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

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

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

Additional Housing

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

Figure 4-23: Latest Planned Housing Developments

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

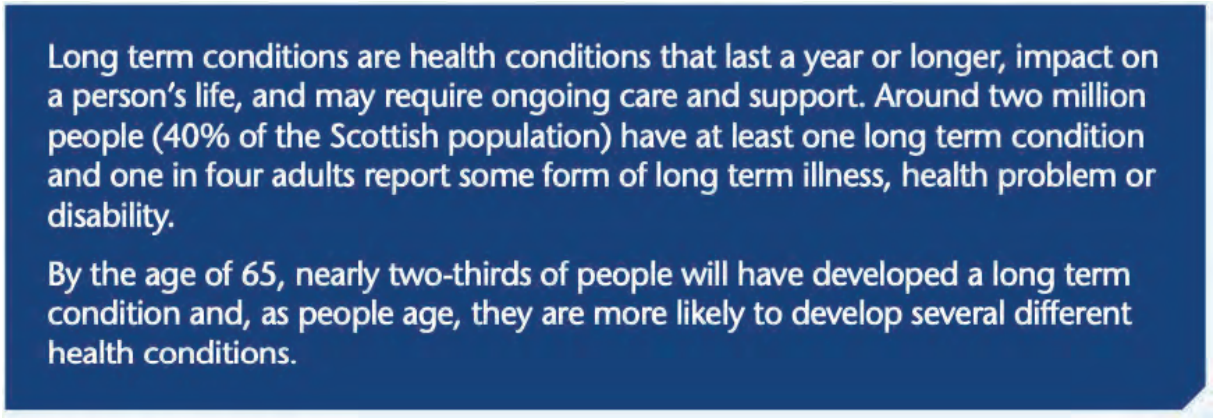
Rising demand for long-term care

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

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

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

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



Demand & Capacity

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

Figure 4-25: Demand & Capacity

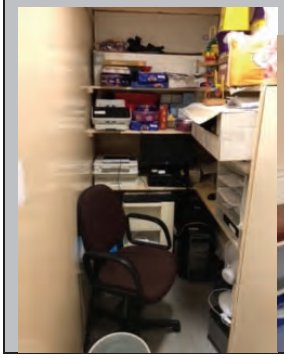
Workforce	Registrations per 1wte	Total wte required – current population (322k)	Current wte	Current gap	Future wte – projected population (331k)	Impact demographic	Projected gap from current
GP	1,500	214.7	193	(21.7)	221.0	6.3	(28.0)
Pharmacotherapy Services	5,000	64.4	61.5	(2.9)	66.3	1.9	(4.8)
Primary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

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

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

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

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



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

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

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

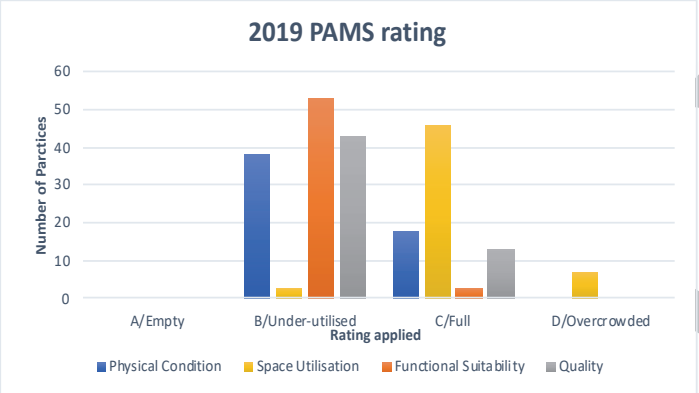
Figure 4-27: Rating scale for PAMS assessment

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

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

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

Figure 4-28: How Practices were rated in 2019



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

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

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

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

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

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

Notes:

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

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

Supporting NHS Forth Valley Property Strategy

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

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

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

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

Learning from the COVID-19 pandemic

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

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

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

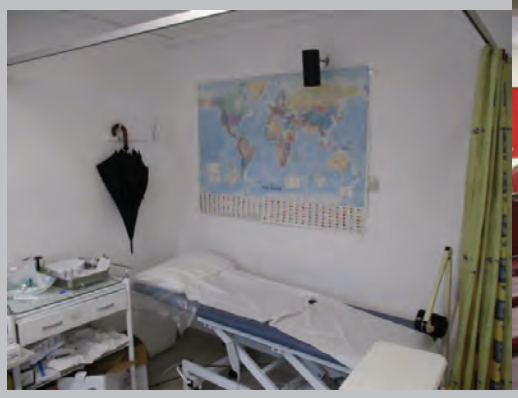
Figure 4-30: Case Study 4: Inadequate facilities including building and IT infrastructure; unable to fully implement digital models due to IT infrastructure

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

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

- Acoustic privacy within consulting rooms poor due to wall construction






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

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

Current service models do not always offer person-centred care

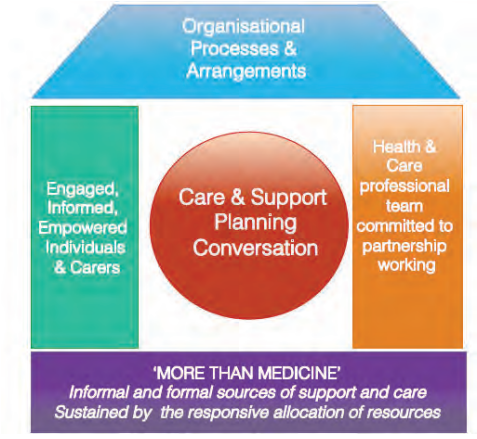
4.3.51 How we engage with those that use our services is changing. Realistic medicine puts the person receiving health and social care at the centre of decisions made about their care. It encourages health and care workers to find out what matters most to the person so that the care of their condition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

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

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

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

Figure 4-31: House of Care framework



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

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

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

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

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

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

Focus on citizen wellness rather than patient illness

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

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

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

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

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

Advancements in Digital Health capabilities

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

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

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

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

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

Placemaking & 20 Minute Neighbourhoods

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

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

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

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

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

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

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

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

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

Summary of the Need for Change

4.3.71 The table below summarises the need for change:

Figure 4-33 :Summary of the need for change

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

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

4.4 What is the organisation seeking to achieve?

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

Figure 4-34: Investment Objectives

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

4.5 What measurable benefits will be gained from this proposal?

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

Figure 4-35 : Measurable Benefits

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

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

Patient and Citizen Benefits

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

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

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

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

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

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

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

Wider Socio-Economic Benefits

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

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

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

4.6 What risks could undermine these benefits?

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

Figure 4-36: Risks

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

4.7 Are there any constraints or dependencies?

4.7.1 The following constraints and dependencies have been identified:

Constraints

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

Dependencies

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

ECONOMIC CASE

5 WHAT IS THE PREFERRED STRATEGIC/ SERVICE SOLUTION?

5.1.1 This section will include the following:

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

5.2 Do Nothing

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

Figure 5-1: Do Nothing/ Minimum Option

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

5.3 Service Change Proposals

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

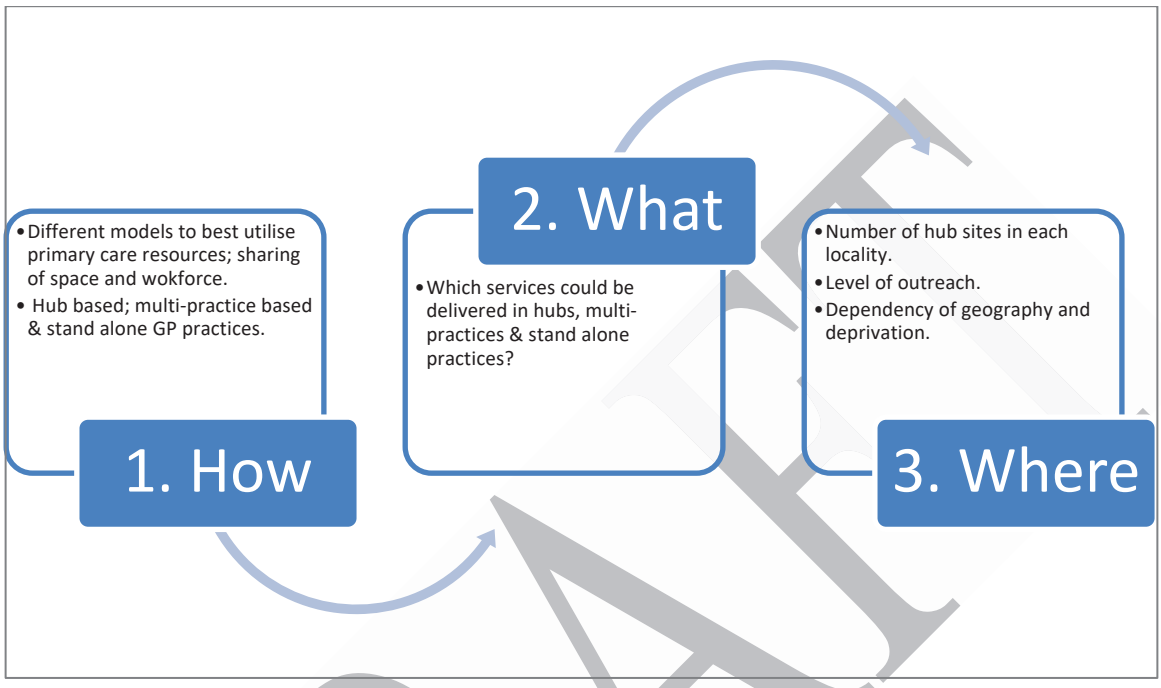
5.3.2 The proposals are multi-faceted, including the range and way in which each service is delivered and the resultant impact within each practice and locality. Furthermore, as a programme approach is being undertaken there are different considerations for each population base. The board has sought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

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

5.4 Developing and assessing the long list of proposed solution

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

Figure 5-2: Option Development Stages



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

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

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

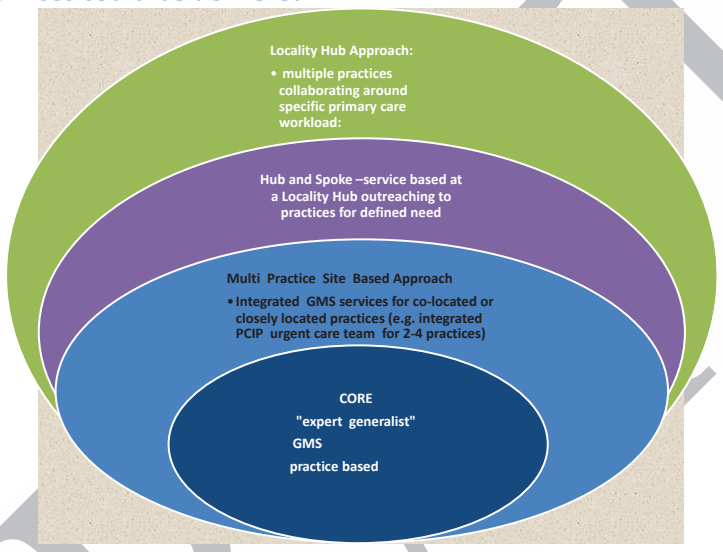
- An ambition to focus on wellness, wellbeing and supporting the needs of citizens rather than designing a system to treat illness.

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

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

5.4.4 The resultant options are summarised in the diagram below:

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



5.4.5 These models range in scope as outlined below:

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

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

Figure 5-4: Option Assessment – Service Arrangement

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

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

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

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

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

Figure 5-5: Service provision attributes

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

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

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

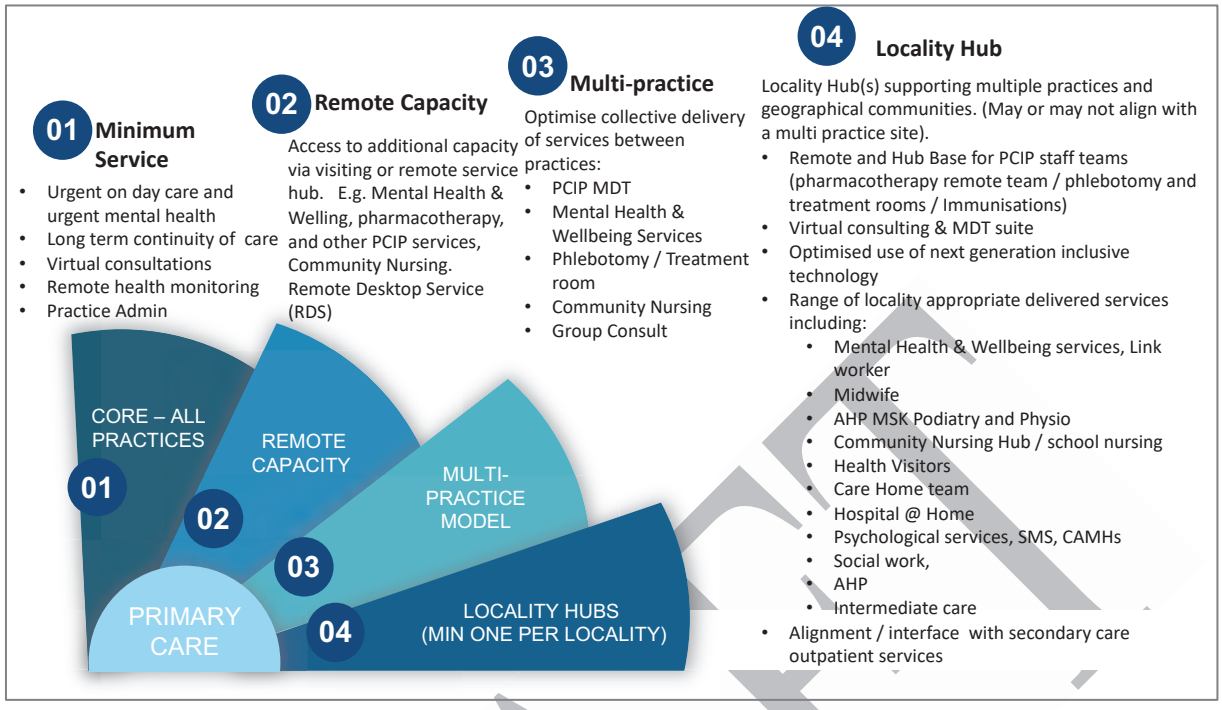
5.4.10 The assessment for each service is shown at **Appendix F.**

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

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

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

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



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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

5.5 Indicative Cost

Capital Costs

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

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

Revenue Costs

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

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

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

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

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

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

Economic appraisal assumptions

5.5.7 The economic appraisal is based on the following assumptions

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

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

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

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

5.6 Design Quality Objective

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

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

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

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

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

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

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

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

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

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

COMMERCIAL, FINANCIAL AND MANAGEMENT CASES

6 IS THE ORGANISATION READY TO PROCEED WITH THE PROPOSAL?

6.1.1 This section will outline:

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

6.2 Commercial Case

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

6.3 Financial Case

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

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

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

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

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

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

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

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

6.4 Management Case

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

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

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

The Programme Board has the following duties:

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

6.4.3 The Programme Board consists of the following key stakeholder:

Figure 6-2: Programme Board Membership

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

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

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

6.4.6 The project team is responsible for:

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

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

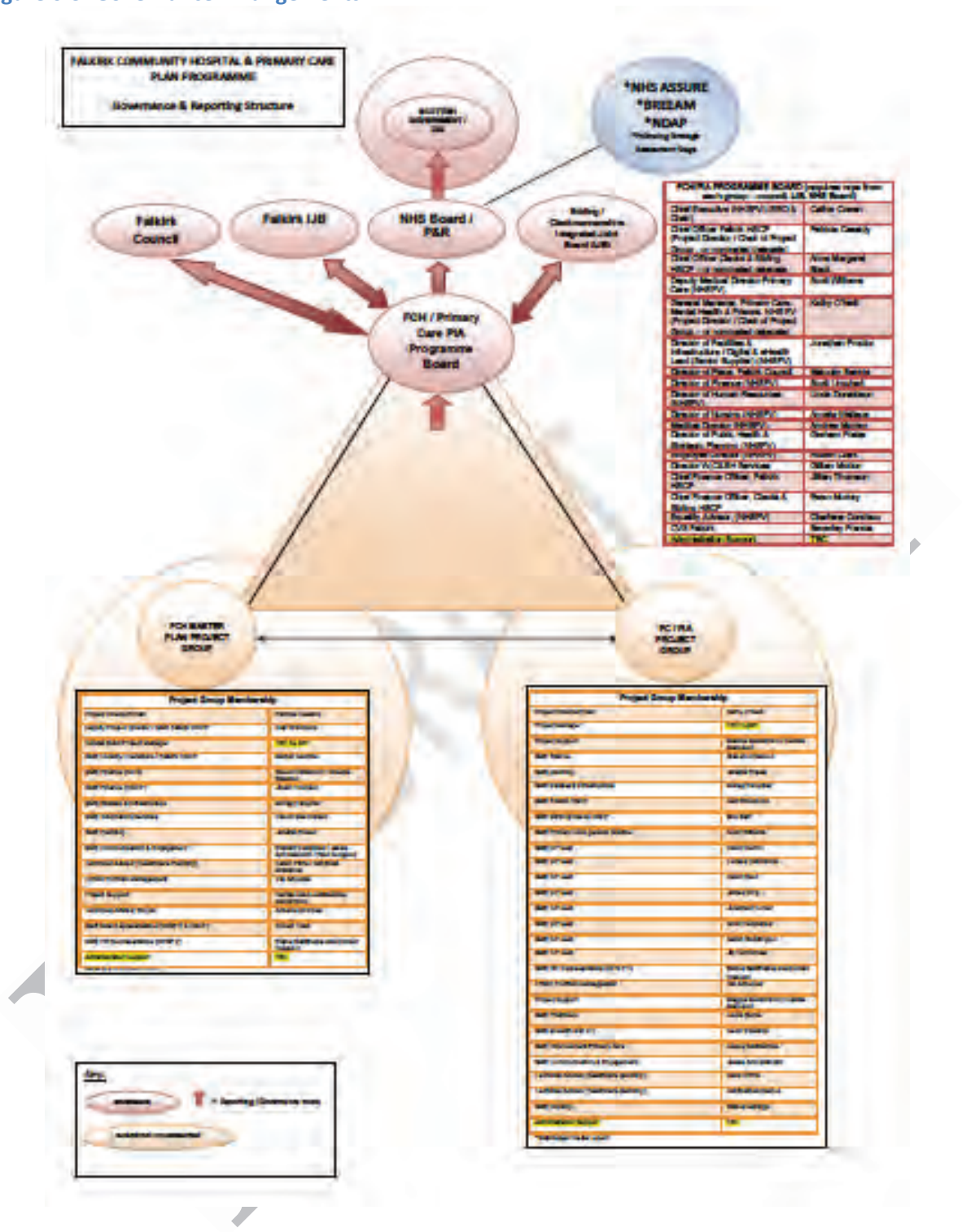
6.4.8 As the project develops, it will be supported by a project team which will be led by health care planning and technical planning/ capital project management. The Corporate Portfolio Management Office will provide support to the capital and health care planning project managers to establish and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

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

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

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

Figure 6-3: Governance Arrangements



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

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

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

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

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

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

Figure 6-4: Project Plan

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

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

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

Addressing Code of Practice

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

7 CONCLUSION

7.1 Is this proposal still important?

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

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

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

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

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

Programme Initial Agreement
Primary Care – Volume of Appendices

NHS Forth Valley

17th May 2022

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

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

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

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

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

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

Primary Care Improvement Plan Implementation and Learning

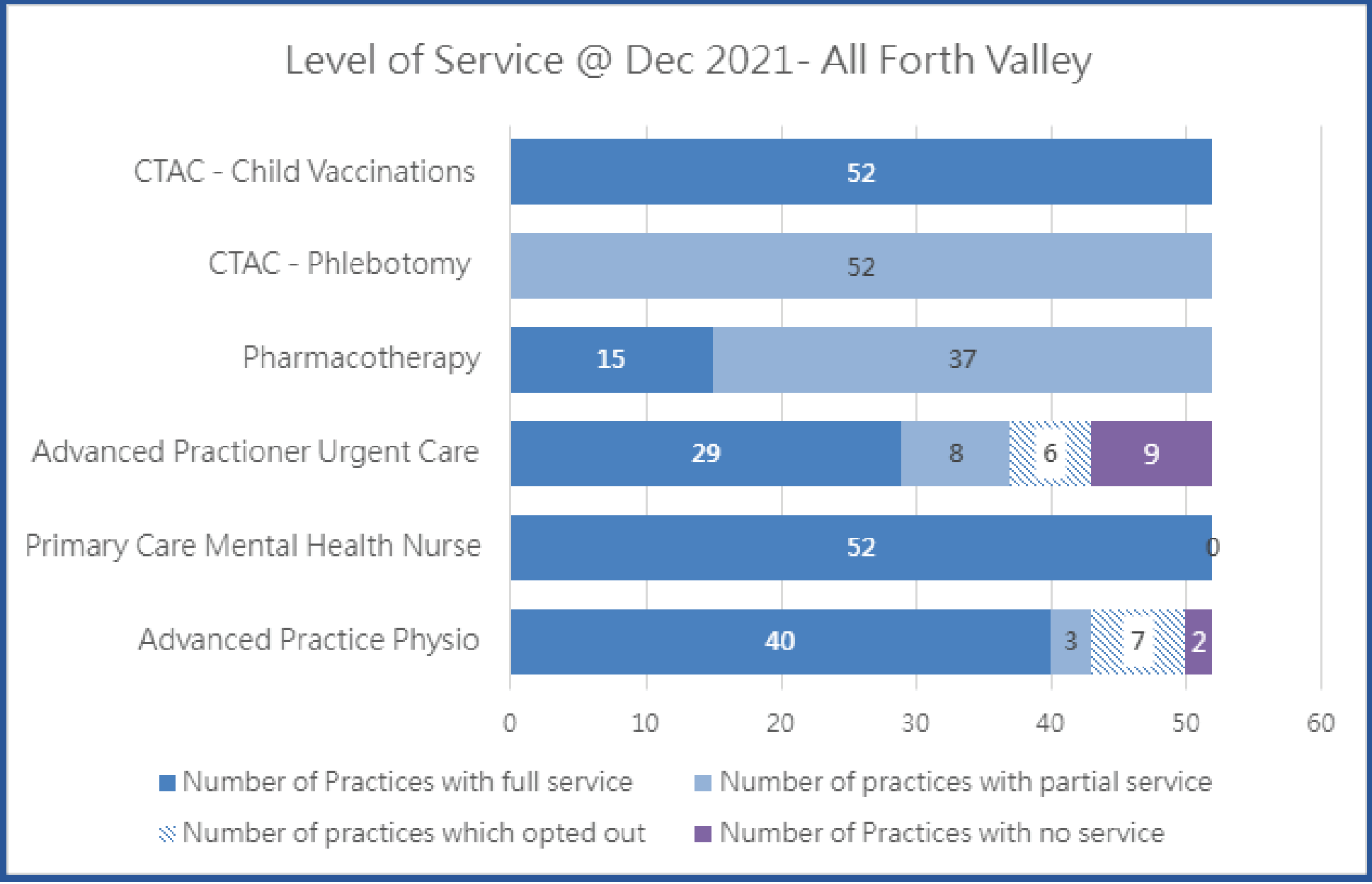
2018-2021

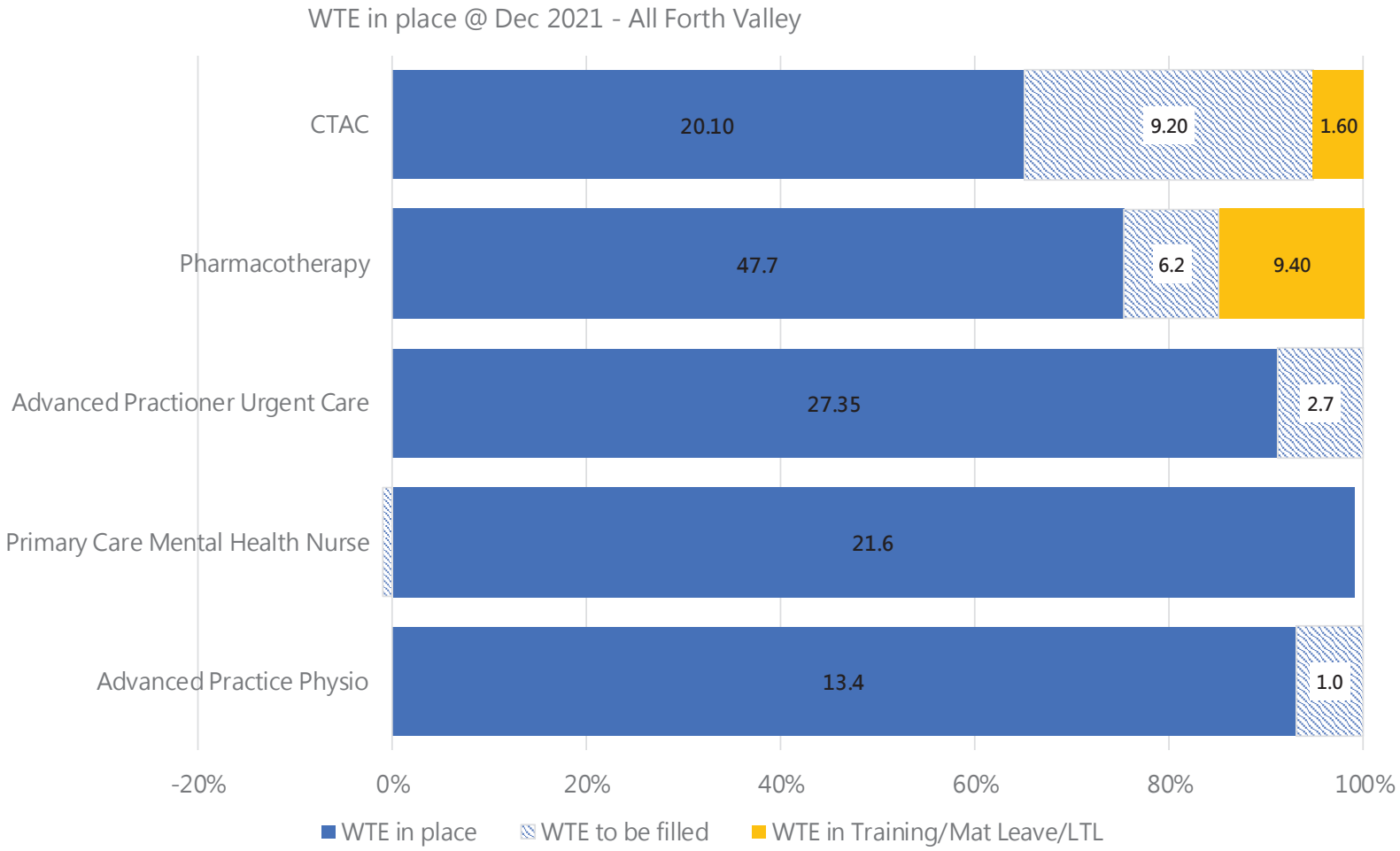
Lesley Middlemiss, Primary Care Improvement Programme Manager

6 Priorities over 4 years

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

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


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


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

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