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
1st June 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 Overview

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.

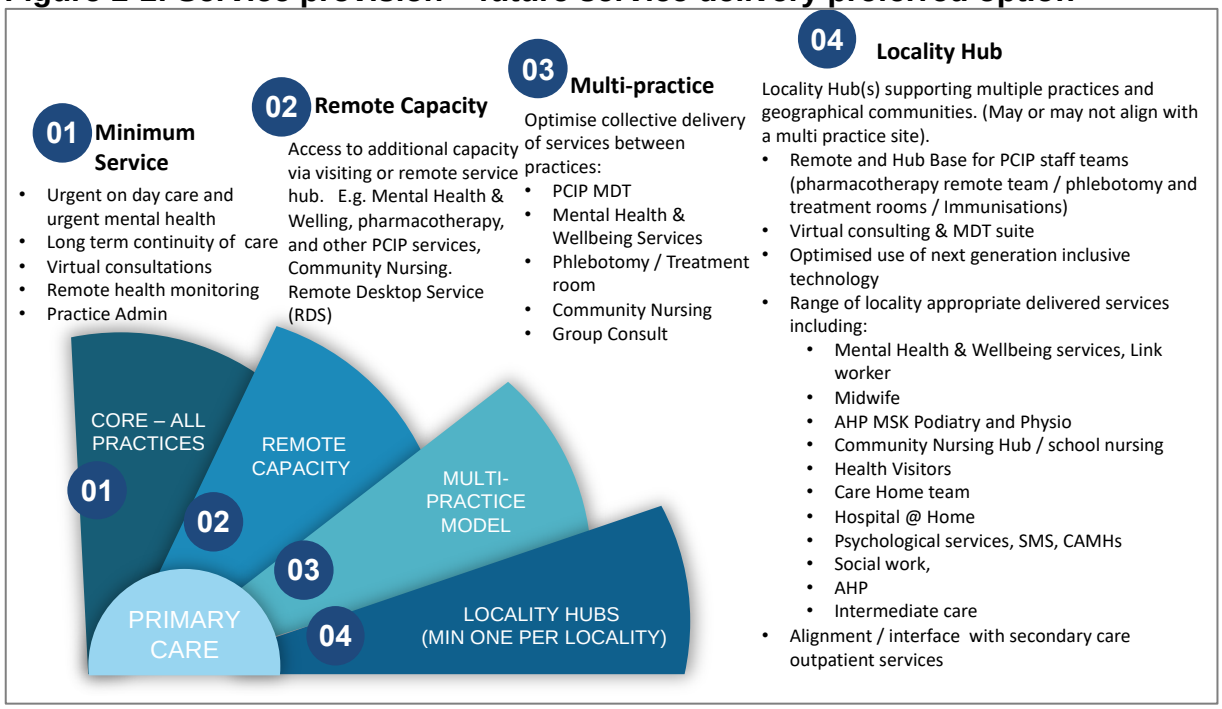
- Improved access to a wider range of services
- Ability to meet current and future demand
- Reduced waiting times for mental health advice and physiotherapy

- 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-	• 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-	• Investment to hub locality services across Grangemouth and Bo'ness • Optimised links with Falkirk central hub.

	GMS services within the locality hub. • Meadowbank catchment also likely to use Falkirk Central locality services.	owned premises to HB ownership. • Meets demand from new housing	

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.	• Locality hubs addressing the spread of population • Improving service delivery and alignment	• Reprovision of, and improved, locality services between the existing CCHC and a new Hillfoots hub.	• Investment creates a 2nd hub within the Hillfoots villages. • Investment addresses

• 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.	between the existing CCHC and a hub servicing the Hillfoots villages (Menstrie, Alva, Tillicoultry, Dollar & Muckhart).	• Potential to improve services limited by poor building quality • Includes a shift of practice owned premises to HB ownership. • Meets demand from new housing.	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 Overview

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 Overview

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*

Stakeholder Group:	Engagement that has taken place	Confirmed support for the proposal
		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.

Stakeholder Group:	Engagement that has taken place	Confirmed support for the proposal
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

NHSScotland Strategic Investment Priority:	How the proposal responds to this priority	As measured by:
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	• Carbon emissions • Take up rates for health improvement services • Staff surveys • Proportion of staff working agile • Reduction in number of desk spaces

NHSScotland Strategic Investment Priority:	How the proposal responds to this priority	As measured by:
	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.	

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

Our Vision is a of a future where:
Prevention: keeps people well whilst early treatment and support stops conditions getting worse
Health and social care services are **Person Centred** recognising that people have differing needs, circumstance, and expectations of care.
Health **Inequalities** are reduced and people are encourage and supported to take **Personal Responsibility** for managing their own health and health conditions.
Care is provided **Closer to Home,** and fewer people need to go to hospital.
Planning Ahead and working in **Partnership** with staff, patients, local councils and community organisations avoids emergency hospital admissions and reduced A&E attendances.
Unnecessary **Delays** and **Variations** in services are minimised and our **Workforce** is fully supported to deliver high quality, safe and effective care.

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 • 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	Further increase in the workforce within primary and community based care, all of whom require facilities from which to deliver health and care services.

	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	This programme presents an opportunity to implement place making principles and co-location and integration of services to support

	prosperous communities. In addition, this will support Forth Valley as an Anchor Institution.	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	This publication from the King's Fund in 2018 concludes that delivering person-centred and	The key themes highlighted are

general practice June 2018	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.	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 Overview

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.

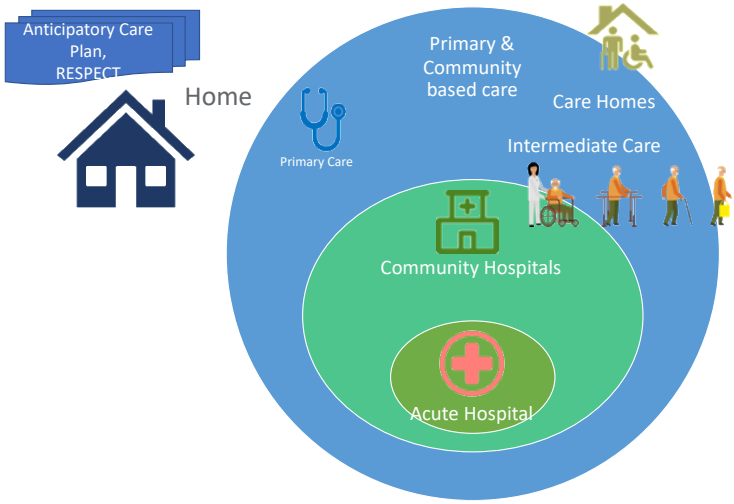
4.2.2 The Board serves a population of around 300,000 in a diverse geographical area which covers the heart of Scotland.

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

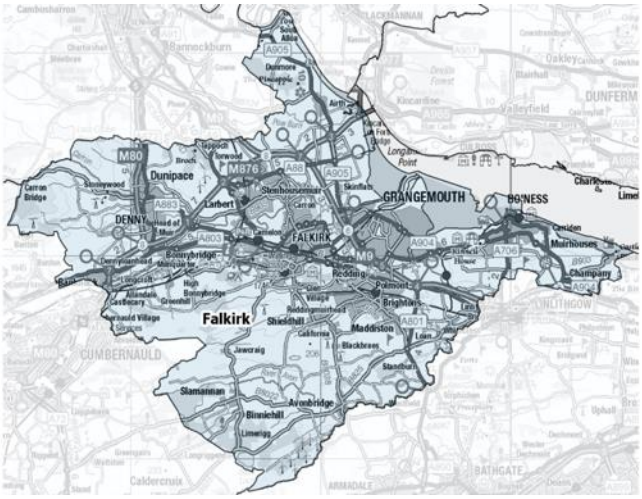
primary care and community health services, mental health services and some hospital services.

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



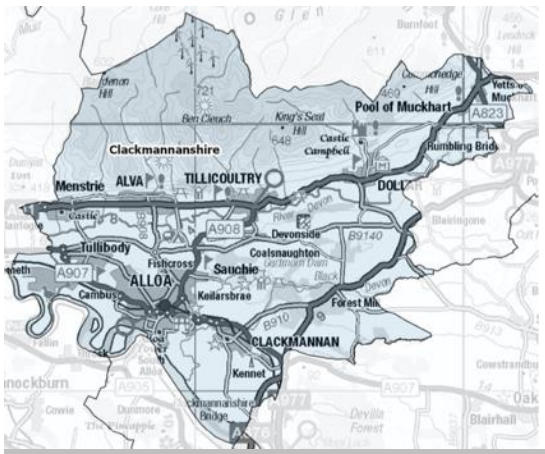
- estimated population of 160,340, increase of 2.5% since the 2011 census and projected to rise each year to 2041;
- 29,769 hectares and hosted 72,672 households in 2019;
- 1460 births in 2019, with a life expectancy from birth of 77.3 years for males and 80.5 years for females (compared to Scottish 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).

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

[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.

	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
- 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

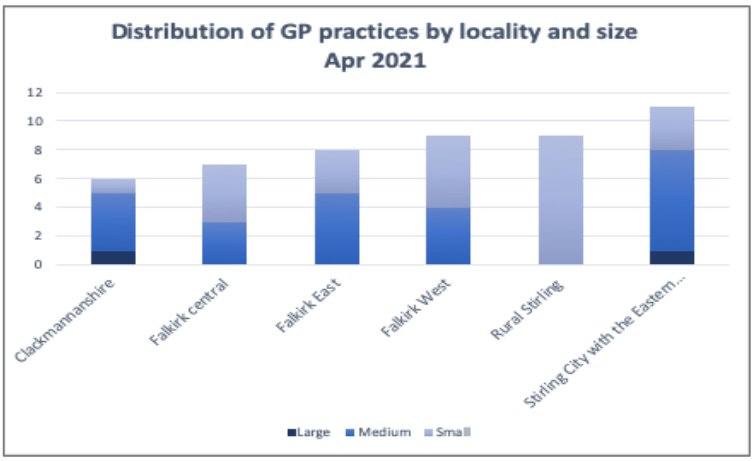
*one practice at three locations across NHS Forth Valley

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

Figure 4-11: Distribution of practice sizes by locality designations



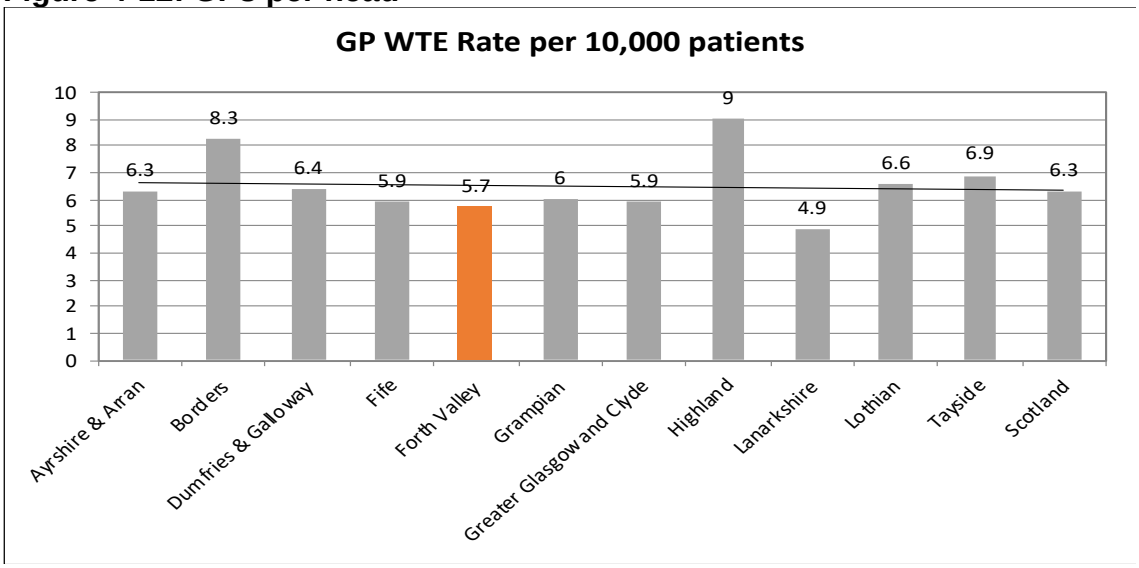
Current workforce

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%.

4.2.20 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 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



[2] Latest survey 2017; no update available since

4.1 What is the need for change?

4.1.1 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.

4.1.2 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.

4.1.3 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

4.1.4 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.

4.1.5 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.

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

4.1.7 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 201

Key Points

- The GP as expert medical generalist will focus on undifferentiated presentations, complex care and quality and leadership. All are equally important.
- GPs will lead and be part of an extended team of primary care professionals.
- GPs will have more time to spend with the people who need them most.

4.1.8 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

Key Points

- GP and GP Practice workload will reduce.
- New staff will be employed by NHS Boards and attached to practices and clusters.
- Priorities include pharmacy support and vaccinations transfer.
- Changes will happen in a planned transition over three years when it is safe, appropriate and improves patient care.
- There will be national and local oversight of service redesign and contract implementation involving SG PC ad Local Medical Committees.

4.1.9 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.

4.1.10 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.

4.1.11 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.

4.1.12 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).

4.1.13 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.

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

4.1.15 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.

4.1.16 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

4.1.17 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.

4.1.18 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

4.1.19 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.

4.1.20 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.

4.1.21 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**	**Pharmaco-therapy**	**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

4.1.22 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.

4.1.23 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.

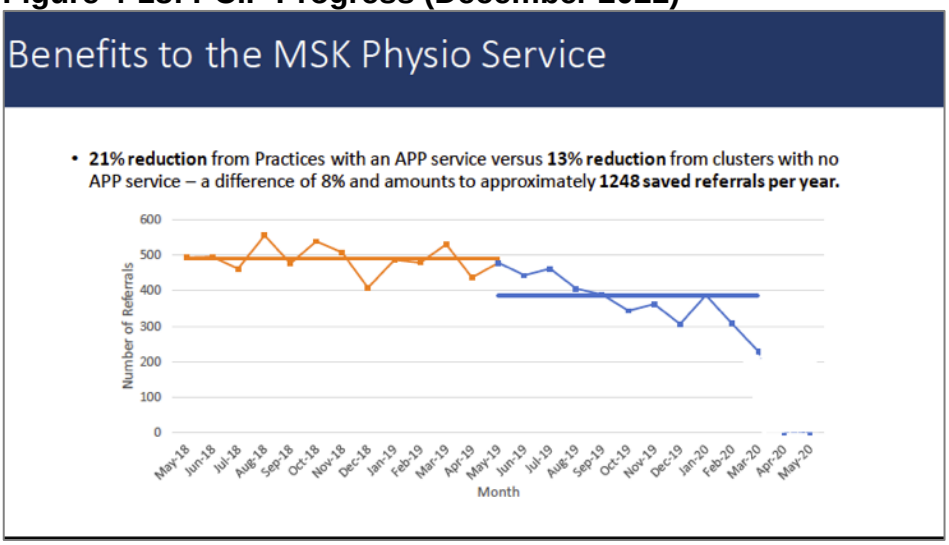
4.1.24 To support the creation of new roles, appointing additional members of staff as part of the primary care MDT with a breadth of skill and experience available to help manage the workload traditionally delivered by GPs, it is equally imperative that the appropriate environments and sufficient physical capacity is provided to accommodate them.

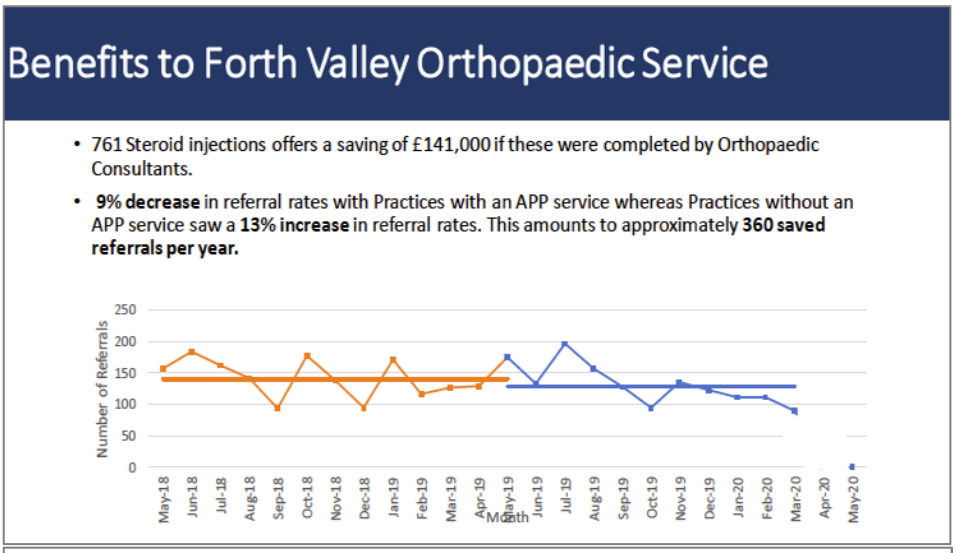
4.1.25 CTAC centres have been introduced in a number of locations across NHS Forth Valley geography, but examples show that there could be better co-ordination and shared visibility of resources.

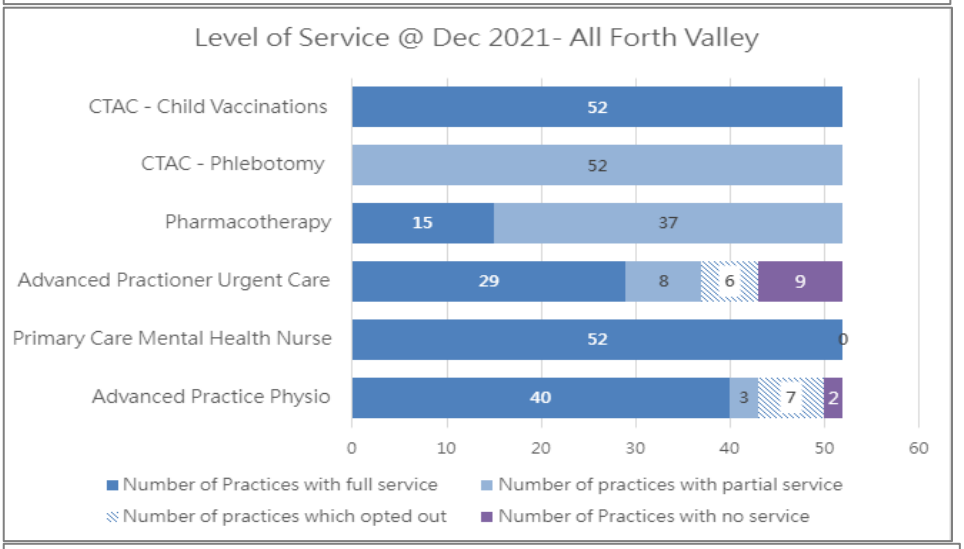
4.1.26 While great progress has been made in identifying, training and recruiting new members of staff to our primary care delivery teams to support this aim, constraints in physical infrastructure and capacity are limiting the extent to which the plan can be fully implemented.

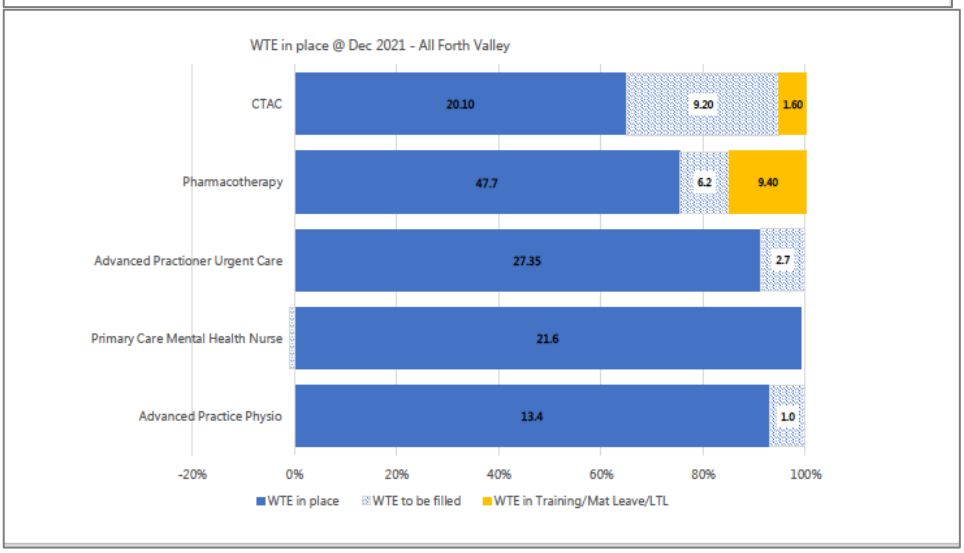
4.1.27 Significant progress has been made in implementing the Primary Care Improvement Plan with 141,000 additional consults provided. **Appendix B** provides a copy of the latest Board update on PCIP; a number of key charts have been extracted and shown below:

Figure 4-18: PCIP Progress (December 2021)









Supporting shift from acute to community-based models

4.1.28 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.

4.1.29 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.

4.1.30 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:

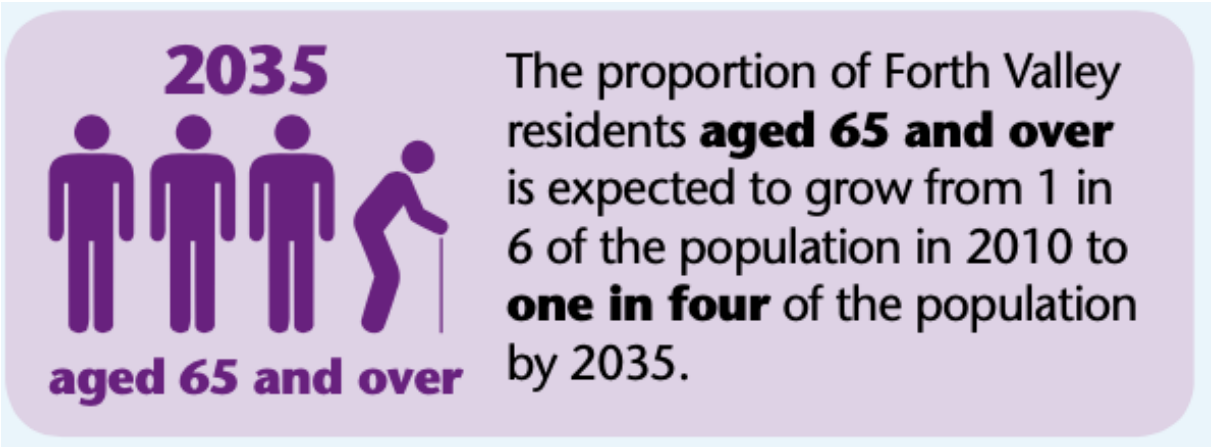
- All practices operating “open but full” status; not routinely accepting new patients
- In areas with new housing planned (circa 2600 homes)
- Unable to offer Vaccination or Community Treatment & Care Services within the locality; patients required to travel to Falkirk Community Hospital site.
- Practices 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

4.1.31 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



4.1.32 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.

4.1.33 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

4.1.34 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

Rising demand for long-term care

4.1.35 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.

4.1.36 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

Long term conditions are health conditions that last a year or longer, impact on a person's life, and may require ongoing care and support. Around two million people (40% of the Scottish population) have at least one long term condition and one in four adults report some form of long term illness, health problem or disability.
By the age of 65, nearly two-thirds of people will have developed a long term condition and, as people age, they are more likely to develop several different health conditions.

Demand & Capacity

4.1.37 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)
Pharmaco-therapy 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 Physio-	20,0000	16.1	10.1	(6.0)	16.1	0.5	(6.5)

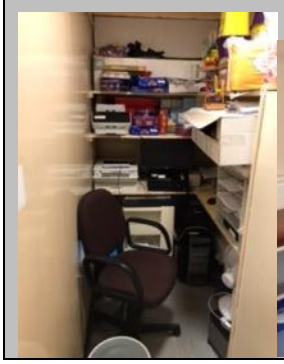
Workforce	Registrations per 1wte	Total wte required – current population (322k)	Current wte	Current gap	Future wte projected population (331k)	Impact demographic	Projected gap from current
therapists (APP)							
Urgent Care - Advanced Nurse Practitioners (ANP)	11,000	29.3	30.8	1.5	30.1	0.9	0.7
Community 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)**

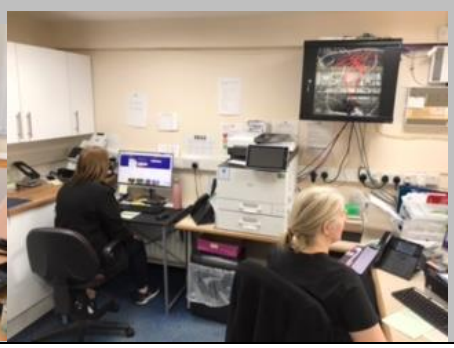
4.1.38 The table above suggests current gap of circa 32 wtes; rising to 42wte by 2041.

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

4.1.39 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.

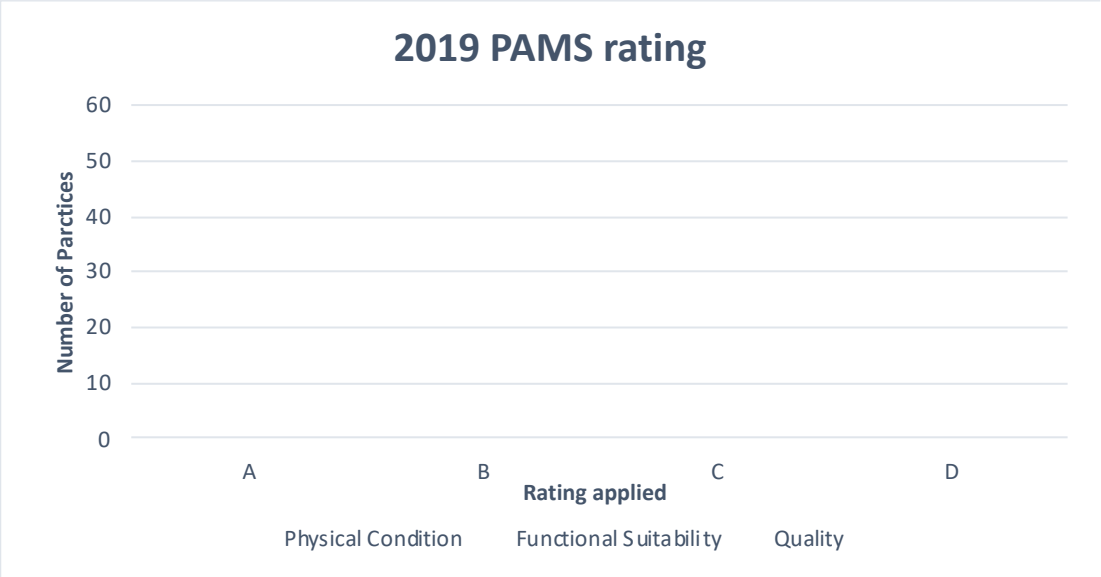
4.1.40 Three aspects are measured on an A-D rating scale, namely Physical condition, functional suitability and Quality. Space utilisation is measured using E, U,F & O (Empty, Underutilised, Full and Overcrowded respectively). The following table gives an indication of the meanings of those ratings as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

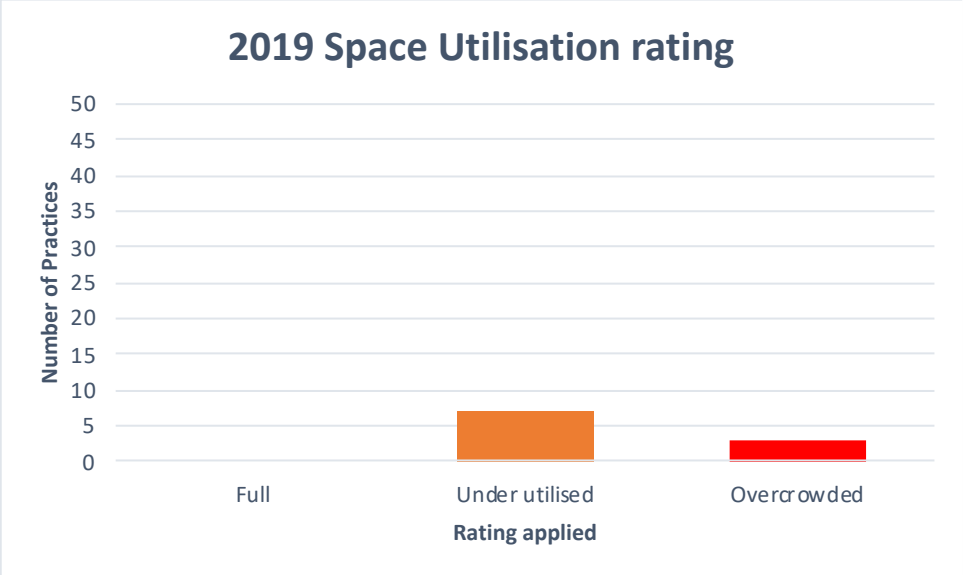
Figure 4-27: Rating scale for PAMS assessment

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

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

Figure 4-28: How Practices were rated in 2019





4.1.42 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.**

4.1.43 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.

4.1.44 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.

4.1.45 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

4.1.46 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.

4.1.47 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.

4.1.48 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

4.1.49 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.

4.1.50 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

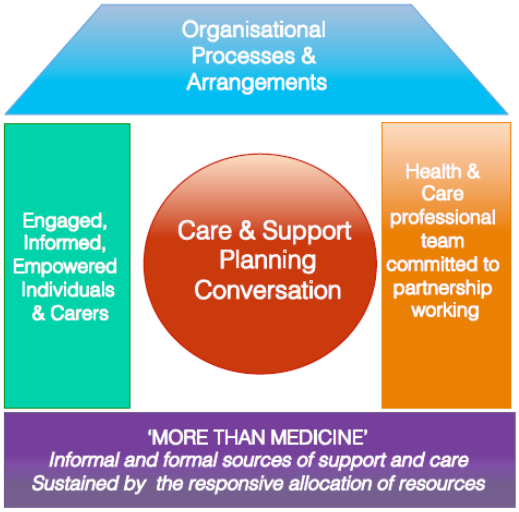
4.1.51 How we engage with those that use our services is changing. Realistic medicine puts the person receiving health and social care at the centre of decisions made about their care. It encourages health and care workers to find out what matters most to the person so that the care of their condition 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.

4.1.52 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.

4.1.53 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 the 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

4.1.54 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.

4.1.55 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.

4.1.56 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.

4.1.57 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

4.1.58 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.

4.1.59 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.

4.1.60 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.

4.1.61 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

4.1.62 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.

4.1.63 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.

4.1.64 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.

4.1.65 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

4.1.66 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.

4.1.67 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.

4.1.68 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.

4.1.69 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).

4.1.70 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

4.1.71 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 sustainability, recruitment and retention of expanded primary care teams.	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 retention issues associated with GP owned facilities	Ensure patients seen in the appropriate setting; insufficient access to primary care will impact on the demand for 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"

What is the cause of the need for change?	What effect is it having, or likely to have, on the organisation?	Why action now:
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	Benefits of integrated services unable to be achieved. Increased workforce and costs in already overstretched health and care services

What is the cause of the need for change?	What effect is it having, or likely to have, on the organisation?	Why action now:
	health and social care services available with localities. Unable to gain wider community benefits	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.

4.2 What is the organisation seeking to achieve?

4.2.1 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.	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 meet post-pandemic impact e.g. long covid, waiting times, growing aging/ complex patient group	
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**

4.3 What measurable benefits will be gained from this proposal?

4.3.1 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

4.3.2 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.

4.3.3 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.

4.3.4 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.

4.3.5 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.

4.3.6 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.

4.3.7 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.

4.3.8 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

4.3.9 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.

4.3.10 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.

4.4 What risks could undermine these benefits?

4.4.1 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

4.5 Are there any constraints or dependencies?

4.5.1 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 Overview

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.

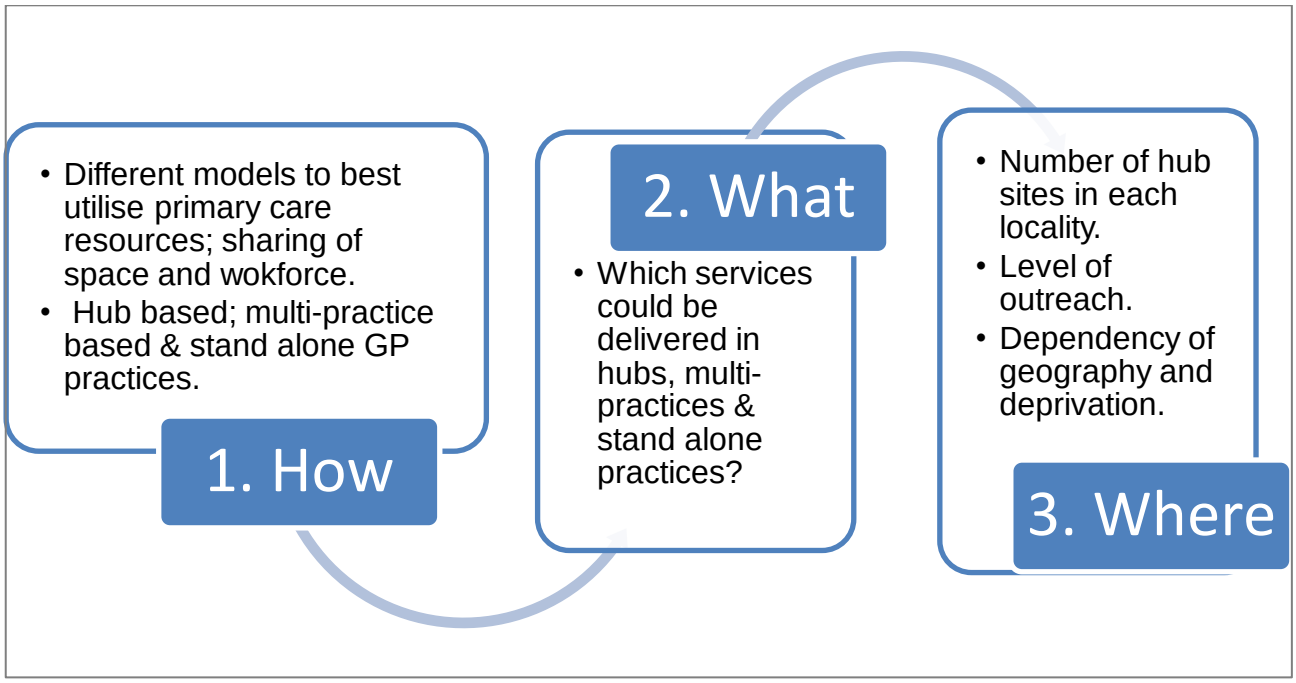
Furthermore, as a programme approach is being undertaken there are different considerations for each population base. The board has sought to explore a number of service delivery models to inform the option development process from traditional to radical. These focus on the level of service which could 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

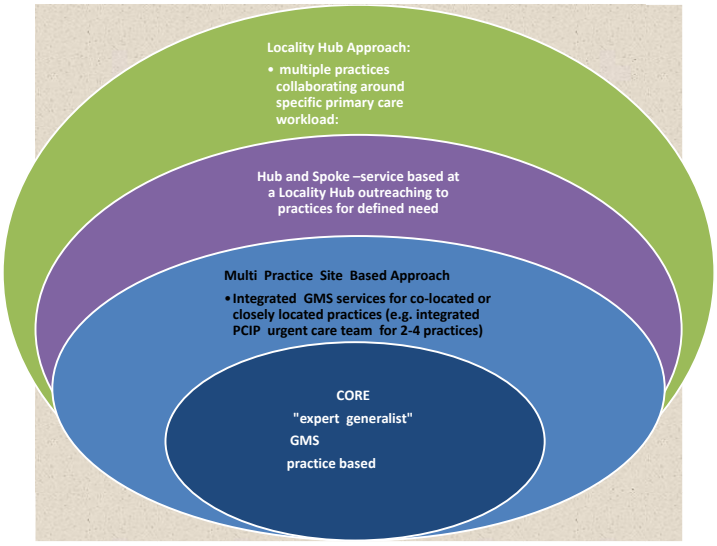
5.4.2 The alternative delivery options were based on the following attributes:

- 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 f67flexibility 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	• Increased patient travel and potentially reduces physical access to services	• Increased need for space in hub site • Potential issues in securing space for	• Potential impact to perception of what is available	• Potential impact to perception of what is available

	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	• 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	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 site	• 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 for increased travel • Increased need for space in hub site • Potential loss of GP income

	Do Nothing	**Do Minimum**	**Remote Capacity**	**Integrated multi-practice model**	**Locality Hub**
	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

5.4.8 The Do Nothing option does not meet the investment objectives identified and therefore rejected as a future delivery model.

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

5.4.9 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

5.4.10 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.

5.4.11 The assessment for each service against each attributes is shown at **Appendix F.**

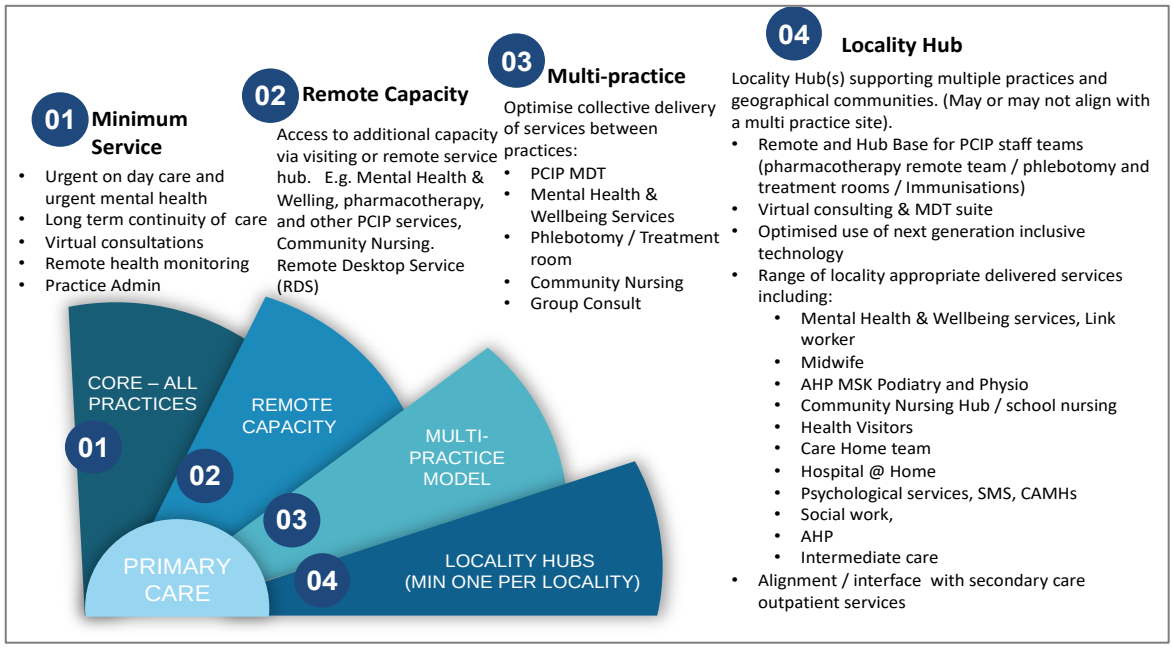
5.4.12 To support the options development process, a survey was issued to primary care staff to assess the appetite and opportunity for alternative service options. In total 73 responded, including 49 GPs. The outputs are shown at **Appendix G,** in summary this suggested:

- 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.

5.4.13 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



5.4.14 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.

5.4.15 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.

5.4.16 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.

5.4.17 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.

5.4.18 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

5.4.19 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.

5.4.20 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.

Locality	Proposed Configuration	Investment Impact
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.
Clackmannan shire Locality	• 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).	• Investment to create 2nd hub within the hillfoots villages. • 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.

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

5.4.22 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

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

5.5.6 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.

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**

5.5.8 The do nothing costs are included as a benchmark; noting that this option done not meet the investment objectives of the project.

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 Overview

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 (NHS FV) (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	**AnneMargaret Black**
Depute Medical Director Primary Care / Co-chair PC PIA (NHS FV)	**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 & e-Health Lead (Senior Supplier) (NHS FV)	**Jonathan Proctor**
Director of Place, Falkirk Council	**Malcolm Bennie**
Director of Finance (NHS FV)	**Scott Urquart**
Director of Human Resources (NHS FV)	**Linda Donaldson**
Director of Nursing (NHS FV)	**Angela Wallace**
Medial Director (NHS FV)	**Andrew Murray**
Director of Public Health & Strategic Planning (NHS FV)	**Graham Foster**
Employee Director (NHS FV)	**Robert Clark**
Director W,C&SH Services (NHS FV)	**Gillian Morton**
Chief Finance Officer, Falkirk HSCP	**Jillian Thomson**
Chief Finance Offices, Clacks & Stirling HSCP	**Ewan Murray**
Equality Advisor (NHS FV)	**Charlene Condeco**
CVS Falkirk	**Beverly 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.

Figure 6-3: Project Team Membership

FCH / PIA PROGRAMME BOARD (requires reps from each group – council; IJB, NHS Board)	
Project Director/Chair	Kathy O'Neill
Project Manager	Moira Straiton
Project Support	Maggie Mackinnon
SME finance	Steven Kirkwood
SME planning	Janette Fraser
SME Estates& Infrastructure	Morag Farquhar
SME Falkirk HSCP	GailWoodcock
SME Stirling/Clacks HSCP	Bob Barr
SME Primary care general practice	Scott Williams
SME GP lead	David Herron

SME GP lead	Teresa Cannavina
SME GP lead	David Reid
SME GP lead	James King
SME GP lead	Jonathan Turner
SME GP lead	Scott Henderson
SME GP lead	Sarah Boddington
SME GP lead	Jill Carmichael
SME Pharmacy	Laura Byrne
SME eHealth and ICT	Kevin Edwards
SME Improvement/Primary care	Lesley Middlemiss
SME Communication & engagement	Jessie Ann Malcolm
Technical Advisor (healthcare planning)	Karen Pirrie
Technical Advisor (healthcare planning)	Gill Bratt-Mcmanus
SME Nursing	Elaine Kettings

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.

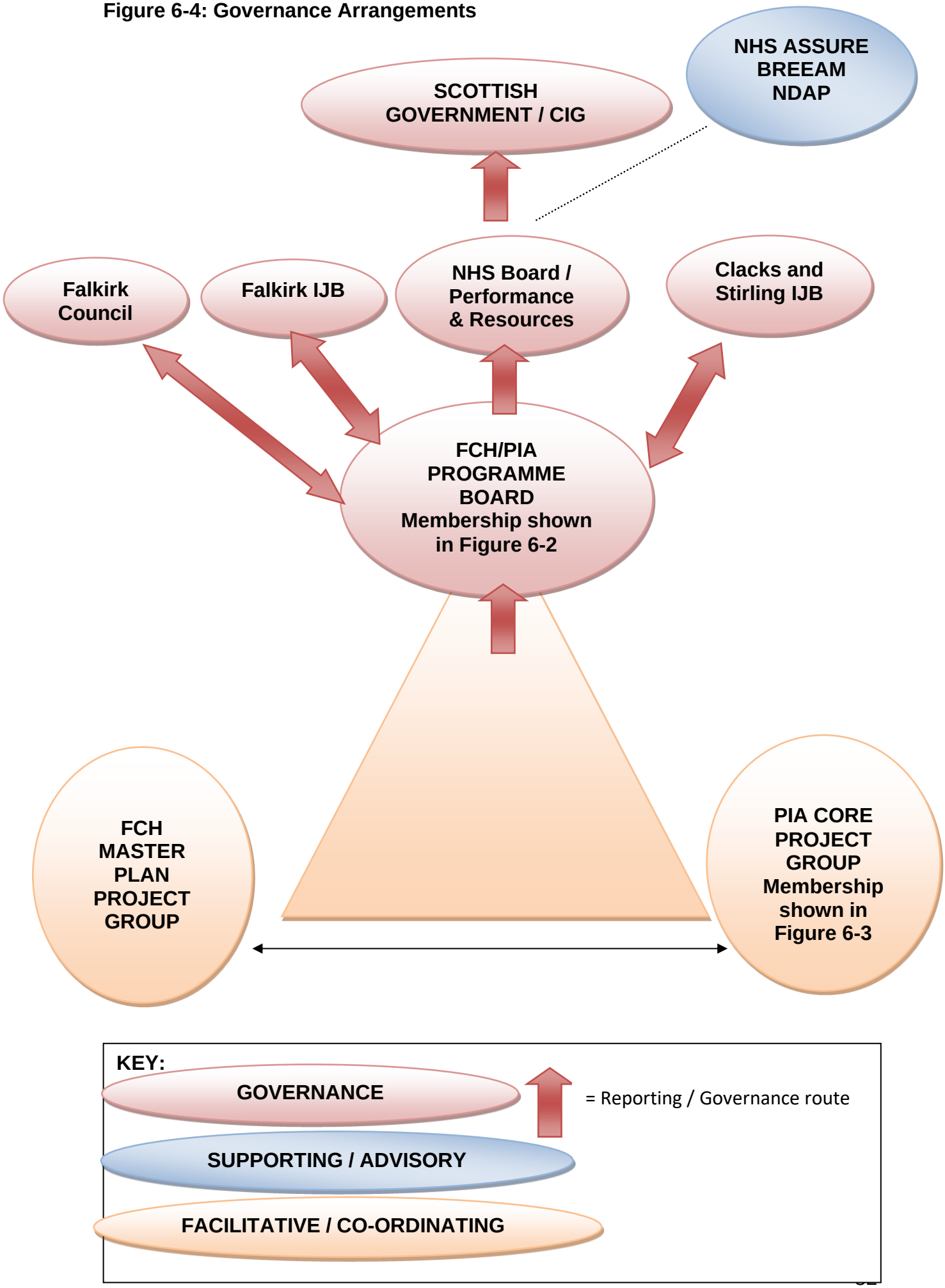
6.4.8 As the project develops, it will be supported by a project team which will be led by health care planning and technical planning/ capital project management. The Corporate Portfolio Management Office will provide support to the capital and health care planning project managers to establish and 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 6-4: 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 6-5: 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. 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