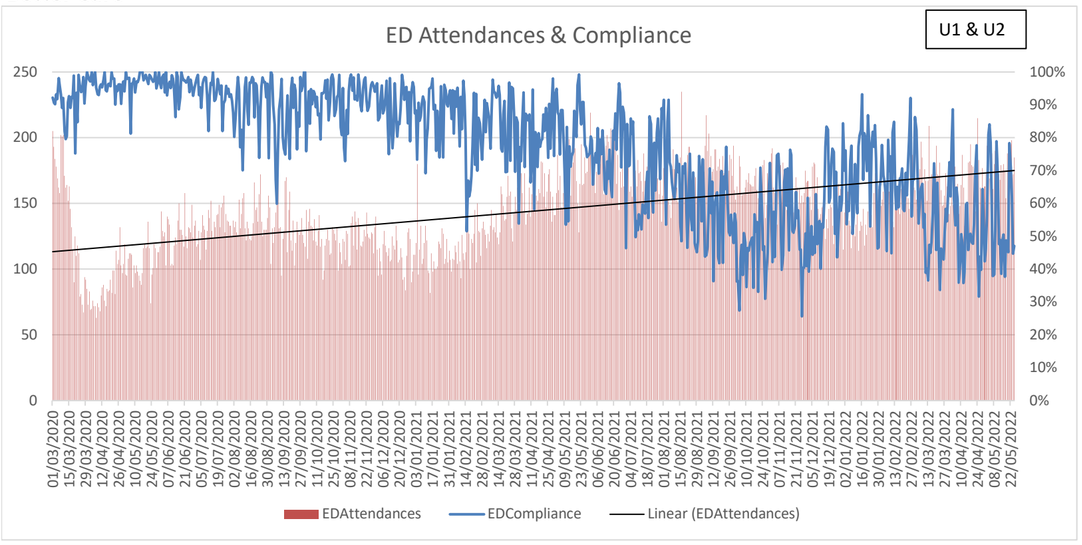
REF		FREQUENCY	MEASURE	DATE	TARGET	CURRENT POSITION	PREVIOUS POSITION	RUN CHART	DIRECTION OF TRAVEL
V1	FV	Weekly	Number of Delayed Discharges at FVRH	16-May-22	Reduction	37	39	✓	▲
V2	FV	Weekly	Number of Delayed Discharges at Community Units	16-May-22	Reduction	95	95	✓	◄►
V3	SG	Weekly	Total Delayed Discharges at census - Standard, Code 9 & Guardianship	26-May-22	Reduction	104	104	✓	◄►
			Falkirk	26-May-22	Reduction	69	68	✓	▼
			Clackmannanshire	26-May-22	Reduction	6	4	✓	▼
			Stirling	26-May-22	Reduction	29	32	✓	▲
V4	FV	Weekly	% Bed Occupancy - FVRH	16-May-22	85%	112.8%	113.0%	✓	▲
V5	FV	Weekly	% Bed Occupancy - Assessment Units	16-May-22	85%	108.1%	104.2%		▼
V6	FV	Weekly	% Bed Occupancy - ICU	16-May-22	85%	73.7%	75.9%	✓	▲

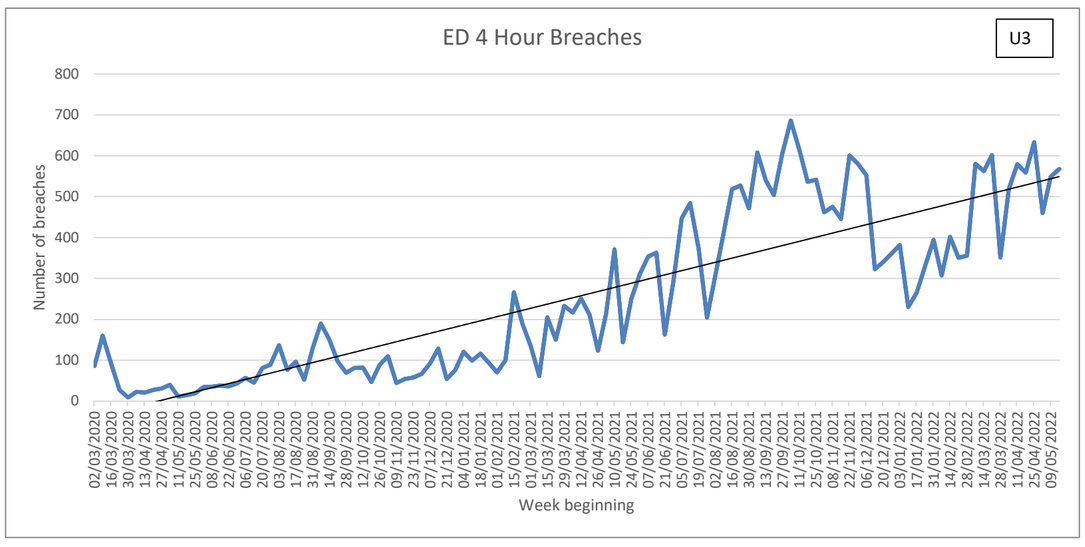
FINANCE

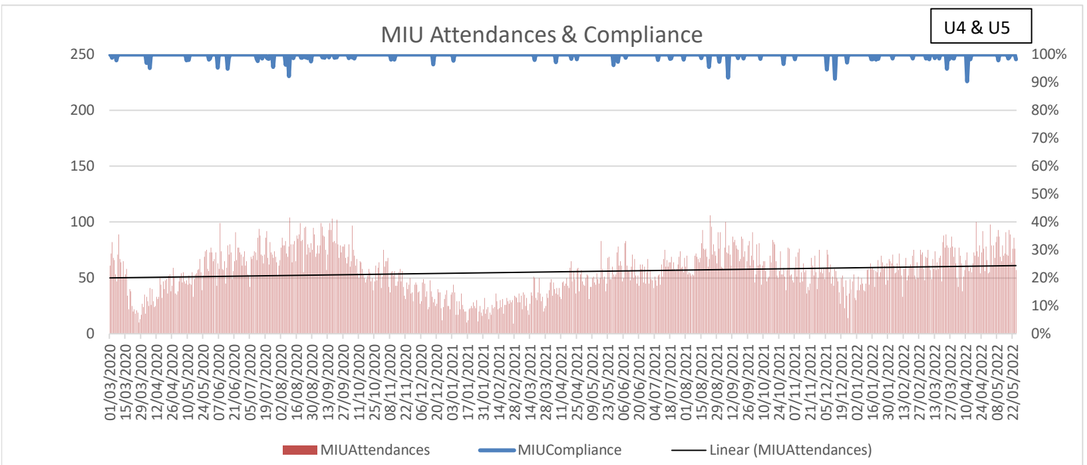
Regular and comprehensive updates provided by Director of Finance at System Leadership Team, Performance & Resources Committee and the NHS Board

RECOVERY GRAPHS

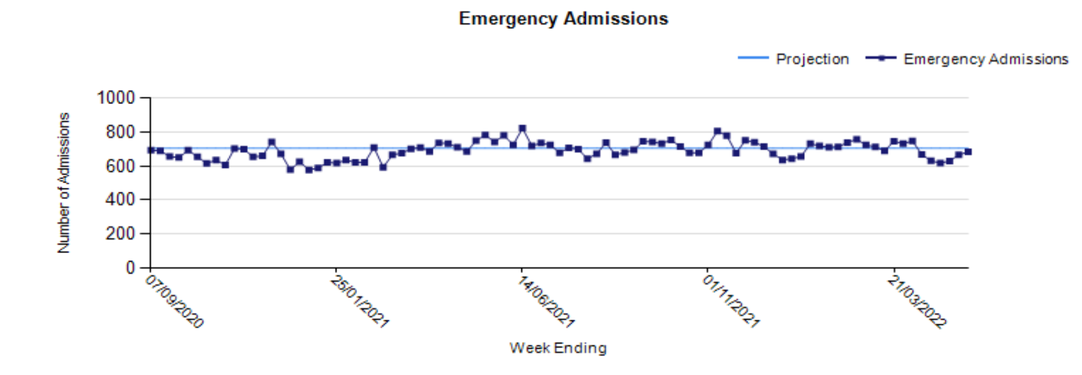
Better Care



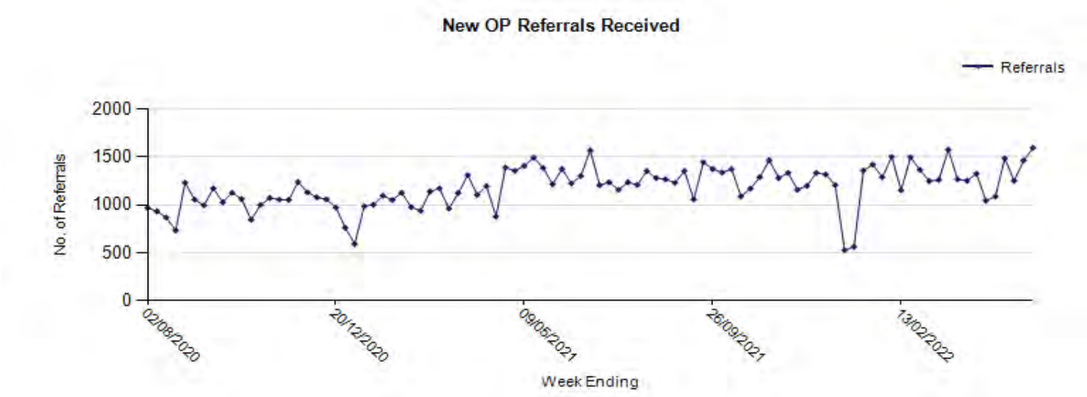




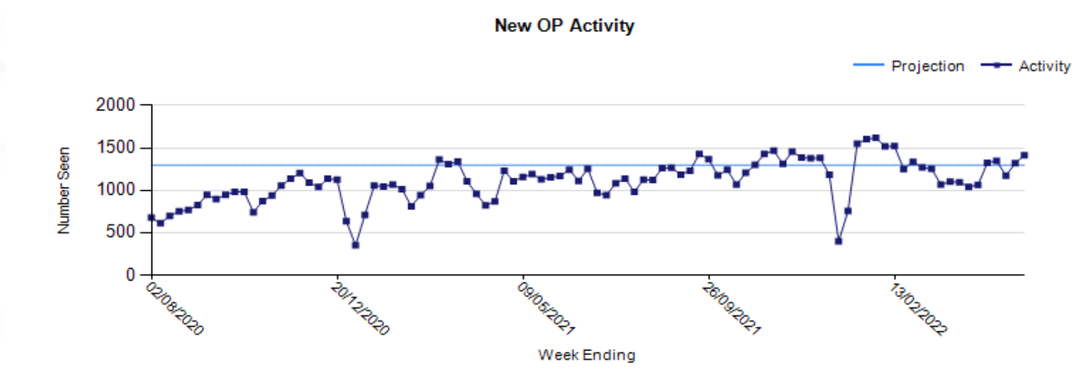
U6



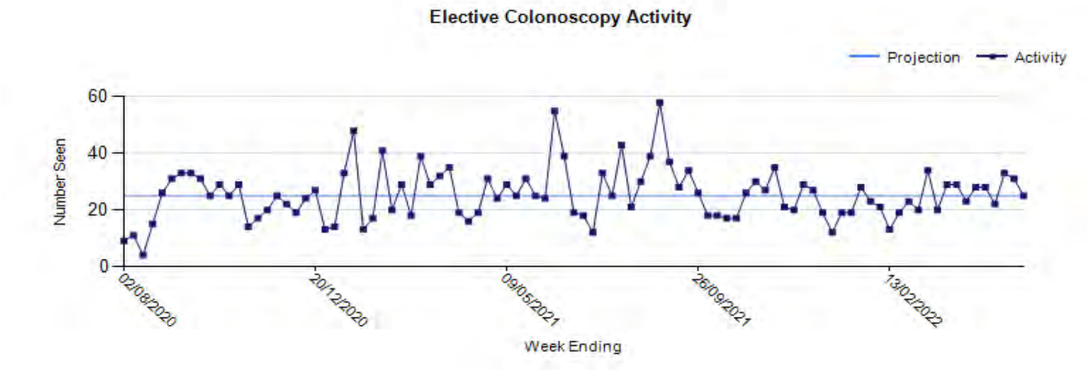
S1



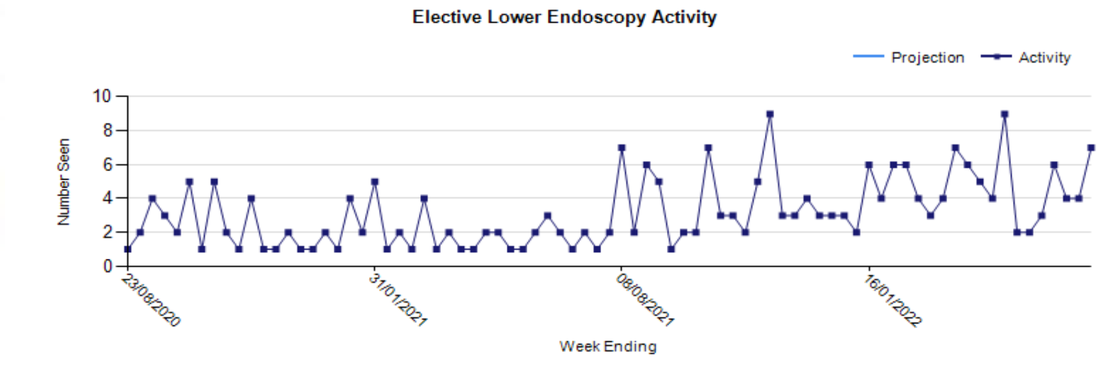
S2



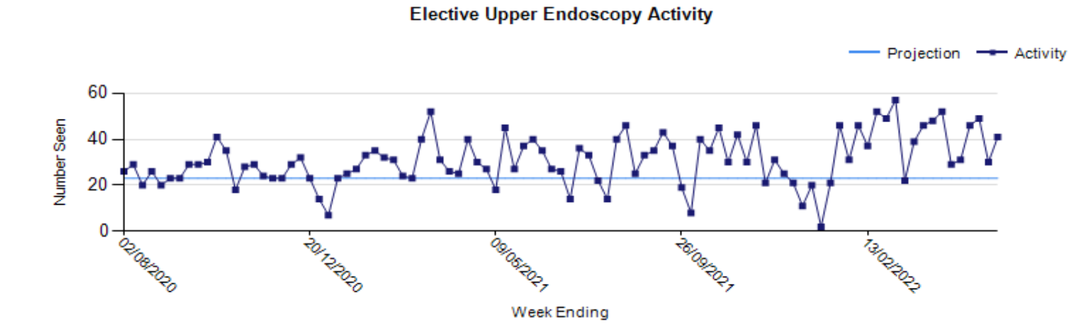
S3



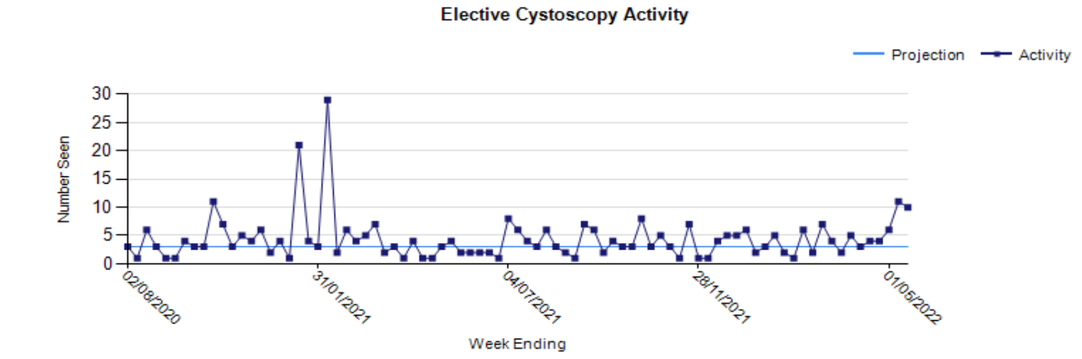
S4



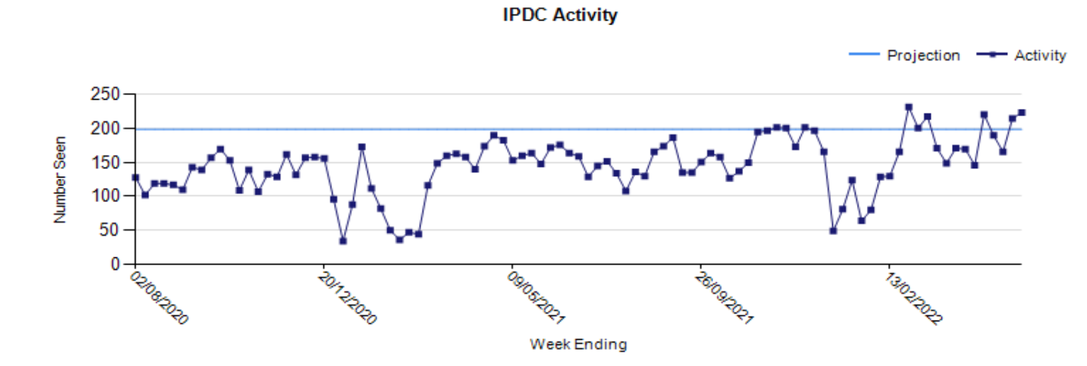
S5



S6

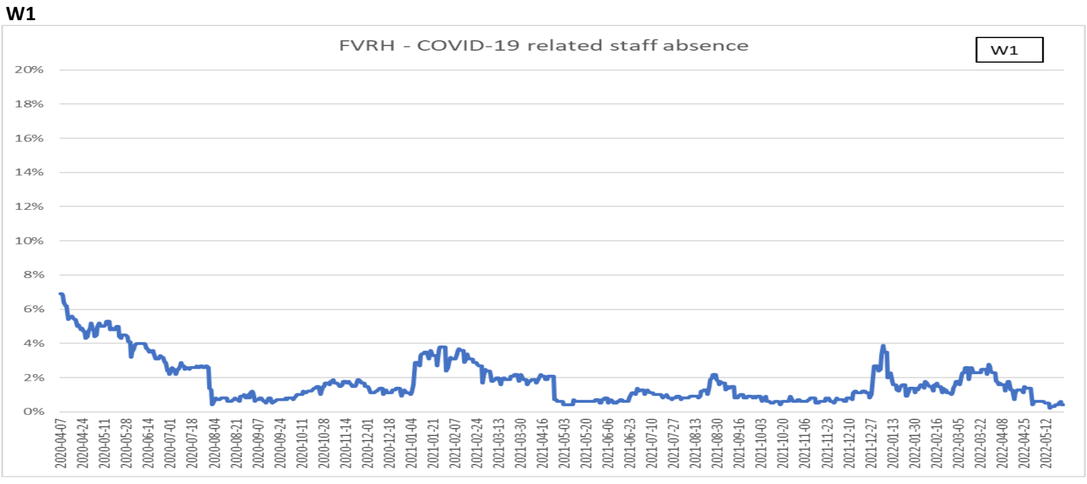


S7

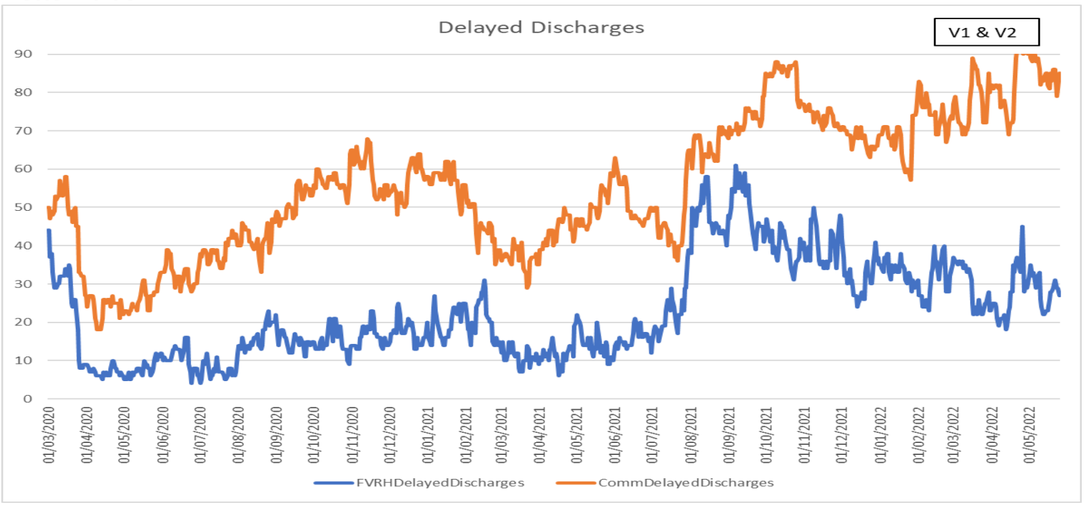


Better Workforce

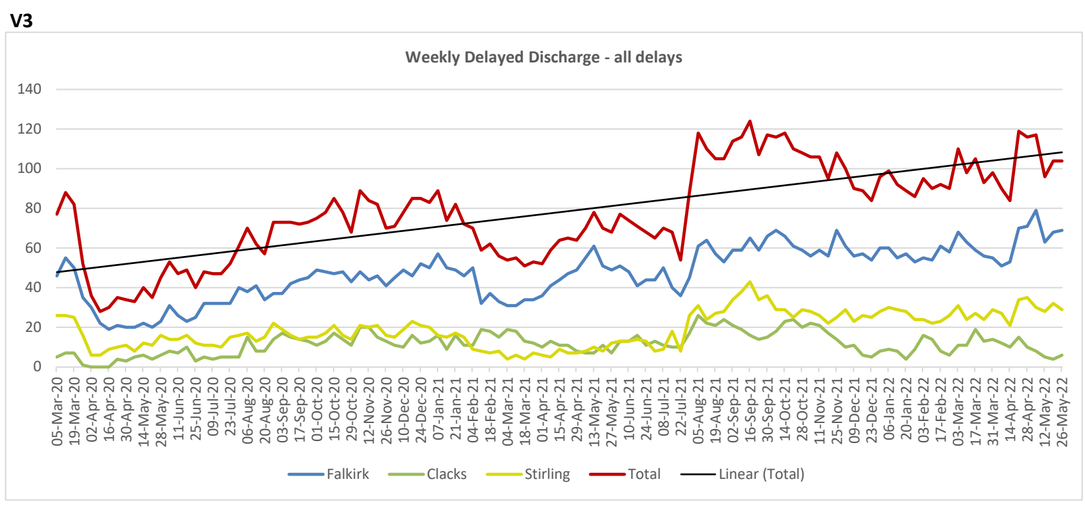
W1



Better Value



V3



KEY PERFORMANCE MEASURES COVID-19

BETTER CARE

REF	Target Type	FREQUENCY	MEASURE	DATE	TARGET	CURRENT POSITION	PREVIOUS POSITION	RUN CHART	DIRECTION OF TRAVEL
UNSCHEDULED CARE									
US1	FV	Monthly	Number of ED attendances - Mental Health	30-Apr-22	-	75	78	-	-
US2	FV	Monthly	Emergency Department % compliance against 4 hour access target - Mental Health	30-Apr-22	95%	33.3%	41.0%	-	▼
US3	SG	Monthly	Emergency Department % compliance against 4 hour access target	30-Apr-22	95%	53.0%	55.4%	✓	▼
US4	SG	Monthly	NHS Forth Valley Overall % compliance against 4 hour target	30-Apr-22	95%	66.3%	68.4%	✓	▼
US5	SG	Monthly	Minor Injuries Unit % compliance against 4 hour target	30-Apr-22	95%	99.5%	99.4%	-	▲
SCHEDULED CARE									
Outpatients									
SC1	SG	Monthly	Total Number of New Outpatients Waiting	30-Apr-22	Reduction	15,855	16,138	✓	▼
SC2	SG	Monthly	Number of New Outpatients waiting over 12 weeks	30-Apr-22	Reduction	6,214	6,587	✓	▲
SC4	Audit	Monthly	Outpatient Unavailability	30-Apr-22	Monitor	0.7%	0.6%	✓	▲
SC5	FV	Monthly	New Acute Services Outpatient % DNA	30-Apr-22	5%	8.4%	7.9%	-	▼
	FV	Monthly	Return Acute Services Outpatient % DNA	30-Apr-22	5%	6.1%	6.1%	-	▼
Diagnostics									
SC6	SG	Monthly	Percentage waiting less than 42 days - Imaging	30-Apr-22	100%	54.6%	56.2%	✓	▼
		Monthly	Number waiting beyond 42 days - Imaging	30-Apr-22	0	2861	2812	-	▼
SC7	SG	Monthly	Percentage waiting less than 42 days - Endoscopy	30-Apr-22	100%	61.2%	59.2%	✓	▲
		Monthly	Number waiting beyond 42 days - Endoscopy	30-Apr-22	0	188	206	-	▲
Cancer									
SC8	SG	Monthly	62 Day Cancer Target - Percentage compliance against target	31-Mar-22	95%	71.2%	70.1%	✓	▼
	SG	Monthly	62 Day Cancer - Number seen within target against total	31-Mar-22	-	74/104	61/87	-	-
SC9	SG	Monthly	31 Day Cancer Target - Percentage compliance against target	31-Mar-22	95%	99.1%	100.0%	✓	▼
	SG	Monthly	31 Day Cancer Target - Number seen within target against total	31-Mar-22	-	106/107	96/96	-	-
SC10	SG	Quarterly	62 Day Cancer Target - Percentage compliance against target	31-Mar-22	95%	72.2%	79.8%	✓	▼
SC11	SG	Quarterly	31 Day Cancer Target - Percentage compliance against target	31-Mar-22	95%	97.9%	98.6%	✓	▲
Inpatients & Day cases									
SC12	SG	Quarterly	Number of patients that waited >12 weeks - Completed Wait	31-Mar-22	0	734	956	-	-
	SG	Quarterly	% Compliance with 12 week TTG Standard	31-Mar-22	100%	60.7%	51.9%	-	-
SC13	SG	Monthly	Total Number of Inpatients/Day cases Waiting	30-Apr-22	Reduction	3,859	3,921	✓	▲
SC14	SG	Monthly	Number of Inpatients/Day cases waiting over 12 weeks	30-Apr-22	Reduction	1,860	1,649	✓	▼
SC15	Audit	Monthly	Inpatient/Day case Unavailability	30-Apr-22	Monitor	9.6%	8.4%	✓	▼
Readmissions									
R1	FV	Monthly	Readmissions - Surgical 7 day	30-Apr-22	-	1.7%	3.0%	-	▲
	FV	Monthly	Readmissions - Surgical 28 day	30-Apr-22	-	4.4%	7.0%	-	▲
	FV	Monthly	Readmissions - Medical 7 day	30-Apr-22	-	1.7%	1.5%	-	▼
	FV	Monthly	Readmissions - Medical 28 day	30-Apr-22	-	4.5%	4.0%	-	▼
MENTAL HEALTH									
MH1	SG	Monthly	Psychological Therapies - 18 week RTT compliance	30-Apr-22	90%	66.1%	80.0%	✓	▼
MH2	SG	Monthly	Child & Adolescent Mental Health Services - 18 week RTT compliance	30-Apr-22	90%	54.5%	73.7%	✓	▲

BETTER WORKFORCE

REF		FREQUENCY	MEASURE	DATE	TARGET	CURRENT POSITION	PREVIOUS POSITION	RUN CHART	DIRECTION OF TRAVEL
WF1	SG	Monthly	Overall Absence	31-Mar-22	4.5%	5.52%	5.61%	✓	▲
WF2	SG_R	Monthly	COVID-19 related absence - number of employees	31-Mar-22	-	1250	732	-	▼
WF3	FV	Monthly	Absence for Covid-19 reasons	31-Mar-22	-	5.02%	3.14%	✓	▼

BETTER VALUE

REF		FREQUENCY	MEASURE	DATE	TARGET	CURRENT POSITION	PREVIOUS POSITION	RUN CHART	DIRECTION OF TRAVEL
VA1	FV	Monthly	Delayed Discharges - excl. Code 9 & Guardianship (Standard Delays)	30-Apr-22	Reduction	81	61	✓	▼
			Falkirk	30-Apr-22	Reduction	46	28	✓	▼
			Clackmannanshire	30-Apr-22	Reduction	9	11	✓	▲
			Stirling	30-Apr-22	Reduction	24	19	✓	▼
			Outwith Forth Valley	30-Apr-22	Reduction	2	3	✓	▲
VA2	FV		Code 9 & Guardianship Delays	30-Apr-22	Reduction	35	36	✓	▲
			Falkirk	30-Apr-22	Reduction	23	24	✓	▲
			Clackmannanshire	30-Apr-22	Reduction	1	2	✓	▲
			Stirling	30-Apr-22	Reduction	9	8	✓	▼
			Outwith Forth Valley	30-Apr-22	Reduction	2	2	✓	◄►
VA3	FV		Total Bed Days Occupied by Delayed Discharges	30-Apr-22	Reduction	1627	1369	✓	▼
			Falkirk	30-Apr-22	Reduction	860	662	✓	▼
			Clackmannanshire	30-Apr-22	Reduction	204	257	✓	▲
			Stirling	30-Apr-22	Reduction	545	357	✓	▼
			Outwith Forth Valley	30-Apr-22	Reduction	18	93	✓	▲
VA4	FV	Monthly	FVRH Acute Wards Average Length of Stay (Days)	30-Apr-22	Reduction	6.41	7.06	-	▲

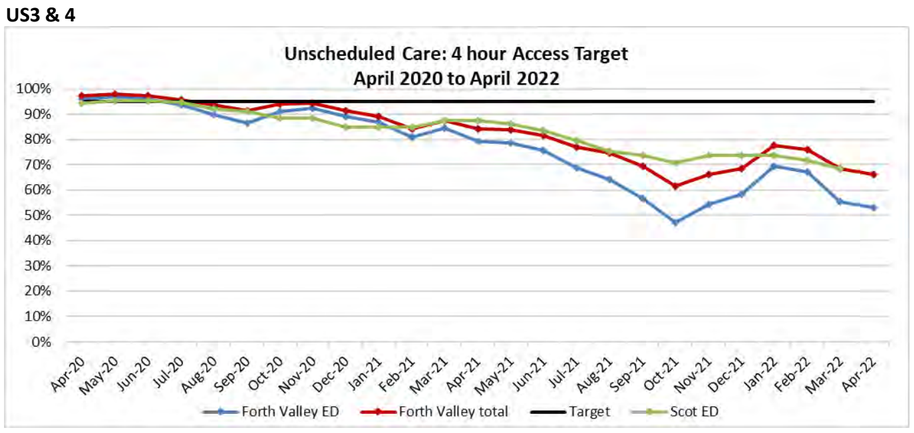
Finance

Regular and comprehensive updates provided by Director of Finance at System Leadership Team, Performance & Resources Committee and the NHS Board

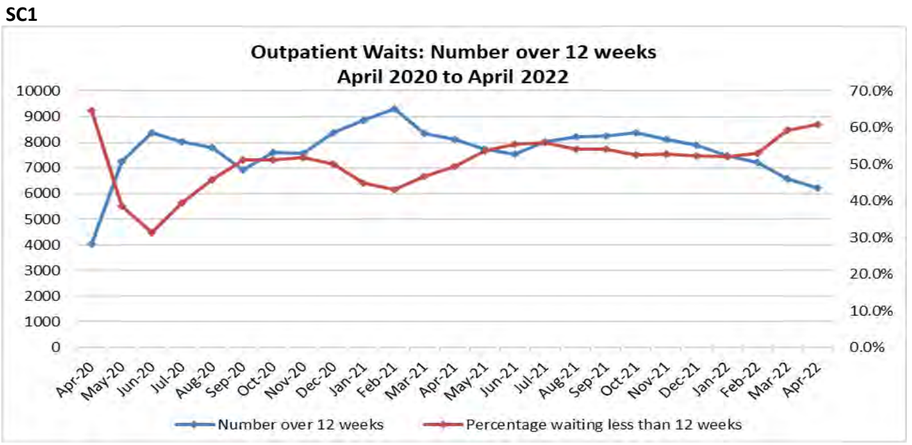
MONTHLY KEY PERMANCE GRAPHS

Better Care

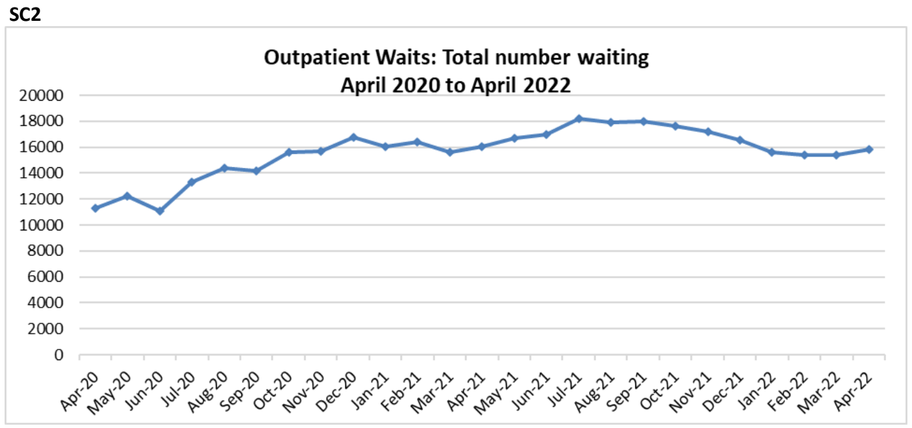
US3 & 4



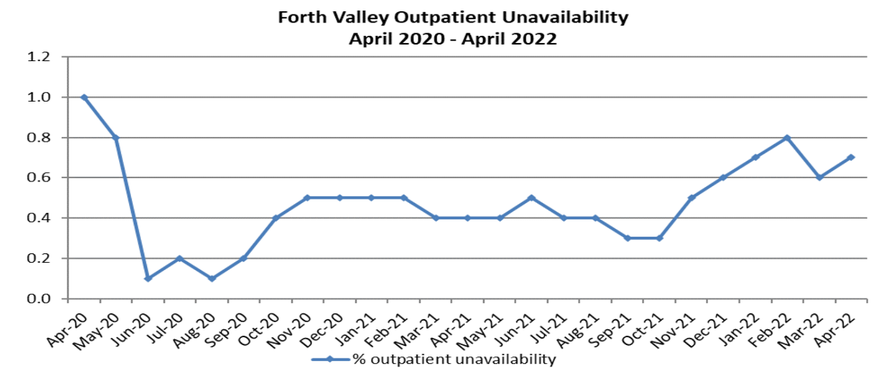
SC1



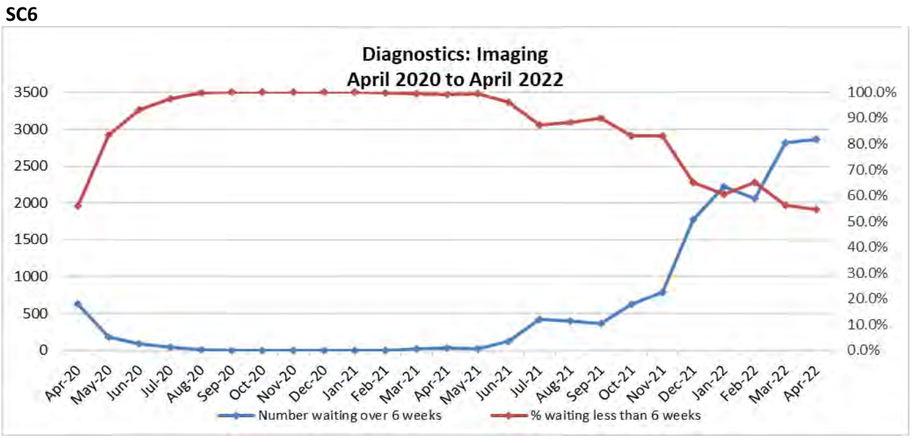
SC2



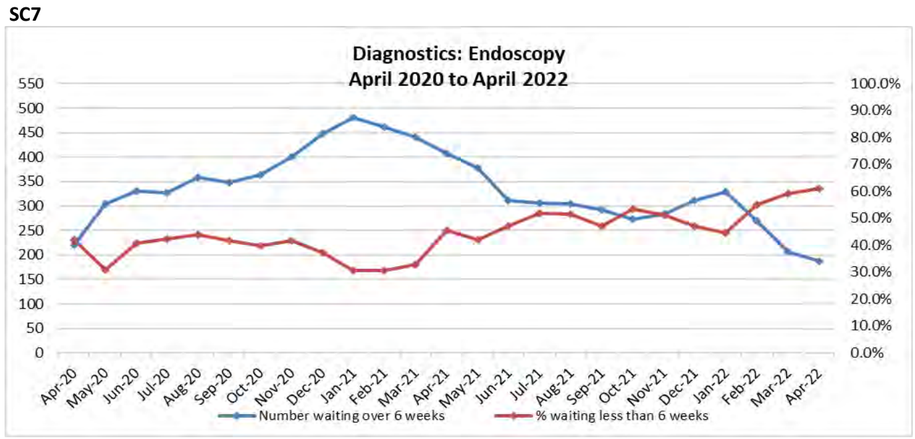
SC4



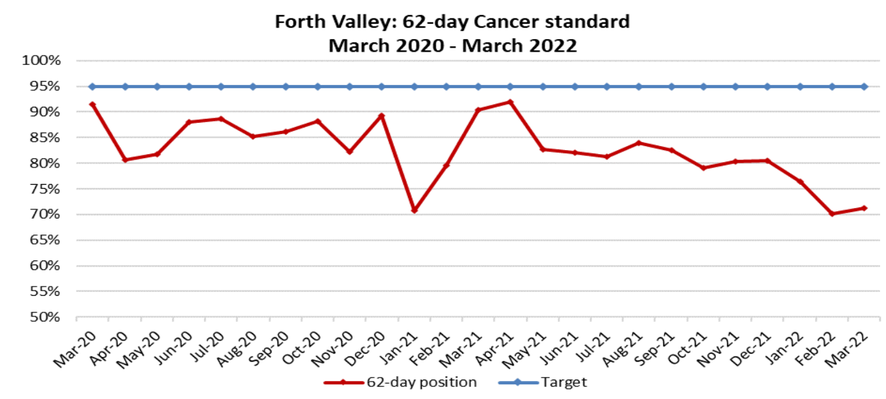
SC6



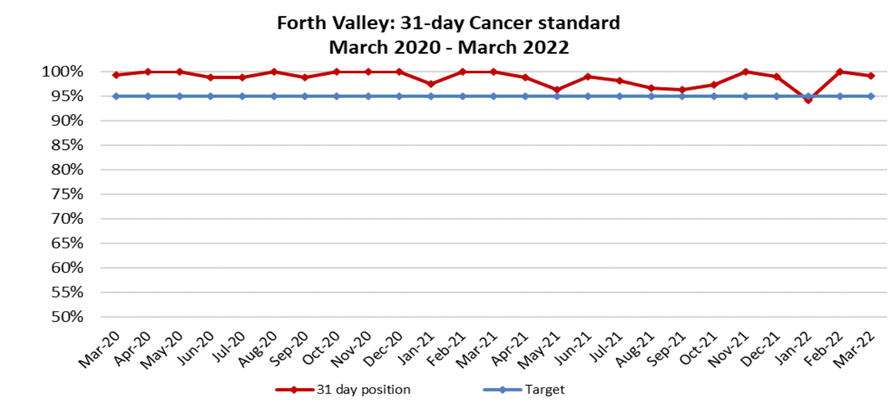
SC7



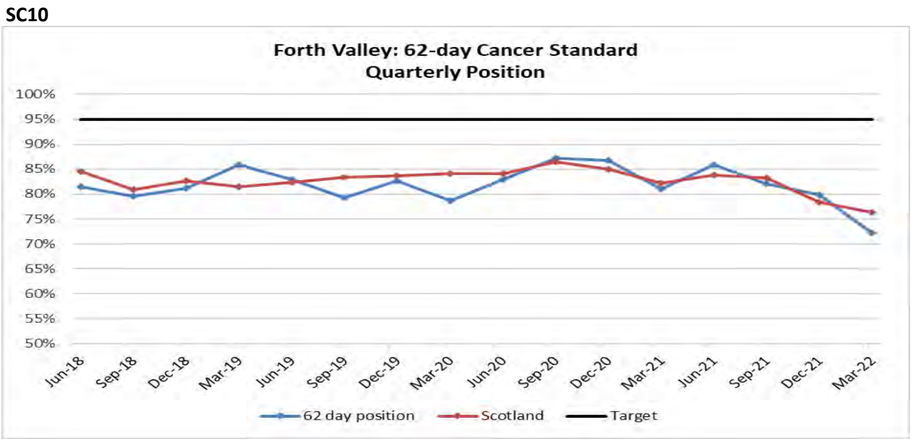
SC8



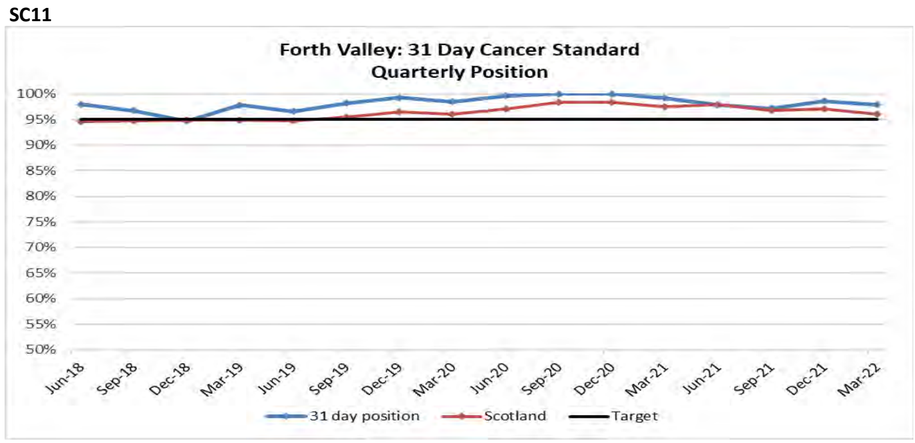
SC9



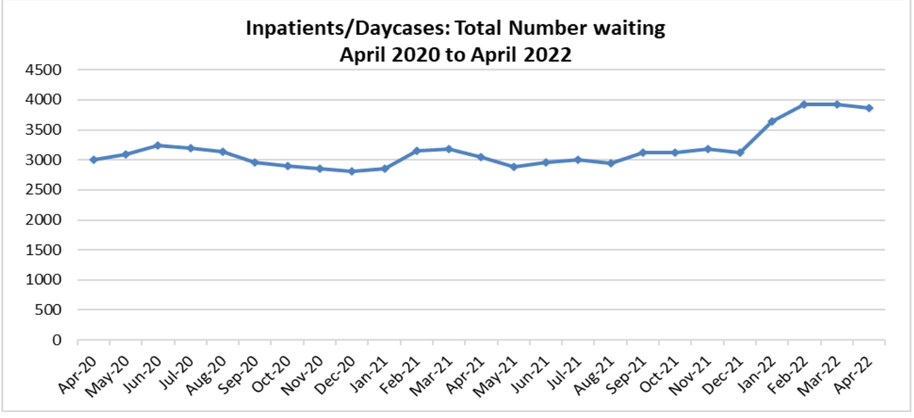
SC10



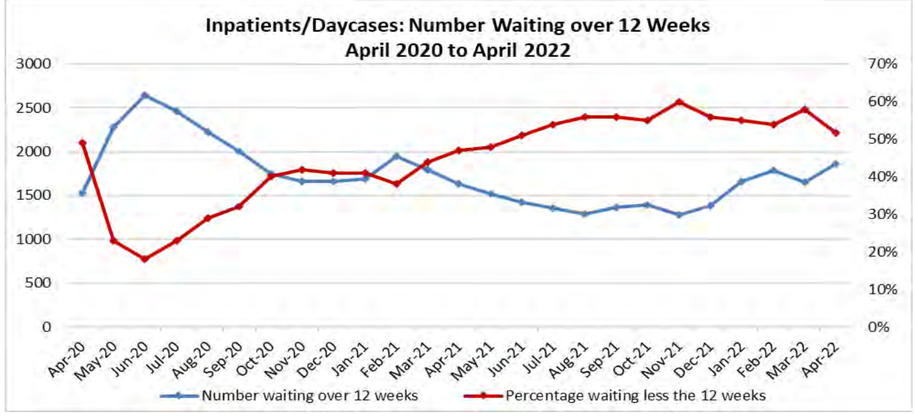
SC11



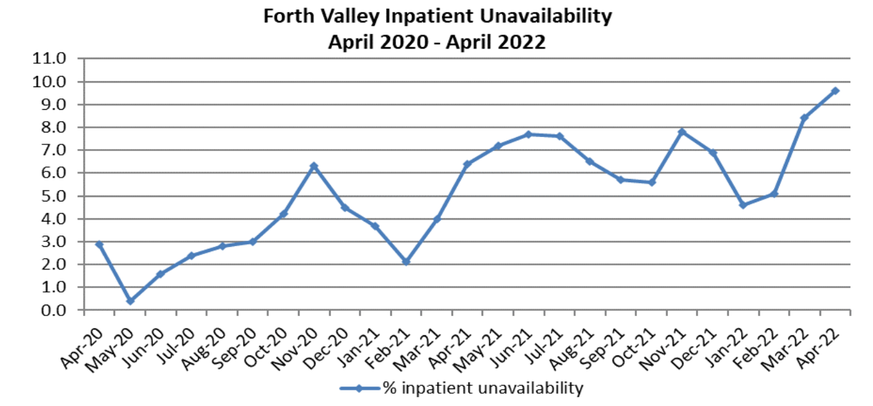
SC13



SC14

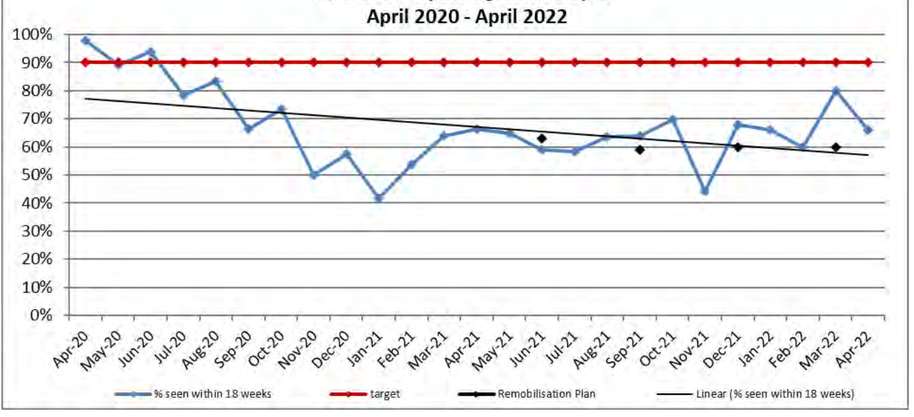


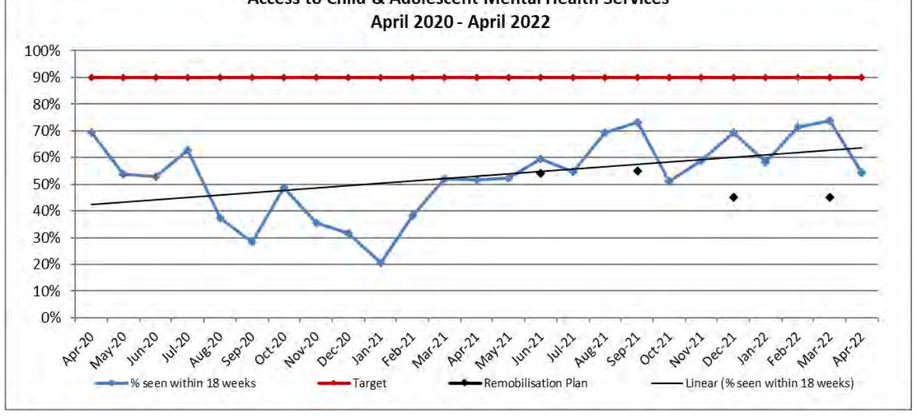
SC15



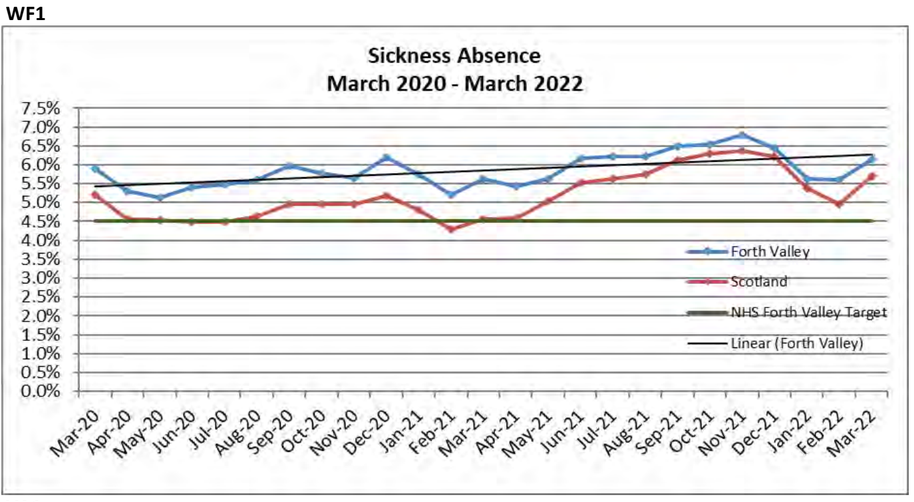
MH1

MH2

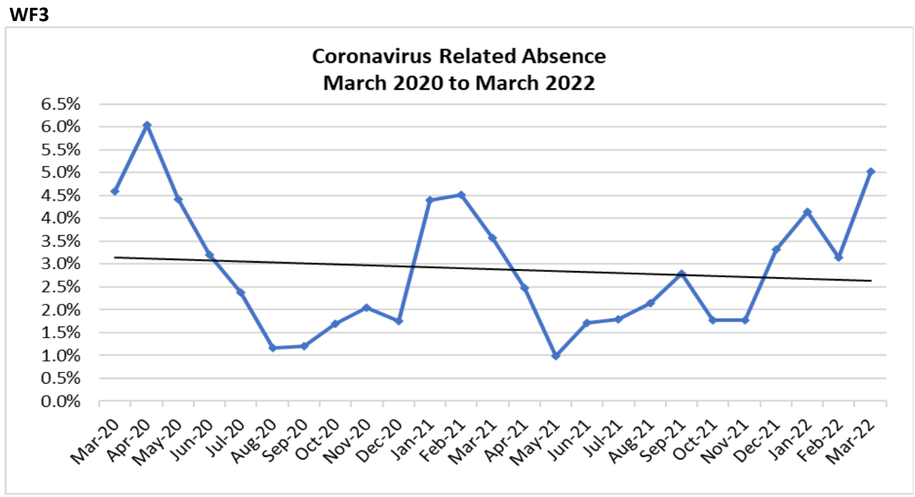




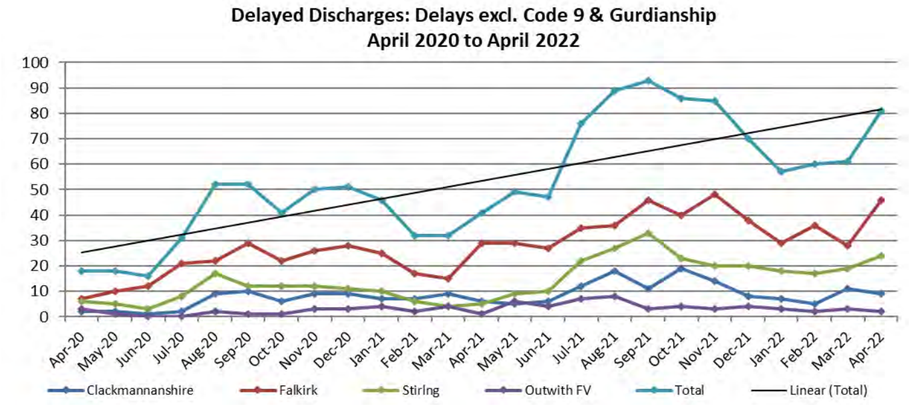
WF1



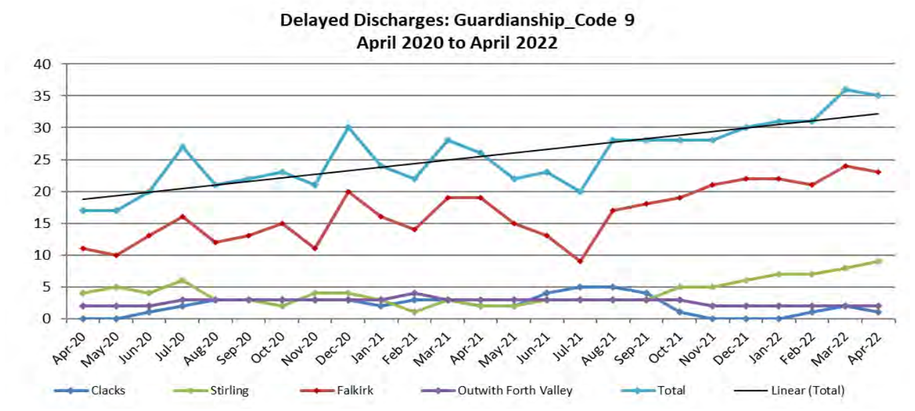
WF3



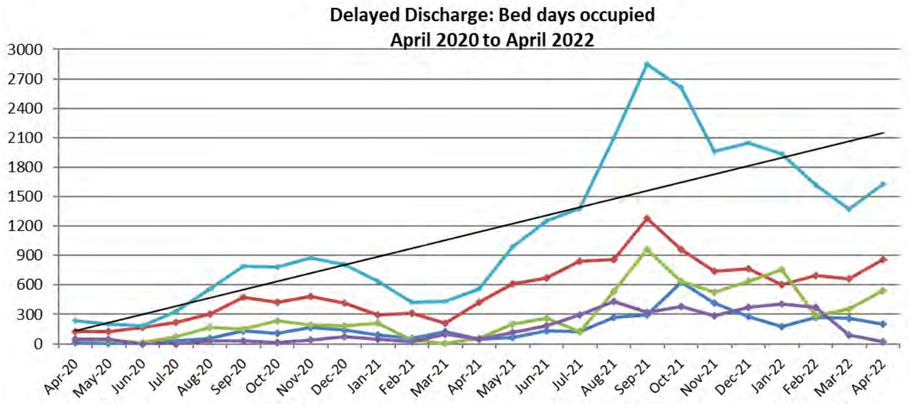
VA1



VA2



VA3



KEY RESPONSE MEASURES COVID-19

BETTER HEALTH

REF	Target Type	FREQUENCY	MEASURE	DATE	TARGET	CURRENT POSITION	PREVIOUS POSITION	RUN CHART	DIRECTION OF TRAVEL
H1	FV	Daily	Number of deaths in hospital since start of outbreak	26-May-22	-	510	506	✓	-
H2	FV	Weekly	Number of deaths since start of outbreak by local authority - total	16-May-22	-	894	893	-	-
			Number of deaths since start of outbreak by local authority						
		Weekly	Falkirk	16-May-22	-	486	486	-	-
		Weekly	Clackmannanshire	16-May-22	-	167	167	-	-
		Weekly	Stirling	16-May-22	-	241	240	-	-
H3	FV	Weekly	Number of new confirmed COVID-19 patients in hospital	16-May-22	Decrease	38	31	✓	▼
H4	FV	Weekly	Number of confirmed COVID-19 cases in hospital over the 7 day period	16-May-22	Decrease	45	44	-	▼
H5	FV	Weekly	Number of confirmed COVID-19 cases ICU over the 7 day period	16-May-22	Decrease	5	3	-	▼
H6	FV	Weekly	Number of COVID-19 positive patients ventilated over the 7 day period	16-May-22	Decrease	2	0	-	▼
H7	FV	Weekly	Total number of patients ventilated over the 7 day period	16-May-22	-	12	8	-	▼
Test & Protect									
T1	SG	Weekly	Staff Testing Numbers - Cancer	31-Mar-22	-	100.0%	100.0%	-	◄►
T2	SG	Weekly	Care Home Testing - Staff - Total	18-Apr-22	70%	88.7%	90.4%	-	▼
			Care Home Testing - staff - by Partnership						
		Weekly	Falkirk	18-Apr-22	-	96.8%	88.0%	-	▲
		Weekly	Clackmannanshire and Stirling	18-Apr-22	-	82.8%	91.8%	-	▼
T3	SG	Weekly	Contact Tracing - unique contacts within Health Board	25-Apr-22	-	865	1315	-	-
T4	SG	Weekly	Percentage of Index Cases reached within 24 hours	25-Apr-22	-	98.8%	98.6%	-	-
T5	SG	Weekly	Percentage of Index Case interviewed to complete within 24 hours	25-Apr-22	-	98.7%	99.0%	-	-
COVID Vaccination Programme - Percenatge of number eligible vaccinated						**1st Dose**		**2nd Dose**	
						26-May-22	19-May-22	26-May-22	19-May-22
CV1	SG	Weekly	Age 80 and over	26-May-22	-	100%	100%	97%	97%
CV2	SG	Weekly	Age 75 to 79	26-May-22	-	102%	102%	101%	101%
CV3	SG	Weekly	Age 70 to 74	26-May-22	-	103%	103%	103%	103%
CV4	SG	Weekly	Age 65 to 69	26-May-22	-	97%	97%	96%	96%
CV5	SG	Weekly	Age 60 to 64	26-May-22	-	102%	102%	102%	102%
CV6	SG	Weekly	Age 55 to 59	26-May-22	-	101%	101%	100%	100%
CV7	SG	Weekly	Age 50 to 54	26-May-22	-	96%	96%	94%	94%
CV8	SG	Weekly	Age 40 to 49	26-May-22	-	90%	90%	88%	88%
CV9	SG	Weekly	Age 30 to 39	26-May-22	-	90%	90%	86%	86%
CV10	SG	Weekly	Age 18 to 29	26-May-22	-	82%	82%	78%	77%
CV11	SG	Weekly	Age 16 to 17	26-May-22	-	91%	91%	76%	76%
CV13	SG	Weekly	Total	26-May-22	-	94%	94%	91%	91%
CV12	SG	Weekly	Age 12 to 15	26-May-22	-	78%	78%	62%	61%
Note that individuals may fall into more than one of the cohorts below									
CV15	SG	Weekly	At highest risk clinically extremely vulnerable	26-May-22	-	97%	97%	96%	96%
CV16	SG	Weekly	Unpaid carer	26-May-22	-	95%	95%	93%	93%

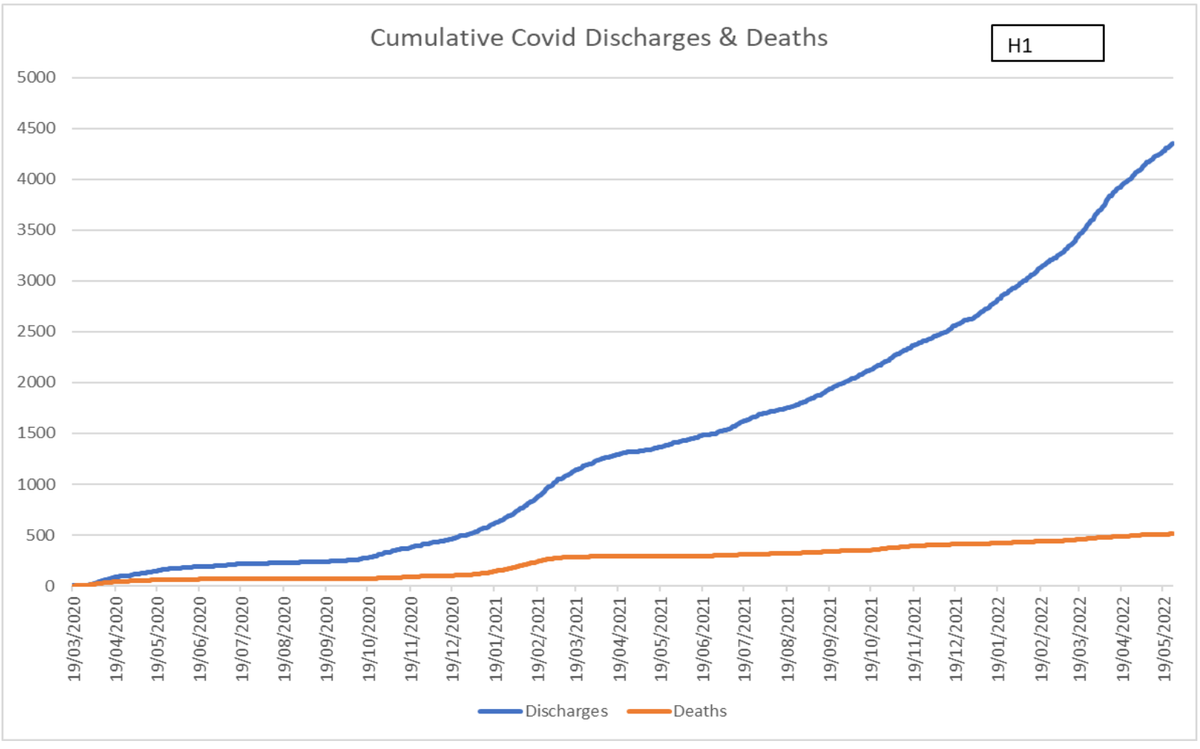
PPE

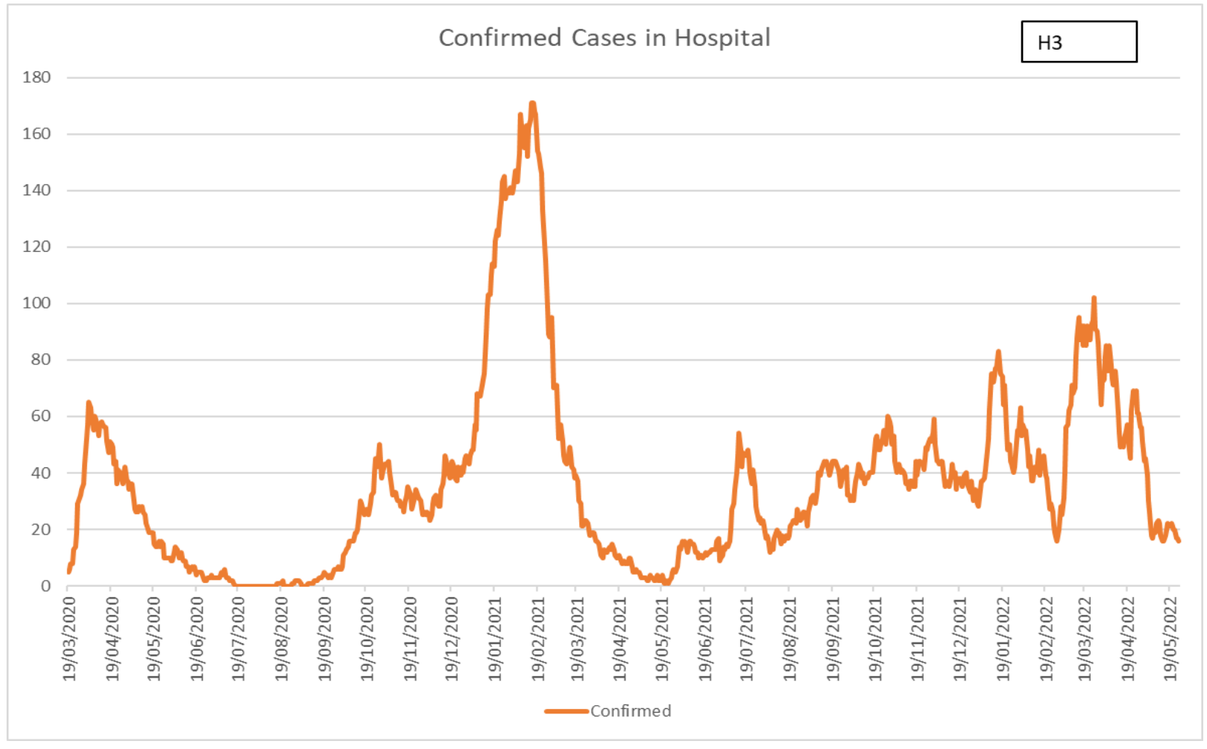
Weekly update received. Currently no issues however the position will be kept under review

CRITICAL MEDICINES

Daily update however currently no issues. The position will be kept under review

Better Health





FORTH VALLEY NHS BOARD
TUESDAY 31 MAY 2022

7.3 Whistleblowing Standards and Activity Report
For Assurance

Executive Sponsor: Gillian Morton, Interim Executive Nurse Director

Author: Miss Claire Peacock, PA to Executive Nurse Director / Whistleblowing Officer

---

Executive Summary

The new National Whistleblowing Standards were launched on 1 April 2021 and a significant amount of work was and continues to be undertaken to ensure that the standards are implemented across NHS Forth Valley.

This paper is presented to the NHS Board to provide an update on the implementation of the Whistleblowing Standards and the Whistleblowing activity in NHS Forth Valley for Quarter 4 (Q4).

Recommendation

The Forth Valley NHS Board is asked to: -

- **note** Whistleblowing activity in NHS Forth Valley in Quarter 4 of 2021/22

Key Issues to be Considered

1. Purpose of the Paper

This paper is presented to the NHS Board to provide an update on the implementation of the Whistleblowing Standards and the Whistleblowing activity in NHS Forth Valley.

2. Position

2.1 During quarter (Q3) work continued across NHS Forth Valley to fully implement the national Whistleblowing Standards. The guide, which sets out the local procedures for raising a concern under the national Whistleblowing Standards, is now available on the intranet and NHS Forth Valley website and in turn has been shared with our key contractors for wider distribution. The guide includes details of the local arrangements, contacts and procedures in place – ***refer to Appendix 1.***

2.2 The Whistleblowing Oversight Group (WBOG) and Whistleblowing Implementation Group (WBIG) was paused for a period of time due to the covid 19 pandemic and pressures across the organisation, however these meetings have now been reinstated and will focus on the outstanding actions within the delivery plan – ***refer to Appendix 2***.

2.3 A continued key focus of the WBIG will be to identify the cohort of staff that are required to complete the training developed by INWO *(1 hour module for staff and 3 hour module for managers)* and to develop a robust training plan for senior managers and staff for their areas to ensure training is implemented across the organisation and beyond.

In addition Whistleblowing training reports are now accessible from TURAS which will support the developments of training arrangements.

3. Whistleblowing Activity

3.1 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 ***(see Appendix 2)*** as outlined in the Whistleblowing Procedure.

Whistleblowing Key Performance Indicators RAG status

The table below provides an overview of the current performance in Quarter 4 against each of the Key Performance Indicators. Further details on each of the indicators are provided throughout the report.

Measure	Status	As at	RAG Status
KPI 1 Learning from Whistleblowing Concerns		Apr-22	
KPI 2 Whistleblowing Procedure Experience		Apr-22	
KPI 3 Self Awareness & Training		Apr-22	
KPI 4 Total Number of Concerns Received	5	Apr-22	
KPI 5 Concerns Closed at Each Stage	2	Apr-22	
KPI 6 Concerns Upheld or Not Upheld	3	Apr-22	
KPI 7 Average Times	0	Apr-22	
KPI 8 Closed in full within the timescales	2	Apr-22	
KPI 9 Number of Cases where an extension is authorised	0	Apr-22	

Key Performance Indicator One: Learning from Whistleblowing Concerns

The Indicator requires NHS Forth Valley to demonstrate any changes or improvements to services or procedures as a result of a Whistleblowing concern.

The learning and improvement identified from the Whistleblowing concerns in this quarter (Q4) included:

Clinical Care
Communication
Cleanliness

At this time activity is too low to extrapolate any meaningful themes at this point. This is consistent across NHS Scotland but will evolve overtime.

<u>Independent National Whistleblowing Officer (INWO)</u>

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 in the

NHS Whistleblowing Procedure and offers an independent view on whether the NHS has reasonably responded to a Whistleblowing concern.

The INWO has received 0 cases relating to NHS Forth Valley Whistleblowing concerns during this quarter (Q4). The table below provides detail of the outcomes as at quarter 4 from the investigations. It may be worth noting that the number detailed below was from Q3 update.

2021/22 INWO Outcomes	Total Number
Fully Upheld	0
Partly Upheld	0
Not Upheld	0
No Investigation Conducted	1
Withdrawn	0

Key Performance Indicator Two: Whistleblowing Procedure Experience

The Whistleblowing Procedure requires NHS Forth Valley to gather feedback from the person making the complaint regarding their experience of the process.

To note that a feedback and learning system is planned for later this year, however at this time any individual wishing to have areas considered under the Whistleblowing procedure is supported and followed up in relation to the Whistleblower or their concerns.

Key Performance Indicator Three: Self Awareness and Training

There is a requirement to report on levels of staff perceptions and awareness of training.

In this quarter (Q4) the data is not available, however this section of the report will evolve overtime as activity increases.

Key Performance Indicator Four: Total number of Concerns Received

During this quarter (Q4) there was 2 cases considered and investigated under Stage 1 of the Whistleblowing procedure. A Senior Manager was identified to look into the concerns raised and a written response was provided within the 5 working day Stage 1 target.

The table below details the number of concerns received to date:

Concerns Type	Number of Concerns	Number of concerns closed at each stage
Stage 1	5	2
Stage 2	0	0
Stage 2 after escalation	0	0

Key Performance Indicator Five: Concerns Closed at Each Stage

The table below details the number of concerns closed at each stage during this quarter (Q4):

Concerns Type	Number of concerns closed at each stage
Stage 1	0
Stage 2	0
Stage 2 after escalation	0

Key Performance Indicator Six: Concerns Upheld and Not Upheld

To meet the requirements of Indicator Six, a breakdown of the formal outcome (upheld, partially upheld, or not upheld) against Stage 1 and Stage 2 concerns is provided below:

The table below provides a breakdown of the formal outcome of the total number of concerns closed at Stage 1 for this reporting period:

Stage 1	No. Of Concerns Closed	% of Concerns Closed at Stage 1
Upheld Concerns	0	
Not Upheld Concerns	2	100%
Partially Upheld Concerns	3 *(under consideration)*	100%

The table below provides a breakdown of the formal outcome of the total number of concerns closed at Stage 2 for this reporting period:

Stage 2	No. Of Concerns Closed	% of Concerns Closed at Stage 2
Upheld Concerns	Not applicable	Not applicable
Not Upheld Concerns	Not applicable	Not applicable
Partially Upheld Concerns	Not applicable	Not applicable

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 and a detailed breakdown is provided in the table below:

	Average Times	Closed Concerns
Stage 1	Not applicatble	Not applicatble
Stage 2	Not applicatble	Not applicatble

In this quarter (Q4) there has been minimal activity. This section of the report will continue to be develop overtime dependant on the activity.

Key Performance Indicator Eight: Closed in Full within the Timescales

Overall Whistleblowing Performance

Stage 1 and Stage 2 Performance

During this quarter (Q4), a total of 2 complaints were investigated under Stage 1 of the Whistleblowing Procedure and responded to within the 5 working day target.

A breakdown of the numbers of concerns received and investigated at each stage is detailed in the table and below:

	Acute	Corporate	Mental Health/Learning Disabilities/Prisons	HSCP	Estates & Facilities
Stage 1	1	0	3	0	1
Stage 2	0	0	0	0	0

TOTAL	1	0	3	0	1

Key Performance Indicator Nine: Number of Cases where an Extension is Authorised

It is important that we respond to their concerns timeously however not all investigations will be able to meet this deadline; however the Whistleblowing Procedure allows an extension where it is necessary to complete the investigation.

The table below details the number of concerns whereby an extension has been authorised against the total number of concerns received at each stage.

Concerns Type	Extension
Stage 1	Not applicatble
Stage 2	Not applicatble
Stage 2 after escalation	Not applicatble

4. Conclusion

Key to the full implementation of the national Whistleblowing Standards was the development of NHS Forth Valley's local guide, which sets out the local procedures for raising a concerns under the national Whistleblowing Standards and includes details of the local arrangements, contacts and procedures in place for staff to raise their concerns.

It is worthwhile noting that although Whistleblowing numbers remain low there has been some activity and 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 procedure.

Furthermore a future key focus of the WBIG & WBOG is to build into our approach an ongoing impact evaluation and learning system with feedback and improvements captured and shared as its core to build the confidence of the staff in these new standards overtime. This will evolve overtime as activity increases.

5. Recommendation:

The Forth Valley NHS Board is asked to: -

- **note** Whistleblowing activity in NHS Forth Valley in Quarter 4 of 2021/22

Financial Implications

No major impact other than the potential post noted in Workforce Implications, and in addition a small one off cost of £1500.00 and a recurring cost of approximately £500 per annum to support the development within safeguard to data capture the Whistleblowing process.

Workforce Implications

We had agreed an interim model of corporate support for the implementation of the standards and ongoing co-ordination of Whistleblowing processes. A dedicated admin post has been developed and a request for funding for a Band 4 post. This post is currently being supported within the nursing directorate.

The cohort of Speak Up Ambassadors and Advocates have been established and are required to undertake these roles in additional to their substantive posts. However, a local agreement of how

senior leaders can enable staff in their teams and departments to fulfil these duties within working hours and will require to be developed and supported over time.

There are no further workforce impacts at this time although supervision and support will be required for Speak Up Ambassadors, Advocates and Confidential Contacts is a key element of our approach.

Risk Assessment

Effective whistleblowing processes can act as both detective and preventative risk management controls to support the organisation and its staff.

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.

There is also a public confidence and reputation 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.

Relevance to Strategic Priorities

The introduction of the Independent National Whistleblowing Officer Service aims to ensure everyone delivering NHS services in Scotland is able to speak up to raise concerns when they see harm or wrong doing 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 is a key priority for NHS Forth Valley in 2021/22.

Equality Declaration

The author can confirm that due regard has been given to the Equality Act 2010 and compliance with the three aims of the Equality Duty as part of the decision making process.

Further to an evaluation it is noted that:

- Screening completed - no discrimination noted

NHS Forth Valley is also carrying out a local Equality Impact Assessment as part of the implementation plan.

Consultation Process

This paper has been developed and considered to date by the following groups. The groups have either supported the content, or their feedback has informed the development of the content presented in this report.

- Whistleblowing Implementation Group
- Whistleblowing Oversight Group
- Staff Governance Committee
- Executive Leadership Team (ELT)

Appendix 1 – Whistleblowing Local Guide and Procedure


Whistleblowing Local Guide_Procedure.doc


Stage 1 WB Flowchart .docx


Stage 2 WB Final Flowchart Final.docx

Appendix 2 – Whistleblowing Delivery Plan


NHS FV Whistleblowing Stand

FORTH VALLEY NHS BOARD
TUESDAY 31 MAY 2022

8.1 Finance Report
Seek Assurance

Executive Sponsor: Cathie Cowan Chief Executive

Authors: Scott Urquhart, Director of Finance
Jillian Thomson, Deputy Director of Finance

Executive Summary
This paper provides an update on the 2021/22 outturn and annual accounts process and a high-level summary of the early 2022/23 financial position including consideration of new and emerging potential risks and progress on the cost improvement programme.

Recommendation
The Forth Valley NHS Board is asked to:

- **note** that progress with finalising the year-end annual accounts and audit process for 2021/22 remains on track within planned timescales.
- **note** the updated draft year-end revenue position for 2021/22 is a surplus of £0.290m, subject to External Audit confirmation.
- **note** the early financial position reported for Month 1 2022/23 and the associated financial risks and uncertainties.
- **note** the progress on development of recurring Cost Improvement Plans with an update scheduled to the June Performance and Resources Committee meeting.

Key Issues to be considered
Issues are highlighted within the attached Finance Report

Financial Implications
Any relevant financial implication will be discussed within the Finance Report

Workforce Implications
Any workforce implications are highlighted within the Finance Report

Risk Assessment
Key risks are highlighted within the appropriate level of Risk Register

Relevance to Strategic Priorities
There is a statutory requirement for NHS Boards to ensure expenditure is within the Revenue Resource Limit (RRL) and Capital Resource Limit (CRL) set by Scottish Government.

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

- Paper is not relevant to Equality and Diversity

Consultation Process
Directorate Management Teams with Finance colleagues

1.0 EXECUTIVE SUMMARY

1.1 Draft Outturn Financial Year 2021/22

The 2021/22 financial outturn has now been updated to reflect the final funding allocation letter from the Scottish Government and confirmation of draft IJB positions. As a result, the draft revenue surplus is now reported at £0.290m (an increase of £0.064m on previously reported position), subject to External Audit review.

External Audit field work is underway and good progress is being made as we work towards a target completion date of 10 June 2022. The audited accounts are expected to be submitted to the Audit and Risk Committee for consideration on 22 June 2022 and the NHS Board thereafter for approval on 24 June 2022, in line with statutory requirements.

1.2 2022/23 Financial Performance

An overspend of £0.886m is reported for the first month of the financial year. This reflects sustained workforce pressures (largely within Acute and Specialist Mental Health Services), ongoing costs increases in both Hospital and Primary Care prescribing (reflecting increased volumes and uptake of new drugs), together with an element of unachieved recurring efficiency savings carried forward from the previous year. Specific year to date performance issues are considered within the body of this report.

In addition, several new and emerging risks are identified at this early stage in the financial year, including the cost associated with the re-grading of Health Care Support Workers, non-pay inflationary pressures (in relation to energy and fuel costs), uncertainty regarding a range of anticipated allocations and ongoing Covid-19 related expenditure. Note that the Scottish Government has confirmed that a letter will be issued imminently to clarify expectations and accountability in relation to Covid costs and funding which will be important in quantifying the level of associated financial risk.

In terms of efficiency savings, work is underway in conjunction with the CPMO to progress the cost improvement programme (including the review and strengthening of internal financial and workforce controls). Individual engagement sessions are being carried out with Directors and a detailed update will be presented to the June 2022 Performance & Resources Committee.

1.3 Future Years Financial Planning

The Scottish Government is expected to publish multi-year spending plans within the Resource Spending Review and refreshed Medium Term Financial Framework on 31st May 2022, which will help inform future year plans at portfolio level. Further information and any specific highlights for Health spending will be relayed to the Performance and Resources Committee.

2.0 CLINICAL DIRECTORATES

A net overspend of £0.452m is reported for the 1 month period ending 30 April in respect of Clinical Directorates as summarised in the table below.

Directorate	Annual Budget £m	YTD Budget £m	YTD Spend £m	YTD Variance £m
Acute Services	180.891	13.722	15.088	(1.366)
Cross Boundary Flow	57.739	4.803	4.808	(0.005)
Community Services incl Prisons	14.391	1.181	1.193	(0.012)
Women & Children	47.044	4.143	4.291	(0.148)
Specialist Mental Health	17.185	1.431	1.641	(0.210)
Ringfenced and Contingency Budgets	50.885	1.227	0.000	1.227
Income	(26.927)	(2.228)	(2.290)	0.062
Total	**341.208**	**24.279**	**24.731**	**(0.452)**

Note these budgets include services defined as 'Set Aside'

Significant ongoing operational service pressures continue to reported in Acute Services and Specialist Mental Health areas which require the use of supplementary staffing to support the position. Additional Covid expenditure and increasing drugs costs (particularly within oncology) also contribute to the reported overspend.

3.0 CORPORATE SERVICES AND FACILITIES

A net overspend of £0.443m is reported for the 1 month period ending 30 April in respect of Corporate Services and Facilities as summarised in the table below.

Service	Annual Budget £m	YTD Budget £m	YTD Spend £m	YTD Variance £m
Facilities & Infrastructure	97.925	8.026	8.074	(0.048)
Corporate Services				
Director of Finance	3.655	0.305	0.301	0.004
Area Wide Services	4.525	0.363	0.403	(0.040)
Medical Director	8.218	0.220	0.227	(0.007)
Director of Public Health	2.808	0.195	0.535	(0.340)
Director of HR	4.390	0.357	0.351	0.006
Director of Nursing	2.946	0.127	0.201	(0.074)
Chief Executive	2.139	0.175	0.163	0.012
Portfolio Management Office	0.565	0.042	0.030	0.012
Immunisation / Other	1.112	0.093	0.061	0.032
Total	**128.283**	**9.903**	**10.346**	**(0.443)**

The key pressure area relates to Public Health which reflects the costs of the local Covid Test and Protect team. This is currently unfunded, further information is awaited from the Scottish Government as this is expected to be financially managed on a national basis going forward. Emerging pressures are also being reported against the Director of Nursing budget relating to enhanced Care Home Support and MacMillan nursing support for cancer services.

4.0 HEALTH AND SOCIAL CARE PARTNERSHIPS

A net underspend of £0.443m is reported for the 1 month period ending 30 April in respect of Corporate Services and Facilities as summarised in the table below.

HSCP	Annual Budget £m	YTD Budget £m	YTD Spend £m	YTD Variance £m
Falkirk				
Operational Services	63.228	5.385	5.039	0.346
Universal Services	78.667	5.913	6.156	(0.243)
Subtotal	141.895	11.298	11.195	0.103
Clackmannanshire and Stirling				
Operational Services	49.695	4.138	4.077	0.061
Universal Services	80.614	6.112	6.267	(0.155)
Subtotal	130.309	10.250	10.344	(0.094)
TOTAL	**272.204**	**21.548**	**21.539**	**0.009**

The budgets outlined in the table above are designated as in scope for Health and Social Care Integration and exclude delegated services defined as Set Aside. Financial pressures relating to 'Set Aside' services are directly managed by NHS Forth Valley and this is currently captured within the Clinical Directorate section of the report.

In line with previous years, the key financial challenge in both HSCP's relates to primary care prescribing. Volume growth in the number of items prescribed and the average cost per item both remain higher than original planning assumptions. This reflects ongoing demand and short supply issues, together with delays in achieving efficiency savings.

FORTH VALLEY NHS BOARD
TUESDAY 31 MAY 2022

9.1 Climate Change and Sustainability: National Direction and Local Response
For Assurance

Executive Sponsor: Mrs Cathie Cowan, Chief Executive

Director Lead: Jonathan Procter – Director of Facilities & Infrastructure

Author: Jonathan Procter – Director of Facilities & Infrastructure, Derek Jarvie, Environmental & Sustainability Manager, Morag Farquhar – Assoc Director of Facilities & Infrastructure,

---

Executive Summary

Scotland's First Minister declared a Climate Emergency in summer 2019 and committed Scotland to legally-binding 'net-zero emissions' targets. Progress in terms of responding to the climate emergency was affected by the Covid-19 pandemic and in November 2021 DL (2021) 38 (attached at Appendix 1), the NHS Scotland Policy on the Climate Emergency and Sustainable Development, came into force.

DL38 is underpinned by the NHS Scotland Climate Emergency and Sustainability Strategy - 2022 to 2026 that is currently being finalised by the Scottish Government (following consultation).

These documents clearly set out what NHS Scotland Boards are expected to do to mitigate the impacts of climate change and shift onto a net-zero trajectory. The Scottish Government (SG) has set out challenging aims and targets for NHS Scotland's response to the climate emergency and environmental sustainaibility.

The Scottish Government Health & Social Care Directorates (SGHSC) have established an NHS Scotland Climate Emergency and Sustainability Board to provide leadership and governance and to monitor each Board's efforts in responding to the global climate emergency.

Recommendation:

The Forth Valley NHS Board is asked to: -

- **acknowledge** the scale of the climate emergency and net zero challenge
- **note** the governance, operational and reporting arrangements
- **support** the whole-system change-management process that will be required to shift climate emergency considerations to the core of this organisation's decision-making
- **consider** appointing a Board member to act as the NHS Forth Valley champion
- **note** the Resourcing and Financial Implications and associated risks

Summary & Key Issues to be Considered:

Five priority areas have been identified by the SG:

- Sustainable Buildings & Land
- Sustainable Travel
- Sustainable Goods & Services

- Sustainable Care
- Sustainable Communities

NHS Boards are required to:

- Reduce carbon emissions to net-zero by 2040 and decarbonise the NHS Scotland estate by 2038 (i.e. no gas heating);
- Reduce energy use and resource consumption
- Promote/deliver environmentally sustainable models of care
- Support establishment of a circular economy
- Make better use of greenspace as part of the healing/caring process and to support biodiversity
- Support procurement of sustainable goods and services
- Reduce pollution resulting from the Board's activities
- Promote more environmentally sustainable methods of accessing health care, such as active travel and public transport

NHS Scotland Boards are required to establish a strong management structure to ensure delivery of the aims of DL38 and fully integrate these aims into all planning, management decisions and operational practices.

- Each NHS Scotland body must:
    - appoint a member of its Board to act as champion for its climate emergency response
    - appoint an executive lead for climate emergency and sustainability
    - establish a Climate Emergency and Sustainability Group or designate an existing committee as the lead group for climate emergency and sustainability.

This Board's climate emergency/sustainability governance, operational and reporting requirements were reviewed by the existing Sustainability Working Group and a restructure proposed. The required changes and proposed restructure are set out in Appendix 2.

The following governance arrangements have been agreed with the Chief Executive:

- NHS Forth Valley's Climate Emergency & Sustainability Lead: Director of Facilities & Infrastructure
- NHS Forth Valley's Climate Emergency & Sustainability Board will be established. The Chair and membership of this group is to be confirmed. Membership may include, but will not be limited to:
    - Chief Executive
    - Director of Facilities & Infrastructure
    - Director of Finance
    - Director of Pharmacy
    - Director of Public Health & Strategic Planning
    - Medical Director
    - Employee Director
    - Assoc Director of Facilities & Infrastructure
    - Others TBC
- Board-level champion for the NHS Forth Valley climate emergency response TBC
- Each Health Board is expected to put in place a Climate Emergency Response and Sustainability Team with the right resources to help the Health Board deal with the scale and complexity of the challenges of decarbonisation and environmental sustainability. The Team for NHS Forth Valley will be chaired by the Associate Director of Facilities & Infrastructure – Asset Management and will be supported by the following Working Groups:

- Energy/net-zero: buildings estate/facilities
- Waste management: minimisation and recycling
- Transport: fleet operations and active transport
- Greenspace & Biodiversity
- Sustainable Care Medical Planning – aligned with existing Realistic Medicine agenda and includes Green Theatres and the Forth Valley Greener Practice Group
- Procurement, Supply Chain & Circular Economy
- Sustainable Communities – aligned with Anchor Institution/Community Wealth Building activity

The focus of each Working Group will be on identification and implementation of projects and initiatives that will underpin this Board's response to the climate emergency, and support development of a sustainable health service. Each Working Group will agree a set of actions and outcomes that will inform the NHS Forth Valley Climate Emergency & Sustainability Action Plan.

The following reporting arrangements will be implemented:

- An assessment of each Board's progress against the aims of DL38 will form part of each NHS Scotland body's annual ministerial review
- Each NHS Scotland body must publish a report on its public website by November each year summarising its progress against the aims of DL38 using a template approved by the SGHSC. This report is in addition to existing annual climate change reporting and the National Sustainability Assessment that is carried out annually by all NHS Scotland Boards. The progress report must be approved by the NHS Scotland body's Chief Executive and be provided to the:

    - NHS Scotland body's staff
    - NHS Scotland body's board members; and
    - Scottish Government Health and Social Care Directorates

The NHS Forth Valley Climate Emergency & Sustainability Board will Report to the Executive Leadership Team (ELT) and the Performance & Resources Committee (P&RC) and will be aligned with existing annual mandatory submissions (e.g. Public Bodies Duties Climate Change Report and the National Sustainability Assessment) and requirements within DL38. This will be six-monthly to the ELT (more frequently if/when required) and annually to the P&RC, with the next update to P&RC scheduled for June 2022.

Financial Implications

Each Health Board is expected to put in place a Climate Emergency Response and Sustainability Team with the right resources to help the Health Board deal with the scale and complexity of the challenges of decarbonisation and environmental sustainability.

In November 2021, the SG carried out a resourcing gap analysis to determine and quantify the sustainability staffing shortfall within each NHS Scotland Board. NHS Forth Valley submitted the information that was requested and awaits a response from the SG. The SG has set up a short life working group to identity options to resolve/fund the staffing shortfall, Directors of Finance from representative Boards have been invited to participate.

At present, this Board has one FTE focused wholly on this agenda. The aim initially is to deliver from within existing resources, however it is assumed that Scottish Government and/or Board funding will be made available to build a Climate Emergency & Sustainability Team. Any collaboration opportunities on a regional basis will also be explored.

The more immediate financial implications are associated with the limited staff resource currently available within this Board to build an effective Climate Emergency Response and Sustainability

Team. This may be addressed wholly or partially by the SG, but additional Board funding is likely to be required to bridge the gap.

Workforce Implications

This has been covered in the sections above.

Risk Assessment

The formal risk assessment is under development and will be reviewed by the NHS Forth Valley Climate Emergency & Sustainability Board and will include the potential risks:

- Limited dedicated staff resources
- Underestimating the complexity and time it will take to implement
- Lack of senior management buy-in
- Increased costs for more sustainable choices
- Conflicting priorities impacting on availability of key individuals in the project
- Ongoing impact of COVID-19 pandemic
- Operational challenges affecting implementation
- Other risks to be identified and assessed

Relevance to Strategic Priorities

Aligns with/contributes towards:

- Plan for the Future
- Improving the health and wellbeing of the people of Forth Valley whilst reducing health inequalities - The climate crisis is a health crisis and many of the drivers of climate change are drivers of ill health and health inequalities.
- Improves the focus on safety and quality
- Values and develops our people
- Delivers best value using our resources
- Promotes and builds integrated services locally and regionally
- Displays leadership behaviours that nurture and support transformational change across our health and care system

Equality Declaration

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

- Paper is not relevant to Equality and Diversity

Consultation Process

The Board's Sustainability Working Group has contributed to the consultation process and the proposed governance restructure.

Appendix 1

Health Finance, Corporate Governance &
Value Directorate
Richard McCallum, Director

Scottish Government
Riaghaltas na h-Alba
gov.scot

T: 0131-244 3475
E: richard.mccallum@gov.scot

NHS Chairs
NHS Chief Executives
via email

10th November, 2021

Dear Colleagues

A POLICY FOR NHS SCOTLAND ON THE CLIMATE EMERGENCY AND SUSTAINABLE DEVELOPMENT - DL (2021) 38

I am writing to share with you the attached policy statement, a '**Policy for NHS Scotland on the Global Climate Emergency and Sustainable Development**'.

This policy statement supersedes CEL 2 (2012) 'A Policy on Sustainable Development for NHSScotland 2012'.

Addressees should ensure that this letter is cascaded to all appropriate staff within their area of responsibility.

The attached document has been prepared in consultation with Health Boards and relevant Scottish Government and public sector stakeholders. It takes account of relevant wider Scottish Government policies and existing statutory duties on Health Boards.

The policy sets out aims and associated targets for NHS Scotland to work towards. The forthcoming NHS Scotland Climate Emergency and Sustainability Strategy will provide proposals for action to assist in meeting those aims and targets.

The Policy for NHS Scotland on the Global Climate Emergency and Sustainable Development takes immediate effect.

Responding to the climate emergency is one of the Scottish Government's highest priorities and I look forward to working with you on this crucial matter.

Yours sincerely

Richard McCallum
Director of Health Finance and Governance

A Policy for NHS Scotland on the Global Climate Emergency and Sustainable Development

Introduction

Responding to the global climate emergency is one of the Scottish Government's highest priorities. Sustainable development, the concept that the needs of the present must be met "without compromising the ability of future generations to meet their own needs"[1] is integral to the Scottish Government's overall purpose. The Scottish Government's National Performance Framework shares the same aims as the United Nations' Sustainable Development Goals.

The purpose of this policy is to provide a framework for NHS Scotland to maximise its contribution to mitigating and limiting the effects of the global climate emergency and for the development of an environmentally and socially sustainable health service that is resilient to the locked-in impacts of climate change. **As such, the policy is mandatory for all NHS Scotland bodies and its scope extends to all of their activities.**

The aims of this policy must be fully integrated into all planning, management decisions and operational practices across NHS Scotland in order to respond fully to the global climate emergency and achieve an environmentally and socially sustainable health service.

Background

The planet is in the midst of a climate emergency as a result of human activity and urgent action is required to reduce greenhouse gas emissions, adapt to the changes caused by climate change and achieve an environmentally and socially sustainable society.

Climate change presents a serious risk to the health of people around the world and has been described by the Lancet Commission on Managing the Health Effects of Climate Change as "*the biggest global health threat of the 21 century*"[2].

At the same time, many of the actions to mitigate and adapt to climate change and improve environmental sustainability also have positive health benefits to such an extent that the Lancet Commission has described tackling climate change as "*the greatest global health opportunity of the 21st century*".[3] It is therefore incumbent on NHS Scotland to be an exemplar in responding to the climate emergency and achieving environmental sustainability.

Meeting the needs of the present requires action to address the inequalities in our society, inequalities which manifest themselves in significantly poorer health outcomes for the most deprived. Many of the health benefits of action to address the climate emergency and ecological crisis will have the greatest benefits for those with the worst health outcomes.

---

[1] Report of the World Commission on Environment and Development: Our Common Future (1987) ("the Brundtland Report") Para. 27.

[2] Reference

[3] The Lancet Commission on Managing the Health Effects of Climate Change (2015) – complete reference

Policy Aims

- Ensure that NHS Scotland bodies, as an integral part of their commitment to the health and wellbeing of the community, contribute to the achievement of the United Nation's Sustainable Development Goals.
- Ensure that NHS Scotland becomes a net-zero greenhouse gas emissions health service by 2040 or earlier where possible.
- Ensure that NHS Scotland's assets and activities are resilient to the impacts of a changing climate, particularly extreme weather events.
- Establish a culture of stewardship within NHS Scotland, where natural resources are safeguarded and responsibly used to provide environmentally sustainable healthcare.
- Establish NHS Scotland as part of the circular economy through designing out waste and pollution, keeping products and materials in use and contributing to the regeneration of natural systems.
- Increase NHS Scotland's contribution to tackling the ecological emergency and restoring biodiversity.

Governance

1. Each NHS Scotland body must implement a strong management structure as a means of ensuring the delivery of this policy's aims. Each NHS Scotland body must either establish a Climate Emergency and Sustainability Group or designate an existing committee as the lead group for climate emergency and sustainability. In either case, the group must be chaired by a member of its senior / executive management team and its membership must be of sufficient authority to ensure that the aims of this policy are fully integrated into all planning, management decisions and operational practices across the NHS Scotland body.

2. The Scottish Government Health and Social Care Directorates (SGHSC) have established an NHS Scotland Climate Emergency and Sustainability Board to provide leadership and governance to NHS Scotland's overall efforts in responding to the global climate emergency and achieving an environmentally and socially sustainable health service.

3. Each NHS Scotland body must appoint an executive lead for its climate emergency response and sustainability.

4. Each NHS Scotland body must appoint a member of its board to act as champion for its climate emergency response and sustainability at a strategic level to assist in articulating and promoting its sustainability priorities.

5. Each NHS Scotland body Chief Executive is accountable to the SGHSC for their organisation's implementation of this policy.

6. NHS Scotland bodies which encounter issues with or barriers to the implementation of this policy or its aims which cannot be resolved at NHS Scotland body level must escalate those issues to the NHS Scotland Climate Emergency and Sustainability Board.

7. As assessment of its progress against the aims of this policy will form part of each NHS Scotland body's annual ministerial review.

Integrated approach and co-operation

8. NHS Scotland bodies must take an integrated approach to the achievement of the aims of this policy. In developing plans or taking action, NHS Scotland bodies must consider the full range of this policies' aims.

9. NHS Scotland bodies must co-operate with each other with a view to achieving the aims of this policy.

10. The achievement of this policy's aims will require NHS Scotland bodies to work with their local communities and patients and with organisations outside of the NHS who have similar aims or who can assist NHS Scotland to achieve its aims. In particular, territorial Health Boards are required to use all reasonable efforts to work with the local authorities for their areas to achieve this policy's aims.

A Just Transition

11. In implementing this policy, NHS Scotland bodies must:

    a) plan, invest and implement a transition to an environmentally and socially sustainable, climate resilient, health service in a way which builds on Scotland's economic and workforce strengths and potential;

    b) create opportunities to develop resource efficient and sustainable approaches which help address inequality and poverty; and

    c) design and deliver low carbon and climate resilient investment and infrastructure, making all possible efforts to create decent, fair and high value work.

Net-zero

Scope 1 and 2 emissions

12. Having regard to national plans to decarbonise the UK's electricity supply by 2035, each NHS Scotland body must reduce the greenhouse gas emissions from its activities, the activities under its control and from the electricity, steam and heat purchased by it to net-zero by 2040 or earlier where possible. The UK's independent, statutory Climate Change Committee advises that most sectors will need to reduce emissions close to zero without offsetting.

13. All NHS owned buildings must be heated from renewable sources by 2038 or earlier where possible.

Scope 3 greenhouse gas emissions

14. NHS Scotland bodies must, as a minimum, reduce their associated greenhouse gas emissions from the following sources to net-zero by 2040 or earlier where possible:

    - energy transmission and distribution, having regard to national plans to decarbonise the UK's electricity supply by 2035
    - waste disposal
    - business travel, including grey fleet

- water consumption
- waste water treatment
- leased assets

15. Each NHS Scotland body must take sufficient action to influence a reduction in those greenhouse gas emissions which are linked to its activities but are from sources which it does not own or control (and are not included in paragraph 14) to maximise its contribution to reducing emissions to net-zero by 2045 or earlier where possible.

Interim targets

16. Where the 1990 baseline is known for an emissions source, the NHS Scotland body must reduce the emissions from that source by at least 75% by 2030.

17. Where the 1990 baseline is not known for an emissions source, the NHS Scotland body must set interim targets for reducing emissions from that source which are consistent with achieving the net-zero target for the emissions type.

Greenhouse gas emissions reporting

18. Each NHS Scotland body must assess their progress towards net-zero emissions via their annual Public Bodies' Climate Change Duties Report which is to be submitted to the Scottish Government by 30 November each year. NHS Scotland bodies should, as a minimum, report on their annual emissions associated with their:

    - building fossil-fuel energy use
    - owned and leased fleet fuel use
    - fluorinated gases and anaesthetic gases (where relevant)
    - purchased energy use (electricity, heat, steam)
    - energy transmission and distribution
    - waste
    - water consumption
    - waste water treatment
    - business travel, including the use of grey fleet
    - leased assets

Climate change adaptation

19. Each NHS Scotland body must undertake a Climate Change Risk Assessment covering all operational areas and produce and implement a Climate Change Adaptation Plan to ensure resilience of service under changing climate conditions and these should be reviewed and updated at least every 5 years.

20. In relation to existing facilities, these assessments and plans should cover a period at least 20 years into the future from the time of assessment.

21. In relation to planned facilities, these assessments and plans should cover a period at least 50 years into the future from the time of assessment.

22. The key risks from the Climate Change Risk Assessment must be incorporated into each NHS Scotland body's corporate risk register.

23. Progress on undertaking Risk Assessments and implementing Adaptation Plans, including in terms of how these are supporting national Scottish Climate Change Adaptation Programmes, is to be set out in each bodies' annual Public Bodies' Climate Change Duties Report.

Sustainable care

24. Each NHS Scotland body will foster and promote a culture of stewardship, where staff are mindful of the resources they use and share a vision of green and sustainable healthcare.

25. Each NHS Scotland body must ensure their workforce consider the environmental impacts of treatments when making decisions about the care they provide.

26. Each NHS Scotland body will ensure all employees are educated and trained on the principles of practising sustainably.

Procurement

27. Each NHS Scotland body must consider social and environmental sustainability when it is procuring goods and services. The procurement of goods and services by NHS Scotland bodies must further the aims of this policy.

28. NHS Scotland bodies are reminded of the sustainable procurement duty established by section 9 of the Procurement (Scotland) Act 2014, which can be viewed here: Procurement Reform (Scotland) Act 2014 (legislation.gov.uk). NHS Scotland bodies are required to follow the guidance and use the tools issued by the Scottish Government to assist in optimising the economic, social and environmental outcomes of their procurement activity.

29. It is the responsibility of each NHS Scotland body to review the supply chain of the goods and services that it procures to determine the extent of the associated greenhouse gas emissions and social and environmental impacts. Where an NHS Scotland body procures goods and services on behalf of another organisation, it is the responsibility of the procuring body to review the supply chain.

Circular economy

30. Each NHS Scotland body must contribute to the creation of a circular economy, working with National Procurement and with suppliers to design out waste and consider the entire life cycle of products and services, reducing the environmental impact, keeping products and materials in use and contributing to the regeneration of natural systems.

31. In particular, NHS Scotland bodies must:

    - promote the use of items and assets which have been designed for durability and upgradability;
    - prolong the use of items and assets through proper maintenance and promoting their reuse; and
    - promote the use of items and assets which can be recycled at the end of their useful life.

32. NHS Scotland bodies, with support from National Procurement, must identify and assess the life cycle of products and services and take action to reduce their environmental impact through the avoidance of pollution (including toxic chemicals, micro-plastics and pharmaceutical residues) and waste throughout their life cycle.

Water

33. Each NHS Scotland body must monitor its water usage and take action to reduce unnecessary water consumption.

Resource and Waste Management

34. Each NHS Scotland body must put in place a system for recording and reporting the volume and type of waste which it generates and the destination of that waste.

Targets

35. By 2025, each NHS Scotland body must:

    a) reduce its domestic waste arising by a minimum of 15%, and greater where possible, compared to a financial year 2012/13 baseline;
    b) ensure that no more than 5%, and less where possible, of all its domestic waste goes to landfill;
    c) reduce the food waste it produces by 33% against a financial year 2015/16 baseline; and
    d) ensure that 70% of all its domestic waste is recycled or composted.

36. Each NHS Scotland body must set appropriate targets for reducing the volume of healthcare waste it produces through measures including greater use of reusable items, improvements to waste segregation and increased recycling of recyclable materials.

Biodiversity and Greenspace

37. Under section 1 of the Nature Conservation (Scotland) Act 2004, it is the duty of each NHS Scotland body in exercising its functions to further the conservation of biodiversity so far as is consistent with the proper exercise of those functions. In addition to that duty, each NHS Scotland body must promote improvements to biodiversity in so far as is consistent with the proper exercise of its functions.

38. All NHS Scotland bodies must assess, and then take action to improve:

    a) the extent and quality of the greenspace they have;
    b) the contribution its estate makes to biodiversity; and
    c) the value of the ecosystem services its greenspaces provide.

39. Greenspace can have benefits for the health and wellbeing of staff, patients and communities. NHS Scotland bodies must manage their greenspace to increase its provision and improve access, quality and regular use by staff, patients and the local community.

40. Greenspace can have benefits in relation to climate change mitigation and adaptation through, for example, reducing flooding and absorbing heat. NHS Scotland bodies

must manage their greenspace to assist with climate change mitigation and adaptation.

41. All NHS Scotland bodies must collaborate with local partners to improve the natural links between NHS greenspace and other local areas of greenspace.

42. Where an NHS Scotland body proposes an action which would result in the loss in quantity or quality of greenspace to the NHS or its contribution to biodiversity, it must refer the proposal to the SGHSC.

43. It is the duty, under section 2A of the Nature Conservation (Scotland) Act 2004, of each NHS Scotland body to publish a report every three years on the actions taken by it in pursuance of its duty under section 1 of that Act during the period to which the report relates. These reports must be forwarded to SGHSC when they are published.

Travel and transport

44. All NHS Scotland bodies must take action to reduce the carbon emissions resulting from travel associated with their activities, including those associated with staff and patient travel. Those actions must include:

    - Actions to reduce the need for travel;
    - Actions to increase active travel;
    - Actions to increase the use of public or community transport to access services and sites;
    - Actions to reduce car use in support of the Scottish Government's aim to reduce the number of kilometres driven in Scotland by 20% by 2030 compared to a 2019 baseline; and
    - Actions to support the use of vehicles powered by renewable energy in preference to vehicles powered by fossil fuels.

45. The actions set out in the paragraph above must be taken in a way which supports access to services with a particular focus on addressing inequality of access.

46. Each NHS Scotland body must remove all petrol and diesel fuelled cars from their owned and leased fleets by 2025 or earlier where possible.

47. Each NHS Scotland body must phase out the need for it to purchase or lease any petrol or diesel light commercial vehicles by 2025 or earlier where possible.

48. Each NHS Scotland body must phase out the need for it to purchase or lease any petrol and diesel vehicles by 2030 or earlier where possible.

49. Each NHS Scotland body must decarbonise its owned and leased fleet by 2032 or earlier if possible.

50. Each NHS Scotland body will develop a sustainable transport and travel policy.

Facilities

51. All NHS Scotland bodies must take sufficient action to ensure that the buildings they own or occupy achieve net-zero greenhouse gas emissions by 2040 or earlier if possible. The UK's independent, statutory Climate Change Committee advises that

most sectors will need to reduce emissions close to zero without offsetting. Therefore, the public sector's owned estate needs to achieve as close as possible to absolute zero direct emissions.

52. All NHS Scotland new buildings and major refurbishments must be designed to have net-zero greenhouse emissions. Where a net-zero design is not currently practicable, the project must only be approved where a credible route map showing how net-zero emissions will be achieved before 2040 is produced.

53. In addition, all NHS Scotland owned buildings must be heated from renewable sources by 2038. All NHS Scotland new buildings must be designed to achieve that target. Where a renewable heat source is not currently practicable, the project must only be approved where a credible route map showing how renewable heating will be achieved before 2038 is produced.

54. All NHS Scotland buildings should be assessed for resilience to the locked in impacts of climate change over the expected lifespan of that building. Where resilience is not considered sufficient, an action plan must be set out to improve this.

55. Each NHS Scotland body's Property and Asset Management Strategy must support the achievement of this policy's aims and in particular the requirements to reduce carbon emissions, adapt to the changing climate and promote greenspace and biodiversity.

Environmental Management Systems

56. Each NHS Scotland body must implement the following management standards to further the aims of this policy: ISO 9001 and 14001 or equivalent. NHS Scotland bodies are not required to seek external confirmation or certification of its conformance with these standards.

57. Each NHS Scotland body must have an effective Environmental Management System in place which has been approved by the SGHSC.

Resourcing

58. Each NHS Scotland body must have a Climate Emergency and Sustainability Team which is sufficiently resourced in light of the scale and complexity of the challenge of decarbonisation, sustainability and climate resilience faced by that NHS Scotland body.

59. Each NHS Scotland body must appoint an Environmental Management Representative (EMR) with the responsibility, resources and authority to implement this policy in respect of environmental management.

60. Each NHS Scotland body must appoint a Waste Management Officer with the responsibility, resources and authority to implement this policy in respect of waste. The Waste Management Officer must have responsibility for all aspects of waste management within the organisation consistent with the Scottish Government's commitments towards zero-waste and a circular economy.

61. Each NHS Scotland body must appoint an officer with the responsibility, resources and authority to implement this policy in respect of greenspace and biodiversity.

62. Each NHS Scotland body must appoint an officer with the responsibility, resources and authority to implement this policy in respect of travel.

63. Each NHS Scotland body which provides clinical services must include a sustainable care medical planning team as part of its Climate Emergency and Sustainability Team.

Assessment of Sustainability

64. Each NHS Scotland body must assess its contribution to the achievement of the United Nation's Sustainable Development Goals on an annual basis using the National Sustainability Assessment Tool provided by NHS National Services Scotland.

Awareness and Reporting

65. Each NHS Scotland body must publish a report on its public website by November each year summarising its progress against the aims of this policy using a template approved by the SGHSC for that purpose. The progress report must be approved by the NHS Scotland body's Chief Executive and be provided to:

- The NHS Scotland body's staff
- The NHS Scotland body's board members; and
- SGHSC.

66. The annual progress report will form part of each NHS Scotland's body annual ministerial review.

67. Each NHS Scotland body must have a clear communications plan to ensure that staff, patients and the local community are aware of that NHS Scotland body's climate emergency and sustainability plans, policies and processes, and to support them to make sustainable choices. The communications plan must include measures to publicise the annual progress report.

Review

68. This policy and its implementation will be reviewed annually by the NHS Scotland Climate Emergency and Sustainability Board.

Appendix 2

Climate Emergency & Sustainability – Proposed Restructure

1. Introduction

This paper summarises the climate emergency/sustainability governance, operational and reporting requirements that have been mandated by Scottish Government (SG) and sets out details of the proposed restructure that is required to ensure NHS Forth Valley is compliant.

2. Background

DL (2021) 38, the NHS Scotland Policy on the Climate Emergency and Sustainable Development came into force in November 2021. DL38 is underpinned by the NHS Scotland Climate Emergency and Sustainability Strategy - 2022 to 2026 that is currently being finalised by the SG (following consultation).

The purpose of DL38 and the NHS Scotland Climate Emergency and Sustainability Strategy is to provide a framework for NHS Scotland to maximise its contribution to mitigating and limiting the effects of the global climate emergency. The climate crisis is a health crisis and many of the drivers of climate change are drivers of ill health and health inequalities.

These documents are very prescriptive in terms of what NHS Scotland Boards are expected to do to mitigate the impacts of climate change and shift onto a net-zero trajectory. The following section summarises the governance, operational and reporting requirements within these documents.

3. Requirements within DL38

Governance

- Boards should establish a strong management structure to ensure delivery of the policy's aims and fully integrate these aims into all planning, management decisions and operational practices.
- Each NHS Scotland body must:
    - appoint a member of its board to act as champion for its climate emergency response
    - appoint an executive lead for climate emergency and sustainability
    - establish a Climate Emergency and Sustainability Group or designate an existing committee as the lead group for climate emergency and sustainability.
- the Chief Executive will be responsible to the SG for implementation of DL38. The Scottish Government Health & Social Care Directorates (SGHSC) have established an NHS Scotland Climate Emergency and Sustainability Board to provide leadership and governance and to monitor each Board's efforts in

responding to the global climate emergency (Co-Chaired by John Burns and Gregor Smith and attended by Richard McCallum, Alan Morrison and other Directors tbc).

Operational/Staff Resources

- Each Health Board will put in place a Climate Emergency Response and Sustainability Team with the right resources to help the Health Board deal with the scale and complexity of the challenges of decarbonisation and environmental sustainability. That team will report directly to the Board with the executive lead holding overall responsibility for its performance. The SG will ensure that NHS Climate Emergency Response and Sustainability Teams have the authority, resources, training and skills they need.

Each NHS Scotland body must appoint:

- an Environmental Management Representative (EMR) with the responsibility, resources and authority to implement DL38 in respect of environmental management.
- a Waste Management Officer with the responsibility, resources and authority to implement DL38 in respect of waste.
- an officer with the responsibility, resources and authority to implement DL38 in respect of greenspace and biodiversity.
- an officer with the responsibility, resources and authority to implement DL38 in respect of travel.
- Each NHS Scotland body which provides clinical services must include a sustainable care medical planning team as part of its Climate Emergency Response and Sustainability Team.

In November 2021 the SG carried out a resourcing gap analysis to determine and quantify the sustainability staffing shortfall within each NHS Scotland Board. NHS FV submitted the information that was requested and awaits a response from the SG.

Reporting

- An assessment of each Board's progress against the aims of DL38 will form part of each NHS Scotland body's annual ministerial review
- Each NHS Scotland body must publish a report on its public website by November each year summarising its progress against the aims of DL38 using a template approved by the SGHSC. This report is in addition to existing annual climate change reporting and the NSAT assessment The progress report must be approved by the NHS Scotland body's Chief Executive and be provided to:
- · The NHS Scotland body's staff
- · The NHS Scotland body's board members; and
- · (SGHSC).

4. NHS FV Climate Emergency Restructure

The proposed restructure set out in this section is designed to shift climate emergency considerations to the core of this organisation's decision-making processes and ensure compliance with DL38.

The following changes to the existing arrangements are required:

Working groups will be established in the following priority areas:

- Energy/net-zero: buildings estate/facilities
- Waste management, minimisation and recycling
- Transport: fleet and active
- Greenspace & Biodiversity
- Sustainable Care and Realistic medicine (includes Green Theatres and the Forth Valley Greener Practice Group i.e. Primary Care/GPs)
- Procurement & Circular Economy
- Sustainable Communities

The working groups will be formed largely from membership of the existing Sustainability Working Group (SWG). However, Project Leads will be identified to take responsibility for each working group, and they will have the option to include in their team other colleagues not currently included in the SWG.

Each working group will agree a set of actions and outcomes etc that will inform the NHS FV Climate Emergency & Sustainability Action Plan. The focus of each working group will be on identification and implementation of projects and initiatives that will underpin this Board's response to the climate emergency, and support development of a sustainable health service.

Collectively, the Project Leads will form the NHS FV Climate Emergency Response & Sustainability Team, this group will be Chaired by Associate Director of Facilities & Infrastructure - Asset Management.

Cross-cutting aspects of delivery that affect the whole organisation will also be addressed by the NHS FV Climate Emergency Response & Sustainability Team. For example, input and support will be invited/available in the following areas:

- HR
- Unions
- Finance/Capital Planning
- Organisational Development
- Awareness & Communications
- Environmental Management System
- Compliance

In the initial stages of establishing the operational aspect of the Board's climate emergency response (i.e. setting up Working Groups and the NHS FV Climate Emergency Response & Sustainability Team), support will be provided by the Board's Corporate Project Management Office (CPMO).

The Climate Emergency Response & Sustainability Team will report progress on a quarterly basis to the NHS FV Climate Emergency & Sustainability Board. This group will be chaired by the Director of Facilities & Infrastructure and membership will include, but not be limited to:

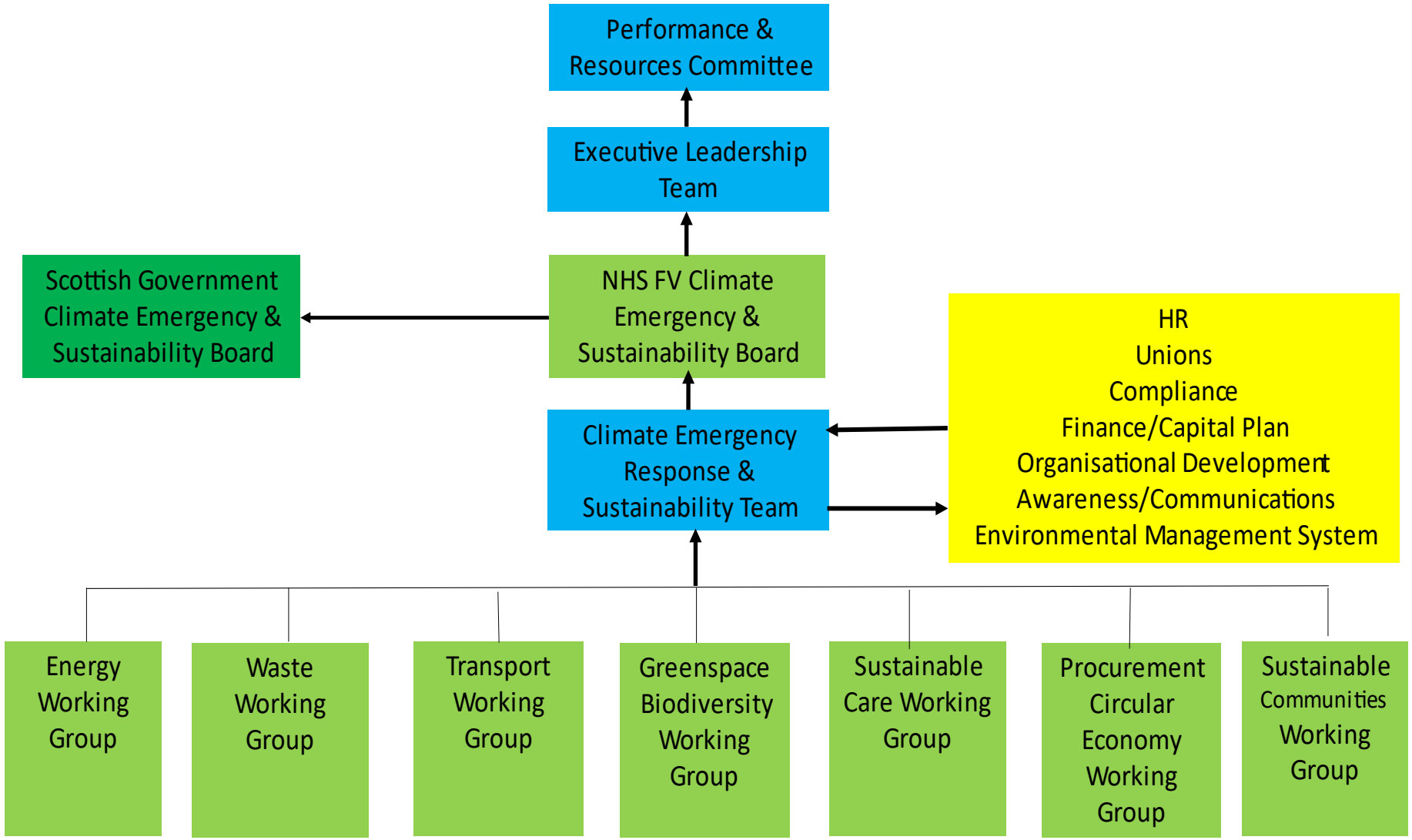
Chief Executive
Director of Finance
Director of Pharmacy
Director of Public Health & Strategic Planning
Employee Director

Reporting to the Executive Leadership Team (ELT) and the Performance & Resources Committee (P&RC) will be aligned with existing annual mandatory submissions (e.g. Public Bodies Duties Climate Change Report and the National Sustainability Assessment) and requirements within DL38. This will be six-monthly to the ELT (more frequently if/when required) and annually to the P&RC.

The NHSFV Sustainability Lead at Board level will be the Director of Facilities & Infrastructure.

5. Conclusion

The organisational chart below summarises the proposed changes. The SWG is invited to consider the proposed changes and provide comments and input at the SWG meeting that will be held on 18/05/2022.


Performance & Resources Committee
Executive Leadership Team
Scottish Government Climate Emergency & Sustainability Board
NHS FV Climate Emergency & Sustainability Board
HR
Unions
Compliance
Finance/Capital Plan
Organisational Development
Awareness/Communications
Environmental Management System
Climate Emergency Response & Sustainability Team
Energy Working Group
Waste Working Group
Transport Working Group
Greenspace Biodiversity Working Group
Sustainable Care Working Group
Procurement Circular Economy Working Group
Sustainable Communities Working Group

FORTH VALLEY NHS BOARD
TUESDAY 31 MAY 2022

9.2 ED Improvement Action Plan
For Assurance

Executive Sponsor: Mrs Cathie Cowan, Chief Executive
Authors: Gillian Morton, Andrew Murray, Linda Donaldson, and Cathie Cowan

---

Executive Summary

The purpose of this paper is to provide an update from each of the Executive Leads on the delegated responsibilities placed on each of the Assurance Committees, notably to:

- oversee implementation
- monitor progress
- escalate issues

and how these relate to the nursing workforce & professional oversight of safe staffing (referred to as 'nursing' hereafter), clinical, staff and corporate governance recommendations as set out in the Health Board's approved Emergency Department (ED) Improvement Action Plan (attached at Appendix 1).

Recommendations:

The NHS Board is asked to:

- **consider** the content of the paper and acknowledge the responsibility placed on the Health Board to seek assurance from Committee/ED Improvement Action Plan Executive Leads on the implementation of the Nursing, Clinical, Staff and Corporate Governance ED Improvement Action Plan recommendations and actions
- **note** that the Chief Executive will be sharing quarterly reports (having been considered by the Health Board) with the Integration Joint Boards to enable the IJBs to fulfil their oversight role
- **note** the commission of Internal Audit to provide assurance on the Health Board's response to the ED external review

Key Issues to be considered

On 25 January 2022, the Health Board endorsed the proposal from the Board's ED Oversight and Assurance Sub Committee to delegate scrutiny and assurance for the ED Improvement Action Plan ongoing implementation and associated risks to the Health Board's designated Assurance Committees. The following actions were agreed:

- Nursing workforce and Professional oversight to the Performance and Resources Committee
- Clinical Governance to the Clinical Governance Committee
- Staff Governance to the Staff Governance Committee
- Corporate Governance to the Performance and Resources Committee

The Health Board agreed the Chief Executive would lead on a quarterly report/update to the Health Board on progress against all of the actions. This report will also be shared with both Integration Joint Boards.

The Health Board having endorsed the proposal to delegate scrutiny and assurance for the ED Improvement Action Plan to its Assurance Committees acknowledged the pace of progress in addressing the recommendations with the vast majority now completed or on track for completion. The Board in seeking assurance is asked to consider:

- the impact and effectiveness of recommendations/actions which have been completed
- those recommendations which are partially completed and to monitor and seek assurance on progress
- any escalated risks (including mitigations) for recommendations which have not been implemented in full within the agreed timescales

A key part of the OD work will be to determine the impact and effectiveness of actions implemented this will feature in an update to the October Board meeting.

Nursing ED Improvement Action Plan (IAP) recommendations and actions

The Nursing section of the ED IAP has four recommendations - recommendation 4 was added to by the Health Board and nine sub recommendations relating to workforce and safe staffing. Recommendation one refers to the appointment of a Clinical Nurse Manager (CNM) to lead the nursing workforce within ED. This role has been appointed to and the CNM took up post in January 2022. In addition (recommendation 2) the professional structure within the Acute Services Directorate has been reviewed and in addition to the ED CNM appointment two further CNM appointments have been to cover Ambulatory Care Services and the General Inpatient wards. The CNM role in Acute Assessment continues. More recently two ED Senior Charge Nurses have been recruited and have yet to take up post.

The remainder of the recommendations and sub recommendations refer to workforce numbers and skill mix. A paper has been developed that will set out the ED (and wider clinical nurse leadership 24/7) workforce requirements to ensure appropriate:

- ED leadership covering 7 days
- resuscitation response
- induction and protected learning time to support e.g., triage
- workforce numbers and skill mix informed by the roll out of eRostering

This paper will require to be costed and shared with the Area Partnership Forum and the Executive Leadership Team.

In addition, evaluation of induction to support ongoing improvement has been completed with a report being prepared, the outcome of the findings will be presented to the August meeting of the P&R Committee. In summary of the four recommendations and nine sub recommendations relating to workforce and safe staffing have been reported as implemented with no escalation actions to highlight.

ED OD Programme and Plan

To support this improvement journey, a dedicated OD Programme led by Margaret Kerr, Head of OD and Learning is being implemented.

The Employee Director and Chief Executive invited all ED staff to participate in further individual discussions to help inform this important programme of work. Unfortunately, the ED/OD programme which had been due to start in April was postponed due to service pressures. However, it is good to report the programme began in early May and is supported by the Nurse Educators and the Clinical Nurse Managers from across the Acute Services

Directorate. The main ED/OD programme is scheduled to start on 1st June, and this will provide time for staff to be rostered to attend and our OD Team will run duplicate sessions in order to accommodate the team and their work patterns.

- **Clinical Governance**

The Clinical Governance section of the ED IAP has fifteen recommendations, (recommendation 14 and 15 were added to by the Health Board). Many of the recommendations were in progress prior to the External Review process and so have been completed or enhanced as part of the Board's commitment to improvement. For example, the Vincent Framework rollout, completion of Quality Strategy, and refresh of the Board's SAER policy including processes.

In addition, whilst visibility and engagement with staff (i.e., Patient Safety leadership walk rounds) is referred to in the Corporate Governance recommendations section the Medial Director and his Clinical Governance Team (with input from Non-Executive Members who tested the approach) have been instrumental in creating a refreshed walk round programme that many Board members to date have been involved in.

Recommendation 14 - Redesign of Urgent and Emergency Care informed by the vision of 'Transforming our Care' was added to the Plan to ensure the whole system work being progressed was captured. This has been redirected to the Policy & Resources Committee to monitor and oversee given its system wide coverage and impact that goes beyond ED. In summary of the fifteen recommendations eleven have been reported as implemented with no escalation actions to highlight and one has been referred back to the Policy & Resources Committee.

- **Staff Governance**

The Staff Governance section of the ED IAP has fifteen recommendations, (recommendation 13 and 14 were added to by the Health Board. Many of the recommendations were in progress prior to the External Review process and so have been completed or enhanced as part of the Board's commitment to improvement. For example, the development of the HR Dashboard, the refreshed corporate induction, the Speak Up initiative and refresh of the Health & Safety arrangements and Strategy. In summary, of the fifteen recommendations fourteen have been reported as implemented with no escalation actions to highlight.

- **Corporate Governance**

The Corporate Governance section of the ED IAP has eight recommendations. Two relate to assessment of relationships and behaviours of members of the SLT (now referred to as the Executive Leadership Team) and Board members. An OD Programme coproduced with ELT members and the facilitators has now been completed. A joint session with Board and ELT members is being planned and a meeting of the Board Chairman and OD Facilitators has progressed to inform this Board related OD work.

The remainder of the recommendations refers to Board assurance that is intended to build on the Board's commitment and track record to improvement in all three governance areas, notably fiduciary, strategic, and generative as set out in the regular Board Blueprint for Good Governance reports and Code of Corporate Governance.

In addition, Board visibility and engagement with staff has begun through the excellent 'walkaround' work led by the Medical Director.

Recommendations 7 and 8 relate to Management Arrangements within the Acute Services Directorate with reference to Clinical Nursing Leadership 24/7. This has been addressed within the Workforce paper referred to above. This Workforce paper is being costed and it is proposed to offset bank and agency costs with nurse permanent appointments. In summary, of the eight recommendations five have been reported as implemented with no escalation actions to highlight.

Financial Implications
The Health Board received a paper in November 2021 setting out the investment to date to support the actions recommended by each of the Lead Directors. An additional investment of £0.778m was approved, this allocation funded additional ED nursing staff and clinical governance roles. Investment in an additional Education Facilitator role and ED protected learning time for nurses will be absorbed within current budgets.

Work is underway to cost a staffing business case, and this will be presented to a future Executive Leadership Team.

Workforce Implications
The Health Board paper referred to above set out the workforce implications to date including investment in additional staff and resources.

Risk Assessment
A Risk Register - attached at Appendix 2 with mitigations has been developed to inform the implementation of the ED Improvement Action Plan and it was agreed that risks relating to each of the Health Board's Assurance Committees also be delegated and subject to review. No escalation actions have been identified and the risk assessment scoring and mitigations remain unchanged.

Relevance to Strategic Priorities
This paper takes account of the Health Board's approved Corporate Objectives notably valuing and developing our staff.

Equality Declaration
The author can confirm that due regard has been given to the Equality Act 2010 and compliance with the three aims of the Equality Duty as part of the decision-making process, it is noted that the paper is not relevant to Equality and Diversity.

Consultation Process
This paper has been developed with input from the Acute Services Directorate Interim Chief Nurse.

Nursing Workforce and Professional Oversight of Safe Staffing (previously led by Professor A Wallace, Nurse Director, picked up by G Morton, Acting Nurse Director)

	Recommendations	Response/Action(s)	Timescale	RAG Status/% achieved to date	Notes
1.	The Board should consider creating a Clinical Nurse Manager post to support services across ED and Minor Injuries units. The postholder should fulfil the role of Senior Nurse, be an expert ED nurse who has completed a minimum, level 2 competencies (as set out by RCN or equivalent) and has responsibility for overall clinical support and supervision overseeing quality improvement and assurance, workforce management etc. The postholder should fulfil a supervisory role and have an average two fixed clinical sessions per week.	Clinical Nurse Manager in post - appointed 10 January 2022		100%	Complete
2.	The Board should review the Professional nursing structure and implement a more fit for purpose leadership structure. Core to this should be enhancing visibility and engagement with front line staff and patients to improve trust and confidence; create a culture of openness where staff feel listened to and supported.	May update - The Acute Services Directorate nursing structure review had been completed by the Interim Chief Nurse. The review resulted in the creation three additional 3 Clinical Nurse Managers notably to provide cover in the Emergency Department (ED) (as referred to) Ambulatory Care & Inpatient areas. The Acute Assessment Area is currently covered by the existing post holder. An evaluation of this resource is being finalised with findings to be presented to the Executive Leadership Team. The ED Nursing Structure review continues. Key to this review is the CNM role which commenced on 10 January 2021.The remaining aspects of this review is in progress led by the new CNM and will be completed during Feb 2022. A business case to support additional staffing is being finalised.	July 2022 (revised timescale)	90%	In progress - no escalation required
3.	The Board should take into account of information provided within this report, consideration should be given to applying	As reported previously, in place. NHS Scotland has a national workforce and workload planning tool in place in line with CEL 32/2011.NHS Forth Valley was a test site for the	In place	100%	Complete

	Recommendations	Response/Action(s)	Timescale	RAG Status/% achieved to date	Notes
	the key Nursing Workforce standards set out by RCEM and RCN in October 2020 particularly as it applies to:	development of the ED staffing tool for both nursing and medical staff and this has been used consistently since 2014.			
a.	Further review of workforce numbers and comparable benchmarks	May update - The ED Nursing Structure review continues. Key to this review is the CNM role which commenced on 10 January 2021.The remaining aspects of this review is in progress led by the new CNM and will be completed during Feb 2022. A business case to support additional staffing is being finalised and will be presented to the Executive Leadership Team. As reported previously the Directorate continues to secure safe staffing levels using supplementary staff.	July 2022 (revised timescale)	90%	In progress - no escalation required
b.	Appropriate skill mix at Charge Nurse (Team Leader); Staff Nurse; Foundational Staff Nurse and Clinical support worker level, with an overall 80-20 skill mix	May update - eRostering system to inform an 80:20 skill mix is built with training in place - go live date on 13th June 2022.	June (revised timescale)	95%	In progress - no escalation required
c.	Explicit attention should be given to safe and consistent staffing of the RESUS area and the concerns raised by staff	May update - The ED Nursing Structure review continues. Key to this review is the CNM role which commenced on 10 January 2021.The remaining aspects of this review is in progress led by the new CNM and will be completed during Feb 2022. A business case to support additional staffing is being finalised and will be presented to the Executive Leadership Team. As reported previously the Directorate continues to secure safe staffing levels using supplementary staff.	July 2022 (revised timescale)	90%	In progress - no escalation required
d.	Clarity on the “streaming role” in particular staff concerns about patient safety and clinical competency to undertake this role.	Clinical Educator role appointed to, training & education program for triage in place and ongoing.	September 2021	100%	Complete
e.	Review of departmental induction for staff at all grades and consideration of a period of supernumerary status for nurses new to the department and nurses at Foundation level	Update 16th November 2021 - newly qualified staff received corporate, professional, and departmental induction and a protected supernumerary period based on individual needs. An Acute Services Directorate wide questionnaire will evaluate success of program and inform of any improvements required to the programme. Update 10th January 2022 - Induction evaluation being completed by PDU team. May update - evaluation being finalised.	July 2022 (revised timescale)	95%	In progress - no escalation required
f.	Development of an ED career linked to recognised emergency planning nursing, clinical competencies supported by an ED training plan	The Band 5 and 6 competency frameworks have been reviewed with the competency frameworks now aligned with the RCN guidelines. The Interim Chief Nurse has ensured that all staff have been measured against this framework. Training Plan presented and agreed and will be subject to regular review via the Transformational Group.	September 2021	100%	Complete
g.	Development of the Team leader role as a clinical expert providing on the job clinical support and supervision and expert across a range of areas included within the Emergency nursing competency frameworks and clear links with departmental quality outcome monitoring.	May update - two Senior Charge Nurses appointed with start dates to be agreed.	May 2022 (revised timescale)	100%	Complete
h.	Improved scrutiny around Rostering practices with a particularly focus on staff competency levels alongside variation in clinical demand.	May update - As per recommendation and action 3b	June 2022 (revised timescale)	95%	In progress - no escalation required
i.	The Nursing workforce governance group should consider the existing terms of reference and membership and whether they	In place. The Nursing Workforce overarching governance group already established includes staff side representation from Unison and RCN.	In place	100%	Complete

	Recommendations	Response/Action(s)	Timescale	RAG Status/% achieved to date	Notes
	are sufficiently sighted on the short- and long-term staffing challenges, links to quality outcomes and should consider reviewing membership and inclusion of staff side input and reporting arrangements.				
4	Increased clinical nurse leadership to provide mentoring and supervision in ED designated service areas – e.g., triage	May update - ED Senior Nurse structure will be in place by end of May. The Clinical Nurse Manager and Clinical Nurse Educator and two Senior Charge Nurses will support supervision and mentoring. Performance will be monitored through the Organisational Development program and performance meetings.		100% and ongoing	Complete

Clinical Governance - led by A Murray, Medical Director

	Recommendations	Response/Action(s)	Timescale	RAG Status/% achieved to date	Notes
1.	The Board should immediately review its entire Clinical Governance arrangements to ensure a clear line of responsibility and accountability from the Board to point of care and from point of care to the Board. This should include reviewing all work streams and groups to ensure adequate depth and breadth of assurance. This will enable the committee to provide the Board with assurance of safe effective person-centred care.	May update - initial review completed. In November the Committee agreed to extend the scope of the review – this work is ongoing and being overseen by the Committee.	October 2021	80%	In progress - no escalation required
2.	All members of the Clinical Governance Committee should be given support to discharge their responsibilities by identifying training and education requirements.	May update - good progress being made and due for completion by July 2022	July 2022 (revised timescale)	80%	In progress - no escalation required
3.	The Clinical Governance Committee should consider developing a communication strategy which clearly raises the profile and awareness of the Committees Role purpose and work plan to provide front line staff with a better understanding.	In progress. The Code of Corporate Governance will be presented to the Board in November 2021 and as part of this process a communication piece will set out the Governance arrangements including all Board Assurance Committees.	November 2021	100%	Has been duly considered. Incorporated into Code of Corporate Governance
4.	The Clinical Governance minutes should provide evidence of the level of the committee's discussion and scrutiny to demonstrate assurance of safe and effective person-centred care.	In place. Minutes will include Committee member's discussion to demonstrate active scrutiny and assurance actions.	In place	100%	Confirmed by the Committee
5.	The Executive Director of NMAHPs must clarify the lines of professional nurse leadership, governance and accountability in the Acute Division and ensure staff in these roles are supported to effectively discharge their responsibilities.	In place. The Executive Nurse Director has provided the necessary clarity and in going forward Heads of Nursing will report directly to the Chief Nurse.	In place	100%	
6.	The Executive Medical Director must immediately develop an implementation plan for the Role out of the Vincent Framework ensuring there is strong visible committed clinical leadership at every level of the organisation this will help staff understand the benefits of the Framework and the expectations of them.	In place. The Executive Medical Director introduced the Vincent Framework to both measure and monitor patient safety in July 2020. This new approach is intended to provide enhanced assurance; Committee members have welcomed the Framework. The roll out of this approach is underway and will be adopted by Directorates and Partnerships.	December 2021	100%	Update given at CGC 16/11/21, indicating completion of this recommendation by end Nov with Staff Brief roll out Completed Nov 2021
7.	The Board should prioritise the progression of the Quality Strategy ensuring that the workforce is consulted and engaged in its development and implementation.	Completed. The development of a new Quality Strategy (QS) was paused during the pandemic and picked up again in early 2021. Following an extensive engagement process the new Strategy was presented to the Board for approval in July 2021.	Complete	100%	QS approved by Board in July 2021
8.	NHS Forth Valley Adverse events policy was due for revision in December 2020. The Board needs to review how this policy is made easy for frontline staff to understand then subsequently implemented and monitored to be able to demonstrate the Boards commitment to promoting an open and honest culture that is based on supporting staff within a culture of continuous improvement.	In progress. The SAER policy was refreshed in early 2021 and feedback from staff was gathered in April 2021 this will inform the in-depth review planned for later in 2021. The output from this review will inform the Policy update. This will be presented to the Clinical Governance Committee for approval in November 2021. May update - Recruitment of new reviewers complete, timescale for full policy review extended to end of 2022.	December 2022 (revised timescale)	90%	Policy amended in February and will be formally reviewed by the end of 2021, incorporating review recommendations

	Recommendations	Response/Action(s)	Timescale	RAG Status/% achieved to date	Notes
					Due to operational pressures, this has had to be deprioritised and date pushed back to end March 2022.
9.	The Review Team were unable to establish the existence of a robust SAER tracking system. The Board are encouraged to confirm or develop such a system ensuring that the workforce is aware of this and how to use this effectively.	In place. The SAER tracking process has been in place for a number of years and is presented regularly to both the Clinical Governance Working Group and Clinical Governance Committee. This recommendation will be discussed at the Clinical Governance Committee and assurance provided to members regarding the established tracking system in place.	August 2021	100%	Both the SAER report and the new version on Pentana meet these requirements Tracking system in place
10.	The Board should ensure that reports on adverse events with links to improvement plans are prepared; disseminated and analysed in a timely manner. That analysis is shared at department / operational level and through quality and safety for a at Divisional and Board level.	In progress. The NHS Board's approach to adverse events learning is through Learning Summaries which are presented and discussed at Departmental and Clinical Governance Working Group meetings. It is intended that these will be presented to future Clinical Governance Committee (CGC) meetings. The Clinical Governance Team will be expanded to ensure this work is progressed.	Reporting will be expanded to include the CGC from November 2021	100%	Action plans are included in the oversight SAER process, with the generation of Learning Summaries which are disseminated system-wide Update at CGC 26/11/21 with pentana reporting for SAERs shown incorporating improvement plans and learning summaries. This system also underpins the process at CGWG. Learning summaries in place at CGWG
11.	The Board should ensure arrangements are in place to support staff involved in adverse events.	In place. Every SAER has a staff support member on the review group in keeping with National Policy.	In place	100%	Every SAER has a staff support member
12.	The Board should urgently review ED staff awareness of Duty of Candour	In place. Registered clinicians should be aware of their own professional Duty of Candour; Organisational Duty of Candour was featured in the Governance event held in April 2021. Duty of Candour will be included in Corporate Induction.	In place	100%	

	Recommendations	Response/Action(s)	Timescale	RAG Status/% achieved to date	Notes
13.	The System Leadership Team should consider how all members of the team are cited on emerging clinical and patient safety/patient facing priority issues and consider creating an action group that supports a nimbler approach to considering emerging issues.	In progress. The System Leadership Team (SLT) members are currently updated at every meeting on emerging key issues through a dedicated check in process on the agenda. This will be strengthened to explicitly request clinical and patient safety emergent issues. A prompt and agile response to issues raised will be commissioned and evidenced in the SLT minutes. May update - Directorate and Partnership Performance meetings will be re-established from July 2022 – piloted in Women & Children and Acute Services Directorate - these meetings will focus on services including patient safety issues/priorities, workforce, and budget performance.	In place July 2022 (revised timescale)	100%	SLT now has standing patient safety check in. Directorate Reviews - draft paper circulated to Execs w/b 15/11/21. Delayed due to pandemic pressures This was on the Clinical Governance Committee Agenda on 20 May 2022
14.	Redesign of Urgent and Emergency Care informed by the vision of 'Transforming our Care' and implemented via the agreed 3 workstreams – Access, Optimise and	Programme structure to support implementation being designed and will report to Unscheduled Care Programme Board.	March 2022	50%	Programme commenced but significant challenges around programme management which have been escalated UC update to P&R Committee 2022 UC programme refocused Transferred to P&R Committee oversight
15.	Increase access to Quality Improvement training for ED staff	Invest in QI skills and approaches for ED staff	December 2021	100%	This will be a priority for the new CD for ED who is in process of being appointed. Update 18/11/21 confirms QI support and learning for ED commences 2/12/21

Staff Governance - led by L Donaldson, Director of Human Resources

	Recommendations	Response/Action(s)	Timescales	RAG Status/% achieved to date	• Notes
1.	Urgent review of the arrangements for the implementation of iMatter within the ED specifically but also for the Board as a whole in terms of ensuring that there is oversight of performance at a Board and Staff Governance Committee level to ensure that there is a more proactive approach taken to both identify and support "red / amber areas".	• In progress. Previous Board wide iMatter surveys have had no 'red' ratings. The iMatter plan for 2021 with corresponding timetable was presented and approved by the Staff Governance Committee on May 2021. • Organisation wide preparation (including the Emergency Department) concluded and iMatter survey went live on 23rd August 2021 and closes on 13th September. Directorate updates being provided regarding uptake and to flag hot spot areas • iMatter Training materials have been provided to all managers. This includes the role of the team managers in relation to the administration and management of iMatter; exploring how to manage hosting team meetings to discuss the outcomes and signposts managers to resources to support the team to develop their actions plans. This includes responsibilities in relation to the iMatter continuous improvement process. • iMatter assurance process to measure participation levels and action planning activities geared to support learning and improvement at team and Directorate/Partnership levels are being developed to coincide with publication of survey results. iMatter compliance reporting e.g., action planning will be discussed at Directorate/Partnership performance meetings and organisational assurance reporting will be presented to all Staff Governance Committee meetings.	August - October 2021	100%	All reports issued to Directors SGC / Board - complete
2.	Increase the Staff Governance content for Board performance monitoring and "Balanced Scorecard" to include performance on statutory and mandatory training, eKSF / TURAS compliance, iMatter and relevant H&S KPI's (the introduction of Pentana should support this) to be better able to triangulate meaningful workforce related KPI's to identify "hot spots" in a more effective manner.	• In place. The HR Dashboard developed during 2020/2021 was presented to the System Leadership Team in May 2021. Workforce Performance Groups (WPG) established in April 2021 are now meeting monthly linked with Directorate/Partnership Management Teams. • Enhanced Partnership Chair and HRD meetings involving senior staff side representatives commenced in June 2021. These meetings provide an opportunity to triangulate data/information to then report on to the System Leadership Team, Area Partnership Forum and thereafter quarterly to the Staff Governance Committee.	In place	100%	Complete
3.	Review all of the Staff Governance Standards in terms of an internal self-assessment to review any areas for improvement and develop appropriate action plans, key milestones and leads as appropriate.	• In place. Plan to report on the 5 strands of the Staff Governance Standard was presented and approved at the Staff Governance Committee in May 2021. • The Employee Director and Director of Human Resources will jointly sign off and present this report to the Staff Governance Committee having been approved by the Area Partnership Forum. • Currently completing the National annual review of Staff Governance Standards which is due for return on 24th September 2021 • Progressing with the assessment tool for all Directorates to inform future Staff Governance Reports as identified in the Staff Governance Assurance Plan	In place	100%	Complete
4.	Urgent review of Partnership arrangements at a Board and local level to ensure that these are as inclusive as possible to reap the benefits of positive partnership working and also that appropriate senior commitment is given to Partnership Fora at both a Board and local level.	• In progress. Joint working and enhanced partnership arrangements highlighted and have been agreed and a review of the Acute Partnership Forum working arrangements is underway. • Moving to monthly meetings of APF from quarterly meetings. The first month will concentrate on Strategic issues and will be Chaired by Cathie Cowan. The second month will deal with operational issues and will be Chaired by Robert Clark	September 2021	100%	Complete

	Recommendations	Response/Action(s)	Timescales	RAG Status/% achieved to date	• Notes
		• Agreed to meet as a APF on a weekly basis when in 'extremis' with 'live' weekly communication to all members of APF – this will be 2-way communication and will allow feedback through staff side from employees.			
5.	Provision of Support / Training to both the Employee Director and Partnership Representatives to ensure that they understand the roles and responsibilities that come with operating in a committed partnership environment and that they are able to fulfil these in a meaningful and effective way.	• In progress. The Employee Director, Director of Human Resources and Chief Executive with the full involvement of staff side representatives will determine enhanced ways of working to support ongoing effective partnership working. • Agreed to have training sessions with HR and Staff Side representatives to understand and communicate roles and responsibilities when undertaking organisational change, moving on to implementation of National Workforce Policies.	September 2021	100%	Complete
6.	Ensure that Partnership working is embedded as the "business as usual model" within NHS Forth Valley and work is done to raise awareness of this with line managers and HR staff who should also be encouraged to act as ambassadors for partnership working with managers in the day-to-day operation of the Board	• In progress. The External ED Review has highlighted that our escalation process is working. However, as highlighted by the Review Team the response to issues highlighted at appropriate levels had not been acted on. Action 5 (above) will explore this recommendation to consider any change in reporting arrangements.	September 2021	100%	Complete
7.	In line with the issues also raised within other sections of this report to review the induction, training and development and TURAS arrangements and compliance by both managers and staff to ensure that these are fit for purpose throughout the Board.	• In place. Revised corporate induction arrangements paused during the pandemic - refreshed and launched in June 2021. Work is underway to refresh Directorate/Partnership induction. • TURAS appraisal updated, and system re-launched.	In place	100%	Complete
8.	Review of Induction, skills assessment and learning and development plan within ED to ensure that staff are competent to carry out their role safely as this has a direct bearing in terms of patient safety and also as individual's their professional registration requirements.	• In progress. ED Working Group with staff representatives will be established to oversee ED induction programme specifically for nursing (medical and student nurse induction in place). Education Facilitators will be appointed to support ED and Acute Assessment areas to provide structured education and training. Posts will report directly to Head of Learning and OD. Interviews on 15th September 2021 • Implementation of Essential Training passport is in development and will provide all staff with at least 2 days each year to complete mandatory training. • ED Organisational Development Support Workplan nearing completion and ready for implementation. Consultation has included Staff Side colleagues; Acute Directorate Management; Medical and Nursing staff to date. Organising focus groups and ready for implementation date. This will be in 2 phases: Phase 1: Diagnostic and will involve 1:1 meeting with staff to have support Phase 2: 12 workshops over 12 months	October 2021	100%	Complete
9.	Review of workforce planning arrangements in partnership to ensure that these are "fit for purpose in order to support the overarching Workforce Strategy and People Strategy and Integration Plans.	• In place. As per the Internal Control Evaluation Plan (attached at Appendix 1) 'Our People Strategy' (i.e., Workforce and People Strategy) will be reviewed by December 2021. • Interim Workforce Plan in line with national guidance was presented and approved at the APF and Staff Governance Committee in May/June 2021.	In place	100%	Complete
10.	Implementation of the post-Sturrock governance and action plan to be able to assess the overall organisational culture and develop an improvement plan to ensure that staff feel safe and able to speak up and also work within a positive environment.	• In progress. The NHS Board has a Sturrock Review Group in place. The Group has developed and approved an Action Plan. The actions are reported to the Staff Governance Committee. Monthly meetings established Next meeting 14th September 2021 • The NHS Board has approved a new Speak Up initiative; this initiative also supports the implementation of the Whistleblowing legislation and has been developed in	August 2021	100%	• Speak Up 2 ambassadors & 6 advocates appointed Service has been running now for 4

	Recommendations	Response/Action(s)	Timescales	RAG Status/% achieved to date	• Notes
		partnership with staff and staff side representatives. Two Speak Up Ambassadors have been recruited and will commence in September 2021. Six Speak Up Advocates are currently being recruited. Interview to take place in September. Specialist Training will take place in October with launch of the Service thereafter.			months - complete
11.	Ensure that the Health and Safety governance Structures and responsibilities are approved as a matter of urgency and disseminated throughout the Board.	• In progress. The NHS Board has an established Health and Safety Committee Structure in place including a revised policy. The development of a Health & Safety Strategy, in addition to the policy was paused during the pandemic; this will be presented to the NHS Board's for approval in September 2021.	September 2021	100%	Complete
12.	It is recognised that the Staff Governance Standards must be owned at a local level and committed to by managers in order to make them meaningful for staff, however, it is important that the HR Director in Partnership with the Employee Director takes a robust monitoring and performance management role in order to be assured and to be able to provide assurance to the Board and Staff Governance Committee of overall performance in all of the strands.	• In place. See Staff Governance Action 3 above.	In place	100%	Complete
13	Protected Learning time for ED Nurses to be compatible with medical staff and trainees/student	• Introduce to 2 hours protected learning time per week or 1 day per month. Two Education Facilitators reporting to the Head of Learning and Organisational Development (OD) will be appointed to provide on-site (AAU and ED). In addition, there will be a range of Organisational Development initiatives to support multidisciplinary team working.	December 2021	100%	Education facilitators for ED and AAU in place now Learning on the job training with flash cards in place - complete
14	Staffing levels	• Review ED clinical nurse staffing levels 24/7 and agree investment in HSCW role and development • Band 2 – 3 work progressing – competency-based focus involving nursing; staff side and HR colleagues	July 2022 (revised timescale)	85%	Band 2 - 3 work progressing linking with National programme All staff identified Job descriptions complete Process agreed Meetings with CEO, HRD, AHRD, ED and staff side in May 2022 In progress - no escalation required
15.	ED Induction for new nurse starts	• Develop a programme of inductions – establish a short life working group this work beginning in late-August 2021. The Head of Learning and OD will support this	November 2021	100%	Refreshed induction

	Recommendations	Response/Action(s)	Timescales	RAG Status/% achieved to date	• Notes
		work as part of the Health Board's investment in organisation wide induction for all new starts. • Work progressing well with ED Induction led by Directorate of Nursing and Acute Directorate – nearing conclusion and dovetails with Corporate Induction for all staff			programme in place Evaluation process developed - complete

Corporate Governance - led by C Cowan, Chief Executive

	Recommendations	Response/Action(s)	Timescale	RAG Status/% achieved to date	Notes

1.	That there is an external expert assessment of relationships and behaviours between members of the SLT, clarity on roles and contributions; what is expected of them collectively and individually and in particular ability to challenge peers.	May update - SLT (new Executive Leadership Team) OD sessions complete	October 2021	100%	Complete
2.	That there is an external assessment of relationships and behaviours between the System Leadership Team and Non-Executive Board members with a particular focus on how they engage, scrutinise and utilise the information presented to them and use this to make an informed assessment for assurance purposes.	The Board in June 2020 approved an extension of Board membership to include all SLT members. The Board in line with the NHS Corporate Governance systems is committed to ongoing regular self-assessments in response to the NHS Scotland DL (2019) - Blueprint for Good Governance. A workshop to explore and provide clarity on relationships and behaviours between SLT and Non-Executive members took place in November 2021 led by NHS Education for Scotland. Board Development sessions, pre Covid-19 focused on governance related topics and took place bimonthly. These sessions were paused during the pandemic and Board meetings were increased to monthly as part of revised governance arrangements. Board Seminars recommenced in January 2021; the January session led by the Board Chair focused on 'Active Governance'.	October 2021 – date extended to November 2021	100%	Complete
3.	The Board should revisit the results of the 2019 self-assessment on the Blueprint for Good Governance taking account of the findings of this review and expedite the plans to introduce "Active Governance".	In progress. The update to the Blueprint for Good Governance - Improvement Plan was presented and approved by the NHS Board in March 2021. This Plan will be further updated following the Board's self-assessment workshop and as in previous years will be facilitated by NHS Education for Scotland. Board revisited the 2019 self- assessment on the Blueprint for Good Governance at its Sept 2021 Board meeting – updated improvement plan approved. Action completed, updates in line with our commitment to good governance will continue.	October 2021	100%	Complete
4.	The Board should consider any recommendations arising from the national work to improve assurance systems and develop a local assurance framework that embeds and refreshes relevant information flows and timely data to support scrutiny and assurance Board /Committees. (consider qualitative as well as quantitative data and benchmarking)	May update - Board Assurance Framework seminar session due to Covid related absence resulted in seminar being cancelled. Rescheduled for June 2022.	June 2022 (revised timescale) and will be reset to complete on receipt of national recommendations	80%	The Board will consider any recommendations arising from the national work to inform and enhance assurance. In the meantime, the Board has completed its Active Governance session led by NHS NES. In progress - no escalation required
	Recommendations	**Response/Action(s)**	**Timescale**	**RAG Status/% achieved to date**	**Notes**
5.	The Board should consider developing a more proactive simplified communication plan to help paint a clear picture of how the organisation is governed, how	In progress. The Board has appointed a Board Secretary and a refresh of the Board's Code of Corporate Governance is underway. This will be presented to the Board for approval in November 2021.	November 2021	100%	Complete

	priorities are developed and well communicated and to raise awareness and understanding by all stakeholders.				
6.	The Board should develop a structured programme of visibility and engagement with staff in order to demonstrate Board values; encourage staff to speak up and be heard and reinforce a culture of continuous improvement. (This could be through Patient Safety leadership walk rounds, meet the Board sessions or a range of other engagement initiatives)	May update - Programme in place	September 2021	100%	Complete
7.	NHS Forth Valley should urgently review the current Acute Division management arrangements to ensure there is sufficient Senior Clinical leadership to provide oversight of whole hospital issues. This needs to provide clarity on lines of accountability for operational and professional governance, so that staff understand the routes of escalation if they have any issues or concerns. In doing this ensure that robust operational management systems are in place to drive continuous improvement involving staff at grass roots level.	May update - The Acute Services Directorate nursing structure review had been completed by the Interim Chief Nurse. The review resulted in the creation three additional 3 Clinical Nurse Managers notably to provide cover in the Emergency Department (ED) (as referred to) Ambulatory Care & Inpatient areas. The Acute Assessment Area is currently covered by the existing post holder. An evaluation of this resource is being finalised with findings to be presented to the Executive Leadership Team. (see Nursing section)	July 2022 (timescale revised)	80%	Investment in senior clinical leadership being progressed. Investment in additional posts including Band 2 to 3 posts and protected learning for nurses working within ED in line with medical staff have all been progressed. In addition, medical staffing has been recently reviewed and a realignment of job plans has increased clinical commitment. System wide we have also invested in nursing roles to support urgent care in line with 'Right Care Right Place' policy direction. This investment also supports 24/7 senior nurse leadership within the Acute Directorate. In progress - no escalation required
8.	That this review of management arrangements needs to be complemented by a thorough review of Hospital governance arrangements that compliments the Board assurance framework and promotes and assures Safe, Effective and Person-Centred Care from ward to Board	In progress. This will be factored into the review of the Acute Division management arrangements. May update - The Acute Services Directorate nursing structure review had been completed by the Interim Chief Nurse. The review resulted in the creation three additional 3 Clinical Nurse Managers notably to provide cover in the Emergency Department (ED) (as referred to) Ambulatory Care & Inpatient areas. The Acute Assessment Area is currently covered by the existing post holder. An evaluation of this resource is being finalised with findings to be presented to the Executive Leadership Team. (see Nursing section)	August 2022 (revised timescale)	90%	Rec 8 links to Rec 7 (above). In addition, the Medical Director having adopted the Vincent Framework prior to this Review has rolled out a consistent approach to agenda setting. The Directorate and Partnership reviews will also provide greater assurance. An Internal Audit scoping piece to review the implementation of this Improvement Action Plan is being progressed - In progress - no escalation required

Appendix 2 - Risk Register: ED External Review

Overview

This Risk Register has been established to identify, log, and track potential risks associated with the implementation of the ED External Review recommendations and agreed actions. The risks set out below reflect 'unexpected' events that would impact negatively (or positively) on the actions described and timescales set out and approved by the Board when it met in August 2021.

ID	Risk Descriptor	Likelihood	Impact	Severity	Owner	Mitigation	Progress on actions
1	There is a reputational risk if the ED Improvement Plan, approved by the Health Board, is not implemented, in line with agreed actions and timescales.	3	4	12	C Cowan	The Chief Executive (CEO) is accountable to the Health Board for directing and overseeing the implementation of the ED Improvement Plan. The Plan has four governance themes: Nursing Workforce and Professional Oversight delegated to the Executive Nurse Director, Clinical Governance delegated to the Medical Director, Staff Governance delegated to the Director of Human Resource and Corporate Governance led by CEO. A Board Oversight and Assurance Sub Committee has been established to oversee the implementation of the ED Improvement Plan and to take corrective action should a recommendation and corresponding action fail to be implemented and/or be delayed.	Evidence of progress can be found from the filed Sub Committee minutes and ED Improvement Plan updates for all 4 Board-wide governance sections. The Sub Committee has now delegated scrutiny and assurance responsibilities to the Board's Assurance Committees and directly to the Board - evidence of progress can now be found in Assurance Committee and Health Board minutes.
2	There is a risk to the ongoing delivery of safe and effective care if the ED Improvement Plan workforce related actions approved by the	3	4	12	G Morton	The previous Executive Nurse Director directed a review of staffing levels to ensure the ED has a designated senior nurse with overall clinical support and supervision responsibility for safe staffing of the Department including the resuscitation area. Investment in two Education Facilitator posts to	Investment in the appointment of Senior Nursing posts for ED is set out in the updated Action Plan. Workforce tools have been run to ensure the ongoing delivery of safe staffing levels and there are updates within the Action Plan. Protected learning time for

	Health Board are not implemented. (Delegated to P&R Committee)					support protected learning has been approved by the Health Board (see Staff Governance section).	nursing staff is being put in place and appointment of two Education Facilitators to support this work is now in place. The ED OD Plan is also being implemented.
ID	**Risk Descriptor**	**Likelihood**	**Impact**	**Severity**	**Owner**	**Mitigation**	**Progress on actions**
3	There is a risk that the Health Board's corporate objective (improve the focus on safety and quality) will not be met if the Improvement Plan Clinical Governance actions are not implemented in line with agreed actions and timescales. Recommendation fourteen has been added to the Health Board's Strategic Register and is being monitored regularly with progress being reported to the Health Board	3	4	12	A Murray	The Medical Director has directed a review of the Clinical Governance arrangements to ensure a clear line of accountability from the Health Board to point of care and vice versa. This review will include: the adoption and implementation of the Vincent Framework methodology to inform agenda discussions at all Directorate (inc. Depts) and Partnership levels, completing the work underway to implement a new Quality Strategy; a review of the Serious Adverse Events (SAE) policy and corresponding monitoring system, actions to increase staff awareness of responsibilities in relation to key clinical policies including Duty of Candour and a refresh of the patient safety walkround approach and programme. In addition, the Health Board has invested in quality improvement training, resources, and support for all staff inc. ED QI training.	The Clinical Governance Committee of the Health Board had already adopted the Vincent Framework and its roll out to all Directorate and Partnership clinical governance arrangements. The remaining mitigations have transferred to the Clinical Governance Committee and evidence can be found from the Committee's minutes. Recommendation 14 - scrutiny and assurance responsibilities has transferred to P&R Committee. (Unscheduled Care – Strategic Risk is reported to the Board as part of Strategic Risk Register updates)

4	There is a risk that the Health Board's corporate objective (value and develop our people) whilst working in partnership with Staff Side will not be met if the Improvement Plan Staff Governance actions are not implemented. In addition, there is a risk the Health Board will not meet a number of the national staff governance standards.	3	4	12	L Donaldson	The Director of Human Resources (HR) has directed a review of iMatter (including how this is reported to the Health Board through the Staff Governance Assurance Committee) and its implementation during 2021. In addition. the Director of HR will complete work to complete the development of an HR Dashboard - including Health & Safety KPIs which in turn will inform reporting to the Staff Governance Committee and Area Partnership Forum at Directorate and Partnership levels. The output will inform reviews led by the Chief Executive across these areas.	The Sub Committee and now Staff Governance Committee is receiving scheduled updates on all fifteen recommendations within the Staff Governance section of the ED Improvement Plan with many of the recommendations also included in a refreshed Staff Governance Committee forward planning programme.
ID	**Risk Descriptor**	**Likelihood**	**Impact**	**Severity**	**Owner**	**Mitigation**	**Progress on actions**
4	As above	3	4	12	L Donaldson	Staff side engagement at all levels of decision making will include the Employee Director who is a member of the Executive and Corporate Leadership Teams. ED specific induction, staff levels and protected learning time (including appointment of Education Facilitator roles) for ED nurses are all being implemented.	See updated Action Plan

5	There is a risk that the Health Boards' corporate governance requirements as described within the Blueprint for Good Governance will not be met if the Improvement Plan actions are not implemented. (Delegated to P&R Committee)	3	4	12	C Cowan	The Health Board has approved a programme of external facilitated OD support and development which involves members of the System Leadership Team and Health Board. This support and development will also include a review of the national Blueprint and the Health Board's Blueprint Improvement Plan. The Blueprint Improvement Plan will also include the development of a Board Assurance Framework as part of the wider work to assess the Board's culture and values	The Sub Committee and now Performance & Resources Committee is receiving scheduled updates on all eight recommendations within the Corporate Governance section of the ED Improvement Plan. A number of these recommendations cross refer to all three sections of the ED Improvement Plan notably: Clinical Governance (rec six and developing a structured programme of staff engagement and strengthened leadership and visibility); Nursing Workforce and Professional Oversight and Staff and Clinical Governance (recs 7 and 8 and having a senior clinical leadership presence for the acute hospital with alignment to hospital governance arrangements).

FORTH VALLEY NHS BOARD
TUESDAY 31 MAY 2022

9.3.1 Performance & Resources Committee Update – 26 April 2022
For Assurance

Chair: Mr John Ford, Non-Executive Board Member

The agenda item below was approved by the Performance & Resources Committee:

- **Item 6.1 Performance & Resources Committee Forward Planner**

The Performance & Resources Committee Forward Planner outlined the major items and areas of work the Performance & Resources Committee had to consider as part of its schedule of work for 2022/2023 in supporting the committee to fulfil its terms of reference.

It was noted that a formal forward planner had been developed in Pentana and work had been undertaken to capture key information that supports the provision of assurance to the committee linking the level of assurance, risks and any financial, workforce, sustainability, infrastructure, and quality/patient care implication. This work was scheduled to be presented to the Board Seminar in June 2022 and supports delivery of a recommendation from Internal Audit.

Key points to note from the meeting:

- **Item 7.1 Elective Care Update**

The Committee received a presentation in respect of balancing risks and improving performance in Scheduled Care. The presentation included the immediate response to the Covid-19 Pandemic and the impact of significant delays to treatments which was causing potential harm and poorer outcomes for the patients of Forth Valley. Several priorities and opportunities were highlighted, including the opportunity to radically re-design to ensure sustainable services and scale up new ways of working, ensuring that all fallow theatre capacity was staffed, proleptic appointments in areas where capacity was needed, and improving theatre productivity.

It was noted that several bids had been made to the Scottish Government in support of the new ways of working and to assist in proleptic appointments. The Performance & Resources Committee will be updated following decision and response.

NHS Forth Valley was noted to have a 7% reduction in the outpatient activity performance during the pandemic compared with a 30% reduction nationally. It was agreed that successes and good news stories should be captured and communicated through the media and social platforms.

- **Item 8.1 Finance Report**

The draft financial outturn position indicated that all three mandatory financial targets set by the Scottish Government had been achieved as of 31 March 2022:

- A surplus of £0.227m against the revenue resource limit of £789.950m.
- A break-even position against the capital resource limit of £21.462m.

- A break-even position against the cash requirement with a closing balance of less than £0.050m.

It was noted that the outturn position remained subject to External Audit review and confirmation of final Scottish Government budget allocations which were expected by 30 April 2022. Preparation of the 2021/22 Annual Accounts was noted to be underway and an initial draft would be submitted to the NHS Board's External Auditor on 6 May 2022. Presentation to the Audit Committee scheduled on the 22 June 2022 was anticipated followed by the special Board on the 24 June 2022. The final outturn was also subject to confirmation of risk sharing arrangements in respect of Clackmannanshire and Stirling IJB.

Recurring savings target of £32.398m were identified for 2021/22. During the course of the year recurring savings of £15.474m were delivered, with the residual balance of £16.924m achieved through non-recurring savings. The underlying deficit brought forward from 2021/22 has been factored into the total savings requirement of £29.312m in 2022/2023.

- **Item 8.2 Corporate Portfolio Management Office Update**

The Corporate Portfolio Management Office continued to support priority projects and initiatives at pace with the continued deployment of resources to support the National Treatment Centre, the Unscheduled Care Programme, and the implementation of a new eRostering system.

It was noted that the Corporate Portfolio Management Office continued to work with key stakeholders to progress programmes and projects identified to be beneficial in supporting achievement of organisational financial objectives and had been working in partnership with the Director of Finance to establish the Cost Improvement Oversight Group.

The Corporate Portfolio Management team hosted a three-day interagency Agile Project Management training course in November 2021. This course supported delegates to increase and adapt their knowledge and skillset to use agile methodology to meet the needs of a project or programme of work, releasing benefits throughout the process rather than only at the end. This training was attended by members of the Corporate Portfolio Management Office team along with colleagues from Health and Social Care and members of the Acute Service Improvement Team.

PERFORMANCE & RESOURCES COMMITTEE

Minute of the Performance & Resources Committee meeting held on Tuesday 01 March 2022 at 9.00am via Microsoft (MS) Teams

---

Present:	Mr John Ford *(Chair)*	Dr Michele McClung
	Mr Robert Clark	Mr Andrew Murray
	Mrs Cathie Cowan	Cllr Les Sharp
	Dr Graham Foster	Mr Scott Urquhart
	Mr Gordon Johnston	Prof. Angela Wallace
	Ms Janie McCusker	
In Attendance:	Karen Bonnar	Ms Jackie McEwan
	Deirdre Coyle	Hazel Meechan
	Mr Martin Fairbairn	Dr Oliver Milling-Smith
	Ms Claire Giddings	Mrs Kathy O'Neill
	Ms Laura Henderson (Minutes)	Mr Jonathan Procter
	Steven Kirkwood	Mr John Stuart
	Ms Kerry Mackenzie	Mrs Phyllis Wilkieson

1. DECLARATIONS OF INTEREST

There were no declarations of interest offered at this time.

2. APOLOGIES FOR ABSENCE

Apologies intimated on behalf of Mr Allan Rennie, Mr Stephen McAllister and Mrs Gillian Morton.

3. MINUTE OF PERFORMANCE & RESOURCES COMMITTEE MEETING HELD ON 18 JANUARY 2022

The Minute of the meeting held on 18 January 2022 was approved.

4. MATTERS ARISING

There were no matters arising.

5. ROLLING ACTION LOG

It was noted that three items on the rolling action log featured on the agenda. Other items would be presented to the Performance & Resources Committee at a later date.

6. FOR APPROVAL

6.1 Sustainability Loan – Tillicoultry Health Centre

The Performance & Resources Committee received a paper, 'Sustainability Loan – Tillicoultry Health Centre', presented by Mr Scott Urquhart, Director of Finance supported by Mr Steven Kirkwood, Senior Finance Manager.

The Performance & Resources Committee was advised that Tillicoultry Medical Practice had made an application for a loan and that the request had met the applicable criteria set out in the Scottish Government circular.

Following discussion Mr Urquhart confirmed that the lender is Scottish Ministers, through the Health Board, and that funding for the loan would be provided by Scottish Government, to be repaid on the basis set out in the circular. Accounting transactions would be made in line with detailed guidance prepared by the NHS Technical Accounting Group.

In relation to the Health Board's role on the GP loan application process it was confirmed that the Health Board would record and receipt the application and confirm that necessary information and documentation requirements had been met and verified. The decision on loan approval would be made by the Scottish Government.

It was noted that this application was the first of a number of GP practices in Forth Valley to reach this stage of the process and others were still in progress, both locally and across the rest of Scotland.

The Performance & Resources Committee:

- ***Noted the GP Sustainability Loan application***
- ***Noted that the application met the criteria set out by Scottish Government circular DL(2018)22***
- ***Noted that funding would be met by Scottish Government***
- ***Noted that the GP Sustainability Loan for Tillicoultry Medical Practice should be progressed to the next stage for Scottish Government consideration***

7. BETTER HEALTH

7.1 Community Planning Partnership Update

The Performance & Resources Committee received a paper and presentation 'Community Planning Partnership Update' led by Mr Graeme Foster, Director of Public Health and Strategic Planning supported by Ms Hazel Meehan, Public Health Specialist.

It was highlighted that Scottish Government statistics estimated that 19% of the Scotland population were living in relative poverty after housing costs in 2017 – 2020. Before housing costs, 17% of the population (910,000 people) were living in poverty. It is estimated that 17% of the population (900,000 people each year) was living in absolute poverty in 2017 – 2020. The absolute poverty indicator providing a measure of whether incomes of the poorest households are keeping pace with inflation.

The percentage of working age adults in relative poverty is also 19% after housing costs. Before housing costs, 17% of the population were living in poverty. 14% of pensioners were

in relative poverty after housing costs in 2017-2020 noting the poverty rate for pensioners has been consistently lower than that for working-age adults and children.

24% of children in Scotland were in persistent poverty after housing costs in 2017-2020. After a long fall in child poverty rates from the late nineties to 2010-2013, child poverty rates have been gradually rising again. 68% of children in poverty in Scotland live in working households in 2017-2020. Scottish Government child poverty priority groups are more likely to be in relative poverty compared to all children particularly for those in ethnic minority households, and those with a single parent

It was noted that Clackmannanshire, Falkirk and Stirling Community Planning Partnerships have focused on tackling poverty for a number of years and all three Local Outcome Implementation Plans have a strong emphasis on this.

Since initial scoping of a plan for Health Foundation's Economies for Healthier Lives funding in October 2020, NHS Forth Valley has moved at pace to develop the organisation's role as an anchor organisation to support local community wealth and health building. An Anchor Springboard Group had been established, with monthly meetings, to drive momentum to deliver a contribution based on the principles of local community wealth building. An anchor institution consortium would be set up in the near future further engaging with partners.

The Scottish Government Child Poverty Action plan is currently being refreshed and community planning partners will take cognisance of the strategic direction of this guidance in developing Local Child Poverty Action Reports for 2022 and beyond. Work has commenced with local partner child poverty leads and Public Health Scotland to develop a Public Health approach to better understand the local child poverty systems and pull together child poverty data sources to support improved child poverty partnership planning locally.

NHS Forth Valley continues to provide support to children's services planning with all three community planning partnerships. It was noted work was progressing at scale and pace across many services to tackle the socio-economic impacts of the pandemic.

The Performance & Resources Committee:

- ***noted the content of the report***
- ***noted assurance that NHS Forth Valley was meeting its obligations in relation to community planning as a mechanism to build community wealth and health and tackle poverty in Forth Valley.***

8. BETTER CARE

8.1 Recovery & Performance Scorecard

The Performance & Resources Committee received a paper, 'Recovery & Performance Scorecard', led by Mrs Kerry Mackenzie Head of Policy & Performance.

The Recovery & Performance Scorecard considered the System-Wide Remobilisation Plan which set out how to safely continue the resumption of services along with a focus on establishing more of a 'norm' going forward with the inclusion of monthly key performance measures.

Key performance issues were noted in respect of unscheduled care with overall compliance against the 4-hour access target in January 2022, 77.6%; Minor Injuries Unit 99.8%, Emergency Department 69.5%. A total of 1351 patients waited longer than the 4-hour target

across both the ED and Minor Injuries Unit (MIU); with 145 waits longer than eight hours and 33 waits longer than 12 hours. This was a significant reduction or improvement from the December position. The main reason for patients waiting beyond 4 hours remains wait for first assessment with a cohort of 719 patients. The position within ED continues to be challenging with variation in performance.

The Forth Valley redirection for same day emergency care pathways had not yet shown an improvement in overall 4 hour compliance and it was noted there were still issues around staffing. It was noted there was a recruitment drive to fill posts which would ensure a steady redirection from the emergency department. The staff absence attributed to covid remain high on the acute site.

The number of patients waiting for a first outpatient appointment and the number waiting beyond 12 weeks reduced at the end of January. Activity against the agreed Remobilisation Plan trajectory highlights the cumulative position from April 2021 to January 2022 was 96% with compliance against the plan for the month of January, 119%. The number of inpatients/daycases waiting and the number waiting longer than 12 weeks increased with activity against the agreed Remobilisation Plan trajectory 83% April 2021 to January 2022 and 57% in January. The reduced activity was as a result of the decision to postpone a number of non-urgent operations in a bid to reduce pressure across the Forth Valley Royal Hospital site and to free up staff to support critical health services.

Despite imaging activity against the agreed Remobilisation Plan trajectory highlighting a cumulative position of 105% compliance and 100% compliance in January the number of patients waiting beyond 6 weeks has increased. Endoscopy activity against the agreed Remobilisation Plan highlights the cumulative position as 108% compliance with the position in January 62%.

The Delayed Discharge position remained volatile with a reduction in the number of standard delays however an increase in guardianship/code 9s. Significant work continued to support flow of patient through Forth Valley Royal and Community sites.

Mrs Cowan added that the position with the Forth Valley acute site remained challenging with an extra patient currently being bedded within each of the 4 bedded bays in the wards. Significant pressures had highlighted the need to re-evaluate bed numbers within the acute site ensuring adequate number of beds to accommodate the growing elderly frailer population. Mrs Cowan highlighted that further work would be shared with Committees following the staff conference in late May early June. A paper would be circulated that set out ambitions and priorities.

The Performance & Resources Committee:

- ***Noted the current key performance issues***
- ***Noted the detail within the Recovery & Performance Scorecard***

8.2 Cancer Services Update

The Performance & Resources Committee received a paper and presentation, 'Cancer Services Update', led by Mrs Phyllis Wilkieson, Acting Director of Acute Services supported by Oliver Milling-Smith Lead Cancer Clinician and Karen Bonnar, Cancer Audit Tracking Manager.

The Clinical Governance Routes for Cancer Services were highlighted along with the Framework for Effective Cancer Management. The framework was refreshed and published in December 2021 and was noted to be central to achieving the 62-Day standard and would

require collective collaboration between primary and secondary care. The Framework was noted to cover the eight key elements of, Corporate Responsibility, Optimal Referral, Initiating the Pathway, Dynamic Tracking & Escalation, Optimal Diagnostics, Effective MDT, Treatment, and Collective Strength, with the patient's needs at the centre. The framework would also serve as a benchmarking tool for Forth Valley Cancer services.

The Quality Performance indicators have recently undergone a review to further strengthen the existing governance process and provide a greater oversight and have been developed across tumour groups to drive continuous quality improvement within cancer services.

The indicators are underpinned by a Regional Annual Governance Process and improvement Framework. It was noted the new exception reports are now shorter and more focused allowing targeted discussion of key clinical exceptions identified during the analysis and clinical review of annual results. Tumour specific Clinical Leads from each tumour network will attend Regional Cancer Advisory Group meetings to discuss issues arising. The Quality Performance indicators were subject to an external review and quality assurance which was carried out by Healthcare Improvement Scotland.

Ms Bonnar highlighted Forth Valleys performance against the 62-day and the 31-day cancer standard. It was noted that Forth Valley consistently meet the 31-day standard but underperforming against the 62-day standard which is in-line with the rest of Scotland position.

NHS Forth Valley has continued to diagnose and treat cancer patients throughout the pandemic and have managed to continue the surgical pathway to good effect. A Clinical Governance Framework has been established for Cancer Services in Forth Valley with a Service Level Agreement agreed with NHS Lanarkshire to ensure the Head & Neck cancer service is sustainable.

NHS Forth Valley was currently placing bids with the Scottish Government to look at 3 session working within Endoscopy to increase capacity. It was noted that there was well established nurse endoscopists teams within Forth Valley which have been in post for several years.

Key challenges and opportunities were described with a request from Performance & Resources Committee that these be compiled into an action plan describing what is required to support a sustainable service to come back to the Performance & Resources Committee.

The Performance & Resources Committee

- ***Noted the updated position and presentation***

9. BETTER VALUE

9.1 Finance Report incl. Financial Plan Update and South East Payroll Consortium

The Performance & Resources Committee received a paper, 'Finance Report', presented by Mr Scott Urquhart, Finance Director.

Mr Urquhart provided a summary of the NHS Forth Valley financial position for 2021/22, further detail on financial planning for 2022/23, and an update on South East Payroll Consortium arrangements.

The Revenue outturn projection for 2021/2022 was noted as a break-even position against annual budget of £756.1m, subject to receipt of final anticipated budget allocations. Any additional funding or credits received beyond expected values at this point in the year would be likely to cause a surplus against budget. The in-year financial position to 31st January 2022 is a small underspend of £0.037m.

Additional contingency beds continued to be required on the acute hospital site to support the sustained increase in demand and patient care requirements, which is continuing to drive an increased level of temporary staffing cost, albeit the rate of increase has slowed. Total supplementary staff costs for the ten-month period to 31st January are £22.4m.

A net savings requirement of £25m - £30m was highlighted, representing approx. 5.5% of recurring budget. Further updates and benchmarking of anticipated costs with other NHS Boards has reinforced a projected requirement for savings at £29.4m in 2022/23. The Senior Leadership Team working collaboratively to deliver the significant level of savings required for next year. Major savings themes had been identified including workforce, medicines which was identified as the largest areas of spend within Forth Valley.

Mr Urquhart added it was a challenging position moving into next year especially around the full year Covid costs and how the pandemic will develop. A full costed saving plan will be submitted the NHS Board Meeting on Tuesday 29th March.

The South East Payroll Consortium Business Case with the addendum commissioned by Consortium Directors of Finance was approved at private session of the NHS Board on 30 November 2021. Following NHS Fife approval of the case in their Board meeting at the end of January all consortium members have now approved the case.

Working with other NHS Directors of Finance to agree the terms of reference for the quality board which is responsible for the financial and quality assurance.

The Performance & Resources Committee:

- ***Noted a projected break-even financial position against revenue and capital resource limits for 2021/22 year-end, subject to key risks highlighted in the report***
- ***Noted the financial planning update for 2022/23, with an indicative savings requirement of £29.4m, and progress made in identifying cost improvement plans***
- ***Noted that a three-year revenue and capital plan will be presented to the NHS Board for approval on 29th March 2022***
- ***Noted the update on South East Payroll Consortium arrangements.***

9.2 Integration Joint Board 2022/23 Financial Planning

The Performance & Resources Committee received a presentation, 'Integration Joint Board 2022/23 Financial Planning', led by Mr Scott Urquhart, Finance Director.

The Integration Schemes for both Integration Joint Boards includes a provision for IJB annual business cases to be presented to constituent bodies for consideration. It was noted that the cases presented had been through an IJB approval process and presented financial planning assumptions for both IJBs in the Forth Valley area.

Discussions have been ongoing with Chief Finance Officers in respect of the budget uplift for health delegated functions for 2022/23. The proposed uplift was based on the conditions set

out in the Scottish Government letter of 9 December 2021 from the Director of Health Finance and Governance to Chief Executives and IJB Chief Officers.

The letter stated that NHS payments to Integration Authorities for delegated health functions must deliver an uplift of 2% over 2021/22 agreed recurring budgets and make appropriate provision for increased national insurance costs. Updated calculations in respect of these payments, subject to NHS Board approval, have been shared with both IJBs and have been factored into the NHS Board financial plans.

Assurance was provided to the Performance & Resources Committee that NHS Forth Valley had applied the Scottish Government requirements in terms of the uplifts for the delegated health services. There has been regular correspondence between the NHS Board finance team and Chief Finance Officers and close partnership working in developing the financial planning parameters and inflationary cost calculations on budgets held within delegated health functions.

The Performance & Resources Committee:

- ***Noted the Integration Scheme states that the IJB financial plan ('business case') shall be presented to the NHS Board and Local Authorities for consideration.***
- ***Noted the Integration Scheme states that parties shall determine and agree their respective payment to the Integration Joint Board for the forthcoming year by 28 February.***
- ***Noted the 2022/23 business case for Clackmannanshire and Stirling Integration Joint Board which was presented to the IJB on 26th January 2022. A letter from the Chief Officer to NHS Board Chief Executive was also attached for information.***
- ***Noted the 2022/23 business case for Falkirk Integration Joint Board, which was presented to the IJB on 19th November 2021.***
- ***Noted that IJB Chief Officers and Chief Finance Officers had been notified of the indicative payments from NHS Forth Valley to respective Integration Joint Boards for financial year 2022/23 for delegated health functions. The payment is based on requirements set by Scottish Government. The Performance & Resources Committee was asked to recommend this approach for approval at the NHS Board meeting on 29 March 2022.***

9.3 Capital Projects, Properties, Equipment & eHealth Update

The Performance & Resources Committee received a paper 'Capital Projects, Properties, Equipment & eHealth Update' presented by Mr Jonathan Procter, Director of Facilities & Infrastructure.

The joint Programme Board for Primary Care premises and Falkirk Community Hospital had met for the first time. The work plan for the strategic assessments had been set out and the initial assessments finalised.

The NHS Board had been successful in attracting Scottish Government funding in relation to the provision of fleet electric vehicles (EV) and also for the provision of charging infrastructure. Formal Variation Enquiries had recently been raised with Forth Health to facilitate this work.

It was noted that remaining vacant land within the Bellsdyke Development, which had been marketed for some time, had now received formal interest from representatives of the Kinnaird Village and The Inches Residents' Association with a formal submission being

prepared for NHS Board within the next few months. A commercial offer had also been received for both parcels of land for which the Association had an interest. Discussions are ongoing.

The GP IT System Replacement plan remained overdue within the Digital & eHealth Delivery Plan for matters outwith Forth Valley local control. Procurement was taking longer than originally expected. Kathy O'Neil, General Manager for Primary Care and Mental Health Directorate was reviewing the local risk assessments and implications. There is a limited number of suppliers with the ability to supply the specification required which means running and older system for longer. Once the risk has been reviewed a decision can be made in terms of waiting on the current system to be updated or shifting to a new vision product in line with other Health Boards. Interdependent systems also require to be reviewed.

Mr Procter added that given recent events that had taken place around the country the Strategic Risk Register would be updated to reflect the current position in relation to cyber resilience.

Assurance was given in relation to Digital, that a review of the financial performance of the programme was presented to the Digital & eHealth Programme Board by the Finance Manager. All financial implications were documented.

NHS Forth Valley was cited in two sets of architectural awards in late 2021: Stirling Health & Care Village was shortlisted in the Healthcare category of the Glasgow Institute of Architects Awards 2021 and Doune Health Centre was 'Highly Commended' in the Best Healthcare Development category in the Building Better Healthcare Awards 2020. The announcement had been delayed due to the pandemic.

The Performance & Resources Committee:

- ***Noted the presented updates regarding Capital & Infrastructure, Medical Equipment and Digital / eHealth***
- ***Noted the position with surplus land in Kinnaird/Bellsdyke.***

10. BETTER GOVERNANCE

10.1 Internal Control Evaluation

The Performance & Resources Committee received a paper 'Internal Control Evaluation' presented by Mr Scott Urquhart, Finance Director.

It was noted the as Accountable Officers, Chief Executives were responsible for maintaining a sound system of internal control and managing and controlling all the available resources used in their organisation. The Internal Control Evaluation, produced by the internal auditors, aimed to provide early warning of any significant issues that may affect the Governance Statement.

Previous detailed discussion at the Audit and Risk Committee noted the assurance on the overall system of controls provided within the Internal Control Evaluation report and agreed that the final report be distributed to Standing Committees for consideration.

The sections within the report points aligned to the remit of the Performance and Resources Committee were highlighted and included Corporate Governance, Financial Governance, Property Asset Management Strategy, Information Governance and Scheduled Care.

Mr Urquhart added that the audit assurance or final opinion on all matters would be outlined in the audit annual report which was scheduled for Audit and Risk Committee after year end. This would highlight any specific issues or significant outstanding actions.

The Performance and Resources Committee:

- ***Noted the assurance on the overall system of controls provided within the Internal Control Evaluation report***
- ***Noted that some aspects may be relevant in the production of the Performance and Resources Committee annual reports and assurance statements.***

10.2 Information Governance Group Annual Report

The Performance & Resources Committee received a paper, 'Information Governance Group Annual Report', presented by Mr Andrew Murray, Medical Director supported by Mrs Deirdre Coyle, Head of Information Governance.

To assist the NHS Board in conducting a regular review of the effectiveness of the systems of internal control, the Information Governance Group was required to submit an annual report to the Performance & Resources Committee. A future highlight report would be submitted to the Performance and Resources Committee specifically to the cover the recommendation from the Internal Control Evaluation Report.

Mrs Coyle highlighted the key successes and achievements highlighted in the Information Governance Group Annual Report including the Year 2 Network Information Security Audit that had been completed in association with the Competent Authority yielding a 10% improvement on the last financial year. Also, successful recruitment of fixed term staff for the Cyber and Information Security Team.

Key staffing achievements were noted as the Lead Data Protection Officer passed a Data Protection Practitioner Course and the Corporate Records Manager completed the IRMS Accreditation which was believed to be the first in Scotland.

The key challenges being faced by the Information Governance Team over the coming year were noted to be the Information Commissioners Office Accountability Framework with work commenced in preparation for Information Commissioners Office Audit in the next financial year. The accountability framework was being used as a marker on performance which will focus on training and information sharing ensuring that all the processes and procedures are up to date.

As the current Head of Information Governance was due to retire there was a requirement to recruitment a new Head of Information Governance. A review of the Information Governance Strategy would require to be updated once the new head was in post.

It was highlighted that a number of fixed term contracts within the Information Governance Team required to be made permanent in both Data Protection and Cyber/Information Security. It was noted that it would be difficult to continue the work without those permanent posts.

The Information Governance Corporate Risk had been reduced to 9. This was mainly due to the staff being in post to get through the workload.

Mr Procter added that the Cyber Resilience Risk in the Strategic Risk Register would be updated to reflect the New Worldwide Risks in Russia. This had been discussed with the

Cyber and Information Security Manager, and the Associate Director of Facilities & Infrastructure Digital & eHealth.

Mr Procter added that the work around the Electronic Patient Record would be documented in the digital eHeath work plan and updated for next year.

The chair concluded with an offer of thanks to Mrs Coyle for the valued years of service ahead of her retirement.

The Performance & Resources Committee:

- ***Noted the Information Governance Group Annual Report***

---

11. ANY OTHER COMPETENT BUSINESS

The chair offered thanks to Prof Wallace for her support on the Performance & Resources Committee over the years and wished her well in taking up her new post at Greater Glasgow and Clyde.

---

12. DATE OF NEXT MEETING

Tuesday 26 April 2022 at 9.00am via MS Teams

FORTH VALLEY NHS BOARD
TUESDAY 31 MAY 2022

9.3.2 Audit and Risk Committee Update – 25 March 2022
For Assurance

Meeting Highlights

- Minute of meeting held on 21st January 2022 was approved as a correct record.
- Internal Audit presented a Progress Report to brief the Committee on the status of delivering the 2021/22 Internal Audit Plan and on the planning process for the 2022/23 Internal Audit Plan.
- External Audit presented the 2021/22 External Audit Plan and summarised the main areas for review.
- External Audit presented the national NHS in Scotland 2021 audit report.
- The Audit Follow Up Coordinator presented the Audit Follow Up report.
- The Head of Performance provided the Committee with Strategic Risk Register Update along with proposed changes for the Quarter 3 reporting period.
- The Director of Finance presented a draft update to the Audit and Risk Committee Terms of Reference to be approved by the NHS Board at its meeting in March 2022.
- The Director of Finance presented the Audit and Risk Committee Annual Report 2021/22.
- The Head of Performance presented a paper of the Code of Corporate Governance and summarised amendments made.
- The Director of Finance presented a paper on the NHS Scotland Accounting Manuals for 2021/22, the purpose of which was to provide the Audit Committee with an update on the status of the Annual Accounts and Capital Accounting Manual updates for 2021/22.
- The Director of Finance presented a Legal Claims paper summarising the position as at 31st December 2021.
- The Director of Finance presented a paper on the National Fraud Initiative that provides a series of reports which provide a match of NHSFV data with the data of other public sector organisations to check for any areas of potential fraud.
- The Director of Finance presented a paper the purpose of which was to provide an update to the Audit and Risk Committee on action taken in respect of securing the Appointment of Endowment and Patient Funds Auditors for the provision of audit services for a period of three years, commencing with financial year 2022/23.
- The Fraud Liaison Officer summarised the latest Counter Fraud Services Report for period ending 31ST December 2021 and highlighted the key issues. In addition, the Committee were provided with an update on the status of Extrapolation Reports.

AUDIT & RISK COMMITTEE

Minute of the Audit & Risk Committee meeting held on 21 January 2022 via Microsoft (MS) Teams

---

Present:	Cllr Les Sharp (Chair) Mr John Ford Cllr Susan McGill Mr Robert Clark
In Attendance:	Mr Scott Urquhart, Director of Finance Mrs Cathie Cowan, Chief Executive Mr Tony Gaskin, Chief Internal Auditor, FTF Audit Services Mrs Jocelyn Lyall, Regional Manager, FTF Audit Services Ms Shona Slayford, Principal Auditor, FTF Audit Services Mr Adam Haahr, Audit Scotland Mrs Kerry Mackenzie, Head of Performance Mr Graeme Bowden, Capital Accountant

1/ APOLOGIES

Apologies for absence were intimated from Mr Stephen McAllister.

2/ DECLARATIONS OF INTEREST

There were no declarations of interest intimated.

3/ MINUTES OF PREVIOUS MEETING

The Minute of the Audit Committee meeting held on 22nd October 2021 was approved as a correct record.

4/ MATTERS ARISING – ACTIONS FROM PREVIOUS MEETINGS

4.1 National Shared Services – Payroll

Mr Urquhart provided the Audit and Risk Committee with an update on progress made in the South East Payroll Consortium programme. The Business Case for delivery of payroll services as part of the South East Payroll Services Consortium was approved at closed session on the NHS Board on 30th November 2021. The Audit and Risk Committee were informed that a paper outlining the next stages in the process would be presented to the Performance and Resources Committee in March 2022.

The Committee noted the update on the progress update on South East Payroll Services Consortium.

5/ INTERNAL AUDIT

5.1 Internal Audit Progress Report

Mrs Lyall presented the Internal Audit Progress Report and highlighted that since the last meeting three final reports had been issued including the Internal Control Evaluation Report, presented separately at a later agenda item. In addition, one Integration Joint Board (IJB) report had also been issued. Mrs Lyall provided the Committee with a summary of Audit Findings.

Mrs Lyall updated the Committee on recruitment ongoing within the FTF Audit team and confirmed that a new Principal Auditor had been appointed and would be commencing in February 2022.

The Committee noted the Internal Audit Progress report.

5.2 Internal Audit Framework

Mr Gaskin presented the Internal Audit Framework paper that included an updated Internal Audit Charter and NHS Forth Valley Internal Audit Reporting Protocol. Mr Gaskin advised that within this review there were no material changes since the previous version of the Framework presented tin October 2019. Mr Gaskin highlighted that the Internal Audit Charter was required to be approved annually by the Audit Committee.

The Committee noted the NHS Forth Valley Specification for Internal Audit Services and approved the updates to the Internal Audit Charter and the NHS Forth Valley Internal Audit Reporting Protocol.

5.3 Internal Control Evaluation

Mr Gaskin presented the Internal Control Evaluation (ICE) for 2021/22. Mr Gaskin advised that the ICE is produced to provide assurance on the system of internal control that supports the achievement of the Board's objectives in parallel with the Sustainable Services review, and Follow-up of previous recommendations. The report also set out progress against the following areas:

- Identification of emerging risks and key actions to manage high priority risks;
- Identification of the key risks and challenges to achievement of strategic objectives and ensured that progress is monitored at governance level;
- Identification of opportunities for change and improvement to develop and implement the organisation's strategic agenda;
- Implementation of revised arrangements to ensure NHS Forth Valley can effectively respond to COVID-19 and discharge its governance responsibilities; and
- Focus on key themes and actions arising from the Annual Internal Audit Report and findings on remobilisation.

Mr Gaskin gave an overview of the report and highlighted some of the positive developments during 2021/22, including the financial risk deep-dive exercise, and the key challenges ahead including risks related to an ageing workforce and ongoing challenges within Unscheduled Care. These however were national issues and not just relevant to NHS Forth Valley.

There was discussion on Section 13 of the report that recommended the ICE report should be shared with each Standing Committee and it was agreed that this should be progressed to share relevant findings and monitor actions.

The Committee noted the Internal Control Evaluation for 2021/22 and agreed that the report would be distributed to Standing Committees for consideration.

6/ EXTERNAL AUDIT

6.1 External Audit Progress Report

Mr Haahr confirmed that planning for the 2021/22 Annual Accounts process had commenced and system reviews were planned to be undertaken in February 2022. Mr Haahr asked the Committee to note that the statutory deadline for submission of annual accounts was currently set at 31st August 2022, and Mr Urquhart confirmed that his team were working on the timetable with Auditors with a view to conclude the process as early as possible.

Mr Haahr asked the Committee to note that this would be the final year of Audit Scotland's term as External Auditors to NHS Forth Valley, and the Board would be informed of the new audit team by Scottish Government.

The Committee noted the External Audit Progress update.

7/ AUDIT FOLLOW-UP

7.1 Audit Follow-Up Report

Mr Bowden presented the Internal Audit Follow-Up Report and reported that:

- 83% of Audit Actions due are complete or partly complete
- 5% of Audit Actions are not yet due for response
- 12% of Audit Actions were overdue for completion.

Mr Bowden confirmed that the Director of Finance had presented a paper to the Systems Leadership Team on 17th January 2022 setting out an overview of the current position of follow up actions and reinforcing the importance of addressing recommendations made within Audit Reports within the agreed timescales. The paper also outlined an update to the escalation process - where recommendations remain incomplete for more than three months beyond their due date, the responsible officer will be invited to attend the Audit and Risk Committee to provide an update.

Mr Ford asked if the RAG Status of outstanding recommendations could be added to the report and this was agreed.

The Committee noted the Audit Follow-Up Report.

8/ GOVERNANCE ISSUES

8.1 Best Value Framework

Mrs Mackenzie presented the Best Value Framework paper and summarised the position against each of the following key themes:

- Vison and Leadership
- Effective Partnerships
- Governance and Accountability
- Use of Resources; and
- Performance Management

Mrs Mackenzie highlighted that forward planner tool and template had been developed within Pentana and introduced to the Performance & Resources Committee in January 2022 for comment. The planner incorporates an assurance plan, linking risks to the responsibilities of the committee, and captures key information that supports the provision of assurance to the committee. The reporting functionality had been developed for roll out to NHS Board Assurance Committees.

The Committee noted the Best Value Framework update.

9/ COUNTER FRAUD SERVICES

9.1 Counter Fraud Services Quarterly report ~ Quarter ending 30th September 2021

Ms Slayford presented the Counter Fraud Services (CFS) Quarterly Report for the period ending 30th September 2021 and highlighted that there had been one new referral made relating to NHS Forth Valley during the quarter. Ms Slayford highlighted that this new referral related to an allegation that an employee had been working while on sick leave, however following initial enquiries the case was closed by Counter Fraud Services. Ms Slayford also indicated that CFS responded to the increased risk of fraud, as a result of the Covid19 pandemic, by compiling a summary of all alerts on a rolling Covid19 document which is distributed by the Fraud Liaison Officer to relevant officers within NHS Forth Valley. The document includes tips on the prevention of procurement fraud and how to improve cyber security; themes have included: cyber security threats, scammers (COVID Passport, WhatsApp, Lost Pet, Phone; and Doorstep Scams).

Regarding Patient Exemption Checking, Ms Slayford indicated that for the period 1st April 2021 to 30th September 2021 NHS Forth Valley had made patient recoveries to the value of £9,964 that represented 4.4% of the Scotland wide total.

The Committee noted the Counter Fraud Services Quarterly Report for period ending 30th September 2021.

There being no further business the meeting closed at 9.50am.

10/ DATE OF NEXT MEETING

The next meeting of the NHS Forth Valley Audit Committee will take place on Friday 25th March 2022 via Microsoft Teams.

FORTH VALLEY NHS BOARD

TUESDAY 31 MAY 2022

9.3.3 Staff Governance Minute – 18 March 2022
For Assurance

Chair: Mr Allan Rennie, Non-Executive Board Member

Minute of the Staff Governance Committee held on Friday 18 March 2022 via MS Teams

Present: Mr Allan Rennie, Vice Chair, NHS Forth Valley Board (Chair),
Mr Robert Clark, Employee Director
Mr Gordon Johnston, Non-Executive Director
Ms Janie McCusker, Chair, NHS Forth Valley Board
Cllr Susan McGill, Non-Executive Director
Ms Karren Morrison, Unison
Ms Janett Sneddon, RCM

In Attendance: Mrs Elaine Bell, Interim Associate Director of HR
Mrs Cathie Cowan, Chief Executive
Mrs Denise Davidson, HR Management Information Co-ordinator
Ms Linda Donaldson, Director of HR
Miss Sinead Hamill, Board Secretary (Minute)
Mrs Margaret Kerr, Head of Organisational Development
Ms Julie McIlwaine, HR Manager
Mr Jonathan Procter, Director of Facilities & Infrastructure
Mr Cameron Raeburn, Head of Health and Safety
Miss Rebecca Reid, Corporate Services Assistant
Mrs Linda Robertson, HR Service Manager
Ms Pamela Scott, Clinical Nurse Manager
Mr John Stuart, Non-Executive Board Member
Prof Angela Wallace, Executive Nurse Director

---

1. Welcome and Introductions

The Chair welcomed everyone to the meeting.

2. Apologies for Absence

None received.

3. Minute of Meetings

The draft minute of the Staff Governance Committee meeting held on Friday 10 December 2021 was approved, subject to the following amendments:

- On page 7, Nurse Director should be changed to Nurse Educator.

4. Matters Arising from the Minute

There were no matters arising.

5. Covid19 update - Impact of Workforce

Cathie Cowan, Chief Executive gave a verbal update on the Impact of Covid-19 on the workforce.

The Staff Governance Committee:

- ***Noted that Forth Valley is showing an upward trend in Covid related community infections, Covid related staff absences (in both health and social care) and Covid related hospital admissions (ITU admissions static and stable). In addition, national modelling showed an ongoing increased hospital capacity (ITU Covid related capacity remained static).***
- ***Noted the system pressures and impact on the 4-hour emergency access standard i.e. Covid admissions, Covid contacts, staff absences in health and care and delayed discharge rates.***
- ***Noted the continued commitment and professionalism of all staff in Forth Valley Royal Hospital, (and across the overall health and care system) despite the ongoing pressures.***
- ***Noted staff absence continues to be monitored.***
- ***Noted Human Resources continue to provide support on site.***
- ***Noted staff concerns, notably the ongoing use of treatment rooms and use of a 5th bed in a 4 bedded bay and the impact on workload and staff morale as highlighted during on-site visits.***
- ***Identified the need for staff to be informed of pressures faced by the organisation as a whole via the Intranet (e.g. recent joint Medical Director and Chief Executive thank you message).***
- ***Acknowledged and gave thanks for the high quality of work delivered by staff in very challenging circumstances.***

6. ED Oversight & Assurance of Staff Governance Section of ED Improvement Plan

Cathie Cowan, Chief Executive informed the Staff Governance Committee members that the paper had been prepared by Linda Donaldson, Director of Human Resources and was intended to provide assurance on progress relating to the ED Improvement Action Plan and HR Review actions.

Linda Donaldson provided an update on the delegated responsibilities placed on the Staff Governance Committee by the Health Board to oversee the implementation, monitor progress, and escalate issues relating to the staff governance recommendations set out in the ED Improvement Action Plan. Committee members in discussing the Action Plans noted the good progress being made in both the ED Action Plan and HR Review actions.

The Staff Governance Committee:

- ***Considered the content of the paper and acknowledged the responsibility of the Committee to oversee the implementation of the outstanding Staff Governance and HR Review actions.***
- ***Noted that the HR case review actions will be included in the Staff Governance Section of the ED Improvement Action Plan.***
- ***Noted the ongoing OD work to provide support and development of ED staff.***

- ***Noted that the Chief Executive will be providing quarterly reports on progress to the Health Board and Integration Joint Authorities.***
- ***Noted the commission of Internal Audit.***
- ***Noted that this will be a standing item within Staff Governance Committee workplan and that progress against the ED Improvement Action Plan (includes HR recommendations and actions) will be reviewed at each meeting.***

7. RISK MANAGEMENT

7.1 Health and Safety Quarterly Report Q3 Oct-Dec 2021

Jonathan Proctor, Director of Facilities and Infrastructure and Cameron Raeburn, Head of Health and Safety presented the quarterly report.

This report advised on the Health and Safety issues for NHS Forth Valley, and those currently being worked upon by the Health and Safety Department. Additionally, it provided detail about the type and number of adverse events being reported via our systems and provided information on any identified improvements that are being undertaken. This report focused on Quarter 3, the period October to December 2021.

The Staff Governance Committee:

- ***Noted the Health and Safety Executive (HSE) had requested additional information relating to a patient who had two RIDDOR reportable falls. The information was provided and to date, no further communication has been received from HSE.***
- ***Noted 108 events involving staff who tested positive for Covid19 have been reported to RIDDOR. These events will also be followed up to determine transmission route.***
- ***Noted an increase in reported adverse events from the same period last year.***
- ***Noted the number of non-clinical adverse events remains stable.***
- ***Noted the delays in reviewing adverse events within the 9 day target, with an increase on Q2 timescales of 20%.***
- ***Noted that whilst there had been an increase in reported events involving Violence and Aggression compared to the same period last year, it does remain relatively stable.***
- ***Noted that whilst Musculoskeletal (MSK) absences were higher than previous quarters, only 7 of 119 were considered to be work related.***
- ***Noted that new fire safety regulations will be introduced on 1 April 2023 and current fire drills will be revisited.***
- ***Noted that Control Book Audits is an ongoing process and will be subject to quarterly audits.***
- ***Noted the actions taken from the Q3 report and the timescales allocated to resolve same.***

7.2 Manual Handling and Violence & Aggression

Jonathan Proctor, Director of Facilities and Infrastructure gave a presentation on 'Manual Handling and Violence & Aggression'.

Mr Proctor explained that there had been an HSE Improvement Notice issued for nursing throughout FVRH with regard to Manual Handling. The report focussed on two main areas:

- Failure to Demonstrate Training Compliance & Adequacy of Training
- Lack of Management Oversight and at Board/Committee.

The Staff Governance Committee:

- ***Noted the amount of work already done in response to the HSE Improvement Notice.***
- ***Noted the new governance arrangements in place around Health & Safety.***
- ***Noted the positive impact Cameron Raeburn, Head of Health & Safety, has had since his appointment.***
- ***Noted there has been a significant increase in the level of Violence and Aggression training.***
- ***Noted the HSE Improvement Notice was lifted in January 2022.***
- ***Noted the 100% compliance target for Violence and Aggression training by June 2022.***
- ***Noted the number of staff currently registered for training and the focus being currently on high risk settings such as ED.***
- ***Noted the concern from staff side around the identified figures in the report, and their request to seek comparisons with other Health Boards. Jonathan Proctor confirmed that other Health Boards are currently facing the same challenges.***
- ***Noted mandatory training is in place and is included in the corporate induction which is reported on a monthly basis.***

The Staff Governance Committee was assured by the report.

8. STAFF GOVERNANCE STANDARD ACTIVITY

8.1 Staff Governance Committee Workplan

Linda Donaldson, Director of Human Resources presented a paper to update members of the Staff Governance Committee on progress made in the development of our Staff Governance Assurance Plan and Work Plan for the year 2022-2023. Since May 2021, this process has been used as a way to provide more assurance in line with each strand of the Staff Governance Standard. At the last Staff Governance Committee, it was agreed that reporting activity to the Staff Governance Committee would be refreshed to provide assurance in line with the 5 strands of the Staff Governance Standard.

The Staff Governance Committee:

- ***Noted progress made against the development of our Staff Governance Assurance Plan and Work Plan template for the year 2022-2023.***
- ***Considered and confirmed that the proposed changes to reporting arrangements including business calendar is sufficient to meet the assurance and scrutiny responsibilities of the Staff Governance Committee.***
- ***Approved the Staff Governance Assurance Plan and Work Plan for the year 2022-2023.***

8.2 Director of Human Resource's Report

Linda Donaldson, Director of Human Resources presented a paper 'HR Director – Staff Governance Report' and welcomed Linda Robertson, HR Service Manager to provide an update on the policies identified therein.

Linda Robertson updated Committee members on:

- Once for Scotland Workforce Policies Programme Board which is due to restart the development of Phase 2 workforce policies at the beginning of April 2022.
- National training has been developed on TURAS eLearning for 3 of the 6 NHS Scotland Workforce Policies.
- A revised national Job Evaluation Policy has been issued.
- The continued work on locally developed policies which do not fall under the Once for Scotland Remit.
- The continued work on the Youth Framework and Employability Agenda.
- Arrangements for Annual Leave Buy Back and Carry Forward 2021/22.
- The continued work around the Workforce Plan 2022-2023 and the National Workforce Strategy.
- Staff Health, Wellbeing and Attendance Management data and updates as provided to the Directorates and Partnerships.
- The highlight report on NHS Forth Valley's workforce performance.
- The work currently ongoing around other key HR Programmes and processes.

Elaine Bell updated the committee on:

- The Workforce Performance groups which have been established for all Directorates and HSCP's. Julie McIlwaine, HR Manager presented the Workforce Performance Report for Falkirk HSCP to demonstrate the detailed monthly information provided.
- The newly launched exit interview process.
- Band 2 Health care support worker Review and progress against the implementation of the New Clinical National Profiles.

Linda Donaldson updated the committee on:

- Progress with International recruitment in NHS Forth Valley.
- Implementation of the nationally agreed eRostering Solution across NHS Forth Valley.
- Armed Forces Employment Recognition Scheme
- Progress relating to Our Staff Wellbeing Plan

The Staff Governance Committee:

- ***Noted the content of the paper.***

8.3 Our People Strategy Progress Update

Linda Donaldson, Director of Human Resources presented the paper 'HR Director - Our People Strategy Progress Update'.

This paper updated the members of the Staff Governance Committee on progress against the workforce strategy Our People Strategy 2018 - 2021[1]. 'NHS Forth Valley is an organisation that believes that if we get it right for our staff, then we will get it right for our patients and the communities we serve'. Our People Strategy sets out our ambitions to support better health, better care and better value underpinned by a culture that enacts the staff governance standards.

The Staff Governance Committee:

- ***Noted progress made against Our People Strategy 2018-2021.***
- ***Noted Our People Priorities next steps and future activity planned.***

[1] Our People Strategy 2018 – 2021 link
https://nhsforthvalley.com/wp-content/uploads/2018/11/Our-People-Strategy-2018-2021.pdf

- ***Noted the impact of the Covid-19 Pandemic on the workplan and the requirement to review and reinvigorate a number of our actions.***
- ***Noted that Our People Strategy 2018 - 2021 is due to be refreshed and with work underway this will be completed by June/July 2022 in line with National Workforce Strategy for Health and Social Care.***
- ***Noted that a further update on progress against Our People Strategy will be brought to the May 2022 meeting of the Staff Governance Committee taking into account the discussions and suggestions given during the meeting.***

8.4 Update on Organisational Development Priorities including Learning, Education and Training and iMatter

Margaret Kerr, Head of Organisational Development presented the update Organisation Developments Priorities including Learning, Education & Training (LET) and iMatter.

The purpose of the paper was to provide the Staff Governance Committee with an update on the progress of the OD and LET priorities being taken forward 2022.2023.

Updates on work already undertaken were provided to the Committee.

The Staff Governance Committee:

- ***Noted the OD team continue to work collaboratively with key stakeholders across the organisation.***
- ***Noted the OD team are currently preparing for the iMatter 2022 cycle.***
- ***Noted the postponement of the Staff Conference due to rising Covid-19 figures and this would now take place at a future date. (post meeting - 23 and 24th of June)***
- ***Noted the contents of the paper.***
- ***Acknowledged future updates on these and other areas will be brought to Committee accordingly.***

8.5 Whistleblowing Standards and Activity Report

Gordon Johnston presented the paper 'Whistleblowing Standards and Activity Report'.

The new National Whistleblowing Standards were launched on 1 April 2021 and a significant amount of work is underway to ensure that the standards are implemented across NHS Forth Valley.

This paper is presented to provide an update on the implementation of the Whistleblowing Standards and the Whistleblowing activity in NHS Forth Valley for Quarter 3 (Q3).

The Staff Governance Committee:

- ***Noted the full implementation of the National Whistleblowing Standards across NHS Forth Valley.***
- ***Noted whistleblowing activity in NHS Forth Valley in Q3 of 2021/22.***

8.6 Speak Up Initiative – Update

Linda Donaldson, Director of Human Resources presented the paper 'Speak Up Initiative - Update' and invited Elaine Bell, Interim Associate Director of Human Resources to provide an update.

The purpose of the paper was to provide an update on progress with delivery of the Speak Up Service following the first 3 months of operation.

The Staff Governance Committee:

- ***Noted the Speak Up Initiative was launched on 13 December 2021 with all Governance arrangements in place.***
- ***Noted that the Speak Up Oversight Group has been meeting regularly.***
- ***Noted further training has been identified for ambassadors and advocates of the service.***
- ***Noted the contents of the paper and look forward to receiving regular reports on progress and any key themes identified.***

9. STAFF GOVERNANCE ANNUAL REPORTS

9.1 Staff Governance Annual Report

The Staff Governance Committee considered a paper 'Staff Governance Annual Report'.

Gordon Johnston wished to highlight that he should be under the membership of the committee instead of 'in attendance'.

The Staff Governance Committee:

- ***Reviewed the key areas of business highlighted within the report.***
- ***Approved the Staff Governance Committee Draft Annual Report prior to presentation at the NHS Board.***

9.2 Staff Governance Terms of Reference

Allan Rennie wished to highlight two changes to the Terms of Reference. Committee members noted that both the Agenda and supporting papers will be sent out at least three clear days in advance of the meetings. Mr Rennie highlight that a Vice Chair will be appointed in addition to the Chair. Janie McCusker informed the Committee members that both she and Mr Rennie will consult on who will be appointed as Vice Chair.

It was confirmed the Vice Chair would have to be a Non-Executive member of the Committee.

It was confirmed that staff side colleagues wished to have 3 lay members instead of 2. It was confirmed that this request would be presented to the NHS Board for consideration.

10. REPORTS FROM COMMITTEES

10.1 Area Partnership Forum

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

10.2 Health and Safety Committee

The Staff Governance Committee **noted** the Health and Safety Committee minute.

ITEMS FOR NOTING

11.1 Circulars and Policies

The Staff Governance Committee **noted** the Circulars and Policies.

11.2 Internal Control and Evaluation

The Staff Governance Committee **noted** and took assurance from the Internal Control and Evaluation report.

12. ANY OTHER COMPETENT BUSINESS

Allan Rennie wished to thank Professor Angela Wallace for her contribution to the Staff Governance Committee and to the Board wishing her all the best for the next stage of her career. Committee members and participants also acknowledged Professor Wallace's significant contribution.

Mr Rennie apologised for the meeting running over. There being no other competent business the Chair closed the meeting.

FORTH VALLEY NHS BOARD
TUESDAY 31 MAY 2022

Clinical Governance Committee Update – 17th May 2022
For Assurance

Chair: Dr Michele McClung, Non-Executive Board Member

Key points to note from the meeting:

Section 6 – In our services, Was Care Safe in the Past?

- The agenda items in section 6 are reports and presentations which are standard items on the CGC agenda. These reports contain key safety metrics and narrative which provides assurance of the overall safety in our services. The reports presented at this meeting were:

  Item 6.1 – Safety and Assurance Report March 2022 – April 2022
  Mr Murray gave an update to the committee

  Item 6.2 – Falls Update
  Ms McKay, Head of Nursing, updated the committee on the programme of work and improvement being undertaken to reduce falls and falls with harm

  Item 6.3 – HAI Quarterly Report – January 2022 – March 2022
  Mr Horwood updated the committee on the detail within the report

  Item 6.4 - Standards and Reviews Report March 2022
  Mrs Bennie gave an update to the committee on guidance and standards published in March 2022.

Section 7 – In our services, Will Care Be Safe in the Future?

- **Item 7.1 Patient Safety Conversation Update**
  Mrs Bennie updated the committee on the Patient Safety Conversation Programme which commenced on 14th April 2022.

- **Item 7.2 – Risk Management Update**
  Mrs Mackenzie was welcomed to the committee and updated the members on the current Risk Management position

Section 8 – Is Our Care Person-Centred?

- **Item 8.1 NHS FV Complaints and Feedback Performance Report March 2022**
  The committee received an update of the detail within the report

Section 9 – Are We Learning and Improving?

- **Item 9.1 – Quality Improvement Report**

Mrs Bishop updated the committee on the current Quality Improvement works teams being supported by the Forth Valley Quality team

- **Item 9.2 Significant Adverse Event Report**
  Mrs Bennie gave an update on the progress and timescales of the Significant Adverse Event Reviews currently being undertaken

Section 10 – Are Our Systems Reliable?

- **Item 10.1 Child Protection Quarterly Report**
  The committee were updated on key areas related to child protection

- **Item 10.2 – Adult Support and Protection Update**
  The committee were updated on key areas related to adult support and protection

- **Item 10.3 – Gender Based Violence and Sexual Assault Service Update**
  The committee were updated on key areas related to the gender-based violence and sexual assault service

Section 11 – Further Assurance

- **Item 11.1 – Medical Appraisal and Revalidation Update**
  The committee received an update on the current medical appraisal and revalidation position

- **Item 11.2 - Clinical Governance Committee Draft Annual Report, Forward Planner and Terms of Reference**
  The committee was asked to approve the draft documents

Section 12 – Reports from Associated Clinical Governance Groups

- **Item 12.1 Minute of Clinical Governance Working Group Meeting – 31.03.2022**