Agenda Item 9

Primary Care Premises Initial Agreement (PIA)

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Falkirk Integration Joint Board

10 June 2022

Primary Care Premises Initial Agreement (PIA)

For Decision

1. Executive Summary

1.1 The Scottish Government's vision for the future of primary care services is that "general practice and primary care at the heart of the healthcare system. People who need care will be more informed and empowered, will access the right professional at the right time and will remain at or near home wherever possible. Multidisciplinary teams (MDTs) will deliver care in our communities and be involved in the strategic planning of our services.**"**

1.2 In April 2021 the Health Board agreed to establish a Project to progress the development of a Programme Initial Agreement (PIA) for primary care premises across NHS Forth Valley. This has been developed in line with the requirements of the Scottish Government Capital Investment Manual and follows the submission of the Strategic Assessment in 2019.

1.3 The aim of the PIA is “to improve GP services for all: Ensuring all GP practices have adequate capacity to deliver core general medical services with access to extended community services within “fit for purpose” premises; responsive to current and changing practice populations.”

1.4 This report presents the draft Programme Initial Agreement document. The PIA will be considered by NHS Forth Valley on 31 May 2022 and, once approved, will be submitted to the Scottish Government Capital Investment Group for consideration at their meeting in June. The outcome of the Health Board meeting will be reported back verbally at the June IJB meeting.

2. Recommendations

The Integration Joint Board is asked to:

2.1 Endorse the Primary Care Initial Agreement document

2.2 Note that following approval of the PIA, work by the Health Board and Capital Investment Group will commence to progress with 4 separate Outline Business Cases; (one for each locality where capital investment is required). The Falkirk Central locality requirements (fifth locality) will be addressed as part of the Falkirk Community Hospital (FCH) Master Planning project. There is paper elsewhere on this agenda regarding the progress of the FCH project.

3. Background

3.1 Integration Joint Board members participated in a workshop on 16 March 2022 where the emerging model of care which underpins this Initial Agreement document was presented and discussed.

3.2 The Falkirk Strategic Planning Group has also received updates on the Initial Agreement as it has developed and members of the SPG participated in workshops to develop the model of care.

4. Emerging Model of Care & Locality Impact

4.1 The focus of the PIA has been to explore with stakeholders the role of primary care within a transformed, integrated care system including how primary care reform may evolve in Forth Valley, noting the current and significant General Practice premises challenges

4.2 An area wide programme approach has been taken in order to try and maximise interdependencies and opportunities for effective and efficient investment which can benefit the breadth of primary care and the wellbeing of the population of Forth Valley as a whole.

4.3 A preferred service model for the future delivery of primary care services is proposed. Underpinning the proposed service model is the need to assure General Medical Service delivery at local population level and to develop existing and new “hub” based models of care. The ethos of these models to provide some elements of primary and community based services within larger premises. For example, the podiatry service post-pandemic has moved to providing the majority of clinical sessions in fewer locations while at the same time increasing the number of sessions for patients

4.4 Digital transformation requires to be at the heart of any future reform. Future business cases will ensure that next generation digital services are core to creating sustainable, quality services. This includes the expansion of virtual appointments, remote health monitoring, remote desktop server solutions and new primary care eHealth systems, ensuring that technology supports a more inclusive, patient led experience

4.5 The diagrams below (tables 1 & 2) summarise the future service delivery options for primary care aligned services and how each service might be provided within the future model:

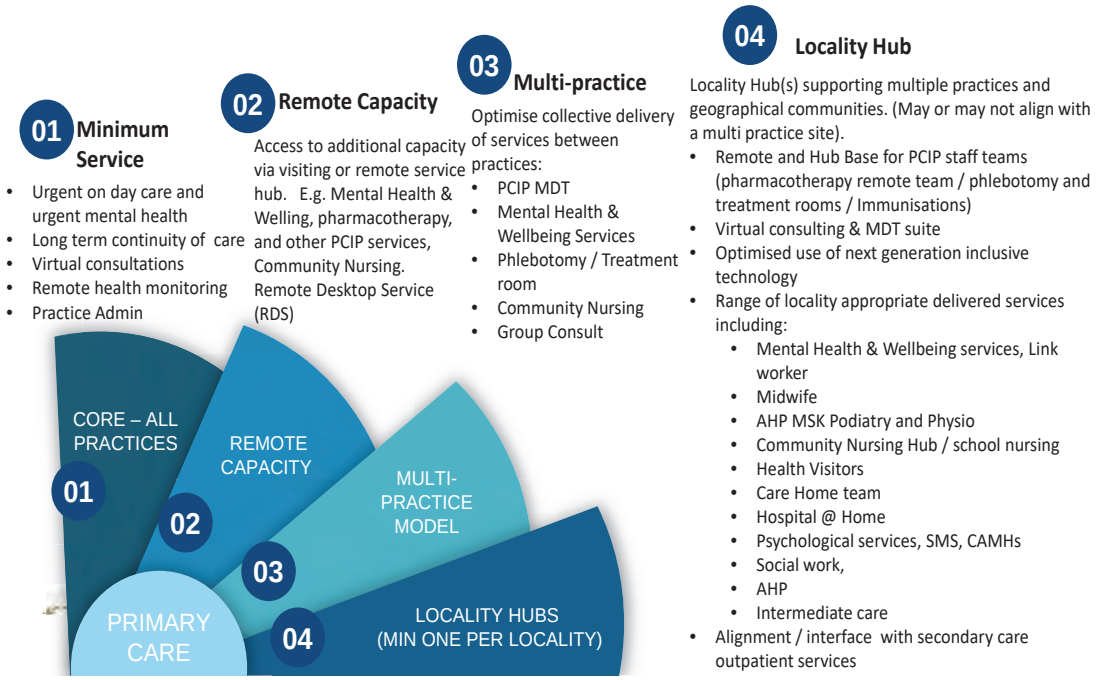


Table 1

Locality options	Proposed Configuration	Benefits	Impact
Option / Level 01	All 50 GP practices in Forth Valley require to deliver contracted, sustainable, person centered General Medical Service to people at community level.	Prioritised, targeted investment has the potential to: • improve a service limited by poor building quality and include a shift of practice owned premises to HB owned • improve services limited by a lack of space • address new Housing Demand	• Re-location of a small number of non GMS community teams and services to strengthen existing and new locality hub models will facilitate space for first contact MDT access in general practice. • Example: - Reprovision of Cowie and Plean • Release of space in Meadowbank
Option / Level 02	Optimise the benefits which can be created through co-location of practices, particularly in urban areas served by more than one GP practices. Opportunity to collaborate and optimise the delivery of care and use of space and technology.	In addition to Level 01 benefits, targeted investment has the potential to: • Facilitate collective and dynamic models of MDT care such as Community Treatment, phlebotomy, pharmacotherapy, mental health, MSK and urgent care through effective delivery of Primary Care Implementation Plan	• Example:- reprovision of premises for up to 4 practices in central Falkirk • Improved service provision in existing co located premises - Stenhousemuir, CCHC, Meadowbank. (a multipractice may or may not be a hub)

Locality options	Proposed Configuration	Benefits	Impact
		Multidisciplinary Team between practices, • Group consultation approaches • Digital and remote support for wider community model.	
Option / Level 03	A hub and spoke option links GMS capacity within Community Hub with stand alone or multipractice models through service hubs or remote / digital support.	• In addition to Level 01 benefits practices would benefit from efficient locality delivered or in reach services such as Community treatment, phlebotomy, remote pharmacotherapy or other shared remote consultation approaches to improve access for patients	• Example – Support for rural practices
Option / Level 04	Provide co-ordinated and collocated non GMS locality teams and services.	• Build on existing models such as Stenhousemuir, Carronbank, CCHC, and Stirling Health & Care Village, to provide modern digitally enabled quality locality services. • Through a planned approach to community services, provide equitable access to patients both at general practice and community service level • To facilitate space for first contact MDT access in general practice.	• Targeted investment to re-locate / consolidate a small number of non GMS community teams and services. • May be in alignment with multipractice investment e.g. Falkirk Community Hospital. • Optimise the use of existing hub facilities

Table 2: Description of options with examples

Project Management & Stakeholder Engagement

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

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

Table 3

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

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

External Assurance

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

- The IA has achieved 'Supported' status via the National Design Assessment Process (NDAP), though it is recognised that some further work is required to the Design Statement to address the recommendations from the review. It is anticipated that this will be completed prior to the CIG meeting but does not affect the status at this time.
- NHS Scotland Assure have been engaged in relation to the Key Stage Assurance Review and it has been confirmed that, due to their other commitments and in agreement with Scottish Government, a full review is not to be undertaken at this time. The alternative, a Lessons Learned workshop with a view to informing the Outline Business Cases, is planned for 10 June 2022.
- In relation to Sustainability, at this stage a commitment is given to application of the Sustainable Design and Construction Guide from OBC onwards.

Approval Process and next steps

- The approvals process is outlined below:

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

Table 4

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

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

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

Table 5

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

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

5. Conclusions

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

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

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

Resource Implications

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

Impact on IJB Outcomes and Priorities

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

Directions

A new Direction or amendment to an existing Direction is not required as a result of the recommendations of this report.

Legal & Risk Implications

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

Consultation

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

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

Equalities Assessment

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

Further to an evaluation it is noted that: *(please tick relevant box)*

□ Paper is not relevant to Equality and Diversity
□x Screening completed - no discrimination noted
□ Full Equality Impact Assessment completed – report available on request.

6. Report Author

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

7. List of Background Papers

7.1 None

8. Appendices

Appendix 1:	Primary Care Premises Initial Agreement
Appendix 2:	Primary Care Premises Initial Agreement : Supporting documents

Primary Care Programme Initial Agreement

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

NHS Forth Valley

17th May 2022

Glossary

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

Contents:

1 EXECUTIVE SUMMARY

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

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

1.2 Development of the Programme Initial Agreement (PIA)

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

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

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

1.3 The Need for Change

Recruitment and retention

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

Access to local services

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

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

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

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

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

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

Rising demand

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

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

IT and infrastructure

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

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

1.4 The Proposed Way Forward

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

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

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

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

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

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

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

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

Benefits

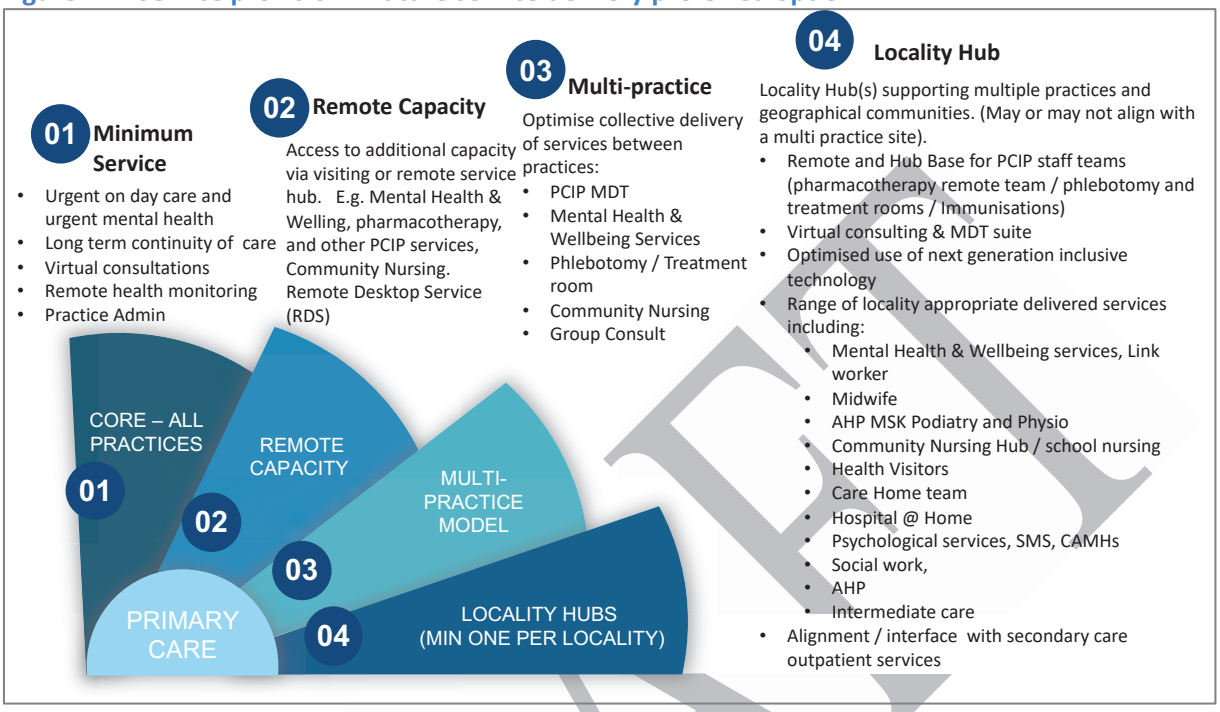
1.4.8 The benefits of the proposed changes are many and wide-ranging. They will not only improve patient care but will also increase staff recruitment and support the delivery of more modern, cost-effective services.

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

Preferred Service Delivery Option

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

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



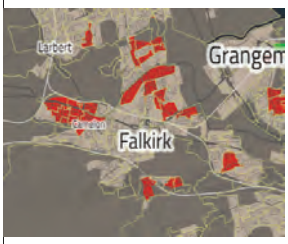
1.4.10 Further details on the specific options are outlined below:

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

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

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

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

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

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

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

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

Figure 1-3: Indicative costs

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

1.5 The Outline Commercial Case

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

1.6 Financial Case

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

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

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

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

1.7 Management Case

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

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

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

Figure 1-5: Project Plan

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

1.8 Is this proposal still important?

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

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

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

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

2 PURPOSE

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

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

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

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

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

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

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

STRATEGIC CASE

3 WHAT IS THE STRATEGIC BACKGROUND TO THE PROPOSAL?

3.1.1 The following section of the PIA will outline:

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

3.2 Who is affected by the proposal?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Figure 3-3: Statements showing 10 key priorities

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

Figure 3-4: National, Regional and Local Strategies

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

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

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

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

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

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

3.5 What external factors are influencing this proposal

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

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

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

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

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

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

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

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

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

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

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

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

4 WHY IS THIS PROPOSAL A GOOD THING TO DO?

4.1.1 This section will set out the following;

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

4.2 Current Arrangements

NHS Forth Valley

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

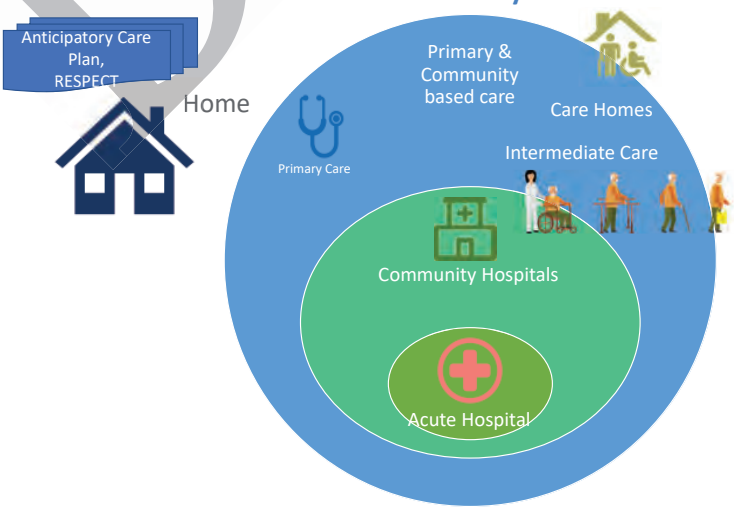
4.2.2 The Board serves a population of around 300,000 in a diverse geographical area which covers the heart of Scotland.

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

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

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

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



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

Health & Social Care Partnerships

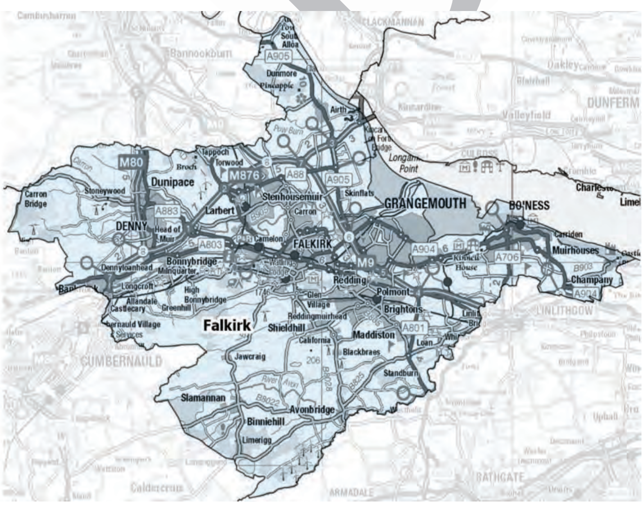
4.2.5 Within Forth Valley, the two Integrated Joint Boards have delegated responsibility for planning and resourcing of adult social care services, adult primary care and community health services, mental health services and some hospital services.

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

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

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

Figure 4-3: Falkirk Council area covered



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

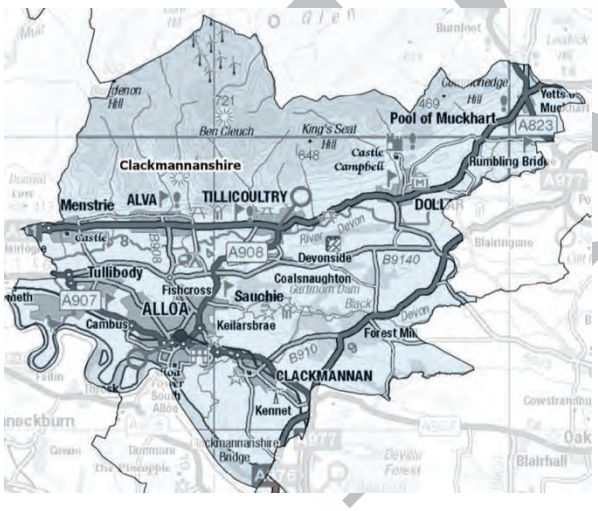
Clackmannanshire and Stirling HSCP (data based on 2019 data from NRS Council area profiles)

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

Figure 4-4: Stirling council area covered

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

Figure 4-5: Clackmannanshire council area covered



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

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

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

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

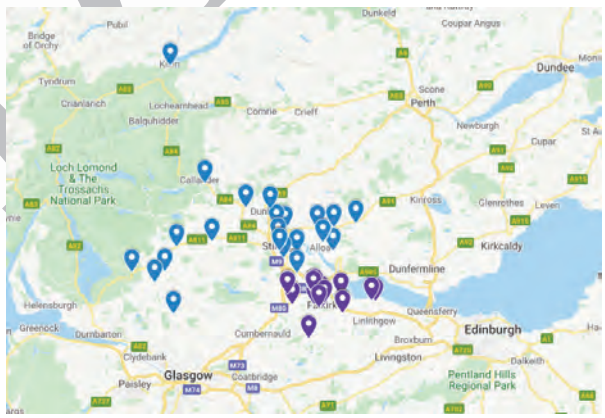
Health-related statistics	Clackmannan-shire	Stirling	Falkirk	ALL Scotland
Comparative Illness Factor: standardised ratio	107.6	81.9	101.7	100
Hospital stays related to alcohol misuse: standardised ratio	79.7	61.5	79	100
Hospital stays related to drug misuse: standardised ratio	87.2	77.6	79.9	100
Standardised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

Primary Care Service

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

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

Figure 4-7:Map of primary care premises locations



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

Service Arrangements

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

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

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

Figure 4-8: Services available to support service delivery

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

Service Providers

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

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

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

- Dentists

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

Figure 4-9: Current Practices

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

*one practice at three locations across NHS Forth Valley

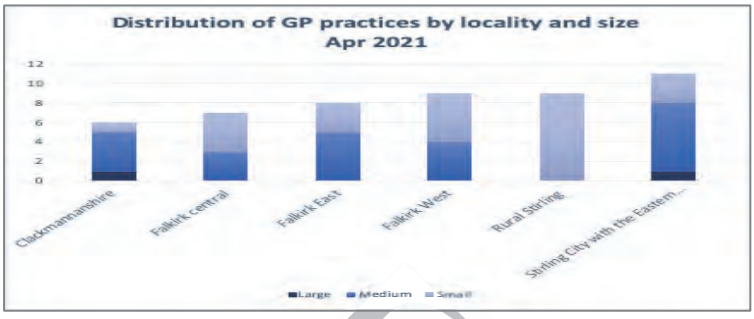
4.2.18 Practices have been classified as small, medium or large based on the populations they serve using the following practice sizes. The distribution by locality is shown in the chart:

Figure 4-10: Practice size

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

of practice sizes by locality designations

Figure 4-11: Distribution



Current workforce

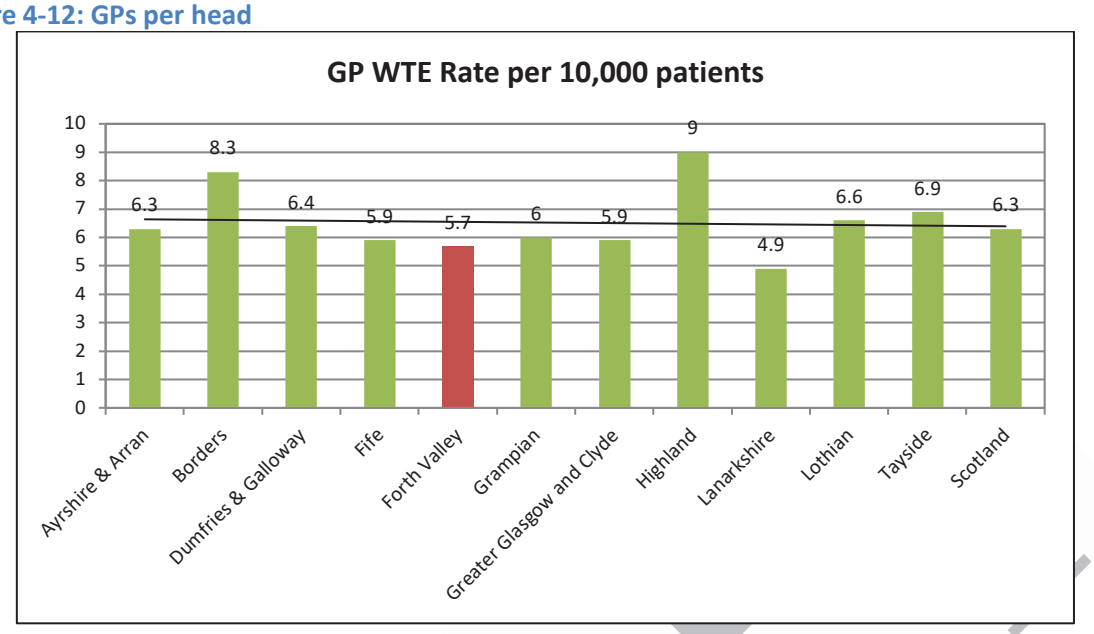
4.2.19 The key results from the latest Primary Care Workforce survey carried out in 2017[2] indicate the following:

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

2 Latest survey 2017; no update available since

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

Figure 4-12: GPs per head



4.3 What is the need for change?

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

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

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

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

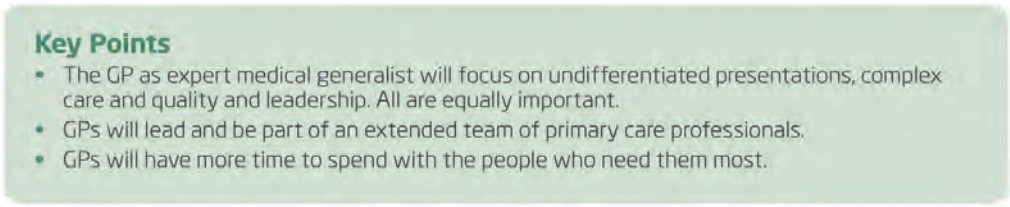
4.3.4 GP sustainability is currently the highest corporate risk for NHS Forth Valley. Without investment in primary care services and premises this risk profile is unlikely to change.

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

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

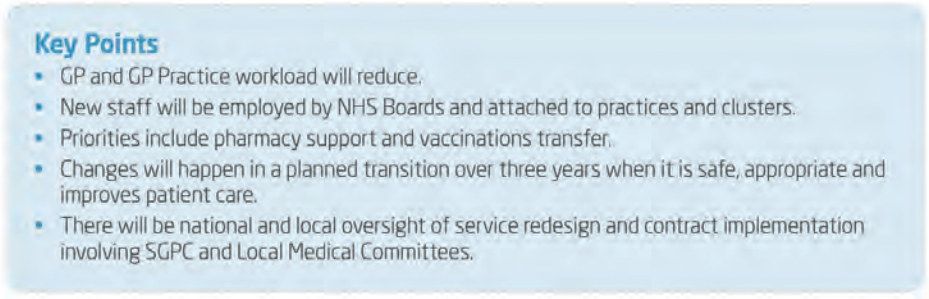
4.3.7 The new contract aims to support the development of the Expert Medical Generalist role for GPs, with a shift over time of workload and responsibilities to enable this.

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



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

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



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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

*Vaccination, Community Links Workers & care home ANPs

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

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

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

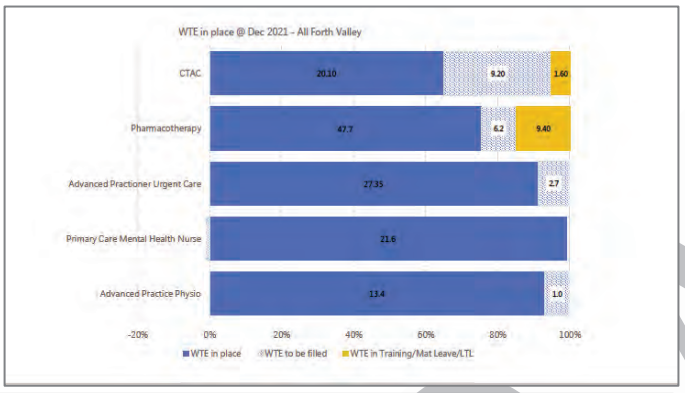
workload traditionally delivered by GPs, it is equally imperative that the appropriate environments and sufficient physical capacity is provided to accommodate them.

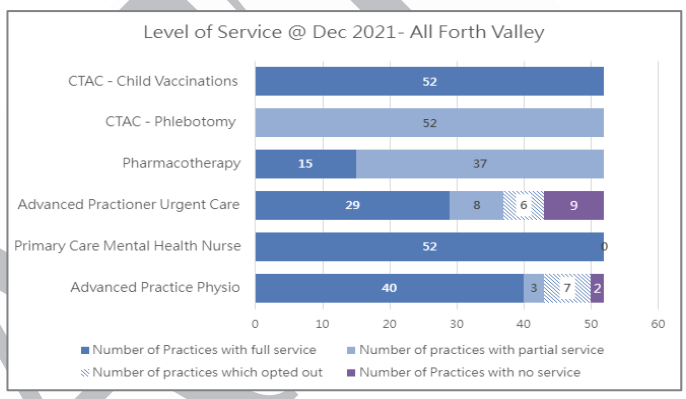
4.3.25 CTAC centres have been introduced in a number of locations across NHS Forth Valley geography, but examples show that there could be better co-ordination and shared visibility of resources.

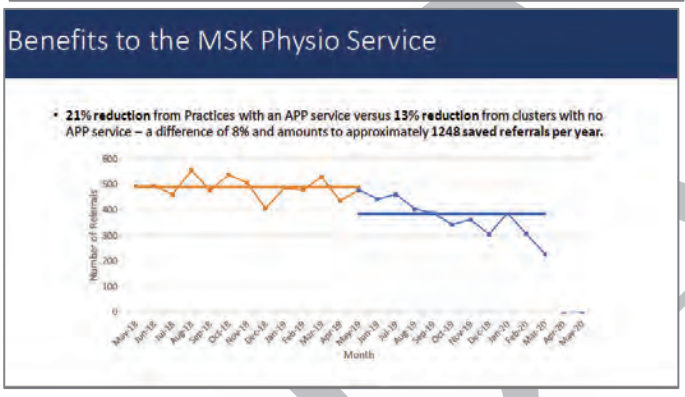
4.3.26 While great progress has been made in identifying, training and recruiting new members of staff to our primary care delivery teams to support this aim, constraints in physical infrastructure and capacity are limiting the extent to which the plan can be fully implemented.

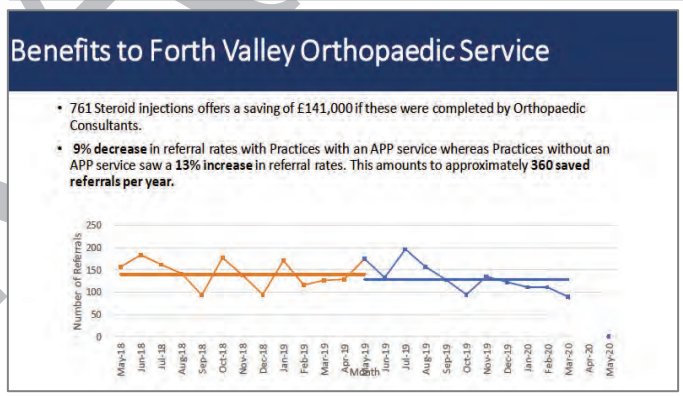
4.3.27 Significant progress has been made in implementing the Primary Care Improvement Plan with 141,000 additional consults provided. **Appendix B** provides a copy of the latest Board update on PCIP; a number of key charts have been extracted and shown below:

Figure 4-18: PCIP Progress (December 2021)









Supporting shift from acute to community-based models

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

4.3.29 The following case studies help demonstrate this ambition.

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

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

Figure 4-20: Integrated Phlebotomy Service

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

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

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

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

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

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

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