A meeting of the **FORTH VALLEY NHS BOARD** will be held on
TUESDAY 26th JANUARY 2016 at **9.00AM** in **FORTH VALLEY NHS BOARD HEADQUARTERS, CARSEVIEW HOUSE, CASTLE BUSINESS PARK, STIRLING, FK9 4SW**

Please notify apologies for absence to Allison Fleming, Corporate Services
Email: allisonfleming@nhs.net or telephone 01786 457248

AGENDA

1.	**APOLOGIES FOR ABSENCE**	
2.	**DECLARATION(S) OF INTEREST(S)**	For Noting
3.	**MINUTE OF FORTH VALLEY NHS BOARD MEETING HELD ON 24 NOVEMBER 2015**	For Approval
4.	**MATTERS ARISING FROM THE MINUTE**	
5.	**QUALITY AND SAFETY**	
5.1	**Volunteering Story** *(Presentation by Professor Angela Wallace, Nurse Director)*	For Noting
5.2	**National Healthcare Associated Infection Reporting Template (HAIRT)** *(Paper presented by Dr Graham Foster, Director of Public Health and Strategic Planning)*	For Noting
5.3	**Nursing & Midwifery Council (NMC) Revalidation** *(Paper presented by Professor Angela Wallace, Nurse Director)*	For Noting
6.	**HEALTH IMPROVEMENT AND INEQUALITIES**	
6.1	**Report of the Director of Public Health 2013 - 2015** *(Paper presented by Dr Graham Foster, Director of Public Health and Strategic Planning)*	For Approval
7.	**CORE PERFORMANCE**	
7.1	**Executive Performance Report** *(Paper presented by Mrs Jane Grant, Chief Executive)*	For Noting
7.2	**Financial Monitoring Report** *(Paper presented by Mrs Fiona Ramsay, Director of Finance)*	For Noting
7.3	**Waiting Times Report** *(Paper presented by Mr David McPherson, General Manager)*	For Noting
7.4	**Communications Quarterly Update Report September – December 2015** *(Paper presented by Mrs Elsbeth Campbell, Head of Communications)*	For Noting
8.	**STRATEGIC PLANNING AND DEVELOPMENT**	

8.1	**Financial Plan** *(Paper presented by Mrs Fiona Ramsay, Director of Finance)*	For Noting
8.2	**Primary Care Workforce Challenges** *(Paper presented by Mrs Fiona Ramsay, Director of Finance)*	For Noting
8.3	**Health and Social Care Integration** *(Paper presented by Mrs Kathy O'Neill, General Manager)*	For Noting
8.4	**Proposed New Build Doune Health Centre Draft Outline Business Case** *(Paper presented by Mrs Fiona Ramsay, Director of Finance)*	For Approval

9. GOVERNANCE

9.1	**Procurement Strategy 2015 – 2018** *(Paper presented by Mrs Fiona Ramsay, Director of Finance)*	For Approval
9.2	**Records Management Plan** *(Paper presented by Miss Tracey Gillies, Medical Director)*	For Approval
9.3	**Governance Committee Minutes**	
9.3.1	**Clinical Governance: 22 May & 13 November 2015**	For Noting
9.3.2	**Performance and Resource Committee: 22 December 2015**	For Noting
9.3.3	**Endowment Committee: 16 October 2015**	For Noting
9.3.4	**Staff Governance Committee: 11 December 2015**	For Noting
9.4	**Advisory Committee Minute**	
9.4.1	**Area Clinical Forum: 19 November 2015**	For Noting
9.5	**2016 Schedule of Meetings** *(Paper presented by Mrs Jane Grant, Chief Executive)*	For Noting

10. ANY OTHER COMPETENT BUSINESS

Forth Valley NHS Board

26 January 2016

This report relates to
Item 3 on the agenda

DRAFT MINUTE OF FORTH VALLEY NHS BOARD MEETING HELD ON 24 NOVEMBER 2015

For Approval

FORTH VALLEY NHS BOARD

DRAFT
Minute of the Forth Valley NHS Board meeting held on Tuesday 24 November 2015 in the NHS Forth Valley Headquarters, Carseview House, Castle Business Park, Stirling.

Present	Mr Alex Linkston (***Chair)***	Mrs Jane Grant
	Dr Stuart Cumming	Mr John Ford
	Dr Graham Foster	Mrs Fiona Ramsay
	Mrs Helen Kelly	Miss Tracey Gillies
	Ms Fiona Gavine	Professor Angela Wallace
	Mr James King	Dr Allan Bridges
	Mr Tom Hart	Mrs Julia Swan
	Councillor Corrie McChord	Councillor Les Sharp
	Councillor Linda Gow	

In Attendance Ms Elaine Vanhegan, Head of Performance Governance
Mr Tom Steele, Director of Estates and Facilities
Mrs Elsbeth Campbell, Head of Communications
Mrs Kathy O'Neill, General Manager, CHP
Mr David McPherson, General Manager, Surgical Directorate
Mr Tom Houston, Lead Officer, Public Health
Ms Tracey McKigen, Interim Chief Officer, Health and Social Care (Clackmannanshire and Stirling)
Ms Shiona Strachan, Chief Officer, Health and Social Care (Falkirk)
Mrs Sonia Kavanagh, Corporate Services *(minute)*

1. APOLOGIES FOR ABSENCE

There were no apologies for absence.

2. DECLARATION(S) OF INTEREST(S)

There were no declarations of interest.

3. MINUTE OF FORTH VALLEY NHS BOARD MEETINGS

3.1 Minute of Forth Valley NHS Board meeting held on 29 September 2015

The minute of the Forth Valley NHS Board meeting held on 29 September 2015 was approved as a correct record.

4. MATTERS ARISING FROM THE MINUTE

There were no matters arising from the minute.

The NHS Board agreed to take item 8.6 at this point in the agenda

8.6 Full Business Case for a Care Village in Stirling (Partial – the Case for Change)

The NHS Board considered a paper "Full Business Case for a Care Village in Stirling (Partial – the Case for Change)", presented by Mr Tom Steele, Director of Estates and Facilities.

Mr Steele reported the first stage of the Full Business Case (FBC) for Stirling Care Village (The case for Change) was complete and ready for submission to the Capital Investment Group. The Care Hub would provide one of the key elements in Stirling's wider plan for re-shaping the care of older people with the capacity designed to be as flexible as possible to meet changing demand for care services. However, it was noted that not all Forth Valley wide specialist psychiatric inpatient beds, currently provided at Stirling Community Hospital, would be re-provided in the Care Hub. Further work was under way to redesign this aspect of the current service on a Forth Valley wide basis.

Mr Steele highlighted that the FBC would not be completed until a national issue in relation to European System of Accounts (ESA) 10 was resolved and this impacted on the programme and potentially the cost of the project. The single largest risk remained the non-recovery of VAT on the Unitary Charge. The FBC would be submitted in 2 stages, 1 for the service case for change and the 2nd for the financial case.

Mrs Grant underlined the importance of the community services infrastructure to support implementation of the whole service model for older people. Work was needed to ensure it was sufficiently well developed to enable the care hub to deliver the proposed outcomes. The development of the 'Closer to Home' model and Advice Line for You (ALFY) supported this approach although currently both in the early stages of implementation. This was currently resourced by the Integrated Care Fund.

The NHS Board noted the first stage of the FBC for Stirling Care Village and approved its formal submission to the Capital Investment Group.

5. QUALITY AND SAFETY

5.1 Patient Story

Professor Angela Wallace, Nurse Director, introduced a poignant short film about end of life care and the experience of a family living through it.

The family spoke of their appreciation at the level of care and kindness shown to their mother during such an upsetting time. The sensitivity and dedication of the staff had shone through, with the respect and compassion shown to their mother evident to the end.

The NHS Board appreciated hearing such a touching and moving story and noted the importance of outstanding end of life care standards.

5.2 National Healthcare Associated Infection Reporting Template (HAIRT)

The NHS Board considered a paper "National Healthcare Associated Infection Reporting Template", presented by Dr Graham Foster, Director of Public Health and Planning.

Dr Foster highlighted the various updates relating to infection prevention and control and noted the encouraging figures.

The number of Staphylococcus aureus bacteraemia (SABs) since April 2015 was 59 with 4 reported SABs for October 2015.

Clostridium difficile infection also remained low, with 3, for October 2015.

There were 6 cases of Device Associated Bacteraemia infections in October 2015, with 1 HAI related death for the same period.

The majority of Estates and Cleaning Compliance figures remained above 90%. Due to revised reporting criteria to ensure standards improved there were consistent reductions across all Community Hospital's compliance.

Rates remained high for Hand Hygiene Monitoring Compliance across the Board at 99%.

The HAI work programme for NHS Forth Valley (2015/16) had been presented to the NHS Forth Valley Clinical Governance Committee and was available to Board members on request.

The NHS Board noted the report and progress to date.

6. HEALTH AND IMPROVEMENT AND INEQUALITIES

6.1 Child Healthy Weight – "The Daily Mile"

The NHS Board received a presentation "The Daily Mile", led by Dr Graham Foster, Director of Public Health and Strategic Planning.

Dr Foster introduced Mr Tom Houston, Lead Officer in Public Health who gave a presentation on a local project called 'The Daily Mile'. The initiative had attracted a lot of focus locally, nationally and internationally.

Mr Houston explained the 'Daily Mile' was devised by the Head Teacher of St Ninians Primary School, Stirling in 2012 to address the fitness levels of the children. She wanted to keep it simple and provide time for the children to go out each day and run/walk with their friends in the fresh air. The 'Daily Mile' was now embedded in the culture of their school community and had resulted in the transformational change of the physical, mental and social health and wellbeing of the children.

The NHS Board discussed the merits of the project and the benefits of introducing it across Forth Valley.

The NHS Board thanked Mr Houston for his interesting presentation and agreed this was a positive and worthwhile programme for children's health.

7. CORE PERFORMANCE

7.1 Executive Performance Report

The NHS Board considered a paper "Executive Performance Report" presented by Mrs Jane Grant, Chief Executive.

Mrs Grant highlighted that significant activity had been undertaken in preparation for the winter season, with the production of the Winter Plan for 2015/16. Delegated authority had been given by the Board for the Performance and Resources Committee to approve the plan in October 2015. A high profile awareness campaign would provide advice and information to local people on how to stay well and detail the range of services and support available.

Progress continued with the Clinical Services Review (CSR) with a staff engagement event held on 20 November 2015 to discuss the next steps in terms of strategy development. The National Clinical Strategy was still to be published with timeframes for this still to be finalised.

To increase engagement with local MPs and MSPs a forum had been re-established, to provide an opportunity to review achievements and challenges such as primary care workforce, the integration of Health and Social Care and progress with the CSR. The first of these meetings took place on 13 November 2015 and was well received.

Mrs Grant updated the NHS Board on core performance for the period to end of September 2015, and relevant updates into October 2015. The RTT position for September 2015 remained above target of 90% at 93.4% against the Scottish average of 87.2%. There had been a rise in overall outpatient numbers waiting over 12 weeks in October 2015 to 1450 from 1345 in September 2015. The main challenges remained within Ophthalmology, Gastroenterology, Anaesthetics and Neurology, with focussed attention on each area. The Performance and Resources Committee had received a detailed presentation in October 2015 regarding the work undertaken in CAMHS and Psychological Therapies to address the particular pressures in these areas. Notable improvement had been seen with the Psychological Therapies RTT, with performance at 79.8% for October and progress also expected in CAMHS over the next 2 to 3 months. Overall Treatment Time Guarantee (TTG) compliance remained high at 99% with 1 patient breach in both September and October.

The Finance Report for period ending 31 October 2015 reported a balanced position in both revenue and capital and would be covered later in the agenda.

NHS Forth Valley had been well represented at a number of events. A number of staff had also been selected as finalists at the Scottish Health Awards 2015.

Mrs Grant reported on the Balance Scorecard and Performance Summary, highlighting particular areas of note.

Safe

The Hospital Standardisation Mortality Ratio (HSMR) target was a 20% reduction by December 2015. The provisional HSMR to quarter ending June 2015 was 0.89 which reflected a reduction from the baseline of 21.2%.

Hand hygiene compliance at October 2015 for Community Hospital was 99.4% and Acute Hospitals 98.8%, both against a target of 95%.

Person Centred

Clinical Quality Indicator (CQI) compliance for Food, Fluid and Nutrition at September 2015 was 93%, however, an improvement had been noted in October with a position of 96%. Work was currently underway to review the metrics in respect of nutrition to improve visibility.

There had been substantial efforts to deliver the LDP standard of 4% for Attendance Management, with the absent rate for September 2015 at 4.77% against the average Scotland position of 5.02%.

The Stroke Care Bundle continued to improve, with the position at September 2015 at 83.3% against the previous position of 73.9% in July 2015.

The Annual Knowledge Skills Framework development reviews completed on eKSF showed a position of 78% at October 2015 against a target of 80%. This was a substantial improvement and acknowledged as important to ensure staff development.

Equitable

The Smoking Cessation target to sustain and embed successful smoking post quits in the 40% most deprived SIMD areas was reviewed for 2015/16. The full year target for NHS Forth Valley for 2015/16 was 219 with the current position of 59 to the end of June 2015 against a trajectory point of 59. Smoking cessation remained a high priority and new models of working were

currently being undertaken by the Stop Smoking Service. The Board discussed eCigarettes and whether marketing promoted an alternative healthier option or attracted non-smokers.

The October 2015 management position for NHS Forth Valley highlighted that 94.1% of pregnant women booked for antenatal care by 12 weeks, ahead of the 80% target.

Timely

The NHS Board noted that further detail would be provided under item 7.3, Waiting Times Report.

Effective and Efficient

Compliance for Emergency Department (ED) 4 hour wait in October 2015 was 95.6%, with Minor Injuries Unit 100% and ED 94.5%. There remained significant variability in performance day to day, with 17 eight hour breaches. Action continued to focus on specific issues with fluctuation in ED demand.

Delayed discharges remained challenging across the partnerships with the October 2015 census at 32 against a zero standard for patients waiting over 14 days. The local authority breakdown was Clackmannanshire 1, Falkirk 19 and Stirling 10. The total bed days lost to delayed discharge decreased to 1094 from 1174 at the September 2015 census. Further focus on processes continued between the Board and Local Authorities and remained a key priority on Integration Joint Board agendas. In response to Mr Linkston's query regarding assessment at home, Mrs O'Neill confirmed the Home Care team provided this service and that there were additional services available from Closer to Home and Advice Line For You (ALFY).

GP prescribing costs per patient showed £188.67 at August 2015 against the Scottish position of £190.76. A slight increase was anticipated for 2015/16 which reflected the uplift in the drug tariff as part of the community pharmacy contract settlement. Ongoing issues were being experienced in relation to volume growth, short supply and uptake of new drugs.

The NHS Board noted the information contained in the Chief Executive's Summary and the main areas highlighted in the Balanced Scorecard and Performance Summary.

7.2 Financial Monitoring Report

The NHS Board considered a paper "Financial Monitoring Report", presented by Mrs Fiona Ramsay, Director of Finance.

Mrs Ramsay provided a summary of the financial position for NHS Forth Valley to 31 October 2015. There was a statutory requirement for NHS Boards to ensure expenditure was within the Revenue Resource Limit (RRL) and Capital Resource Limit (CRL) set by the Scottish Government Health and Social Care Directorate (SGHSCD). The current revenue outturn position was summarised and the key issues noted as:

- A balanced financial position for both revenue and capital.
- Partnership funding including the balance of Transitional Funds, Delayed Discharges and Integrated Care Funds were retained centrally and transferred as plans for utilisation by Integration Joint Boards.
- Funding of £1.2m in respect of New Medicines was released during October 2015, with the majority impacting on Surgical Directorate and Externals as host of local cancer services.
- As approved at the Performance and Resources Committee in October 2015 the Winter Plan funding would be transferred to relevant budget in November 2015.
- Additional bed capacity at Falkirk Community Hospital originally put in place last winter and due to be withdrawn in April 2015 had remained open to manage

patient capacity requirements. Ongoing costs incurred to date were approximately £0.100m per month. Funding of £0.237m from Delayed Discharge monies had been agreed by Falkirk Transitional Board to offset these additional costs, leaving £0.550m to be met from health resources covering the period to end of December 2015.

- Current year cash savings requirements (CRES) were reflected in the financial position and overall delivery plans were on track. However, areas where this had not been achieved required alternatives to ensure pressures were met. Due to anticipated pressures every effort was being undertaken to identify recurrent cash savings for 2016/17.
- Overspends had continued in both Surgical and Medical Directorates with continued meetings held with relevant General Managers, Chief Executive and Director of Finance to address the issues, especially non-core and drug costs.
- Although the financial break-even remained on track, the position carried greater risk than previous years.
- Work had commenced to update the five year Financial Plan 2016/17 – 2020/21 with significant challenges ahead. Directorates were required to submit plans by end of November 2015 with an initial management review session to be held in early December 2015. Similar levels of savings were likely in future years and would be factored into implementation of the Health Care Strategy.
- There were increasing risks in-year to achieve property sales specifically Bonnybridge and especially Bannockburn.

The NHS Board noted the balanced revenue and capital positions with the balanced outturn projection to 31 March 2016 and the financial challenges with the 2016/17-2020/21 Financial Plan. The Financial Plans would be presented to the NHS Board for further consideration in January 2016.

7.3 Waiting Times Report

The NHS Board considered a paper "Waiting Times Report", presented by Mr David McPherson, General Manager.

Mr McPherson provided an update on the NHS Board's position in relation to a range of access targets established by the Scottish Government. It was noted that in September 2015 the 18-week RTT was 93.4%, which was the 6th consecutive month NHS Forth Valley had delivered the 90% standard.

At the October 2015 census, the number of patients waiting over 12 weeks increased to 1450 from 1345 in September 2015 with 483 patients exceeding 16 weeks. Main challenges were within Ophthalmology, Gastroenterology, Dermatology, Anaesthetic and Neurology.

Treatment Time Guarantee (TTG) compliance remained high at 99%, although 1 patient had an on-going wait longer than 12 weeks.

CAMHS and Psychological Therapies remained a challenge in October 2015; CAHMS treated 41.7% of patients and Psychological Therapy services treated 79.8% of patients, both against the 18 weeks RTT standard.

The NHS Board noted the Waiting Times Report, acknowledged the progress made and the remaining challenges to date.

7.4 Equality and Diversity in NHS Forth Valley

The NHS Board considered a paper "Equality and Diversity in NHS Forth Valley", presented by Professor Angela Wallace, Nurse Director.

Professor Wallace provided an update on progress with the Equality and Diversity outcomes within NHS Forth Valley. In accordance with legislation the NHS Forth Valley Equality and Diversity Progress Report 2013-17 was published in April 2015. Although progressing well there was considerable work to be undertaken to ensure that this was fully embedded into service delivery, employment duties and service planning.

Once the new Translation Policy was approved it would be circulated alongside the staff interpretation and translation handbook and the new booking flowchart. It was noted that the "Interpretation and Translation for Languages other than English", tender completed in March 2015 had shown a marked financial saving.

In response to Councillor Sharp's query regarding assistance for refugees, Professor Wallace confirmed all 3 Local Authorities had accepted refugees. Various forms of support would be provided, such as 'Befriending and Translation' packages and registration with GP and Dental practices.

The NHS Board noted the key information and recommendations detailed within the report.

8. STRATEGIC PLANNING AND DEVELOPMENT

8.1 Primary Care Workforce Challenges

The NHS Board considered a paper "Primary Care Workforce Challenges", provided by Mrs Fiona Ramsay, Director of Finance.

Mrs Ramsay provided a summary of the current position and actions taken to address the local implications of the national challenge in respect of the primary care workforce, in particular the GPs.

There were extremely positive developments in the current workforce climate and work continued with practices to ensure ongoing sustainability with the Drymen Practice to revert to independent practitioner status in early December 2015. The NHS Board had approved £0.500m to support the challenges with this funding likely to be required in 2016/17.

In response to Mrs Swan's query regarding national support, Miss Gillies confirmed there were ongoing national discussions and that a new GP contract was due in 2017.

The NHS Board noted the progress to date in addressing the primary care workforce challenges and the ongoing engagement with staff and patients.

8.2 Joint Inspection of Services for Children and Young People in Stirling and Clackmannanshire Community Planning Partnership Areas

The NHS Board considered a paper "Joint Inspection of Services for Children and Young People in Stirling and Clackmannanshire Community Planning Partnership Areas", presented by Mrs Kathy O'Neill, General Manager.

Mrs O'Neill updated the Board on the reports from the Care Inspectorate Progress Reviews following the 2014 joint inspections in Clackmannanshire and Stirling areas. The reports had been considered by the Clinical Governance Committee in November 2015.

Mrs O'Neill outlined the areas for improvements and the encouraging progress the inspectors found within each. The inspectors concluded the initial findings had been taken very seriously and a comprehensive improvement plan and been implemented with significant potential for better outcomes.

The Falkirk inspection had commenced November 2015 and feedback would be presented once the report was received.

The NHS Board noted the progress reviews provided and the positive changes in practice. A progress update would be provided to the NHS Board in Summer 2016.

8.3 Integration of Adult Health and Social Care – Progress Update

The NHS Board considered a paper "Integration of Adult Health and Social Care – Progress Update", presented by Mrs Kathy O'Neill, General Manager.

Mrs O'Neill updated the NHS Board on progress with the implementation of Health and Social Care Integration in Forth Valley. The first meeting of the full Falkirk Integration Joint Board (IJB) took place on 6 November 2015 with Clackmannanshire and Stirling IJB's on 27 October 2015. Organisational development plans for both IJBs and the wider partnerships were in place and their draft Strategic Needs Assessment and Strategic Plan were approved for consultation.

Clackmannanshire and Stirling IJB had agreed on 3 localities across the Partnership; 2 covering Stirling area and 1 covering Clackmannanshire area. Although both Local Authorities had confirmed their intention to re-establish separate Local Authority based education and social work services they had confirmed their commitment to a multi authority Health and Social Care Partnership.

The NHS Board noted the progress with Health and Social Care Integration.

8.4 Falkirk Partnership Draft Strategic Plan

The NHS Board considered a paper "Falkirk Partnership Draft Strategic Plan", presented by Ms Tracey McKigen, Interim Chief Officer.

Ms McKigen outlined the roles of the Strategic Planning Group to develop and oversee the implementation of the Strategic Plan to achieve the national health and wellbeing outcomes and the Partnership's local vision and outcomes.

The Strategic Plan required to be published by 1 April 2016 and would provide strategic context for the commissioning of services as directed by the Integration Authority. There had been a variety of engagement events to focus on integration and the development of the Strategic Plan. Ms McKigen confirmed that there were further public events planned to coincide with the consultation process. Consultation had commenced and would run until 31 December 2015, with a number of formats for feedback highlighted.

A Joint Strategic Needs Assessment was required to understand and demonstrate the needs which existed within the area and to inform the Strategic Plan, a 2nd draft had been completed and would be developed further over the coming year to build on localities profiles and services.

Mr Alex Linkston thanked Ms McKigen for the update provided.

The NHS Board noted the draft Strategic Plan and the request for relevant comments and feedback.

8.5 Clackmannanshire and Stirling Partnership Draft Strategic Plan

The NHS Board considered a paper "Clackmannanshire and Stirling Partnership Draft Strategic Plan", presented by Ms Shiona Strachan, Chief Officer.

Ms Strachan provided an update on the progress of the development of the first draft Strategic Plan by the Strategic Planning Group and stakeholders. The Plan contained the outline of the key principles, with themes for service delivery and development drawn from existing activity and specific engagement events held over the last year.

The Partnership was also required to undertake a Strategic Needs Assessment with the 1st draft presented to the IJB and Strategic Planning Group and would be developed further over the next 12 months to reflect localities and neighbourhood levels.

Mrs Grant highlighted that there was a genuine opportunity to align the Healthcare Strategy to both Partnership Plans and commended Ms McKigen, Ms Strachan and their teams for the work completed in the short time scale. Mr Linkston offered the NHS Board's support in taking the Plans forward.

The NHS Board noted the draft Strategic Plan and the request for relevant comments and feedback.

9. GOVERNANCE AND ADVISORY COMMITTEE REPORTS AND MINUTES

9.1 Clinical Governance – 11 September 2015

The NHS Board noted the minute of the Clinical Governance meeting held on 11 September 2015.

9.2 Performance and Resource Committee – 27 October 2015

The NHS Board noted the minute of the Performance and Resources Committee meeting held on 27 October 2015.

9.3 Audit Committee – 16 October 2015

The NHS Board noted the minute of the Audit Committee meeting held on 16 October 2015.

9.4 Staff Governance Committee – 19 May 2015 and 15 September 2015

The NHS Board noted the minute of the Staff governance Committee meetings held on 19 May 2015 and 15 September 2015

10. ANY OTHER COMPETENT BUSINESS

There being no other competent business, the Chairman closed the meeting at 11.10am.

Forth Valley NHS Board

26 January 2016

This report relates to
Item 5.2 on the agenda

National Healthcare Associated Infection Reporting Template (HAIRT)

(Presented by Dr Graham Foster, Director of Public Health & Strategic Planning)

For Noting

SUMMARY

1. HEALTHCARE ACQUIRED INFECTION REPORTING TEMPLATE – HAIRT REPORT

2. PURPOSE OF PAPER
Report highlighting various relevant updates relating Infection Prevention & Control

3. KEY ISSUES
- LDP targets as noted on pages 1, 2 & 3.
- In order to give a more comprehensive overview of the collective activity of the Infection Prevention and Control Team the paper includes as an appendix the current team work plan.

4. FINANCIAL IMPLICATIONS
None

5. WORKFORCE IMPLICATIONS
None

6. RISK ASSESSMENT AND IMPLICATIONS
Work is ongoing to continually reduce all device associated bacteraemia, SAB and CDI numbers across NHSFV.

7. RELEVANCE TO STRATEGIC PRIORITIES
LDP Standards in respect of SABs & CDI.

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

Further to an evaluation it is noted that: *(please tick relevant box)*
X Paper is not relevant to Equality and Diversity
□ Screening completed - no discrimination noted
□ Full Equality Impact Assessment completed – report available on request.

9. CONSULTATION PROCESS
Infection Prevention and Control Team

10. RECOMMENDATION(S) FOR DECISION
The Forth Valley NHS Board is asked to: -

- Note the **HAI Reporting Template – HAIRT report**

11. AUTHOR OF PAPER/REPORT:

Name:	***Designation:***
Jonathan Horwood	**Area Infection Control Manager**

Approved by:

Name:	***Designation:***
Graham Foster	**Director of Public Health & Strategic Planning, HAI Executive Lead**

Healthcare Acquired Infection Reporting Template - HAIRT

This is a summary report covering all aspects of the HAI agenda including the LDP Standards, surveillance, hand hygiene, cleaning compliance. This will be reviewed on an ongoing basis.

Jonathan Horwood
Area Infection Control Manager

Surveillance

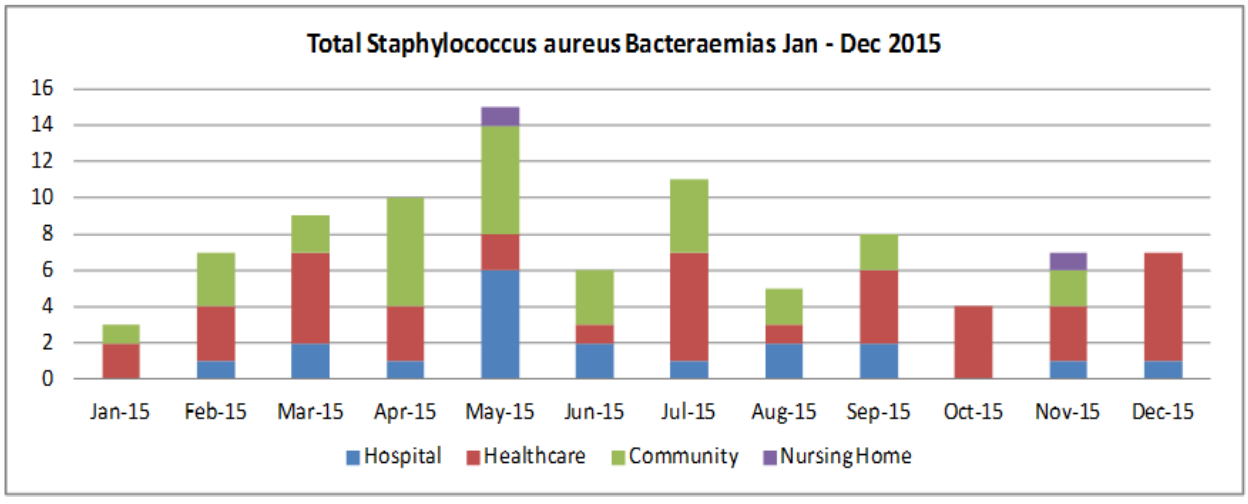
LDP TARGETS

Staphylococcus aureus Bacteraemia (SABs)

The total number of *Staph aureus* bacteraemia infections to date for this financial year is 73. The table below gives a breakdown of last month's infections.

	December
	Totals
Hospital	**1**
Unknown source – NNU	
Healthcare	**6**
IVDU	1
Endocarditis	1
Skin & Soft Tissue	
Abscess	1
Ulcer	1
Fistula	1
Wound	1
Grand Total	**7**

The chart below breaks down the SAB cases into source type for the last 12 months.



Ward specific graphs can be accessed using the following link:

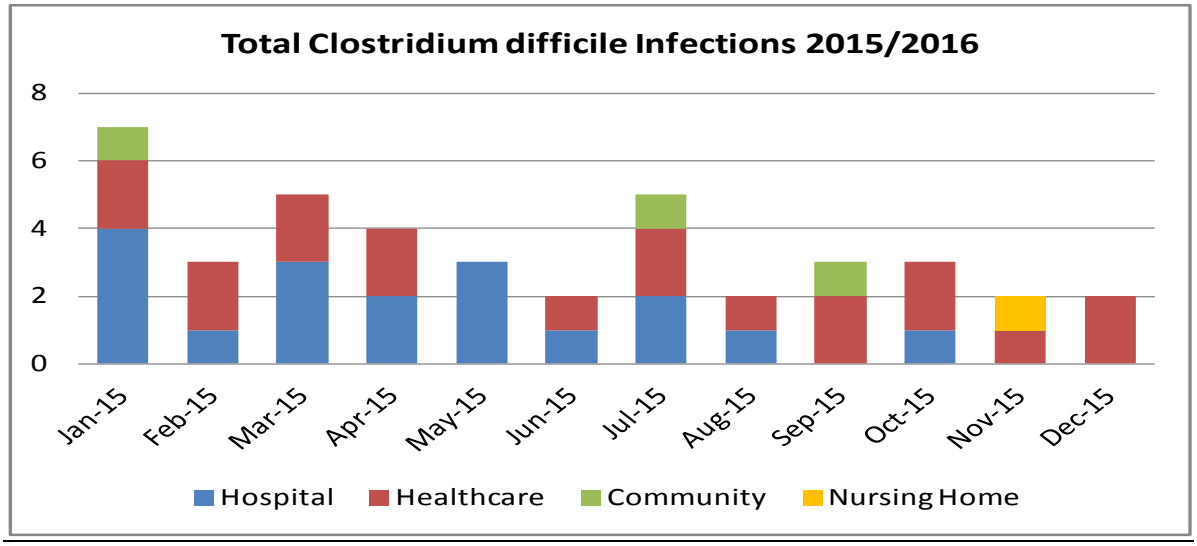
http://staffnet.fv.scot.nhs.uk/index.php/a-z/infection-control/monthly-ward-reports/

Clostridium difficile Infections (CDIs)

The total number of *Clostridium difficile* infections to date for this financial year is 29. The table below gives a breakdown of last month's infections.

Source of CDI	December
Healthcare	2
Grand Total	**2**

The chart below breaks down the CDI cases into source type for the last 12 months.



Ward specific graphs can be accessed using the following link:
http://staffnet.fv.scot.nhs.uk/index.php/a-z/infection-control/monthly-ward-reports/

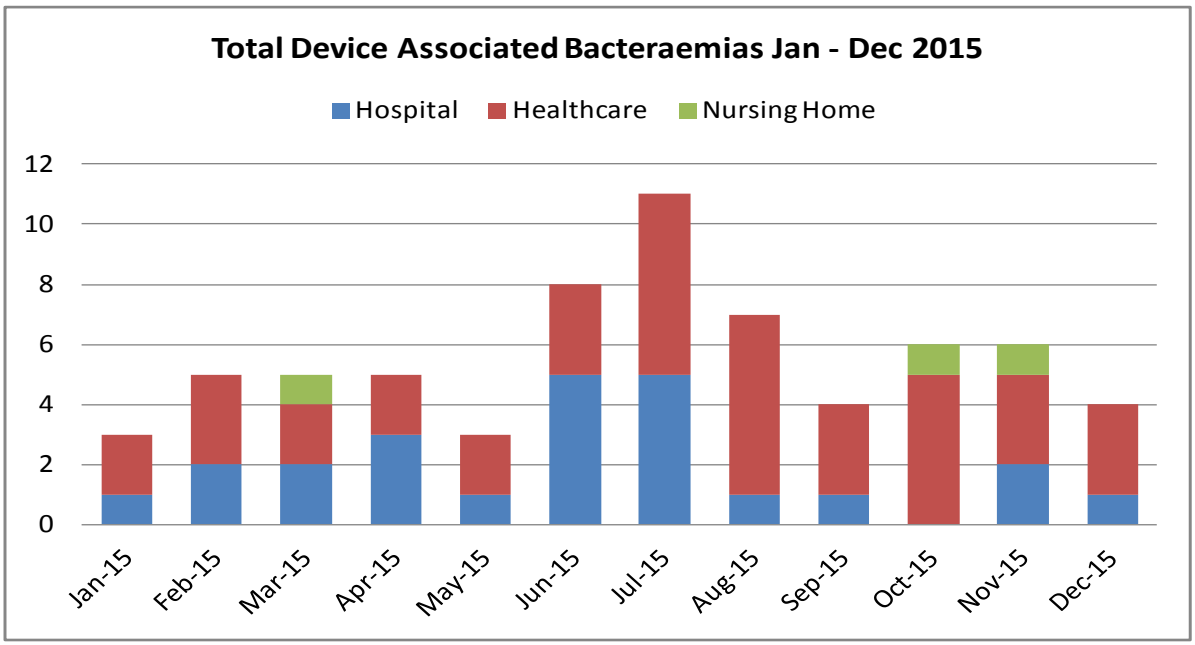
Device associated Bacteraemia (DABs)

All organisms attributed to a device associated bacteraemia are included in the following data. This surveillance is separate and distinct from our SAB surveillance/HEAT target; however it must be noted that this data will also include *Staph aureus* when associated with a device.

The total number of Device associated bacteraemia infections to date for this financial year is 54. The table below gives a breakdown of last month's infections.

Source of DAB	December
Hospital	**1**
B23 – Hickman line	1
Healthcare	**3**
Urinary Catheter	1
Pacemaker	1
PICC line	1
Grand Total	**5**

The chart below breaks down the DAB cases into source type for the last 12 months.



HAI Related Deaths

There were no HAI related deaths this month.

Estate and Cleaning Compliance (per hospital)

Data taken from Domestic Monitoring National Tool Database. Please note submission to Health Facilities Scotland changed in October 2014 to ***quarterly reporting****.* The next update including October - December will be published in the next HAIRT report.

Forth Valley Royal Hospital

	Oct - Dec 2014	Jan – Mar 2015	Apr –June 2015	July – September 2015
Cleaning	97	99	97	97
Estates	99	99	98	98

Clackmannanshire Community Healthcare Centre

	Oct – Dec 2014	Jan – Mar 2015	Apr –June 2015	July – September 2015
Cleaning	97	96	96	97
Estates	96	95	92	92

Stirling Community Hospital

	Oct – Dec 2014	Jan - Mar 2015	Apr – June 2015	July – September 2015
Cleaning	98	95	96	97
Estates	93	92	93	89

Falkirk Community Hospital

	Oct -Dec 2014	Jan - Mar 2015	Apr – June 2015	July – September 2015
Cleaning	95	93	94	95
Estates	93	90	90	90

Bo'ness Hospital

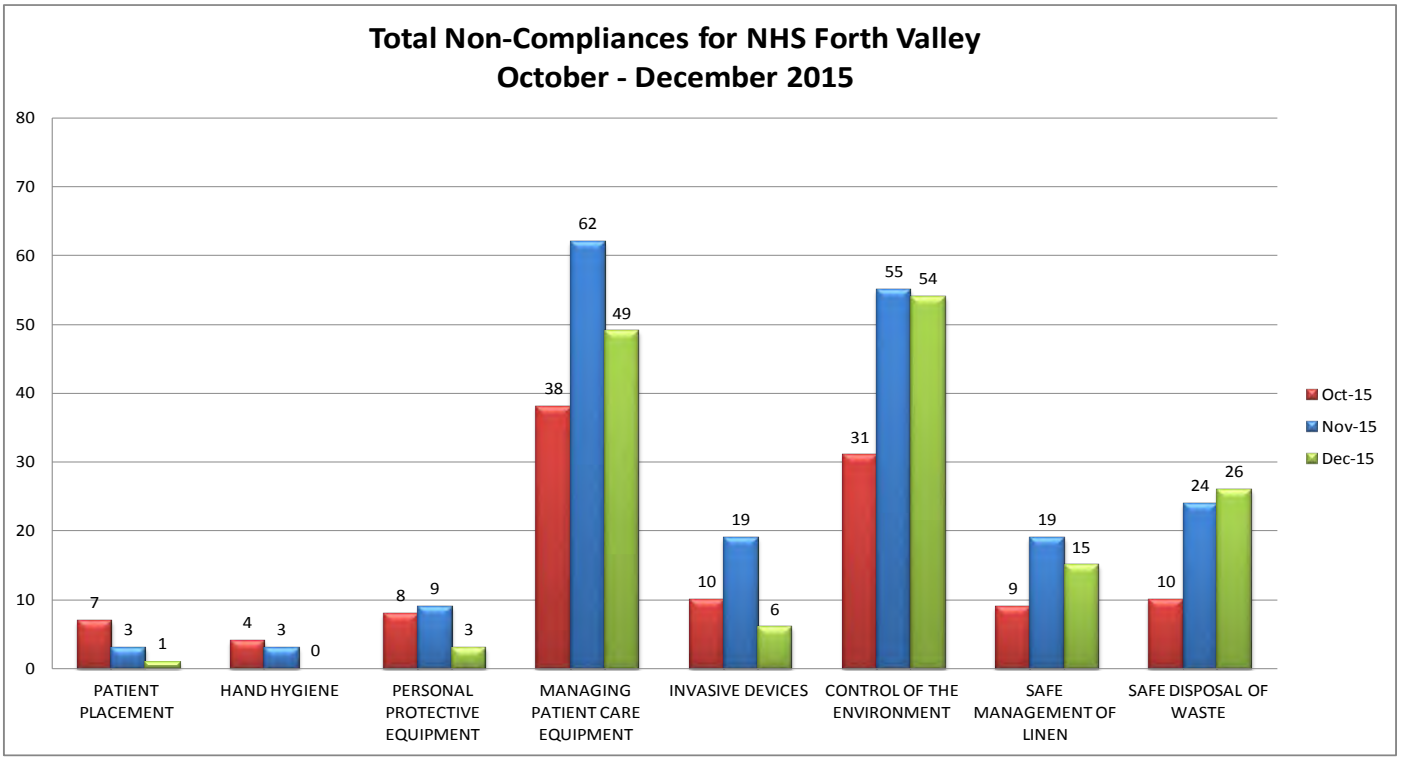
	Oct -Dec 2014	Jan - Mar 2015	Apr – June 2015	July – September 2015
Cleaning	94	97	94	99
Estates	91	92	86	87

Bellsdyke Hospital

	Oct –Dec 2014	Jan - Mar 2015	Apr – June 2015	July – September 2015
Cleaning	96	94	96	92
Estates	92	89	89	87

Ward Visit Programme

This month has seen a reduction in total non compliances compared to last month. Please see table below for details.



	Patient Placement	Hand Hygiene	PPE	Managing Patient Care Equipment	Invasive Devices	Control of the Environment	Safe Management of Linen	Safe Disposal of Waste	Total
Oct-15	7	4	8	38	10	31	9	10	117
Nov-15	3	3	9	62	19	55	19	24	194
Dec-15	1	0	3	49	6	54	15	26	154

Incidence/Outbreaks

There were no incidences or outbreaks to report this month.

Hand Hygiene

Hand Hygiene Monitoring Compliance (%) Board wide

Data taken from TCAB

	Jan 2015	Feb 2015	Mar 2015	Apr 2015	May 2015	June 2015	July 2015	Aug 2015	Sept 2015	Oct 2015	Nov 2015	Dec 2015
Board Total	97	98	99	99	99	99	99	99	99	99	98	99

Announced HEI Inspection to Clackmannanshire Community Healthcare Centre

On the 17th December 2015, NHSFV was informed of an announced HEI inspection to Clackmannanshire Community Healthcare Centre on the 27th & 28th January. Preparations are well underway involving all appropriate stakeholders.

HAI Annual Workplan (2015-2016)

In the past, the HAI work plan has been based on the SGHD HAI Policy units three year work programme, unfortunately the 2015-2018 programme has yet to be published by SGHD so a local HAI work plan was created to highlight progress of the HAI agenda in NHS Forth Valley. The annual plan is also based on the new HAI standards that were published in February 2015 to address any outstanding actions required to fulfil the new standards.

It is proposed when the national work plan is published, relevant actions will be incorporated into this work plan and run on a year to year basis.

Appendix 1 highlights the HAI work programme for NHS Forth Valley.

Standard 1 - Leadership in the Prevention & Control of Infection **Appendix 1**

Ref	Initiative	Rationale (HAI standard ref)	Implemented by	Responsibility	Assurance mechanisms	Expected outcomes	Governance	Start Date	Completion Date	Status	Comments
1.1	Review team structure for appropriateness	Continual assessment of service delivery to FV. (1.4, 1.6, 1.9)	AICM/ Lead Nurse/ICD	AICM/Exec Lead	Audit, formal & informal feedback from stakeholders	Improvement to service appropriate to the needs of the organisation	APCIC	Oct 2015	March 2016		Ongoing review of structure
1.2	To promote learning, research & development	To enable staff to progress with and lead on research within the HAI agenda. (1.10, 1.11)	Lead Nurse/ICD	AICM	IPCT learning and development meetings	Publication of posters both local and national	APCIC	July 2015	March 2016		Monthly meeting to begin in January 2016 to discuss ongoing and potential research proposals
1.3	To promote links with academic institutions.	To create an environment of learning and research. (1.11)	Lead Nurse/ICD	AICM	IPCT learning and development meetings	As above	APCIC	July 2015	March 2016		Links with Lesley Price,GCU.

Complete Progressing to timeframe Progressing outwith timeframe Not progressing Not started

Standard 2 - Education to Support the prevention & control of infection

Ref	Initiative	Rationale (HAI standard ref)	Implemented by	Responsibility	Assurance mechanisms	Expected outcomes	Governance	Start Date	Completion Date	Status	Comments
2.1	Formulate and implement effective communication mechanisms of cascading attendance of mandatory training to service leads	To highlight to service leads staff who have mandatory training outstanding. (2.1, 2.4, 2.5, 2.7)	Lead Nurse	IACM	IPCT meetings	Greater compliance of staff completing mandatory training	APCIC, local CGCs	Sept 2015	Dec 2015		Staff evaluation has commenced in FCH.
2.2	To re-assess the training needs of staff across NHSFV	To ensure appropriate training is given to all staff across FV. (2.1, 2.2, 2.7)	Lead Nurse	IACM	IPCT audit. Formal & Informal feedback	To develop more appropriate training to FV staff	APCIC, local CGCs	Sept 2015	Feb 2016		As above
2.3	To develop an antimicrobial stewardship Learnpro module	To prevent increased bacterial resistance and minimise the risk of CDI. (2.1, 2.4, 2.5, 2.7)	AMG	AMG	IPCT meetings	Improved antimicrobial stewardship	AMG, APCIC	Sept 2015	Jan 2016		
2.4	To maintain core competences of staff	To provide assurance to FV that all IPCT staff are appropriately trained in their roles	Lead Nurse	AICM/Lead Nurse	eKSF, appraisal	Improved knowledge and skills base	APCIC, IPCT meetings	Aug 2015	Mar 2016		eKSF completed by IPCT. Staff undertaking MSc (x2) and

Complete | Progressing to timeframe | Progressing outwith timeframe | Not progressing | Not started

Ref	Initiative	Rationale (HAI standard ref)	Implemented by	Responsibility	Assurance mechanisms	Expected outcomes	Governance	Start Date	Completion Date	Status	Comments
		(2.3)									BSc (x1) in IPC.
2.5	To further develop the HAI education framework	To further improve integration of HAI education within the NHSFV education strategy. (2.1, 2.4)	Lead Nurse	AICM		To be embedded in the board wide education strategy	APCIC, LET Committee	Aug 2015	Feb 2016		Staff evaluation has commenced in FCH.

Complete | Progressing to timeframe | Progressing outwith timeframe | Not progressing | Not started

Standard 3 - Communication between organisations and the patient or their representation

Ref	Initiative	Rationale (HAI standard ref)	Implemented by	Responsibility	Assurance mechanisms	Expected outcomes	Governance	Start Date	Completion Date	Status	Comments
3.1	Engage with Clinical Teams	To increase awareness and ownership of HAI through clinical teams at ward level. (3.9)	IPCT	Lead Nurse	Agenda item on clinical team meetings	Greater integration, reduced infection rates	Local CGCs, APCIC	July 2015	Sept 2015		Engagement of clinical teams underway. Ward specific SABs, DABs & CDIs now communicated as part of the review process
3.2	Review how HAI information is delivered to patients and staff	Regular review of current systems will ensure optimal working. (3.1 – 3.7)	IPCT	Lead Nurse	Ward visits	Improved access to HAI information	Local CGCs, APCIC, IPCT team meeting	Jan 2016	Feb 2016		Review started September 2015. Trial commenced in Dec 2015 in ward B21/22.
3.3	Develop a HAI questionnaire for patients and their visitors	To improve patient experience. (3.9, 3.10)	IPCT/ PPP	Lead Nurse	Ward visits, repeat HAI questionnaires	To improve patient experience and improved infection prevention at ward level	Local CGCs, PPP meetings, APCIC	July 2015	Oct 2015		Questionnaire developed. To be discussed at the next PPP meeting in Oct 2015. To be trialled in a pilot ward in Nov 2015.
3.4	Develop directorate level reporting	To improve communication and data presentation. (3.8, 3.9)	Lead Nurse/ Surveillance Data Manager	IPCT	Regular review of reports	Improved local HAI knowledge at directorate level	Performance Reviews, local CGCs, APCIC	June 2015	July 2015		Reports first published August 2015.
3.5	Establish working links	To create formal links with GPs.	Lead Nurse	IPCT	Update HAI issues at	To enhance HAI reporting to GPs	Local CGCs	Oct 2015	Jan 2016		Met with Practice

Complete | Progressing to timeframe | Progressing outwith timeframe | Not progressing | Not started

Ref	Initiative	Rationale (HAI standard ref)	Implemented by	Responsibility	Assurance mechanisms	Expected outcomes	Governance	Start Date	Completion Date	Status	Comments
	with GP Practice Managers	(3.8)			appropriate GP meetings						Managers in Dec 2015. Create top tips and risk escalation guidance.
3.6	Establish effective working links with district nurses	To create formal links with DNs. (3.8)	Lead Nurse	IPCT	Update HAI issues at appropriate Practice Manager meetings	To enhance HAI reporting to GP practice staff	Local CGCs	Oct 2015	Dec 2015		Met with DN's Oct 2015.
3.7	Establish effective working links with practice nurses	To create formal links with PN Lead	Lead Nurse	IPCT	Update HAI issues	To enhance HAI reporting to practice nurse staff	Local CGCs	Nov 2015	Nov 2015		Met with PN Lead Nov 2015.
3.8	Develop a process where in the event of a HAI death this is communicated to relatives and recorded in the notes	To ensure appropriate information is given to relatives and recorded. To meet the Vale of Leven action plan point 68 (3.7)	AMD	Medical Director / Director of Public Health & Planning	Audit	Improved communication to relatives in the event of a HAI attributed death.	Board CGC, CGWG, APCIC, Local CGCs	Sept 2015	Nov 2015		Information escalated to Medical Director and DPH.

Complete Progressing to timeframe Progressing outwith timeframe Not progressing Not started

3.9	HAI information and related issues are appropriately communicated to all stakeholders across FV	To ensure HAI information is cascaded to stakeholders for action	AICM	AICM/Lead Nurse	Feedback from stakeholders	Improved information cascade and HAI awareness	APCIC,CGC, CGWG, local CGCs	ongoing			

Complete | Progressing to timeframe | Progressing outwith timeframe | Not progressing | Not started

Standard 4 - HAI Surveillance

Ref	Initiative	Rationale (HAI standard ref)	Implemented by	Responsibility	Assurance mechanisms	Expected outcomes	Governance	Start Date	Completion Date	Status	Comments
4.1	Full integration of ICNet with eWard	To provide more comprehensive surveillance data. (4.2)	AICM/IPCT	AICM		To reduce IPCT surveillance times and to provide more robust and relevant data	IPCT, APCIC	May 2015	Sept 2015		Go live February 2016.
4.2	SSI module to be added to ICNet	To provide real time SSI feedback. (4.1, 4.3)	AICM/Lead Nurse	AICM	IPCT	More timely response to SSI and reduce manual data checking	Local CGCs, APCIC	Aug 2015	Sept 2015		SSI module implemented.
4.3	Review of SSI	Continual assessment of service delivery to FV. (4.1-4.8)	AICM/Lead Nurse	AICM		Improved SSI surveillance to FV and timely reporting	Board CGCs, CGCs, APCIC	Aug 2015	Nov 2015		
4.4	Implementation of *E. coli* surveillance	To monitor locally E. coli bacteraemia rates across FV. (4.3,4.5,4.6, 4.7,4.8)	IPCT	Lead Nurse/ICD	National reporting	To have a greater understanding of the epidemiology E. coli bacteraemia	APCIC, Board CGC, CGWG	Sept 2015	March 2016		Surveillance underway and reported to HPS
4.5	Review all existing surveillance systems	To ensure current surveillance is appropriate to the needs of the organisation. (4.3,4.5,4.6, 4.7,4.8)	IPCT	AICM	HAI monthly reports	To improve intelligence of issues identified from surveillance	APCIC, Board CCG, CGWG, local CGCs		ongoing		Ongoing review for appropriateness. HAI ward data uploaded onto Covalent

Complete | Progressing to timeframe | Progressing outwith timeframe | Not progressing | Not started

Ref	Initiative	Rationale (HAI standard ref)	Implemented by	Responsibility	Assurance mechanisms	Expected outcomes	Governance	Start Date	Completion Date	Status	Comments
4.6	To reduce SAB cases across NHS FV	To reduce SABs across NHS FV	AICM	All staff	National reporting, HAI monthly reports	SAB reduction	APCIC, Board CCG, CGWG, local CGCs	Ongoing			SAB reduction plan approved and implemented. (See also 7.1-7.4)
4.7	To reduce DAB cases across NHS FV	To reduce DAB cases across NHS FV	AICM	All staff	National reporting, HAI monthly reports	DAB reduction	APCIC, Board CCG, CGWG, local CGCs	Ongoing			See also 7.1 – 7.4
4.8	To reduce CDI cases across NHS FV	To reduce CDI cases across NHS FV	AICM	All staff	National reporting, HAI monthly reports	CDI reduction	APCIC, Board CCG, CGWG, local CGCs	Ongoing			See also 7.1 – 7.4
4.9	Actively monitor alert organisms to ensure any potential outbreaks are quickly addressed and managed	To reduce outbreaks across NHS FV	AICM	All staff	National reporting, HAI monthly reports	Measures to control and monitor potential outbreaks	APCIC, Board CCG, CGWG, local CGCs	Ongoing			Alert organisms monitored through ICNet. Norovirus/winter planning underway

Complete Progressing to timeframe Progressing outwith timeframe Not progressing Not started

Standard 5 - Antimicrobial Stewardship

Please refer to the Antimicrobial Stewardship work plan

Standard 6 - Infection prevention & control policies, procedures & guidance

Ref	Initiative	Rationale (HAI standard ref)	Implemented by	Responsibility	Assurance mechanisms	Expected outcomes	Governance	Start Date	Completion Date	Status	Comments
6.1	Review and amend ward monthly infection control check for managers	To integrate fully SICPs with ward level monitoring. (6.1, 6.3, 6.5)	IPCT	Nursing Leads	IPCT audit, local CGCs	To align audit to mandatory requirements	Local CGCs	Nov 2015	Jan 2016		Work in progress
6.2	Develop IPCT SOPs	To provide assurance of consistent processes. (4.4)	IPCT	Lead Nurse	IPCT audit	To provide consistency of processes	IPCT meetings, APCIC	Aug 2015	March 2016		Share with team at ICTOG in Jan 2016
6.3	Rollout of CPE screening	To minimise risk of spread of CPE. (6.5, 6.9)	IPCT	Service Leads	Audit by IPCT reported to service leads, GMs	To minimise the spread of MDROs.					Current screening continues in NHSFV.
6.4	To review IPC Policies	To ensure policies are relevant and up-to-date. (6.1-6.5)	IPCT	AICM	IPCT review	Policies appropriate for effective service delivery	IPCT meetings, APCIC	Ongoing			

Complete | Progressing to timeframe | Progressing outwith timeframe | Not progressing | Not started

Standard 7 - Insertion & maintenance of invasive devices

Ref	Initiative	Rationale (HAI standard ref)	Implemented by	Responsibility	Assurance mechanisms	Expected outcomes	Governance	Start Date	Completion Date	Status	Comments
7.1	Rollout of PVC insertion & maintenance bundle	To provide standardisation across FV for the insertion and maintenance of PVCs. (7.1 - 7.10)	IPCT	Service leads	Audit by IPCT reported to service leads, GMs	Improved documentation including recording of VIP score	CGWG, local CGCs, APCIC	July 2015	Aug 2015		Implementation complete. Audits complete to be reported Nov 2015.
7.2	Rollout of Urinary Catheter bundle	To reduce catheter usage and potentially CAUTI. (7.1 - 7.10)	IPCT	SPSP, Service Leads, GMs	Monthly reporting to SPSP, IPCT audit	To reduce urinary catheter use and CAUTI	CGWG, local CGCs, APCIC	June 2014	Aug 2015		Implementation complete. Audits complete to be reported Nov 2015.
7.3	Development of a urinary catheter passport	To provide readily available information to stakeholders relating to date of insertion, rationale of insertion etc of the catheter (7.1 - 7.10)	IPCT	Lead Nurse	Feedback from users and staff	Reduction in catheter days, reduction in inappropriate insertion duration	Local CGCs, IPCT	Nov 2015	Jan 2016		Continence service leading catheter passport.

Complete | Progressing to timeframe | Progressing outwith timeframe | Not progressing | Not started

Ref	Initiative	Rationale (HAI standard ref)	Implemented by	Responsibility	Assurance mechanisms	Expected outcomes	Governance	Start Date	Completion Date	Status	Comments
7.4	Point prevalence of long line in FVRH	To assess insertion, maintenance of long lines across FVRH. (7.1 - 7.10)	IPCT	AMD Surgical Directorate	Feedback given	Identify improvement actions	CGWG, APCIC	July 2015	July 2015		Paper sent to stakeholders, proposing development of an insertion bundle. IPCT will be supporting implementation of insertion bundle.
7.5	Rollout of long line insertion/maintenance Bundle.	To implement a standardised approach in NHSFV.	IPCT/Tim Heron	AMD/Tim Heron	Compliance audit	Standardise insertion maintenance bundle	CGWG, APCIC	October 2015	December 2015		Bundle accepted by N. Arrestis Roll out to start December 15. Compliance audits to commence Jan 2016.

Complete | Progressing to timeframe | Progressing outwith timeframe | Not progressing | Not started

Forth Valley NHS Board

26 January 2016

This report relates to
Item 5.3 on the agenda

NURSING & MIDWIFERY COUNCIL (NMC) REVALIDATION

(Presented by Professor Angela Wallace, Nurse Director)

For Noting

SUMMARY

1. **TITLE:** Nursing and Midwifery NMC Revalidation.

2. **PURPOSE OF PAPER:** This paper outlines the preparations NHS Forth Valley has put in place to support the introduction of the Nursing and Midwifery Council (NMC) revalidation process for registered nurses & midwives.

3. **KEY ISSUES**

- In October 2015 the NMC approved Revalidation implementation from April 2016, with significant changes having been made to the provisional guidance used for the pilot areas. The approved 'How to revalidate with the NMC' was published in October 2015.
- Individual practitioners have a personal responsibility for meeting their revalidation requirements. The NMC has contacted every nurse and midwife personally and through newsletters and bulletins to Boards.
- NHS Forth Valley has an ongoing awareness raising programme for staff and is linking with the national revalidation group to keep staff informed and to offer continuing support.
- If staff fail to meet revalidation requirements they will become de-registered and the re-registration application process may be lengthy.
- A Revalidation Programme Board has been established to support and facilitate the implementation process.

4. **FINANCIAL IMPLICATIONS**

IPSOS MORI and KPG conducted a risk and financial assessment following the national pilots. The reports are not yet available.

5. **WORKFORCE IMPLICATIONS**

If nurses/ midwives fail to revalidate they will become automatically de-registered. It may take some time (possibly in excess of 6 weeks) to complete the re–registration application process. During this time they will be unable to be employed as registered nurses/midwives.

6. **RISK ASSESSMENT AND IMPLICATIONS**

The risk of nurses/midwives failing to fulfil the new requirements is being estimated nationally and a request for local information has been submitted to the NMC.

7. **RELEVANCE TO STRATEGIC PRIORITIES**

The new NMC revalidation process protects patients and families by supporting the NMC Code: Professional standards of practice and behaviour for nurses and midwives (2015)

7. EQUALITY DECLARATION

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

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

√ Paper is not relevant to Equality and Diversity

□ Screening completed - no discrimination noted

□ Full Equality Impact Assessment completed – report available on request.

8. CONSULTATION PROCESS

All four countries have agreed to implementation of NMC Revalidation from April 2016

9. RECOMMENDATION(S) FOR DECISION

- Note the pending NMC Revalidation for all nurses and midwives across the UK.
- Note that NHS Forth Valley has had in place awareness sessions for staff on the new revised code and revalidation since February 2014. Sessions are ongoing and are well attended and received by staff.
- Note that NHS Forth Valley has developed a detailed Project Initiation Document NMC Revalidation and Revalidation Programme Plan that ensures robust and enabling systems to ensure transition of nurses and midwives to register whilst reducing risk to safe care, services and staff transition revalidation.

10. AUTHOR OF PAPER/REPORT:

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APPROVED BY:

Name:	***Designation:***
Professor Angela Wallace	**Nurse Director and Executive Lead, NHS Forth Valley**

Revalidation

Mary Barr & Glynis Gordon

This paper outlines the preparations NHS Forth Valley has put in place to support the introduction of the NMC revalidation process.

Contents

Introduction

1.1 From April 2016 nurses and midwives will maintain their registration through a new revalidation process being introduced by the Nursing and Midwifery Council (NMC). This paper outlines the preparations NHS Forth Valley has put in place to support the introduction of the NMC revalidation process.

1.2 Revalidation has already been introduced for medical staff at the end of 2012, so therefore, is not a new concept for NHS Forth Valley or NHS as a whole. However, the number of nurses and midwives in NHS Forth Valley is 2165 compared to approximately 500 career grade substantive medical/dental staff. This is merely used as an illustration to demonstrate the scale of the exercise and that the potential impact of nurses failing to meet revalidation could have significant consequences for patient care and service delivery

Background

2.1 Following a Nursing and Midwifery Council (NMC) meeting on 12 September 2013, the NMC committed to introducing a proportionate and effective system of revalidation which will enhance public protection by the end of 2015.

2.2 Revalidation will require registered nurses and midwives to regularly demonstrate that they remain fit to practise. The model agreed will require a third party (such as an employer or manager) to confirm that the nurse or midwife who is revalidating is complying with the revised NMC Code: Professional standards of practice and behaviour for nurses and midwives (2015). Nurses and midwives will also need to reflect on feedback from patients, service users, carers and colleagues to improve the services that they provide. Revalidation will take place at the point of renewal.

2.3 As required by current legislation, nurses and midwives will continue to renew their registration every three years and will declare that they have practised for 450 hours during those three years.

Preparations within NHS Forth Valley

3.1 Revalidation consultation – Part 1 – 6 January – 31 March 2014

Online survey (6 January to 31 March 2014) on the revalidation model and the Code:

- Outcomes to inform draft revised Code and revalidation development
- Promoted through NMC and stakeholder communication channels SCN's & Band 6's
- Supported by stakeholder engagement:
- ANMAC/ ACF
- Modernising Services Executive Council

NHS Forth Valley – Consultation on the proposed Revalidation Model sessions held February – March 2014 – 473 – staff attended

3.2 Consultation – Part 2 – Draft Revised Code and Revalidation 31 May – 11 August 2014

The NMC drafted a revised Code for nurses and midwives. The Code is the core publication and sets out the standards expected of all nurses and midwives. Part two of the consultation concentrated more on the draft Code and focused engagement. The Code is central to nursing practice and will therefore be a key part of revalidation. The main objective of this 12 week consultation exercise was to collect feedback on the draft revised Code and the proposed revalidation model.

- 16 May to 11 August 2014 - draft revised Code and revalidation
- Ipsos MORI commissioned to conduct: Online consultation survey
- Focus groups – nurses and midwives
- Outcomes to inform implementing revalidation, Code and revalidation guidance
- Supported by stakeholder engagement:
- ANMAC/ ACF
- Modernising Services Executive Council

NHS Forth Valley – All Senior Charge Nurses (SCN's) and Band 6's involved to participate Part 2 consultation and some attended the NMC summit for Revalidation & revised Code held in Glasgow July 2014

3.3 NMC Revised Code – Professional standards of practice and behaviour for nurses and midwives – **Published 31 January 2015**. In January 2015 SCN'S & Band 6's were sent electronic copies of NMC Revised Code.

The Revised Code: Nursing & Midwifery Council (NMC) The Code: Professional standards of practice and behaviour for nurses and midwives came into **effect from 31 March 2015**. During March, the NMC sent all registered nurses and midwives on the NMC register a hard copy of the revised Code with an accompanying letter outlining the proposed introduction of revalidation and also a request to register with the NMC online.

3.4 To support the introduction of the revised Code and Revalidation, awareness sessions were scheduled from April - June 2015 for all registered nurses & midwives.

NHS Forth Valley Revised Code and Revalidation Awareness Sessions 8th April 2015 – Ongoing -1592 attendees.

3.5 On Nurse's Day on 15th May 2015 Mr Chris Bell from the NMC was invited as a guest speaker at the event. Mr Bell delivered a presentation on the Revised Code and provided an update on progress from the pilot sites testing the proposed Revalidation process as well as providing a question and answer session.

3.6 From June 2015 a local monthly Newsletter on the revised *NMC Code -Professional standards of practice and behaviour for nurses and midwives*, plus details of the proposed *NMC Revalidation process* have been circulated to all Heads of Nursing, members of the Modernising Nursing Executive Council, Band 6 & 7's requesting cascade within their areas of responsibility to all registered nurses and midwives for

information. The Newsletters have also been on the intranet for several days on the week of their release and detailed within the Staff News Bulletin.

3.7 Since June 2015 a copy of the monthly NMC 'Revalidation round-up' has been circulated to Heads of Nursing and members of the Modernising Nursing Executive Council, Band 6 & 7's requesting cascade within their areas of responsibility to all registered nurses and midwives for information The NMC 'Revalidation round up' have also been on the intranet for several days on the week of their release and detailed within the Staff News Bulletin.

3.8 Attendance at Leading Better Care (LBC) Events and CREATE sessions during August, September, October and November 2015, continues to raise awareness to all NHS Forth Valley nurses and midwives who will require to meet the revalidation requirements and, simultaneously, support their greater understanding of the new NMC Code: Professional standards of practice and behaviour for nurses and midwives (2015)

3.9 The Nurse Director and Executive Lead for the process implementation in NHS Forth Valley, supported by the Chief Executive Officer, have raised awareness with Executives, General Managers and the wider Corporate Management Team during recent months. The DNs. ADNs and Heads of Nursing have all made provision with their 2015-2016 personal objectives and are raising awareness through their local management and clinical governance arrangements with the Directorates. Across the 4 countries and within Scotland and NHS Forth Valley locally there is strong partnership awareness and commitment to support moving forward.

3.10 Awareness and promotional events are planned to support the launch and implementation of the Revalidation process.

3.11 MIAD NMC Train the Trainers training programme. NHS Forth Valley has eleven individuals from across the organisation who attended the national training events in November 2015. A cascade training programme for all registered nurses and midwives has been agreed by the Revalidation Programme Board for roll out of the agreed NMC training programme across the organisation. Delivery of the training programme is already taking place across the Directorates. *(MIAD is a trade name of a company appointed by the NMC to deliver the train the trainer programme)*

Support Systems Review

4.1 In August/September requests were made to all registered nurses and midwives to make sure they register on line with the NMC, check their revalidation date and to advise their manager when their revalidation date is. The Heads of Nursing for the Directorates were responsible to coordinate the responses for their areas of responsibility.

4.2 IT have been consulted regarding reviewing existing IT database systems to link systems for ease of collating information on Revalidation dates for Year 1, 2 & 3.

4.3 The gathering of data, revalidation dates for all nurses and midwives is near completion across the Board. The data gathered has been sent to the Workforce Planning & Development Manager to load the information into eESS. eESS at present, although this is being addressed nationally, does not hold an actual field for

revalidation, an interim means of using one of the comments fields for this purpose has been used so that we can report on the data. Identifying the registrants due to revalidate in years 1,2 & 3 will help focus resources and support identified individuals through the revalidation process.

4.4 NHS Forth Valley are promoting learning supports and access to training links - knowledge network, local library services, NHS Education for Scotland (NES).

4.5 Revalidation Information Folders with step by step instructions and linked education supporting networks and templates are available for registrants to view in the Library, Learning Centre, Forth Valley Royal Hospital.

NMC support and communications

5.1 At the beginning of August and again in October 2015, the NMC wrote to every individual NMC registrant to help support and raise awareness of the expected changes and plans for revalidation. Registrants who have already registered online received a personalised email, for those not registered online the NMC mailed a postcard to their listed address.

5.2 Final Revalidation Guidelines were launched in October 2015. The NMC have stated there will be a period of 60 days notice to registrants prior to their Revalidation date.

5.3 The NMC have published an 'Employers' guide to revalidation' to help prepare for revalidation. Supporting revalidation in the workplace will help make sure that nurses and midwives can practise safely and effectively. This guide sets out the type of support employers could provide to help their nurses and midwives revalidate.

5.4 From December 2015 the NMC are aiming to provide a link for employers access for registrants Revalidation Dates

5.5 The NMC have not made a decision as yet on the percentage of nurses & midwives revalidating that will be included in the audit/verification process

5.6 Independent Reports from IPSOS MORI and KPG produced regarding the Pilot site outcomes and cost benefits analysis are as yet not available to the public.

5.7 First nurses and midwives to revalidate - The first nurses and midwives due to revalidate are those whose registration is due to expire in April 2016. This means that for those nurses and midwives they will be able to submit their revalidation application from the beginning of February. These nurses and midwives will have received their first email reminder from the NMC and will receive their formal notices in late January.

5.8 Email programme - In addition to the formal notices to nurses and midwives about revalidation, the NMC have introduced a programme of targeted, segmented email communications for nurses and midwives in the final 12 months leading up to their revalidation application date. These email communications will provide helpful reminders as to what nurses and midwives should be thinking about at different stages of the revalidation journey.

5.9 Update to 'How to Revalidate with the NMC' and other guidance documents - As part of the process of developing the guidance and supporting materials for revalidation the NMC committed to making revisions to these materials where appropriate to ensure

the NMC provide as much clarity to nurses and midwives as possible. 'How to revalidate with the NMC' was updated and re published on 23 December 2015. These changes do not affect the model of revalidation or the revalidation requirements but simply provide more clarification around certain areas and correct minor grammatical errors. The NMC also updated the guidance for employers, guidance for confirmers, various guidance sheets and all forms and templates in line with these minor changes. These forms and templates are available on the NMC's website. Copies of the updated guidelines, templates and forms have been circulated to all Heads of Nursing and Senior Charge Nurses requesting cascade of information to all registered nurses and midwives in their area of responsibility.

5.10 Planned communications products - In addition to the revalidation materials currently available the NMC will be producing a range of communications products in January 2016 to support nurses and midwives through revalidation. Revalidation microsite – to be launched in January, and sitting as part of the NMC main website, this will be one stop shop for all revalidation related information. It will contain guidance on the process and host useful tools such as case studies and videos to support nurses, midwives and employers through revalidation.

Feedback from National Project Group

6.1 Financial Risk not defined, await outcome of independent reports and requested information from NMC to provide percentage of registrants by postcode for non payment of fees.

6.2 Project Group Webex meetings are arranged fortnightly to support leads in each Board area.

6.3 A professional network has been established to make sure there are consistent channels of communication between NHS and non-NHS colleagues.

6.4 MIAD- NMC Train the Trainers training programme scheduled for 9th & 20th November eleven places were allocated to NHS Forth Valley. The NMC agreed training programme is to be cascaded to all registered nurses and midwives. A training programme has been agreed by the Revalidation Programme Board for roll out across the organisation. *(MIAD is a trade name of a company appointed by the NMC to deliver the train the trainer programme)*

7.5.1 An e-portfolio is available through NHS National Education Scotland to support nurses and midwives to prepare for revalidation. The National Project Board supports the use of ePortfolio across Scotland.

6.6 To support organisations with the preparatory and implementation phases for revalidation, the Scottish Government will be providing non – recurring funding to NHS Boards. The funding is equivalent to a band 7, and is for the duration of one year.

Agreed Revalidation Requirements October 2015

The final approved revalidation process and standards were confirmed at a NMC Meeting on the 8th October 2015. http://www.nmc.org.uk/standards/revalidation/how-to-revalidate/

7.1 All registrants are required to meet the following minimum standards for a three year period preceding the date of their application for renewal. Individuals who fail to meet revalidation standards will not legally be able to work in the UK in their profession.

7.2 A minimum of **450 practice hours** within their scope of practice. This scope of practice can be direct patient care, management, education, policy or research in a wide range of health, social care and independent care settings. 900 hours if revalidating as both nurse and midwife

7.3 To undertake **35 hours of continuous professional development (CPD)** relevant to the scope of practice (of which 20 hours must be participatory learning)

7.4 To obtain at least **5 pieces of practice related feedback**, which can be from patients, carers, service users, students, colleagues and annual appraisals.

7.5 Reflection and discussion through a minimum of **5 written reflective accounts** on the code, practice and CPD.

7.6 Reflective discussion – a reflective discussion form which includes the name and NMC PIN number of the NMC registered nurse or midwife that the registrant had the discussion with.

7.7 Declaration of health and character.

7.8 Confirmation of professional indemnity arrangements.

7.9 Confirmation from a third party, usually the manager for the purpose of verifying the declarations.

It is important to clarify that individual registrants are responsible to meet their revalidation requirements. However, the organisation has a professional and managerial responsibility to facilitate the process and guide individual registrants which will improve patient safety and manage organisational risk.

Implementation Phase

8.1 A project management approach is being utilised to ensure that a sustainable approach is adopted. Documentation available includes NHS Forth Valley Project Initiation Document NMC Revalidation, Revalidation Programme Plan, Revalidation Timeline and Revalidation Chart.

8.2 The first meeting of the Revalidation Programme Board was held on 10th November, and focused on developing an understanding of the requirements of the new revalidation arrangements and NHS Forth Valley's position and readiness for the implementation of Revalidation from 1 April 2016.

8.3 The Revalidation Programme Board is chaired by Nurse Director and Executive Lead, NHS Forth Valley.

8.4 Task & Finish groups have been established, made up from members of the Revalidation Project Board, to take forward key pieces of work identified within the Revalidation Project Initiation Document and Revalidation Plan:

- Revalidation Education Group
- Revalidation HR Group
- Revalidation Communications Group

NHS Forth Valley will require to support our staff by developing and maintaining robust systems and processes, capacity and resources to comply with revalidation:

- Professional Lead to oversee the implementation of revalidation
- Systems and support to ensure that NHS Forth Valley staff are facilitated and enabled to meet their appropriate CPD requirements for revalidation.
- Systems, support and capacity to ensure staff receive appropriate yearly appraisals that deliver on the NMC code for revalidation. Up to Date Appraisal system (consideration required for the NHS given impending changes) including 3 year renewal and revalidation date
- Appraisal systems incorporating the Four Elements of the Code as measurement dimensions
- Set of Principles aligned to the appraisal system
- Ensure Information systems that can record and identify nurses and midwives' current registration status and 'flag' system when revalidation dates are due
- Sufficient Numbers of trained Confirmers/Registrants with ability to facilitate Confirmation/Reflection/Reflective Practice
- Identify and support sufficient management capacity to support staff with revalidation and third party verification and confirmation.
- Organisational Information Sharing Protocols established to support personnel whose employment crosses organisational boundaries
- Policies and procedures for identifying and responding to concern
- Clinical Governance Systems with supporting information/data
- HR pre-employment, employment and engagement processes consistently applied and meeting expectations of NMC Revalidation.

Recommendations

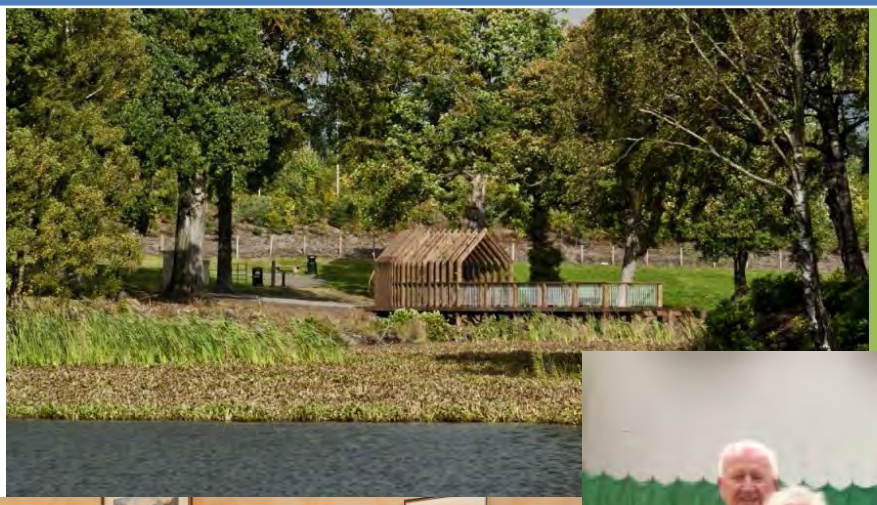
The Forth Valley NHS Board is asked to:

- Note the pending NMC Revalidation for all nurses and midwives across the UK.
- Note that NHS Forth Valley has had in place awareness sessions for staff on the new revised code and revalidation since February 2014. Sessions are ongoing and are well attended and received by staff.
- Note that NHS Forth Valley have developed a detailed Project Initiation Document NMC Revalidation and Revalidation Programme Plan that ensures robust and enabling systems to ensure transition of nurses and midwives to register whilst reducing risk to safe care, services and staff transition revalidation.

Professor Angela Wallace
Nurse Director and Executive Lead, NHS Forth Valley

NHS Forth Valley

Report of the Director of Public Health



The Health of the Population of Forth Valley 2013-2015

Table of Contents

Foreword

As Director of Public Health and Strategic Planning, I am pleased to present this report on the health of the population of Forth Valley for the period October 2013 to Septemnber 2015.

This report describes the demographics and background health of our local population and highlights a number of key areas of work ongoing in NHS Forth Valley described under three main themes;

- Service improvement and development – planning, delivering and evaluating the range of interventions provided by NHS Forth Valley and partners in order to better meet the needs of the population.
- Health improvement – helping people to maximise their wellbeing by making healthy choices, and developing knowledge and skills.
- Health protection – delivering interventions that reduce the risk of communicable disease and environmental hazards.

Each section selects a number of key elements from the above three themes providing an overview of the range of work undertaken, however this report does not attempt to provide comprehensive comment on all areas of work. The report provides only a summary and overview of the vast scope of resources now readily available via the internet. Where possible the electronic version provides web-links to relevant and useful resources.

My vision for Public Health in Forth Valley focuses on the three main areas of;

- children and the early years
- 'worthwhile work'
- substance misuse

Concentrating on these three pillars will help to improve the health and wellbeing of our local population and break the vicious cycle of challenging circumstances in the early years leading to difficulties in securing employment and the potential for increasing substance misuse.

If we can effectively deliver on these three challenges we will do much to tackle the underlying cause of inequalities and ill health, promote wellbeing and positive health including mental health. Focusing on 'worthwhile work' will also deliver additional benefits such as reductions in offending and reoffending. Issues associated with these pillars can form the foundation of many of the problems we see in our society. Work in collaboration with partners in these three areas will influence a much broader spectrum of health outcomes over and above those within the immediate sphere of each pillar.

The health of the population in Forth Valley is continuing to improve. Our health successes include a continuing decrease in the death rate from heart disease, stroke and cancer. As we overcome many of the more "traditional" life threatening diseases such as heart attacks, our focus of healthcare is moving towards treating and supporting people living with long term conditions (LTC). We face significant challenges with changing demographics. Our local population of over 75 year olds, for example, is set to more than double by 2037. People are living longer and are increasingly likely to be living with more than one long term condition. These factors present a huge challenge to our NHS.

In keeping with the Scottish Government, 2011 strategy; 2020 vision[1], NHS Forth Valley has been working, as part of our Clinical Services Review, to provide more efficient services that will help people to live longer healthier lives at home. This will be achieved through; integration of health and social care, a greater focus on prevention, anticipatory care plans and self management and a shift towards treatment in a community setting with day case treatment available when required. Care will be provided to the highest standard of quality whatever the setting. All decisions will be made with the person at the centre and the focus will be on ensuring that people are able to return to their home or community environment as soon as appropriate whilst minimising the risk of re-admission.

Following legislative change around health and social care integration[2], new Health and Social Care Partnerships (HSCP), will be jointly run by Integration Joint Boards who will have delegated authority from the constituent parties and have the ability to direct the NHS and Local Authority through the Strategic Plan. These will be operational by April 2016. There will be two HSCPs in Forth Valley, one for Falkirk and one for Clackmannanshire and Stirling. Currently there are Transitional Boards preparing for implementation in 2016.

We look forward to the publication of the new NHS Forth Valley Health Strategy for the next five years which will be published early in 2016 and will bring together these various strands of activity.

The 2014 Scottish Independence referendum resulted in an overall vote to remain as part of the UK. This has resulted in new powers devolved to the Scottish Government, which have the potential to be used to improve health and reduce inequalities.

Economic austerity has resulted in changes to the benefit system through welfare reform, changes in patterns of employment and reduced funding for the public sector. These factors impact on people's health, particularly those already experiencing health inequalities. The Poverty and Income Inequality in Scotland: 2013/14[3] report states that 14% of children in Scotland are living in relative poverty (before housing costs) or 22% if considered after housing costs. The report from the Scottish Parliament, Welfare Reform Committee; 1st Report, 2015 (Session4); The Cumulative Impact of Welfare Reform on Households in Scotland[4], notes that once the welfare reforms are fully in place (around 2018) the cumulative effect is likely to see incomes reduced, on average by £440 a year, for

[1] 2020 Vision
[2] The Public Bodies (Joint Working) (Scotland) Act
[3] Scottish Government: Poverty and Income Inequality in Scotland:2013/14
[4] Scottish Parliament, Welfare Reform Committee; 1st Report, 2015 (Session4), The Cumulative Impact of Welfare Reform on Households in Scotland

every adult of working age in Scotland. Families with dependent children, in particular lone parents and those with health problems or disabilities who claim benefits are expected to experience a marked impact. The average losses in Scotland have been mitigated following the decision to maintain Council Tax benefits and to offset the 'Bedroom Tax'.

Addressing health inequalities underpins our work. Substantial areas of Forth Valley are deprived and have high levels of behaviours and diseases associated with deprivation, for example, substance use, obesity, heart disease and cancer. For those who live in less deprived areas, health challenges include a lack of physical activity, poor diet and the environmental impacts of our 21st century lifestyle.

Further progress to improve population health will depend on our ability to work with our partners on the 'upstream' issues which are the fundamental causes of inequalities in health.

Dr Graham Foster
Director of Public Health and Strategic Planning, NHS Forth Valley

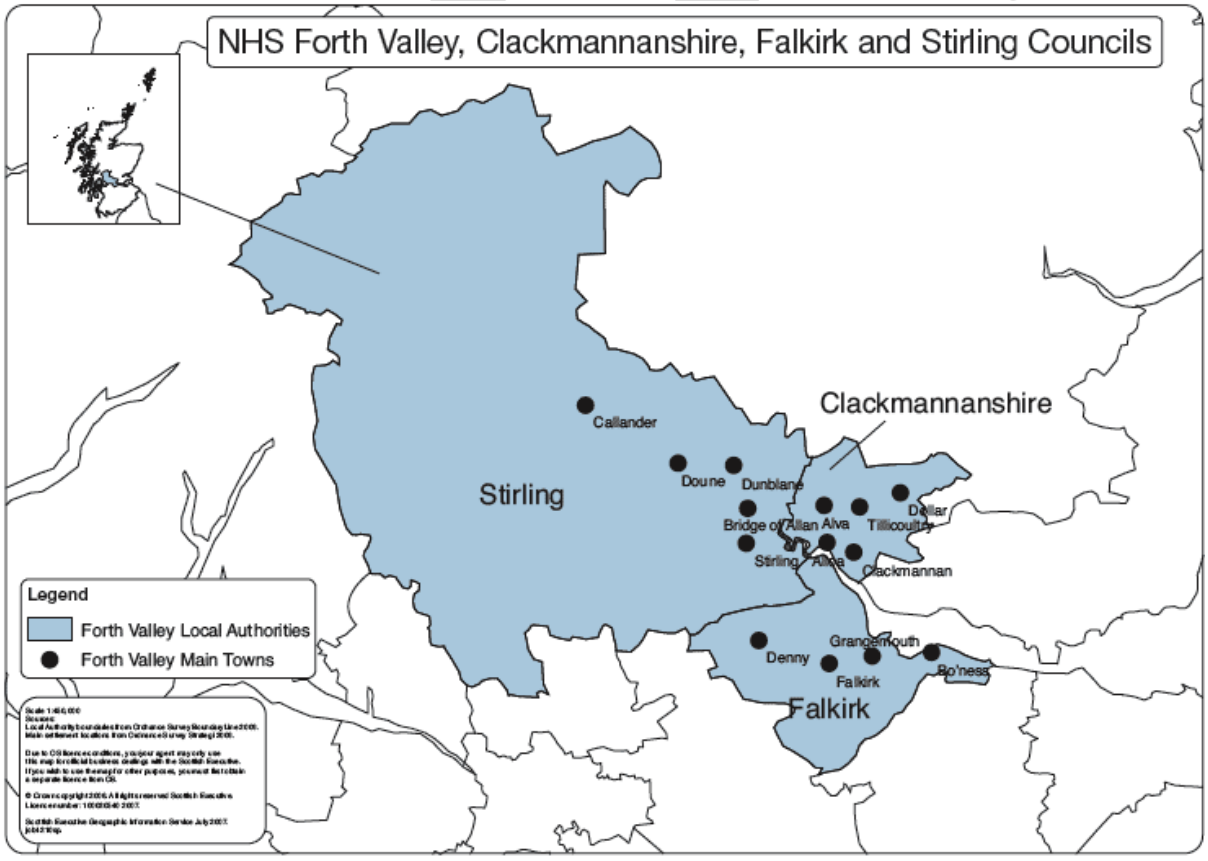
Facts and figures about the people living in Forth Valley

NHS Forth Valley

Around 300,000 people live in the NHS Forth Valley area. Forth Valley lies within Central Scotland and stretches from Killin and Tyndrum in the North to Strathblane and Bo'ness in the South, covering approximately 1,000 square miles (Figure 1).

The boundaries of NHS Forth Valley are co-terminus with the three Local Authorities; Clackmannanshire Stirling and Falkirk. NHS Forth Valley is a single integrated healthcare system comprising acute hospital services, and community based services which have been delivered through three Community Health Partnerships (CHPs). Retrospective data are reported under the three CHP areas.

Figure 1: Forth Valley geographic area



Source: The Scottish Government

The Scottish Public Health Observatory (ScotPHO) health and wellbeing profiles provide detailed information at Local Authority level. It is important to remember that when looking at statistics for small populations the differences are not always statistically significant; therefore it is useful to remember that longer term trends can better demonstrate the true position.

As an example of the type of information available, the estimated smoking prevalence of around 1 in 4 (25.5%) for Clackmannanshire and 1 in 5 (19.9%) in Falkirk is not significantly different from the Scottish average of 23.0 %. In Stirling the smoking prevalence is less than 1 in 5 (18.5%) and is statistically significantly lower than the Scottish average. Given the importance of early years it is concerning for example that the percentage of mothers smoking during pregnancy is 25.3% for Clackmannanshire which is statistically significantly worse than the Scottish average of 20.0%.

Population by age, Local Authority and gender

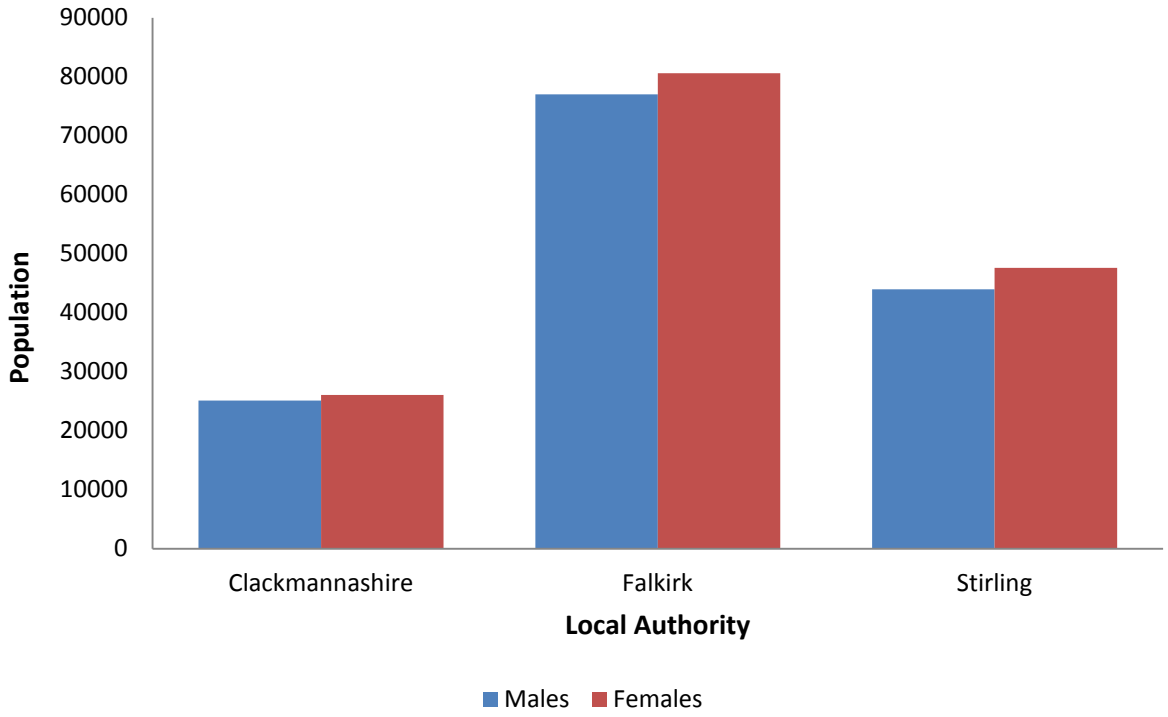
The Forth Valley mid-year estimates for 2014 (Figure 2) indicate greater numbers in age cohorts 45-59 years and 30-44 years in all three Local Authority areas except Stirling where the 30-44 years age band is relatively smaller. This has implications for services such as sexual health and maternity.

Figure 2: Mid Year Population Estimate for Forth Valley by Local Authority; 2014

Source: Data extracted from National Records of Scotland

There are slightly more females than males in all three local authority areas within Forth Valley (Figure 3).

Figure 3: Mid Year Population Estimate; 2014 by gender and Local Authority



Source: Data extracted from National Records of Scotland

Population projections

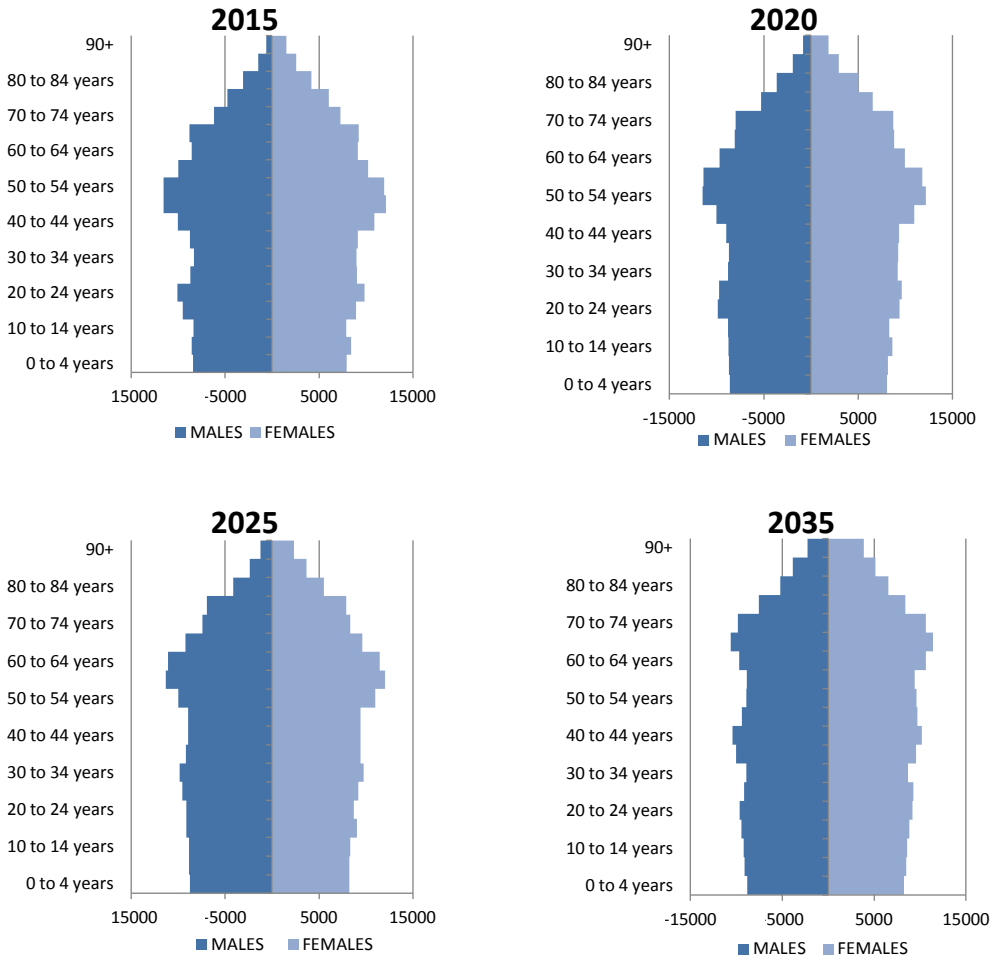
Population projections indicate that the population of Forth Valley is rising faster than the Scottish average. The total population of Forth Valley is projected to increase by 10% between 2012 and 2037 compared to an increase of 8.9% in Scotland overall.

The most notable increase in population projections is within the 65 and over age cohorts where the population is expected to rise by 70.5% from 51,500 in 2012 to 87,700 in 2037, accounting for just over 1 in 4 of the population. The numbers of those aged 75 and over are projected to rise by 101.5% from 22,406 in 2012 to 45,153 in 2037 when this group will represent around 1 in 7 of the population.

> "The population of Forth Valley is projected to increase by 10% between 2012 and 2037."

Figure 4 demonstrates the projected change in the population age profile from 2015 to 2035 with the large group of those currently aged 45-55 years graduating to the 65-75 year age group in 2035, but without a corresponding increase in the younger age groups.

Figure 4: 2012-based principal population projections by sex for Forth Valley over a twenty year period (2015-2035)



Source: Data extracted from National Records of Scotland

Economic circumstances of Forth Valley people

The percentage of working age adults claiming incapacity benefit, severe disability allowance (SDA) or employment support allowance (ESA), is greatest in Clackmannanshire at 5.7% compared to either Falkirk or Stirling. Similarly the rates of income deprivation are also higher in Clackmannanshire (Table 1) [5].

Within Scotland, Clackmannanshire has the highest percentage of 16-19 year olds not in employment, education or training.

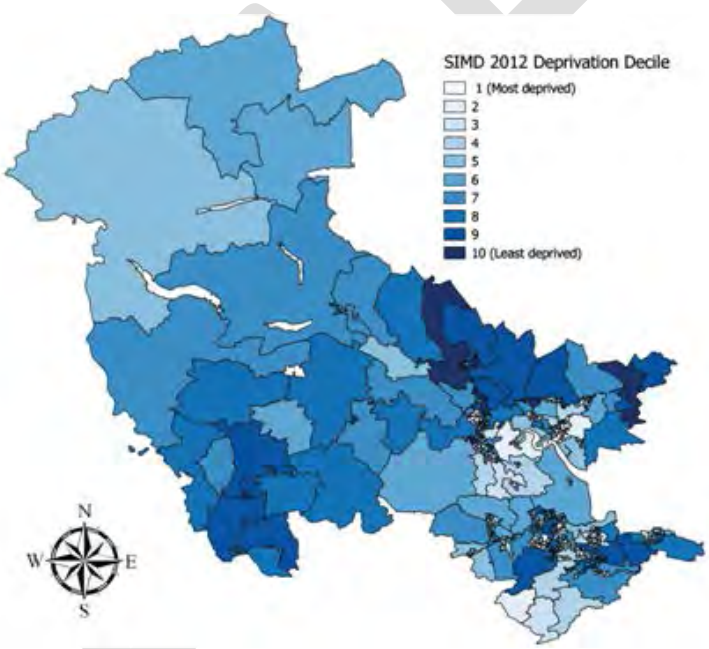
These local data are consistent with Figure 5 which highlights the areas of deprivation within Forth Valley by Scottish Index of Multiple Deprivation (SIMD) deciles with the lighter areas representing the more deprived communities.

[5] SCOTPHO Health and Wellbeing Profiles

Table 1: Social care and economic data for Forth Valley by Local Authority (2013)

	Clackmannanshire	Falkirk	Stirling	Scotland
% Working age adults claiming incapacity benefit, severe disability allowance (SDA) or employment support allowance (ESA)	5.7% CI: 5.5-6.0	4.9% CI: 4.8-5.0	4.0% CI:4.1-3.9	5%
Rate of income deprivation	15.4% CI: 15.1-15.7	12.7% CI: 12.5-12.9	9.9% CI: 9.7-10.1	13.2%
% 16-19 year olds not in employment, education or training (NEET)	12.1% CI: 10.8-13.4	8.6 % CI: 8.0-9.3	5.6% CI: 5.0-6.2	7.8%.

Figure 5: Forth Valley Map detailing areas of deprivation by SIMD datazone



Sources: SIMD 2012, Scottish Government; Ordnance Survey data © Crown copyright and database right 2015;

"The numbers of people in the 65 and over age group is expected to rise by 70.5% between 2012 and 2037."

Trends in common diseases

At UK level, cardiovascular disease (CVD), mainly coronary heart disease and stroke, remains a significant burden and a major cause of death. Of note, in 2012, for the first time, cancer narrowly took the lead as the foremost cause of death at 29% compared to cardiovascular deaths at 28% for both sexes together[6]. Spilt by gender, cancer is the most common cause of death for men (32%) while cardiovascular disease remains the leading cause of death for women (28%). CVD mortality rates are higher in Scotland and the North of England compared to the South of England. Improvements in survival mean that we now experience a higher prevalence of people living with CVD with subsequent increase in relevant prescriptions.

Heart Disease

The number of premature deaths from heart disease in Forth Valley has continued to fall over the past decade. For under-75 year old males in Forth Valley, the mortality rate from ischaemic heart disease per 100,000 population has decreased substantially from 141.3 to 89.1, between 2004 and 2013. For females of the same age range, the rate per 100,000 population has decreased from 44.8 to 27.2. The combined rate per 100,000 population for both sexes has fallen from 93.1 to 58.1, during the same period (Figure 6).

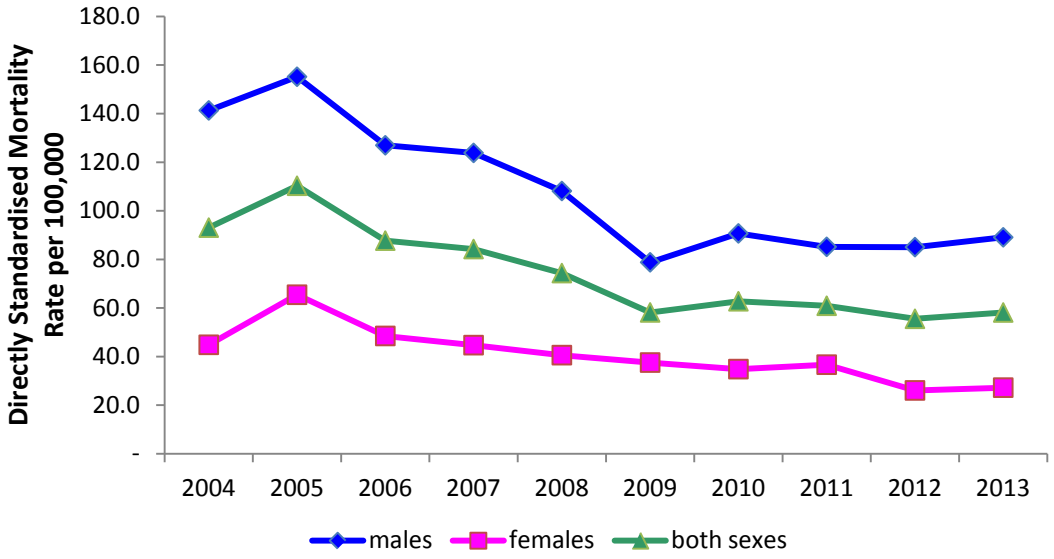
The reduction in premature deaths from ischaemic heart disease reflects a position where more people are surviving and living with the disease. This has resulted in an increased need for treatment and healthcare as the population ages.

Figure **7** demonstrates the differences in mortality (deaths) from coronary heart disease (CHD) across the deprivation quintiles. There has been a reduction in mortality in all the deprivation quintiles over the decade 2004-2013 with a greater reduction observed in CHD mortality rate among the least deprived quintile (46.4%) compared to the most deprived quintile (40.7%). The absolute difference in mortality rate per 100,000 population, between the most and least deprived quintile has decreased from 152 to 102 over the last decade.

Although the situation is improving for all the population it is disappointing that the most deprived quintile are only now experiencing the level of mortality which the least deprived groups achieved 10 years ago.

[6] Bhatnagar P, Wickramasinghe K, Williams J, Rayner M, Townsend N ,The epidemiology of cardiovascular disease in the UK 2014; Heart BMJ, June 2014, http://heart.bmj.com/content/early/2015/05/06/heartjnl-2015-307516.full?sid=b4e64c83-6681-4b9b-a347-e48ee34776ee

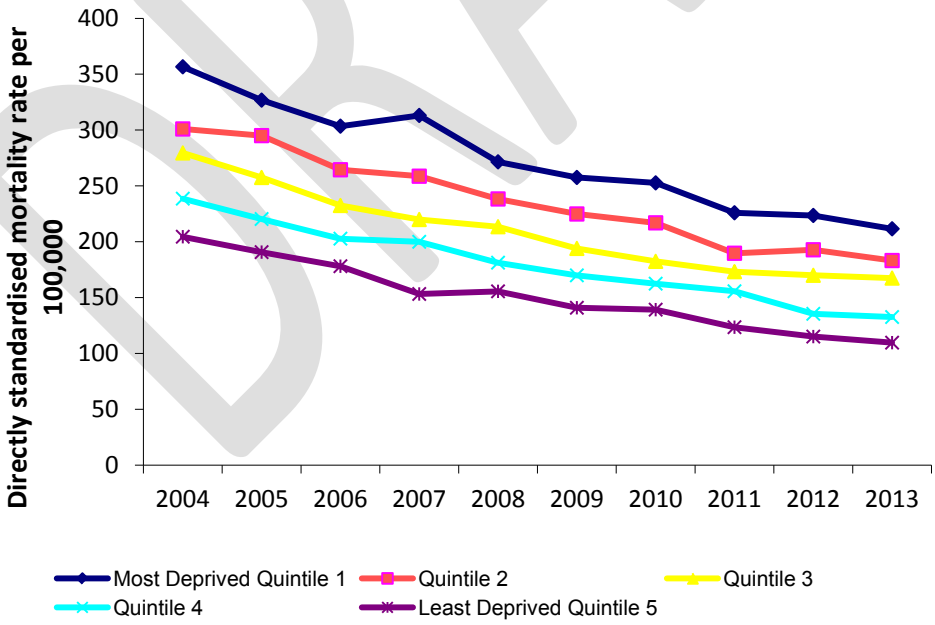
Figure 6: Age-sex standardised mortality rate per 100,000 population[1] for coronary heart disease in under 75 year olds by year of death, Forth Valley residents; 2004-2013



Source: Data extracted from NHS National Services Scotland: Information Services Division

1. The European Standard Population (ESP), which was first used in 1976, was revised in 2013. Figures using ESP1976 and ESP2013 are not comparable

Figure 7: Coronary heart disease[1] deaths by deprivation (SIMD) quintile[2]
2013 European age and sex standardised mortality rates per 100,000 population[3]



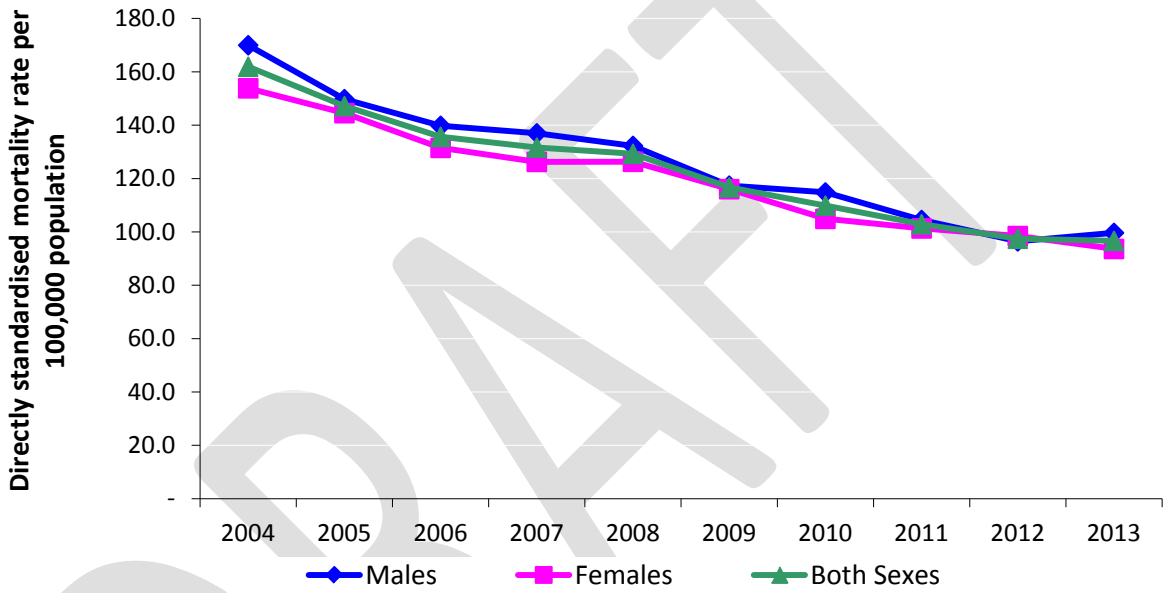
Source: Data extracted from NHS National Services Scotland: Information Services Division

1. Analysis includes ICD-10 codes I20-I25
2. Uses 2012 version of SIMD
3. The European Standard Population (ESP), which was first used in 1976, was revised in 2013. Figures using ESP1976 and ESP2013 are not comparable.

Stroke

The number of deaths from stroke has fallen during the past decade. Deaths for 65-74 year olds in Forth Valley, from 2004 to 2013 are shown in Figure 8. This age cohort is a high risk group for stroke compared to younger age groups and demonstrates mortality rates reducing from 168.5 per 100,000 population in 2004 to 95.1 per 100,000 population in 2013[7].

Figure 8*:* Age-sex standardised mortality rate per 100,000 population[1] for stroke in 64-75 year olds by year of death, Forth Valley residents; 2004-2013



Source: Data extracted from NHS National Services Scotland: Information Services Division

1. The European Standard Population (ESP), which was first used in 1976, was revised in 2013. Figures using ESP1976 and ESP2013 are not comparable

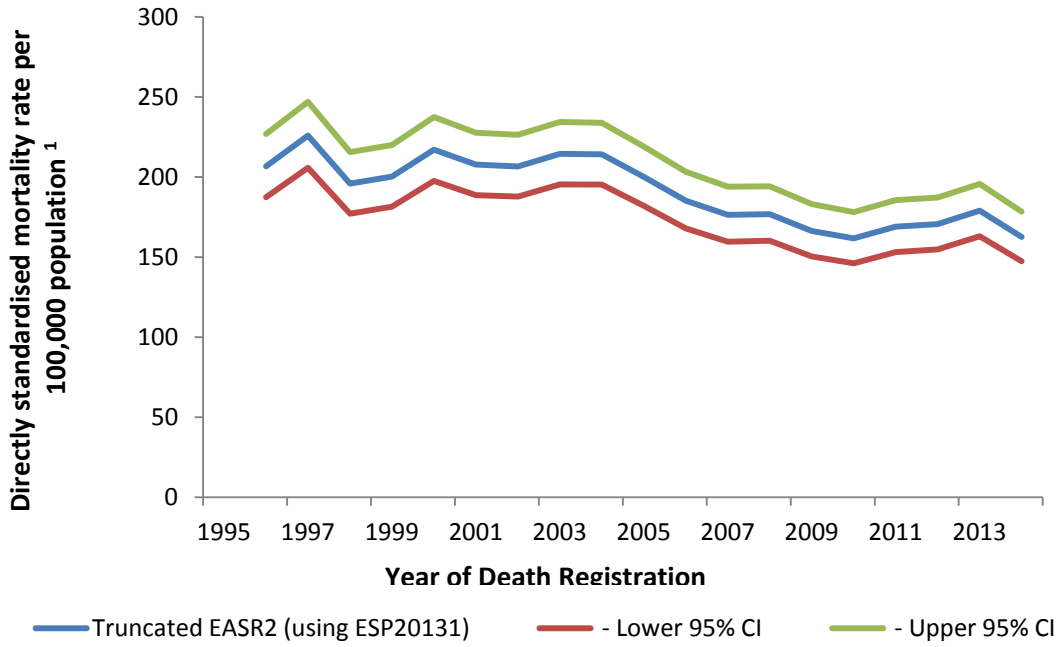
The Scottish Government's 2009 action plan[8] reiterated their earlier target to reduce premature mortality among all those under 75 years from stroke, by 50%. At Scottish level, between 1995 and 2010 there was a 59% reduction in the mortality rate for cerebrovascular disease, with a corresponding 56% reduction in Forth Valley.[9]

[7] ISD Scotland, Stroke, Topic areas, mortality
[8] Scottish Government: Better Heart Disease and Stroke Care Action Plan (2009)
[99] ISD Scotland, Stroke, Background and Policy

Cancer

Within Forth Valley, between 1995 and 2013, the number of deaths from all cancer types has shown a downward trend (Figure 9).

Figure 9: Trends in mortality from all cancer types including non-melanoma skin (ICD-10 C00-C97) Forth Valley; persons under 75, 1995-2013



Source: Data extracted from NHS National Services Scotland: Information Services Division; Cancer Statistics

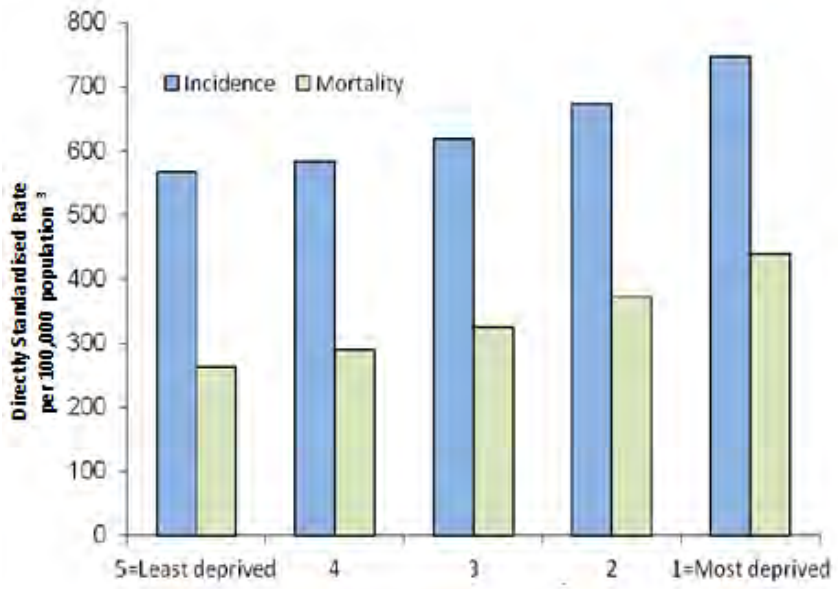
1. The European Standard Population (ESP), which was first used in 1976, was revised in 2013. Figures using ESP1976 and ESP2013 are not comparable.

Although there has been a downward overall downward there continue to be marked differences in the rate of new cases of cancer and deaths from cancer between deprivation groups. In the most deprived areas, rates for all new cancers combined are almost a third higher than those seen in the least deprived areas. Mortality rates are over two-thirds higher in the most deprived areas compared with the least deprived areas.[10] Figure 10 illustrates the correlation of new cancers and deaths from cancer across the deprivation groups.

Certain cancers are more strongly correlated with deprivation. Cancers associated with smoking have the highest incidence (new cases) and mortality rates in deprived areas. Cervical cancer reflects socio-economic differences in exposure to risk factors and lower attendance at cervical screening for women from more deprived areas. Other cancers such as breast cancer and malignant melanoma are associated with a higher incidence in the least deprived areas.

[10] Information Services Division: Cancer Mortality in Scotland (2014)

Figure 10: Cancer[1] Incidence (2009-2013) and Mortality (2010-2014) by deprivation quintile[2] in Scotland. Age-standardised rates[3]



Source: ISD, Cancer Mortality in Scotland (2014);Scottish Cancer Registry, ISD (registrations): National Records of Scotland (deaths)

1 All cancers excluding non-melanoma skin cancers (ICD-10 C00-C97 excl C44).

2 Deprivation quintile based on SIMD 2012.

3.The European Standard Population (ESP), which was first used in 1976, was revised in 2013. Figures using ESP1976 and ESP2013 are not comparable.

Diabetes

The Scottish Diabetes Survey 2012 reported that the number of people with diabetes continues to increase by around 10,000 each year. This increase in new cases against a background of those continuing to live with diabetes presents greater organisational and resource pressures[11].

The 2012 age adjusted prevalence of all types of diabetes across Scotland, using the Scottish population as the reference population structure, ranged from 4.14% to 5.46% with the prevalence in Forth Valley sitting at 5.05%. This represents 14,850 people. The prevalence of diabetes is particularly high among those aged 65 and over, with a crude prevalence in Forth Valley of 15.5%, (Scotland; 15%).

The majority of patients registered with diabetes in Forth Valley had type 2 diabetes (13,091 or 88.2%), a condition mostly affecting the older population. The number of patients with type 1 diabetes continues to rise each year reflecting the rising incidence of type 1 diabetes in children over the last 40 years.

Of those patients with type 1 diabetes and a recorded BMI, 38% were overweight (BMI 25-30kg/m2) while 25.5% were obese (BMI 30kg/m2 or above). Similarly for those with Type 2 diabetes and a registered BMI, 31.6% diabetes were overweight (BMI 25-30kg/m2) and 55.5% obese (BMI 30kg/m2 or above. Almost 1 in 5 people with diabetes were recorded as being a current smoker.

[11] NHS Scotland, Scottish Diabetes Survey 2012;Scottish Diabetes Survey Monitoring Group

Service Improvement and Development

Health and Social Care Integration

The Public Bodies (Joint Working) (Scotland) Act[12] was granted royal assent on 1st April 2014. This presents the framework for integrating health and social care in Scotland through;

- integration of adult health and social care budgets
- nationally agreed outcomes applying across health and social care for which NHS Boards and Local Authorities will be jointly accountable
- a stronger role for clinicians and care professionals along with third and independent sectors in the planning and delivery of services

In Forth Valley work is underway to develop the local vision around local health and social care integration. The current vision[13] is:

to enable people to live full and positive lives within supportive communities.

Work will focus on measures to drive:

- Self Management - individuals, their carers and families are enabled to manage their own health, care and wellbeing
- Community Focused Supports – supports are in place, accessible and enable people, where possible, to live well for longer at home or in homely settings within their community
- Safety - health and social care support systems help to keep people safe and live well for longer
- Autonomy and Decision Making - individuals, their carers and families are involved in and are supported to manage decisions about their care and wellbeing
- Experience –individuals will have a fair and positive experience of health and social care

From April 2016, there will be an Integrated Joint Board (IJB) for each health and social care partnership within Forth Valley; one for Falkirk and one for Stirling and Clackmannanshire. These will oversee the planning, management and delivery of relevant health and social care services.

Clinical Services Review

A Clinical Services Review for NHS Forth Valley has been underway since 2014, to inform the healthcare strategy (2016-2020) in setting out our plans and priorities. In 2011, the Christie Commission[14] noted the need for a change in the design and delivery of public services to tackle the root causes of inequality and move away from the high levels of "failure demand". This term

[12] The Public Bodies (Joint Working) (Scotland) Act
[13] NHS Forth Valley Health and Social Care Integration Scheme
[14] Christie Commission

describes the situation when a high proportion of public spending is spent on dealing with demand that could have been avoided by earlier preventative measures. This work needs to be done by empowering and working more closely with individuals and communities, harnessing their talents and assets, supporting self reliance and community resilience. The report further notes the need to integrate services, prioritise negative outcomes, reduce duplication and share services in order to improve efficiency.

The Clinical Services Review (CSR) aims to reshape services to meet the needs of a rapidly ageing population, manage increasing demand for health services particularly for people with longer term and complex needs and deliver more care at home or in local communities so patients can retain their independence, surrounded by family and friends.

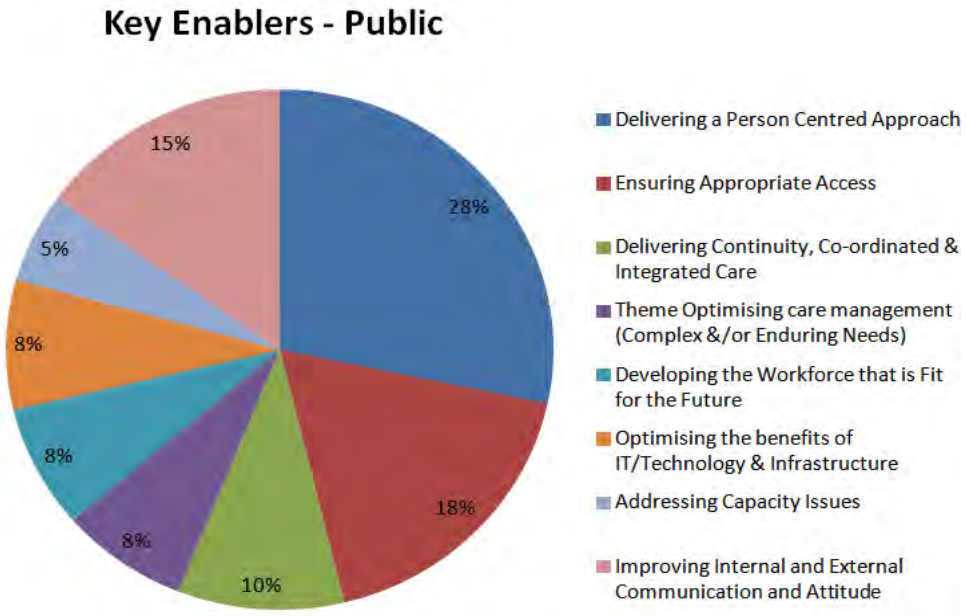
As part of this, the Forth Valley Case for Change[15] details the future trends in the size and age of our local population alongside social factors affecting health and wellbeing, estimating future service activity and forecasting future levels of several common diseases and long term conditions. Demand for healthcare services is exceeding supply in our current model and the analysis in the Case for Change helps inform planning and service delivery to meet future local healthcare needs, keep pace with demand and deliver a safe, effective, person-centred care, to promote population health improvement and to maintain financial balance as detailed in the NHS Scotland 2020 Vision[16].

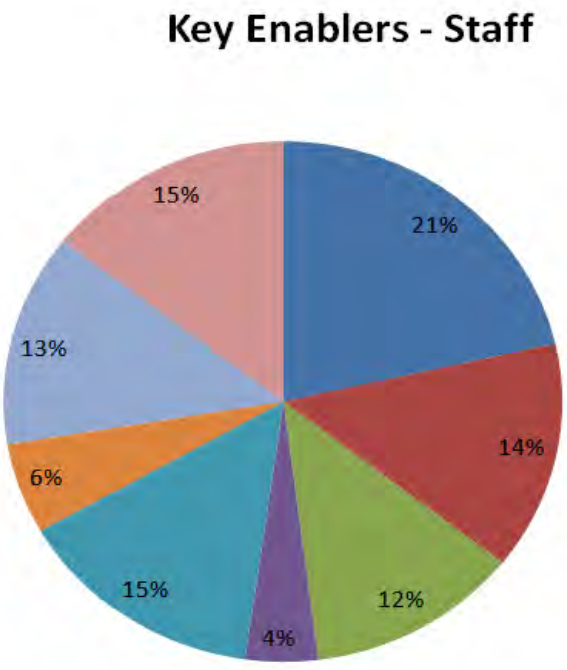
The CSR has eight workstreams, covering the majority of all clinical work, including planned and unscheduled care, topics such as cancer, long term conditions and end of life care, client groups such as women and children and frail older people and clinical support services and infrastructure. Each workstream has a clinical and managerial lead with planning support. There has also been considerable public and staff consultation resulting in over 500 individual public, patient and staff responses, more than 60 meetings with key patient groups, staff postcards and suggestion boxes , focus groups, four public open meetings, 50 work stream meetings and over 2000 specific items of feedback.

The key enablers from both the public and staff were remarkably similar as shown in Figure 11. Delivering a person centred approach and ensuring appropriate access were identified as the main issues. These were followed by the need for continuous, coordinated and integrated care, improved communication and attitude, and the need to address capacity issues.

[15] Forth Valley; Case for Change 2014
[16] Scottish Government: 2020 Vision

Figure 11: Key enablers identified following consultation
(reproduced with permission from Forth Valley Planning team)





The main strategic themes emerging from this consultation focus on person centeredness and integration. Care should be provided in high quality settings as close to home as possible. Staff should be developed for more generic roles working in multidisciplinary community teams based within the locality and formally involving the third sector.

Multidisciplinary teams should facilitate self care and anticipatory care planning and patients will be discharged and assessed in their own surroundings, reducing delayed discharges and improving patient flow through the hospital. End of life care should focus on ensuring that patients end their

days in the most appropriate setting. Services, approaches and workforce need to be more integrated, run across seven days and utilise more IT and technology solutions wherever suitable. Mental health services are important and will receive at least the same priority as those addressing physical health. Prevention needs to be delivered across a range of interventions from the basic aspects of the physical and social environment through to the most highly technical surgical and medical treatments.

A key priority is to ensure services are person centred. This means that individuals should be engaged – with their own health, services and society in general and enabled to help themselves, and make positive changes and improvement that will impact on health and wellbeing.

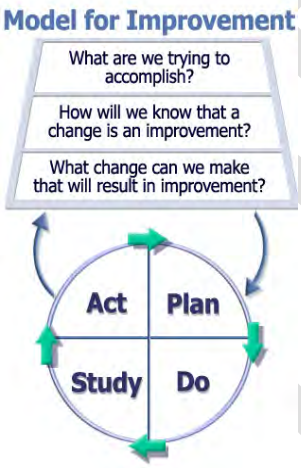
Health Improvement

A wide range of initiatives are delivered under the heading of health improvement. Those targeting children and young people currently have our highest priority. Substance use, prison health and oral and dental health and working with communities are also key areas of local work.

Early Years Collaborative [17]

The Early Years Collaborative (EYC) is an initiative launched by the Scottish Government in October 2012, with the ambition of 'making Scotland the best place in the world to grow up for all babies, children, mothers, fathers and families' (SG 2013). It is the world's first multi-agency quality improvement programme, involving social services, health, education, police and third sector professionals in all 32 Community Planning Partnerships and a wide range of national partners. Its focus is on strengthening and building on services, using an improvement science methodology; - the PDSA cycle – **P**lan, **D**o, **S**tudy **A**ct (Figure 12). This method enables local practitioners to test (through 'tests of change'), measure, implement and scale up new ways of working to improve outcomes for children and families, across four workstreams.

Figure 12: PDSA cycle



Each of the four workstreams have an aim relating to a particular age and stage in the early years. Numerous 'tests of change' have been carried out including; antenatal booking, healthy start vitamins, communications systems and attendance at 27-30 month reviews - resulting in many positive outcomes. Some examples are listed below. NHS Forth Valley is closely involved in the EYC and is currently expanding its tests of change.

Workstream 1: Conception to one year

The aim of this workstream is to ensure that from 2010 to 2015, women experience positive pregnancies, resulting in the birth of more healthy babies as evidenced by a reduction of 15% in the rates of stillbirths and infant mortality.

Forth Valley's maternity services set and achieved the aim of ensuring that, by October 2014, 80% of all newly pregnant mothers had registered with the service by the 10th week of pregnancy for ongoing support and care.

[17] Image taken from http://www.earlyyearscollaborative.co.uk/about-the-collaborative

Workstream 2: One year to 30 months

The aim of this workstream is to ensure that by the end of 2016, 85% of all children have reached the expected developmental milestones at the time of the child's 27-30 month child health review.

Forth Valley's Health Visitors are linking with Child Health to help reduce the number of incomplete review documents requiring follow up.

Workstream 3: 30 months to primary school

The aim of this workstream is to ensure that by end of 2017, 90% of all children have reached the expected developmental milestones at the time the child starts primary school.

Communication impairment is the most common developmental difficulty in early childhood. In Forth Valley, it was identified as the highest area of new concern, at over 10%, at the Health Visitor 27-30 month review. The actual figure is likely to be higher than this as the data only include the families who attended.

In Stirling, LIFT is a universal, asset-based approach offering families living in disadvantaged areas the chance to acquire knowledge and skills to improve the quality of their everyday interactions with their child. This in turn will have positive effects on spoken language development and improved life outcomes.

The project has initially been piloted in year one in three nurseries in three phases and will be extended to a further two nurseries in year two.

Workstream 4: Start of primary to the end of Primary 4

The aim of this workstream is to ensure that by the end of 2012, 90% of all children have reached the expected developmental milestones and learning outcomes by the end of Primary 4.

Forth Valley is supporting the roll-out of the of the 'Daily Mile', an exercise intervention from St Ninian's Primary school to other schools in Forth Valley. "The Daily Mile can do more for the health of children than any other healthcare system" (Maureen Bisognano, CEO, Institute for Healthcare Improvement)

Leadership

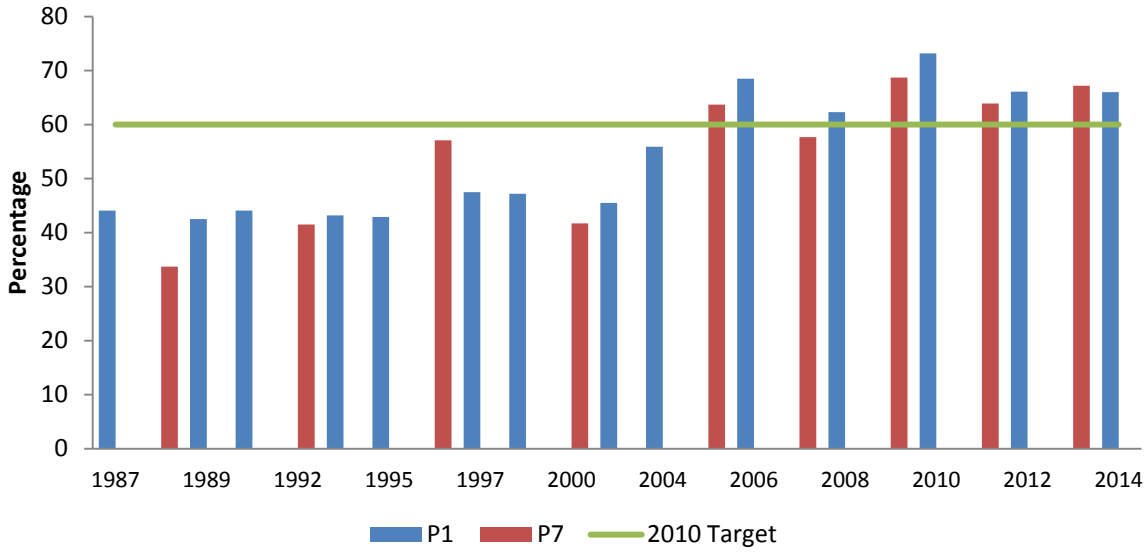
Supporting the four workstreams is a leadership strand that takes a strategic overview of all activity and provides direction. In Forth Valley there are two leadership groups, one covering Falkirk and the other covering both Clackmannanshire and Stirling.

Oral and Dental Health

A key priority in recent years has been to improve the dental health of local children. Scotland has a poor history of dental ill health; childhood dental extractions have for many years been the most common reason for a child requiring a general anaesthetic.

Forth Valley continues to meet its annual target for the proportion of children in Primary 1 (P1) and Primary 7 (P7) with no apparent decay, with 66% of P1 and 67% of P7 free of obvious tooth decay (Figure 13). These improvements in oral health are closely associated with the development of the Childsmile programme (www.child-smile.org) which has been developing and evolving since 2006. The programme integrates four elements providing oral health packs to young children, toothbrushing programmes in all nursery establishments and targeted primary schools. This is supplemented by fluoride varnish applications in nurseries and primary schools in the more disadvantaged areas; currently 28% of nurseries and 25% of primary schools. The improvement in children's dental health has seen falls in the number of fillings and extractions required with a substantial fall in the number of dental general anaesthetics being required from an average of 50 per month in 2009 to 20 per month at the end of 2014.

Figure 13: The proportion of Primary 1 (P1) and Primary 7 (P7) children in Forth Valley free of obvious dental decay 1987-2014



Source: Data from NHS Scotland National Dental Inspection Programme

2014 saw the publication of an updated SIGN guideline[18] on dental interventions to prevent caries in children which was chaired by one of our Dental Public Health Consultants.

[18] Dental Interventions to prevent caries in children: SIGN guideline

In 2015 an Orthodontic Needs Assessment for Scotland[19] was published. This group was chaired by one of our local consultants in Dental Public Health.

The Caring for Smiles[20] programme for those in care homes was rolled out in Forth Valley in 2013 and has promoted additional activity in and around dental care provision within a residential care framework. Public dental service staff are supporting the training and delivery of individual oral care plans for all of Forth Valley care home residents. To date 1,149 carers have received specific training and 73 facilities have participated. Later this year a new SCQF (Scottish Credit & Qualifications Framework) rated qualification will be available and our staff are currently undergoing training to deliver this to care home staff.

In addition a wide range of oral health improvement programmes continue to run in schools, pharmacies, the workplace, in prisons and with other vulnerable groups.

Substance Use

The Forth Valley Alcohol and Drug Partnership (ADP) is chaired by the Director of Public Health who is also the local champion for Recovery Orientated Systems of Care (ROSC).

The Forth Valley ADP commissioned Public Health to produce a Substance Use Healthcare Needs Assessment. This document details the health effects, and impact on healthcare services, of alcohol, drugs and tobacco use by the people of Forth Valley.

Alcohol

Drinking too much alcohol is harmful to health and is estimated to cause around 20 deaths per week in Scotland.[21]

Alcohol-related deaths in Scotland

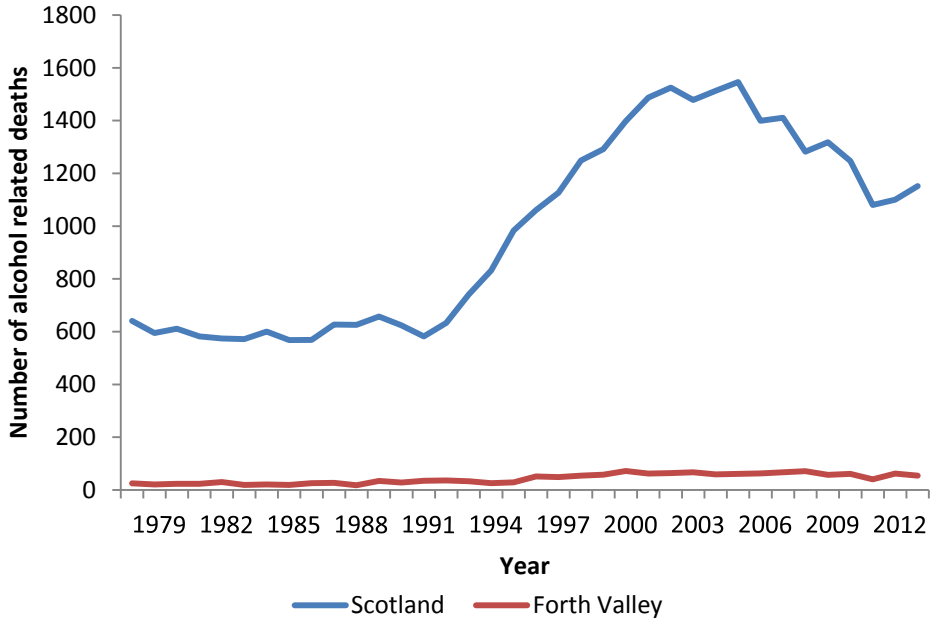
- There were 1,100 alcohol-related deaths in 2013 (where alcohol was the underlying cause of death).
- 741 of those deaths were men, 359 were women.

[19] NHS Scotland, Scottish Dental; An orthodontic needs assessment report
[20] NHS Health Scotland: Caring for smiles- A guide for carers
[21] National Records for Scotland(NRS).

- Over the years since 1979, there have been roughly twice as many male deaths as female deaths.
- 472 deaths were people aged 45-59, 359 deaths in the 60-74 age group, 164 deaths in the 30-44 age group, and smaller numbers for other age groups.
- The 45-59 age group has had the largest number of alcohol-related deaths in almost every year since 1979.
- Although alcohol-related deaths have declined in recent years, rates remain higher than they were in the early 1980s and higher than those in England and Wales.[22]

The decline in alcohol related deaths during the past decade is evident for the whole of Scotland although for individual Boards it is less obvious due to small numbers and wide confidence intervals. See Figure 14.

Figure 14: Number of alcohol related deaths by year 1979-2013: Scotland vs Forth Valley

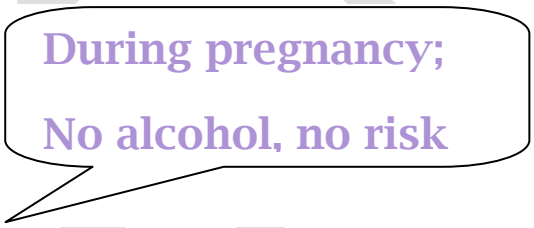


Source: [National Records for Scotland: Alcohol Related Deaths]

Alcohol is classified by the International Agency for Research on Cancer (IARC) as a group 1 carcinogen, meaning it can cause cancer in humans. Tobacco and asbestos are other substances in this group. It is a recognised risk factor in a significant number of different cancers including: the breast, liver, bowel, mouth, throat, larynx (voice box) and oesophagus. It's estimated that alcohol is responsible for around 4% of cancers in the UK, about 12,800 cases a year.[23]

[22] MESAS 4th Annual Report
[23] Parkin, DM, Cancers attributable to consumption of alcohol in the UK in 2010: British Journal of Cancer (2011),195, S14-S18

During pregnancy, current advice is that the safest approach is not to drink alcohol at all. Alcohol can affect the developing fetus with a wide range of differing impacts including lifelong conditions, known under the umbrella term of Fetal Alcohol Spectrum Disorders (FASD). The level and nature of the conditions under the term FASD relate to the amount drunk and the developmental stage of the fetus at the time. Heavy drinking can cause the baby to develop fetal alcohol syndrome (FAS). This is a serious condition where children have restricted growth, facial abnormalities and learning and behavioural disorders, which are long lasting and may be lifelong. Current advice is that the safest approach is not to drink alcohol at all during pregnancy.



A number of steps have been taken nationally to try and reduce the unacceptably high level of alcohol consumption in Scotland, thereby reducing the harm caused by alcohol. This is a complex challenge which requires public agencies to work jointly with the alcohol producers and retailers.

One of the aims is to reduce the amount of alcohol being drunk through making alcohol more expensive. The Alcohol (Minimum Pricing) (Scotland) Act 2012[24] was passed on 24 May 2012. Its implementation has been delayed by the legal challenge led by the Scotch Whisky Association which opposes the Scottish Government's bid to charge a minimum price for alcohol of 50p a unit. This matter was referred to the European Court of Justice.

On December 5, 2014, the Road Traffic Act 1988 (Prescribed Limit) (Scotland) Regulations 2014[25] introduced lower limits for blood alcohol when driving, from 80mg to 50 mg in every 100 ml of blood, bringing Scotland into line with most other European countries. This is anticipated to reduce the number of fatalities and injuries sustained in traffic accidents.

At a local level a representative of the Health Board, usually Public Health is a statutory member of the local Licensing Forum which is run by Local Councils. We contribute to guidance produced by the forums as well as having the opportunity to object to individual license applications submitted to the local Licensing Boards. Despite the best of intentions it can be difficult to influence local licensing decisions due to commercial interests.

[24] The Alcohol (Minimum Pricing) (Scotland) Act 2012
[25] The Road Traffic Act 1988 (Prescribed Limit) (Scotland) Regulations 2014

Smoking

Perhaps the most successful public health measure in recent times has been the adoption of legislation to ban smoking in public places which has seen a significant change in public attitudes and behaviours. Further legislation introduced in April 2013 is the Tobacco Display Regulations (Scotland)[26], which requires large shops to cover up tobacco products (cigarettes, cigars and rolling tobacco) to reduce children and young people's exposure to tobacco products; this was extended to include small shops from April 2015.

In line with the Scottish Government Strategy; hospital grounds are to be smoke-free from March 2015. This has proved difficult to implement and we await further legislation to make this enforceable.

The Scottish Government issued guidance to NHS Scotland and the Local Authorities in 2005 encouraging them to demonstrate leadership in implementing smoking policies and promoting smoke-free lifestyles. This was subsequently re-enforced in the Health Promoting Health Service HPHS, CEL (1) 2012.[27]

In 2013 the Scottish Government published a new tobacco strategy 'Creating a tobacco-free generation: A tobacco control strategy for Scotland 2013'[28], This sets out action requiring all NHS Boards to implement and enforce smoke-free hospital grounds by 31 March 2015. In response to this NHS Forth Valley appointed a Tobacco Control Officer to help reduce smoking at hospital entrances and grounds, by staff, patients and visitors. The post covers Forth Valley Royal Hospital, Clackmannanshire Community Healthcare Centre, Falkirk Community Hospital, and Stirling Community Hospital. Achieving smoke free NHS grounds has proved difficult to implement although we continue to ask the local smokers to respect our smoke-free policy we await further legislation to make this enforceable.

The mental health unit at FVRH is currently working towards the unit being smoke free within the same time frame in partnership with staff and patients.

A report on NHS smoking cessation service statistics contains data for the calendar year 2012. NHS Forth Valley continues to meet HEAT targets in terms of numbers of people stopping smoking within four weeks of setting a quit date with 61% of those quitting (self reported) coming from the 40% most deprived communities. 19% of pregnant smokers are attempting to quit using NHS cessation services. These figures support research which has found that smoking cessation services are effective in reaching deprived communities.

[26] Tobacco Display Regulations (Scotland) 2013
[27] Health Promoting Health Service CEL(2012) 01
[28] Creating a Tobacco-Free Generation, A Tobacco Control Strategy for Scotland

A new HEAT target was set for NHSScotland to deliver universal smoking cessation services to achieve at least 12,000 successful quits, at 12 weeks post quit, in the 40% most deprived within-board SIMD areas (60% for island health boards) over 1 year ending March 2015. For NHS Forth Valley this challenging target proved unachievable but local services are now on track to deliver the further revised 2015-16 target.

More information on HEAT targets can be found on the Scottish Government website.

Prison health

The NHS has had responsibility for prison healthcare since 2011, requiring prisoners to have access to the same quality and range of healthcare services as members of the public. With three prisons, (HMP Cornton Vale, HMP Glenochil and HMYOI Polmont), within its geographical boundary, NHS Forth Valley has responsibility for the healthcare needs of 26% of the total Scottish prison population.

Independent Advocacy services are now available in all three prisons within NHS Forth Valley following a Public Health Review of the Need for Independent Advocacy within Forth Valley Prisons[29] commissioned by the Forth Valley Prison Healthcare Liaison Group. The needs assessment highlighted the extent of mental health need and requirement for Independent Advocacy under the Mental Health (Care and Treatment) (Scotland) Act 2003[30]. The National Prisoner Healthcare Network- Mental Health Report [31] further emphasised the importance of Independent Advocacy for those in and leaving prison. This is a joint responsibility between the local Health Board and Local Authority.

The Public Health Officer, in NHS Forth Valley, has worked with the Criminal Justice Authority at a national level on a scoping exercise covering all Independent Advocacy providers for all prisons in Scotland. This led to the development of a model of implementation for all NHS Boards who have prisons within their boundaries. The final report will be published in November 2015.

As part of an overall programme to reduce health inequalities and re-offending, NHS Forth Valley has been working in partnership with the Scottish Prison Service and the Community Justice Authorities in Forth Valley to improve offender health. In our three prisons this is being taken forward through the implementation of the Better Health Better Lives for Prisoners Health Improvement Framework. The work is being undertaken through a whole prison approach which advocates that when improving health and wellbeing in prison everyone has a role, not solely those with the responsibility for providing healthcare. It recognises that the risk factors for poor health are interrelated and best tackled

[29] A Review of the Need for Independent Advocacy within Forth Valley Prisons
[30] Mental Health (Care and Treatment) (Scotland) Act 2003, section 259 (4)
[31] National Prisoner Healthcare Network- Mental Health Report

through comprehensive, integrated programmes in the context and places where people live their lives.

Offending and poor health and wellbeing are closely linked with social and economic problems. Poor oral health is more common in the most disadvantaged individuals, a greater proportion of who enter our criminal justice system. NHS Forth Valley has worked to improve oral health through measures such as increasing dental hygiene measures, encouraging dental registration on release and increasing access to fresh fruit and vegetables. Successful programmes have been established to provide offenders with the skills and knowledge to cook healthy nutritious meals and this is further supported in the community by Criminal Justice Social Work.

One of our Dental Public Health Consultants has published work on improving dental health in prisoners[32].

For 2015-16 a local team has begun pioneering research to establish the prevalence of tuberculosis (TB) in the Scottish prison population. The local BBV and sexual health MCN (Managed Care Network) is working hard to identify and treat Hepatitis C in prisoners.

[32] Scottish Oral Health Improvement Prison Programme (SOHIPP)

The Value of Community

Working with communities through focussing on their existing strengths and capabilities, encouraging people to take control of their own health; and promoting self esteem and coping skills can help buffer and protect against life's stresses and prevent ill health[33].

Asset based approach

A health 'asset' has been defined as "any factor or resource which enhances the ability of communities and populations to maintain and sustain health and wellbeing and to help reduce health inequalities"[34] . This can include skills, knowledge and connections as well as the physical and economic resources of local places, businesses and organisations. In summary, an 'asset based' approach can be thought of as redressing the balance from needs towards strengths.

Within Forth Valley asset based community development first started in Hawkhill, Alloa. The success of this work has been presented at a national meeting to the Scottish Government and other Health Boards. Other asset based work is ongoing in several communities within Forth Valley.

Hawkhill

Since the introduction of the asset based approach in Hawkhill, there have been many new initiatives including the; "Man Up "group set up by men in the area to support each other, a community garden, a school walking bus, homework clubs, fitness classes, groups for mothers and a ' nifty fifties' club. Further benefits have been gained through work with other agencies, e.g. Job Centre Plus have provided laptops to the job club in response to demand. A local Christmas card initiative for older people provided an opportunity to include information from the Fire Service encouraging uptake of safety checks. As a consequence of the asset based work in Hawkhill Community Centre, participation has risen three to four fold.

Close working with local authority colleagues has resulted in significant housing improvements included replaced boilers/radiators, increased loft insulation and provision of cavity wall insulation.

Initially the local population have prioritised issues such as safety and fear of crime. Calls concerning anti-social behaviour to the police in the area appear to have dramatically reduced and local residents report feeling a considerable improvement in community spirit and reduced fear of crime. For example, there were six calls to police regarding anti-social behaviour in the first three months of 2013 compared to 46 calls in one month alone during the previous year.

Fallin

A similar asset based community project is also underway in Fallin, a former mining village to the East of Stirling. Health improvement staff are working to engage with the local population and address health issues where possible.

[33] Annual Report of the Chief Medical Officer 2009

[34] Morgan A, Ziglio E. Revitalising the evidence base for public health: an assets model. Promotion and Education 2007;14:17.

Camelon

'Our Place' is a place-based initiative funded by the Big Lottery which currently has a five year project in Camelon. The project aims to empower local people and organisations to bring about a lasting positive difference to their neighbourhood using an asset-based community development approach.

Public health is working with health providers, other local agencies and the local community to support this project. The aim is to make a long-lasting difference to those with most need in order to try and reduce inequalities. An event was held for health and other agencies and members of the community to explore local strengths and weaknesses and develop ideas to take forward.
Local people in Camelon and those working in the area are taking part in a community survey to determine their local priorities. Subsequent to this, local groups and organisations in Camelon have been able to apply for funding for projects that are in keeping with achieving the 'vision' developed from this community survey.

Keep well

Keep well Forth Valley is a key part of the general health improvement/ health inequalities programme in Forth Valley and delivers NHS and partner agency aims on: reducing inequality (whether related to deprivation, gender, ethnicity or other,) implementing an assets-based approach, providing person-centred care, integrating health and social care and improving employability. The programme is focussed on a co-production approach through whole-person enablement and empowerment.

Keep well delivers more than 3,000 health assessments per year (equivalent to 2.3% of the local population aged 40-65), mainly to people living within areas of relative deprivation.

Individuals are invited to accept a health assessment with the experienced specialist team and subsequent consultations take a holistic, comprehensive and structured approach. These may identify a wide range of health and wellbeing associated issues with a focus on employability and men's health, identifying opportunities for improvement.

Key themes continue to be - ethos and approach, complexity (recognising and accommodating it), empathy and compassion, innovation and application of a new, unique approach, the importance of giving time; and underpinning it all, an approach based on values and principles.

Outcome reviews are now a standard feature of the Keep well process. These reviews have shown that significant behaviour change can be achieved following the Keep well assessment.

Examples of health improvement work

Healthy weight

As the population both and enjoys improved life circumstances, health challenges such as obesity are becoming increasingly prevalent. In some areas of Forth Valley more than half of adults are clinically overweight or obese. Although NHS Forth Valley does provide a range of clinical supports and interventions for obesity our main priority is to try and focus on the importance of prevention and lifestyle change to reduce obesity at a population level. Adults are encouraged to make use of established and proven weight loss programmes and techniques and supported by our healthy weight website: "Choose to Lose"

We support a wide range of measures to focus public attention on healthy eating and exercise.

In Forth Valley the Child Healthy Weight (HEAT 3) Target has been delivered primarily through the Max in the Middle and Max in the Class programmes designed by the INTERACT team, Health Promotion Services. This work complements ongoing work to support the Curriculum for Excellence Health and Wellbeing experiences and outcomes.

The Max programmes are innovative schools based child health interventions using interactive health promotion to deliver potentially lifelong health benefits to local children in Forth Valley. The programmes aim to empower and educate primary school children in relation to healthy eating, physical activity and life choice using a non- judgmental whole class approach which is memorable, exciting and non- stigmatising.

Between October 2013 and March 2015 the Max programmes were delivered to over 80 primary school classes (approx 2,000 young people) in the Forth Valley area with priority given to schools with a high proportion of free school meals.

The Max in the Middle intervention is a one week 'whole class' programme for primary 6 or 7 which delivers 18 hours of experiential learning on health and well being, promoting enthusiasm and parental engagement whilst limiting stigmatisation. Dance and drama specialists work in small teams with the class teacher.

Parents made the following comments after their children took part in the Max in the Middle Programme in November 2014 and are indicative of the 'ripple effect' from the classroom experience to the home.

"My daughter's attitude and emotions were different, she appeared to be both inspired and motivated by the programme."

"Started having breakfast before school."

"Wanted to cook and make at home what they had learnt on 'Tasty Tuesdays."

"It was easier to get him to go outside and play instead of constantly being in the house."

The Max in the Class intervention is focused on staff development for primary 5 and 6 teachers who are then supported in delivering a six session intervention that is incorporated into the ongoing curriculum.

Health Protection

The work of the Health Protection Team is an important function, providing a 24 hours a day, seven days a week service to protect the local population by ensuring the safety and quality of the general environment including food, water and air, preventing the transmission of communicable disease and managing outbreaks and other incidents which threaten public health.

Statistics and data on the detection and prevention of communicable diseases are available on the Health Protection Scotland website.

Protecting the population from Tuberculosis

Amidst concern that tuberculosis (TB) is increasing and that the epidemiology of the disease has changed, the Scottish Government published the TB Action Plan for Scotland 2011 which made several recommendations to improve surveillance, diagnosis and prevention of the disease.

Since 2005 BCG Immunisation programme has been provided to people who are at risk of TB, living in Forth Valley. The key part is a neonatal programme aimed at protecting those children most at risk of exposure to TB. Although identification of these children can be challenging, all children at risk should be given a BCG and local processes are in place to assist with identifying them.

A Public Health led clinic was set up in April 2013 in Forth Valley Royal Hospital for administration of Mantoux testing and BCG and for assessing contacts of TB cases.

To assist with diagnosis of latent TB and screening of vulnerable groups, a new blood test, Interferon-Gamma Release Assay (IGRA), was introduced for relevant patient groups. This has the benefit of a single patient visit and faster results compared with skin testing.

In terms of diagnostic testing, use of liquid cultures of sputum began in Forth Valley in November 2013. This can reduce the delays in obtaining results and drug sensitivities from weeks to days.

The Health Protection (TB) Nurse and Respiratory (TB) Nurses provide the key worker roles for patients with TB, providing both support with diagnosis and assessment for the provision of the Directly Observed Treatment Service (DOTS). Direct observation of patients taking their prescribed medication in relation to TB ensures compliance to complete the full course of treatment. This helps to prevent the spread of the TB to others and decreases the chances of treatment failure or relapse.

A study is underway to investigate the prevalence of TB in Scottish Prisons. There has been an increase in TB in English prisons with associated policy to mitigate this. The current study will help inform Scottish Government policy for future action.

Screening of high risk 'New Entrants' to Forth Valley for TB is being developed.

Using a preventative approach, faster testing and improved compliance with treatment is likely to reduce the potential for spread within the community.

Immunisations

Childhood Immunisation Programme

NHS Forth Valley meets and regularly exceeds the recommended target of 95% uptake for Primary Immunisations.

The following significant changes to the Scottish Immunisation programme have been successfully implemented since 2013:

- the introduction of Rotavirus into the childhood immunisation programme for infants aged two and three months
- the removal of the second dose of Meningococcal C given at four months and the addition of a dose at the S3 booster appointment
- the introduction of a shingles vaccine for people aged 70 years (routine cohort) with a phased catch up programme over a number of years to protect against herpes zoster
- the phased introduction of an extension to the seasonal flu programme using the intranasal flu vaccine and targeting children from 2 years to primary school age. This programme may be extended to secondary school aged children in the coming years.

The extension of the seasonal flu programme for primary school aged children was initially introduced in a pilot programme (2013-14) and delivered by weekend flu sessions. This pilot focused on a limited number (25%) of Forth Valley primary school aged children, with good uptake of around 62%. Besides the direct benefit of protection afforded by the vaccine, the weekend approach also yielded indirect benefits which included wider engagement of the family and minimal disruption to the child's education and the school nursing service. Unfortunately when rolled out to the full programme in 2014-15, this model of weekend delivery emphasised the dependence on parents to bring the child for vaccination and uptake remained static at around 63%.

Based on experience nationally, and the success of other Health Boards, NHS Forth Valley has adopted the weekday model of delivery for the 2015-16 programme. Furthermore the success of Immunisation Teams in delivering this programme in other Health Boards has also been recognised. A business case for an Immunisation Team was presented to the Health Board and support was given to establish an Immunisation Team within the Public Health directorate.

As well as delivering core immunisation programmes the team represents a significant enhancement to our ability to mobilise nursing resources to health protection incidents and challenges.

From 2015-16, the Immunisation team will deliver the seasonal flu programme in Primary Schools, and also provide support, resilience and flexibility to all current and developing vaccination programmes and the implementation of future national immunisation programmes.

Immunisation uptake statistics for all Boards and CHPs can be found on the ISD website[35].

Seasonal Influenza Vaccination Programme (adult)

NHS Forth Valley has had the highest uptake for the over 65 year olds for the last seven years, and is regularly in the top three Health Boards for the under 65 cohort groups. 2014-15 figures show:

- FV Current uptake >65yrs 79.2% (Scottish average 76.3%)
- FV Current uptake <65yrs 56.5% (Scottish average 54%)
- FV Staff uptake 39.6% (Scottish Average 34.7%)

Human Papilloma Virus Vaccine

The Human Papilloma Virus (HPV) vaccination programme in Scotland started in 2008. The programme helps protect girls against cervical cancer later in life by routinely immunising them in early secondary school, at around 11-13 years of age through a school based vaccination programme. The vaccine protects against the two high risk HPV; types HPV-16 and HPV-18, known to cause over 70% of cases of cervical cancer. In 2014-15 over 94% of S2 girls in Forth Valley received the first dose of the HPV vaccine; this was the highest uptake amongst the Health Boards in Scotland, with the Scottish average at 91.4%. The HPV vaccine does not protect against all cervical cancers, so regular cervical screening is still important.

In September 2014, the schedule changed from three to two doses following revised guidance from the Joint Committee of Vaccination and Immunisation (JCVI).

New Immunisation programmes

Meningitis B Vaccine

The immunisation programme against Meningitis B (Men B) was included as part of the routine childhood vaccination programme, from 1st September 2015, with an appropriate catch up programme for babies at the start of the implementation period. A total of three doses are given at two, four and 12 months of age.

Meningitis ACWY Vaccine

In February 2015 the JCVI recommended the introduction of a meningococcal ACWY vaccination programme for young people to protect against Meningitis W (Men W), following an annual increase in cases since 2009. In Scotland there were 5 cases in 2014 compared to 6 cases in the first half of 2015 of which there was one death. The immunisation programme commenced in summer 2015.
The programme had 2 components:

- The Primary Care based S5 and S6 School leavers and Freshers' Programme which commenced in August 2015
- The school based catch up programme for 14-18 year olds which began in December 2015

In addition, the Men ACWY vaccine will be added to the routine adolescent schools programme from spring 2016 as a direct replacement for the Men C vaccine.

[35] ISD: Child Health Publication

Emergency Planning and Civil Contingencies

Since the last annual report there have been structural changes impacting on national planning for emergencies.

The formation of a single national police service (Police Scotland) and a single Scottish Fire and Rescue Service provides an opportunity to consider the most effective multi-agency emergency planning and response coordination arrangements. The eight existing Strategic Coordination Groups (SCGs), based on the former policing areas structure moved to three Regional Resilience Partnerships (RRPs) in November 2013. At a strategic level, NHS Forth Valley became part of the East of Scotland Resilience Partnership incorporating the former Fife, Lothian & Borders and Central Scotland SCGs. The local working arrangements at tactical level are referred to as Local Resilience Partnerships (LRP) and include Central LRP, Fife LRP and Lothian & Borders LRP.

Emergency planning has been involved in a number of exercises with partner agencies, testing the NHS response to potential major incidents both internally and externally with partner organisations.

There has been considerable Public Health involvement in civil contingency planning. Partnership working is essential to safely deliver large public events, each of which results in a large influx of visitors and consequently a temporary increase in local population. Stirling hosted the 6th Annual Armed Forces Day National event and the Bannockburn 700 year anniversary on the same weekend in June 2014. Glasgow hosted the Commonwealth Games from 23 July to 3 August 2014 leaving a legacy which we hope will lead to improved lifestyles with a positive impact on health and wellbeing. Thereafter in September the Ryder Cup was held at nearby Gleneagles with transport links from Stirling.

Recent global concerns, relating to the increase in terrorist driven incidents has resulted in a UK Government response (Prevent) to encourage public sector staff to be aware of their role in the culture of vigilance around terrorism and in particular to prevent vulnerable individuals from radicalisation, especially on-line.

Prevent Strategy

UK Government's overarching counter terrorism strategy is CONTEST[36], with Prevent being one of four underlying strands. Prevent aims to stop people becoming radicalised or supporting terrorism. The health service is a key partner and plays a significant role in the delivery of Prevent as healthcare staff can recognise and support individuals, both patients and staff, who may be vulnerable and susceptible to radicalisation by extremists or terrorists. The NHS Forth Valley Prevent Implementation Policy describes the escalation process for raising Prevent-related concerns and provides practical guidance, to help reduce the risk of an individual becoming drawn into terrorism. An awareness-raising programme will be put into place to promote the understanding of radicalisation issues, confidence in dealing with Prevent-related concerns, and a culture of vigilance. This programme was rolled out from autumn 2015.

[36] Playing our Part- Prevent Guidance for Health Boards- Jan 2015

Blood borne viruses (BBV) and Sexual Health

In 2011 the Scottish Government published The Sexual Health and BBV framework 2011-15[37] setting out the Scottish Government's agenda in relation to sexual health, HIV, hepatitis C and hepatitis B. The existing structures have been combined into the Forth Valley Sexual Health and BBV Managed Care Network (MCN) which will deliver the main outcomes.

Forth Valley has experienced significant developments in recent years for sexual health services. The Forth Valley Sexual Health Action Plan describes recent changes, successes and improvements with BBV and sexual health teams working closely. This work benefits from being part of the West of Scotland Sexual Health Managed Clinical Network (MCN), established in 2010.

The Forth Valley Sexual Health Action Plan sets out to:

- Improve the sexual health and well-being of Forth Valley population, ensuring that inequalities in sexual health are addressed

The Action Plan identified the following key areas for development over the period of 2011-2013 in Forth Valley:

- men who have sex with men
- unwanted pregnancies
- condoms
- HIV
- increase knowledge of HIV and STIs amongst vulnerable populations
- partnership working

The key areas for development have all been incorporated into the work programme.

Public Health has recently completed a Sexual Health and Blood Borne Virus (BBV) Needs Assessment[38] which will help inform strategic planning, commissioning and development of high quality sexual health services within NHS Forth Valley.

[37] The Sexual Health and BBV framework 2011-15
[38] Forth Valley Sexual Health and Blood Borne Virus (BBV) Needs Assessment

Screening

Adult screening-

Cancer screening: see Table 2

Cervical screening

NHS Forth Valley has developed a best practice guidance paper: "Optingout women from the Scottish Cervical Screening Programme" recognising the need for a consistent and transparent approach to women who opt out of the Scottish Cervical Programme to ensure women are fully informed and all those eligible are maintained on registers. This approach has been adopted by the National Cervical Screening Programme.

Abdominal Aortic Aneurysm screening

The abdominal aortic aneurysm screening programme (AAA) was rolled out across Scotland, with implementation starting in Forth Valley in October 2013. This involves an ultrasound scan of the abdomen for all men when they reach the age of 65 years. NHS Forth Valley manages local scanning and management of results across three sites: FVRH, Stirling Community Hospital and Clackmannanshire Community Healthcare Centre. Uptake has been good – 87% (93% in least deprived quintile), with at least 1,500 scans anticipated per year. Across Scotland there have been fewer referrals requiring surgery than initially expected. The reasons for this are being explored at a national level.

Further information available at: NHS Inform; AAA screening

Diabetic Retinopathy screening

The Scottish Diabetic Retinopathy Screening Collaborative delivers a targeted screening programme for diabetic retinopathy screening. Retinopathy is a condition that is particularly prevalent in people with diabetes and can cause serious damage to the eyes and may result in blindness. If detected early and treated appropriately, damage can be minimised. Screening is offered annually to all patients over 12 years who have diabetes.

Pregnancy and Newborn screening

The public health service continues to support pregnancy and newborn screening programmes. Several different screening tests are undertaken throughout pregnancy and the newborn period. These include blood tests for a variety of inherited blood disorders and high risk infections such as Hepatitis B, ultrasound scans performed at different stages of pregnancy to screen for foetal anomalies, routine examination of the newborn, the newborn bloodspot test and newborn hearing screening.

Scottish Cancer Screening Programmes	Eligibility	Test	Uptake in Forth Valley % (Scottish uptake %)	Programme Developments	Impact
Breast 	Women aged 50-70 Women over 70 can self refer	Mammogram approximately every 3 years	2011-2014; 72.1 (72.9) Over 3 yr rolling period	Recent formal review of breast screening service to ensure it remained effective and sustainable Ongoing transformation from analogue equipment to digital mammography	In 2013-14, over 1,450 cases of screen detected breast cancer were diagnosed in women of all ages. [39] For every 400 women screened regularly for 10 years, one less women will die from breast cancer. This means around 130 women are prevented from dying from breast cancer each year in Scotland. Breast screening is an area that has been recently considered by a group of experts and they estimate that for every 1 woman who has her life saved from breast cancer through breast screening, 3 women will be diagnosed with breast cancer that might never have become life threatening. [40]
Cervical 	Women aged 20-60	Cervical smear every 3 years	2013-2014 72.7 (70.7) Eligible group with smear in previous 3.5 years [41]	From April 2016: • age range will change to 25-64yrs • frequency of cervical screening will continue to be every 3 years from age 25 to age 50, but will change to be every 5 years for women from age 50 to 64 plus 364 days of age. • Women on non-routine screening (where screening results have shown changes that require further investigation/follow up) will be invited up to age 70 years plus 364 days of age (a change from current arrangements up to age 68). [42]	Around 5,000 lives saved in the UK every year 8 out of 10 cervical cancers prevented from developing. [43]
Bowel 	All men and women aged 50–74	Home testing kit for stool every 2 years	2014 Males; 53.8(53.3) Females; 58.6(58.8) Overall;56.3(56.1) [44]	Bowel scope screening being offered to some men and women during pilot phase	Home testing prevents 150 deaths from bowel cancer every year. [45]

Table 2: Adult Cancer Screening programmes

[39] ISD Scotland, Scottish Breast Screening Programme
[40] NHS Health Scotland: Breast Cancer, Helping you decide
[41] ISD Scotland, Cervical screening
[42] National Services Division, NSD Cervical Screening
[43] NHS Health Scotland Cervical Screening Leaflet. Put it on your list
[44] ISD, Scottish Bowel Screening Programme
[45] NHS Health Scotland ;Bowel Screening; The bowel screening test, your questions answered.

Summary

This report provides access to useful information on the health and wellbeing of the local population in Forth Valley as well as presenting an overview of the work within Public Health. Our key priorities are supporting children in the early years, promoting access to 'worthwhile work' and delivering substance misuse services with a recovery orientated focus. We also acknowledge the need to ensure our services address the needs of an ageing population.

I hope that as well as providing a source of Forth Valley specific publications this report will be used as a gateway to Public Health issues and resources, particularly those found on-line.

Acknowledgments

The support and assistance of the following people and organisations are gratefully acknowledged:

Thanks to Dr Rosemary Millar and Dr Aileen Holliday for editing this report.

Those who contributed include: Dr Henry Prempeh, Dr Oliver Harding, Dr Jennifer Champion, Dr Sarah Couper, Mrs Hazel Meechan, Mr Tom Houston, Mrs Alison Morrison, Mr Colin Sumpter, Mr Derek Richards, Ms Jennifer Rodger, Ms Louise Hammell, Dr Jane Bray, Mrs Carol Crawford, Miss Ann McGregor and Mrs Kirsten Pettigrew.

Thanks for helpful comments from our communications department, particularly Mrs Elsbeth Campbell and Miss Lindsay Hathaway.

Any feedback and ideas for future reports will be appreciated:

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Forth Valley NHS Board

26 January 2016

This report relates to
Item 6.1on the agenda

Report of the Director of Public Health 2013 - 2015

(Presented by Dr Graham Foster,
Director of Public Health & Strategic Planning)

For Approval

SUMMARY

1. TITLE

Report of the Director of Public Health 2013-2015

2. PURPOSE OF REPORT

The purpose of this paper is to present this report on the health of the population of Forth Valley for the period October 2013 to September 2015.

3. KEY ISSUES

The report describes the demographics and background health of our local population and highlights a number of key areas of public health work ongoing in NHS Forth Valley, described under three main themes;

- Service improvement and development – planning, delivering and evaluating the range of interventions provided by NHS Forth Valley and partners in order to better meet the needs of the population.
- Health improvement – helping people to maximise their wellbeing by making healthy choices, and developing knowledge and skills.
- Health protection – delivering interventions that reduce the risk of communicable disease and environmental hazards.

Each section selects a number of key elements from the above three themes providing an overview of the range of work undertaken, however this report does not attempt to provide comprehensive comment on all areas of work. Since 2009 we no longer publish a printed report but instead make this available via the NHS Forth Valley website. The report provides only a summary and overview of the vast scope of resources now readily available via the internet. Where possible the electronic version provides weblinks to relevant and useful resources.

The vision for Public Health in Forth Valley focuses on the three main areas of;

- children and the early years
- 'worthwhile work'
- substance misuse

Concentrating on these three pillars will help to improve the health and wellbeing of our local population and break the vicious cycle of challenging circumstances in the early years leading to difficulties in securing employment and the potential for increasing substance misuse.

Work in collaboration with partners in these three areas will influence a much broader spectrum of health outcomes over and above those within each pillar.

In keeping with the Scottish Government 2020 vision, NHS Forth Valley has been working, as part of our Clinical Services Review, to provide more efficient services that will help people to live longer healthier lives closer to home. This will be achieved through; integration of health and social care, a greater focus on prevention, anticipatory care plans

and self management and a shift towards treatment in a community setting with day case treatment available when required. Care will be provided to the highest standard of quality whatever the setting. All decisions will be made with the person at the centre and the focus will be on ensuring that people are able to return to their home or community environment as soon as appropriate whilst minimising the risk of re-admission.

Addressing health inequalities underpins our work. Substantial areas of Forth Valley are deprived and have high levels of behaviours and diseases associated with deprivation, for example, substance use, obesity, heart disease and cancer. For those who live in less deprived areas, health challenges include a lack of physical activity, poor diet and the environmental impacts of our 21st century lifestyle. Local public health work will continue to focus on the 'upstream' underlying causes of inequalities in health.

4. FINANCIAL IMPLICATIONS

Design and printing costs have been saved by having an on-line version only. This also facilitates dissemination and the regular updating of background information.

5. WORKFORCE IMPLICATIONS

No workforce implications.

5. RISK ASSESSMENT AND IMPLICATIONS

Risk assessment not applicable.

6. RELEVANCE TO STRATEGIC PRIORITIES

Requirement for Director of Public Health to produce an annual report.

7. RELEVANCE TO DIVERSITY AND / OR EQUALITY ISSUES

Applicable to everyone within NHS Forth Valley

8. CONSULTATION PROCESS

Staff within Public Health as listed in the acknowledgements

9. RECOMMENDATION(S) FOR DECISION

The Forth Valley NHS Board is asked to: -

- Approve the Report of the Director of Public Health 2013-15 for publication on the NHS Forth Valley website.

10. AUTHOR OF PAPER/REPORT:

Name:	***Designation:***
Dr Rosemary Millar **and** **Dr Aileen Holliday**	**Specialist Trainee Registrar** **Health Effectiveness Coordinator**

Approved by:

Name:	***Designation:***
Dr Graham Foster	**Director of Public Health**

FORTH VALLEY NHS BOARD

26 January 2016

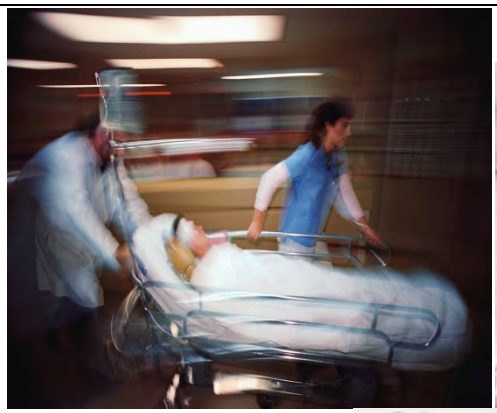
This report relates to
Item 7.1 on the agenda

EXECUTIVE PERFORMANCE REPORT

(Paper presented by Mrs Jane Grant, Chief Executive)

For Noting

NHS Forth Valley
Board Executive Performance Report



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1. PURPOSE OF REPORT

This report summarises the core performance of NHS Forth Valley for the period to end of November 2015 with some relevant updates into December 2015. Further to NHS Board approval of the Annual Plan in June 2015, the Core Performance Report format and Balanced Scorecard have been reviewed to reflect both the LDP 2015/16 and local Annual Plan measures and targets. As previously indicated, the Scottish Government reviewed both the Improvement Priorities for Scotland in 2015/16 and the suite of HEAT Targets and has focused on 6 Improvement priorities and HEAT Standards (as opposed to Targets and Trajectories) within the LDP for 2015/16. The LDP 2015/16 standards are highlighted in Appendix 1. Further review will be undertaken as we review the LDP Guidance for 2016/17.

2. CHIEF EXECUTIVE'S SUMMARY

NHS Forth Valley has experienced a busy period through December, over the festive period and into January. The preparation through the Winter Plan has supported the organisation to respond to periods of higher demand. Although there have been some particularly challenging days in terms of the Emergency Department 4 hour wait, the recovery of the system has been much swifter this year and performance has remained above the Scottish average. Our staff worked extremely hard and I would like to pay tribute to them for ensuring patients were cared for in a safe and comfortable manner during some pressurised periods. A high profile awareness campaign continued throughout December to provide advice and information to local people across Forth Valley on how to stay well this winter and highlighted the range of services and support available. This included a wide range of actions to promote local alternatives to A&E, such as the Minor Injuries Unit (MIU) at Stirling Community Hospital and community pharmacies. This supported an 8% increase in MIU attendances over the period.

The Healthcare Environment Inspectorate notified us on December 17 of an announced inspection to Clackmannanshire Community Healthcare Centre on 27 & 28 January 2016. Work is underway to ensure that our routine policies and procedures are being adhered to and staff are supported and prepared for the inspection. The draft report is expected in early March with a final report publication date of the 6 April 2016.

In respect of the Clinical Services Review, the publication of the National Clinical Strategy is still awaited and, as previously agreed, we will review the content of this prior to finalising the Healthcare Strategy for Forth Valley.

The Scottish Government Spending Review was announced on 16th December 2015 and confirms an uplift of 1.7% for territorial Health Boards for 2016/17. A separate paper on the Financial Plan is on the Board Agenda outlining the issues arising from the draft Scottish Budget. Based on the outcome of the draft Scottish Budget the draft Board financial plan for 2016/17 estimates a requirement for approximately 6% recurrent cash savings (£27m) in 2016/17. All Directorates prepared plans for 3% cash savings and these are currently going through formal review process. The remaining 3% is Board targeted at area-wide cost reduction themes. A Board session to review progress to date will follow the January Board meeting.

The Local Delivery Plan (LDP) Guidance for 2016/17 has been received from the Scottish Government. This requires submission of draft plans by 4th March 2016. To meet this deadline and to meet deadlines for budget allocation to the Integrated Joint Boards, delegated authority to approve the draft LDP including Financial Plan at the Performance and Resources Committee at the end of February 2016 will be required.

3. PERFORMANCE

Forth Valley's overall performance has remained positive through December with the RAG status within the Balanced Scorecard mainly at green or amber. However there are some challenges moving forward into January and February.

In respect of emergency access, the December 2015 compliance with the 4 hour ED target was 97.8%; MIU 99.9%, ED 97.4% with 3, eight hour and no twelve hour breaches, a notable improvement on the same period last year at 84.2%. As noted above there have been some particularly difficult days in January where performance has been variable with both 'wait for bed' and 'wait for first assessment' breaches, however overall Forth Valley has performed well. Action is ongoing to address specific issues as they arise in terms of reviewing staffing levels and skill-mix to ensure it matches activity and fluctuations in A&E demand, and ongoing work to support morning and weekend discharges across all hospital sites.

In respect of the elective programme, the 18 week RTT position in November 2015 was 91.1% against a national position of 87.1%. However, there continues to be a rise in overall outpatient numbers waiting over 12 weeks which increased in December to 2191 from 1572 in November 2015. Going forward the RTT performance will be affected by this increasing trend in volumes of outpatients waiting over 12 and 16 weeks.

With regard to the Treatment Time Guarantee there have been 6 breaches of the TTG since the start of the 2015/16 Financial Year. Overall compliance remains high at 99%. It should however be highlighted that TTG performance is expected to decrease in January 2016, in part due to winter pressures. As at 18 January there have been 48 breaches of the TTG. It is anticipated that this pressure will continue into February 2016. Whilst locally this has become more challenging, Forth Valley remains in a positive position against the national average.

Improvement continues with the Psychological Therapies RTT with performance at 87.6% for December. Progress has also been seen in CAMH services with work underway to achieve the RTT by the end of March. The service is seeing a rising number of referrals which is being considered in discussion with primary care colleagues.

Cancer performance remains positive with the management information for November 2015 highlighting that compliance with the 62 day cancer waiting time standard was 96% and 98.6% for the 31 day cancer waiting time standard.

The position for delayed discharges remains challenging across the partnerships. The position for delays over 14 days at the December 2015 census was 26 against a zero standard. The local authority breakdown is Clackmannanshire zero delays, Falkirk 24 and Stirling 1 and Fife 1. There continues to be focus on those patients who are delayed in their discharge with Code 9 exemptions, which include issues in respect of Guardianship. The number of patients in this group delayed at the December 2015 census was 19. Weekly meetings continue focussing on individual patient needs to ensure appropriate

movement, placement and packages of care. Delayed discharges remain a standing agenda item on Integration Joint Boards and it is acknowledged that significant effort is required to achieve and sustain improvement.

A full review of performance is appended to this report.

4. FINANCE

The Finance Report for the period ending 31 December 2015 reports a balanced position in both revenue and capital. The projected out-turn is a surplus of £0.200m for revenue. However, whilst funding has been provided for specific areas for the winter period there remain capacity pressures in the system which may be exacerbated in January to March. Monthly monitoring meetings are in place with the Medical and Surgical Directorates focussing on delivery of in month financial balance.

5. AWARDS / CONFERENCES / INTEREST

NHS Forth Valley has had an excellent track record of retaining staff over a number years and it was with great pleasure that the Chairman and I hosted another Long Service Awards ceremony in December. Around 130 NHS Forth Valley staff, with a total of 3,300 years service between them, were invited to the ceremony to celebrate their long careers working for the NHS. Each staff member received a specially designed certificate and pin badge. It was a privilege to see these awards presented to staff and to have the opportunity to thank them for the contribution they have made to the NHS during their long and dedicated service.

The work undertaken by volunteers across Forth Valley was also celebrated during December and is featuring on the Board agenda. We cannot underestimate the enormous contribution volunteers make to the experience of our patients through their hard work and dedication in a number of areas across the organisation. The Chairman presented plaques as a gesture of appreciation to representatives from voluntary organisations including the Friends of Forth Valley Royal Hospital, the Royal Voluntary Service, Braveheart, So Precious and Volunteering Matters-RSVP.

I am pleased to report that NHS Forth Valley's Audiology and Volunteer Service has won the 2015 British Academy of Audiology's (BAA) Team of the Year Award. The award was presented to Audiology Services Manager, Jennifer Pow at the recent BAA 12th Annual Conference in Harrogate.

NHS Forth Valley has become the first health board in Scotland to support a campaign to help people with dementia in all its hospitals. John's Campaign is a scheme where patients with dementia stay in the company of carers in their wards so they can be surrounded by familiar faces. Not only will this apply in the acute hospital Forth Valley Royal, but also in the four community hospitals in Falkirk, Stirling, Bo'ness and Clackmannanshire. The initiative was founded by Nicci Gerrard, after her father Dr John Gerrard died at the age of 86 in 2014 after being diagnosed with Alzheimer's disease whilst in his 70s.

6. RECOMMENDATIONS

The Board is asked to:

- Note the key items of information detailed within the Chief Executive's Summary of this report.
- Note the main areas highlighted in the Balanced Scorecard and the Performance Summary - Section 1.

Author of Paper

Name	Designation
Elaine Vanhegan	Head of Performance and Governance

Approved By

Name	Designation
Jane Grant	Chief Executive

January 2016

SECTION 1 - BALANCED SCORECARD & PERFORMANCE SUMMARY

Work continues in respect of developing the BSC to provide a broader range of measures and build upon the qualitative and quantitative data which will enable and support quality improvement and assurance. As previously indicated, following NHS Board approval of the Annual Plan in June 2015, the Core Performance Report format and Balanced Scorecard were reviewed to reflect both the LDP 2015/16 and local Annual Plan measures and targets moving forward. The dimensions within the Balanced Scorecard have been reduced to 5 from 6 with Efficient and Effective collapsed together. Changes to the Balanced Scorecard include the addition of the 10 Patient Safety Essentials and the Stroke Care Bundle. In addition, following the Performance & Resources Committee in October 2015, a small number of Child Dental Health indicators have been incorporated, including Fluoride Varnish Applications.

Format

Key To Abbreviations		**Key to Performance Status**		**Direction of travel relates to same period previous year**	
LDP	NHS LDP Standard	**RED**	Outwith 5% of meeting trajectory	▲	Improvement in period
LKPI	Local Key Performance Indicator	**AMBER**	Within 5% of meeting trajectory	◄►	Position maintained
NR	National Requirement	**GREEN**	On track or exceeding trajectory	▼	Deterioration in period
		GREY	No trajectory to measure performance against	—	No comparative data

- The graphs and commentary will provide contextual information and support
- Appendix 1 lists the NHS LDP Standards 2015/16
- Those areas shaded grey have not been updated for this reporting period

NHS Forth Valley Strategic Balanced Scorecard - NHS Board
Performance Dashboard December 2015

Safe

Type	Measure	As at	Performance status	Direction of travel
NR	Hospital standardised mortality ratio	Jun-15	Green	▲
LKPI	Adverse Events	Sep-15	Green	▲
LDP	Staphylococcus Aureus Bacteraemia	Dec-15	Red	▲
LDP	Clostridium Difficile	Dec-15	Green	◄►
LKPI	Community Hospital hand hygiene	Dec-15	Green	▲
	10 Patient Safety Essentials			
NR	Acute Hospital Hand Hygiene	Dec-15	Green	▲
NR	Leadership Walkrounds	Sep-15	Green	◄►
NR	Communications: Surgical Brief and Pause	Jul-15	Green	◄►
NR	Communications: General Ward Safety Brief	Nov-15	Green	◄►
NR	Intensive Care Unit (ICU) Daily Goals	Jul-15	Green	◄►
NR	Ventilator Associated Pneumonia Bundle	Oct-15	Green	◄►
NR	Early Warning Scoring	Nov-15	Green	◄►
NR	Central Venous Catheter Insertion Bundle	Oct-15	Green	▲
NR	Central Venous Catheter Maintenance Bundle	Oct-15	Green	▲
NR	Peripheral Venous Catheter Maintenance Bundle	Nov-15	Green	◄►

Person Centred

Type	Measure	As at	Performance status	Direction of travel
LKPI	Clinical quality indicators			
LKPI	Falls	Dec-15	Green	◄►
LKPI	Pressure Area Care	Dec-15	Green	▼
LKPI	Food, Fluid and Nutrition	Dec-15	Green	▼
LDP	Sickness Absence Rate	Nov-15	Red	▼
LKPI	Short Term	Nov-15	Grey	▼
LKPI	Long Term	Nov-15	Grey	▼
LKPI	eKSF	Dec-15	Amber	◄►
NR	Stroke Care Bundle	Nov-15	Amber	▼
NR	Admission to stroke unit	Dec-15	Green	▲
NR	Sw allow Screening	Dec-15	Green	▼
NR	Aspirin administration	Dec-15	Amber	▼
NR	Brain scan w ithin 24 hours	Dec-15	Green	◄►
LKPI	Complaints			
LKPI	Responses w ithin 20 days (excl. Prisons)	Nov-15	Green	▲
LKPI	Responses w ithin 20 days (Prisons)	Nov-15	Green	◄►
LKPI	Reduction in complaints (excl. Prisons)	Dec-15	Amber	▲
LKPI	Reduction in complaints (Prisons)	Dec-15	Red	▲
LDP	Dementia Post Diagnosis Support	—	Grey	—

Equitable

Type	Measure	As at	Performance status	Direction of travel
LKPI	Staff Ethnicity recording	Sep-15	Amber	▼
LKPI	Suicide rate	Dec-14	Green	▼
LDP	Smoking cessation	Sep-15	Green	▲
LDP	Alcohol brief intervention	Sep-15	Green	◄►
LKPI	Child Healthy Weight	Mar-15	Green	◄►
LKPI	Child Dental Health			
LKPI	Fluoride Varnish Applications	Mar-15	Grey	▲
LKPI	General Anaesthetic for Extractions	Nov-15	Grey	▼
LKPI	National Dental Inspection Programme	Mar-15	Grey	▲
LDP	Access to Antenatal Care	Dec-15	Green	▲
LDP	Early diagnosis & treatment in first stage of cancer	Dec-14	Green	▲

Timely

Type	Measure	As at	Performance status	Direction of travel
LDP	18 w eek Referral to Treatment	Nov-15	Green	▼
LDP	12 Week Treatment Time Guarantee	Dec-15	Green	▼
LDP	12 Week Outpatient w ait	Dec-15	Red	▼
NR	Outpatient Unavailability	Dec-15	Green	▼
	Inpatient Unavailability	Dec-15	Green	▼
	Diagnostic 42 day w ait			
LKPI	Imaging	Dec-15	Green	◄►
LKPI	Endoscopy	Dec-15	Amber	▼
LDP	Cancer 62 day target	Nov-15	Green	◄►
LDP	Cancer 31 day target	Nov-15	Green	◄►
LDP	Access to drug & alcohol treatment	Dec-15	Green	▼
LDP	IVF Treatment w ithin 12 months	Dec-15	Green	◄►
LDP	% A&E w aits <4 hours	Dec-15	Amber	▲
LDP	Access to child & adolescent mental health services	Dec-15	Red	▲
LDP	Psychological Therapies	Dec-15	Amber	▲
LDP	48 hour access to member of GP team	2013/14	Green	◄►
LDP	Advance booking to GP Practice Team	2013/14	Amber	▼
LKPI	MSK w aits	Nov-15	Grey	▼

Effective and Efficient

Type	Measure	As at	Performance status	Direction of travel
LDP	Finance	Dec-15	Green	◄►
LKPI	Non Core Staff Costs	Dec-15	Amber	▲
LKPI	Reduction in Primary Care Prescribing costs	Oct-15	Green	◄►
LKPI	Delayed discharge >14 days	Dec-15	Red	▲
LKPI	Delayed discharge >72 hours	Dec-15	Grey	▲
LKPI	Bed days lost due to delayed discharge	Dec-15	Red	▲
LKPI	A&E attendance	Dec-15	Amber	▲
LKPI	Long Term Conditions	Nov-15	Green	▼
LKPI	Anticipatory Care Plans	Dec-15	Green	▲
LKPI	Outpatient 'Did Not Attends'	Dec-15	Green	▼
LKPI	Emergency Bed Days Patients 75+	Sep-15	Amber	▲
LKPI	Energy Consumption	Mar-15	Green	◄►
LKPI	CO2 emissions	Mar-15	Amber	◄►

Dimension of Quality:
SAFE

Context

Safe - avoiding injuries to patients from healthcare that is intended to help them.

Staphylococcus aureus bacteraemia (SABs)
The target is that, Staphylococcus aureus bacteraemia (SABs) cases are reduced to 0.24 or less per 1000 acute occupied bed days. The total number of SABs in December 2015 was 7; 1 hospital acquired, 6 healthcare acquired. The in month rate per 1000 acute occupied bed days for December is 0.2 cases, with the provisional 12 month rolling average 0.31, this is against an agreed target of 0.24.

Every SAB continues to be fully investigated to identify the cause of the infection with a full root cause analysis performed with ward staff on all hospital and healthcare attributed SABs. This supports the identification of any issues that are, or may, potentially be related to the SAB acquisition. The required reduction in the SABs rate remains challenging.

Key actions to support a reduction in the number of SABs include:

- PVC insertion maintenance bundle across Forth Valley Royal Hospital implemented
- Implement insertion bundle for long lines. Insertion bundle drafted and awaiting rollout by radiologists
- Continued support of urinary catheter insertion and maintenance bundle implemented across Forth Valley Royal Hospital and rolling out across community hospitals
- Improved communication links with clinicians
- Improved directorate specific HAI reporting to stakeholders on a monthly basis

This issue is scrutinised through the CEO Operational Group.

Clostridium difficile infections (CDI)
The target is to reduce the rate of Clostridium difficile infections in patients aged 15 and over to 0.25 cases or less per 1000 total occupied bed days. The NHS Forth Valley rate of Clostridium Difficile Infections (CDI) in December 2015 is 0.1 per 1000 total occupied bed days. The rolling year rate is 0.2 per 1000 total occupied bed days against a target of 0.25. There were 2 CDIs in December 2015 both of which were healthcare acquired.

Full enhanced surveillance is performed on all CDIs including healthcare and community acquired.

- Further detail in respect of HAI is discussed at **Agenda Item 5.2 - National Healthcare Associated Infection Reporting Template**

Patient Safety Essentials
The ten patient safety essentials being implemented everywhere in Scotland were set out in CEL 19 (2013) 2 September 2013. NHS Boards are expected to have in place arrangements to ensure that staff are supported to deliver these measures reliably and consistently to all patients who could benefit, and that these are reported at NHS Board level.

The list includes a number of areas where good practice should be followed, such as hand hygiene and communication in the ward or theatre, as well as a number of evidence based 'bundles' of care which are collections of interventions and checks to improve both quality and safety of care.

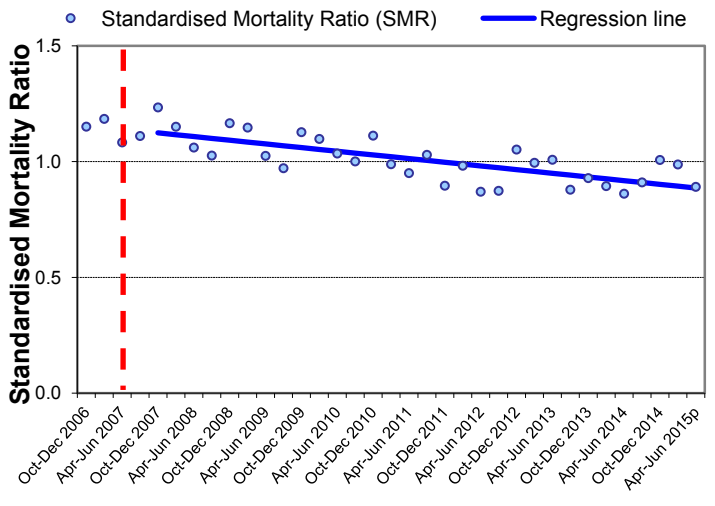
The 10 patient safety essentials are:

1. *Hand Hygiene*
   Health care-associated infections, or infections acquired in health-care settings are the most frequent adverse event in health-care delivery worldwide. Good Hand hygiene is a simple and effective solution to both reduce and prevent the spread of most healthcare associated infections.
2. *Leadership Walkrounds*
   Leadership walkrounds allow senior leaders to have a structured conversation about patient safety with frontline staff, and enquire as to the barriers to caring for patients as safely as possible. They increase awareness of safety issues among clinicians and establish a strong commitment by senior leadership to a culture that encourages patient safety.
3. *Communications: Surgical Brief and Pause*
   Surgical Briefing: is an opportunity to ensure that the entire team understand the expectations for the list and for each procedure. Surgical Pause: is an opportunity to cover the surgical checklist and act as a final reminder of items that must be completed prior to commencement of the operation.
4. *Communications: General Ward Safety Brief*
   Safety Briefings are a simple, easy-to-use tool that front line staff can use to share information about potential safety problems and concerns on a daily basis. They help increase staff awareness of patient safety issues, create an environment in which staff share information without fear of reprisal, and integrate patient safety into daily work.
5. *Intensive Care Unit (ICU) Daily Goals*
   Setting Daily goals allows better document and communication, supports evaluation of patient safety risks and focuses staff attention to early changes in patients' condition. Furthermore, it enhanced communication among team members and patients and their families.
6. *Ventilator Associated Pneumonia Bundle*
   Ventilator Associated Pneumonia (VAP) is a pneumonia infection acquired during mechanical ventilation; this evidence based bundle of care will be administered to all patients daily to prevent a VAP.
7. *Early Warning Scoring (EWS)*
   The EWS identifies patients at risk from deterioration and patients who would potentially benefit from more intensive monitoring from nursing and medical staff. The EWS is used as part of a "track-and-trigger" system whereby an increasing score produces an escalated response varying from increasing the frequency of patient's observations (for a low score) up to urgent review by a Rapid Response or Medical Emergency Team.

8. *Central Venous Catheter Insertion Bundle*
   A Central Venous Catheter (CVC) commonly known as a central line, is a plastic tubing or drip used to administer medicines or fluids into large veins of the body. An evidence based CVC insertion bundle to prevent central line associated blood steam infections will be used every time central lines are inserted.
9. *Central Venous Catheter Maintenance Bundle*
   Central Venous Catheters (CVCs) are a leading cause of device-related blood stream infections. An evidence based CVC maintenance bundle to prevent central line associated blood steam infections will be used every day on every patient.
10. *Peripheral Venous Catheter*
    Use of the evidence based care bundle for Peripheral Venous Catheter (PVC) will help in preventing infections when inserting and maintaining a PVC.

Data on performance in relation to the Ten Patient Safety Essentials has been included in the Clinical Governance Balanced Scorecard reported to the Clinical Governance Committee. There are a number of mechanisms in place to independently assess progress in these areas. This includes assessment of early warning scores and escalation of sick patients as part of the audit of '2222' calls and cardiac arrest calls; casenote reviews using the global trigger tool; root cause analysis of any incidence of device associated bacteraemias; review of compliance with a range of infection control procedures including hand hygiene and compliance with the peripheral vascular catheter bundles as part of the infection control team ward visit programme. The assurance framework for the 10 patient safety essentials will be considered at the Quality Improvement Strategic Leadership Group next week.

Measure	Scottish Patient Safety Programme - 20% reduction in Hospital Standardised Mortality Ratio (HSMR) by December 2015
Current Performance	0.89 @ quarter end June 2015



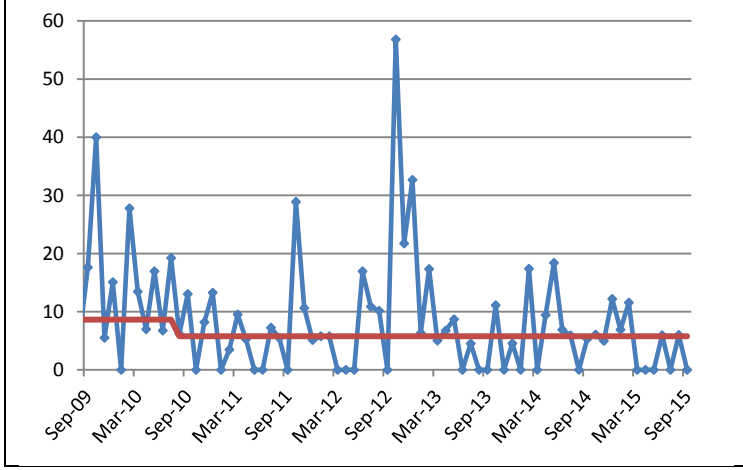
Commentary

HSMR compares actual deaths with expected deaths within 30 days of admission. It fluctuates over time and is influenced by various factors such as age and diagnosis of patient. This will vary between hospitals and is intended to monitor trends over time with a view to seeing improvements against the target.

The graph highlights the provisional HSMR with regression line October 2006 – June 2015 for NHS Forth Valley acute hospitals. The HSMR to the quarter ending June 2015 for NHS Forth Valley is 0.89. This is a reduction from the baseline of 21.2%, with a reduction in the Scottish HSMR of 15.7%.

Data for the quarter ending September 2015 is due for publication in February 2016.

Measure	Scottish Patient Safety Programme - 30% reduction in adverse events per 1000 patient days
Current Performance	Zero @ September 2015



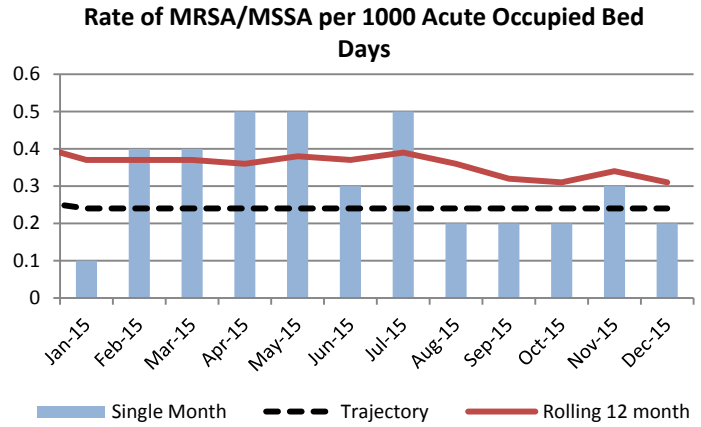
Commentary

Taking the NHS Forth Valley baseline of 25.4 per thousand patient days, a 30% reduction in adverse events sets a target reduction to 17.5 per thousand patient days. Twenty case notes are reviewed monthly and assessed using the Global Trigger Tool, which is a tool to identify triggers that may indicate patient harm. The process of review identifies if this is indeed harm that resulted from healthcare or if the event was part of the illness process itself.

Data is reported on a retrospective basis.

The graph highlights that NHS Forth Valley is within target with zero adverse events per 1000 patient days for September 2015.

Measure	Staphylococcus aureus bacteraemia (SABs) cases are reduced to 0.24 or less per 1000 acute occupied bed days
Current Performance	The 12 month rolling position to December 2015 is 0.31 against a target of 0.24



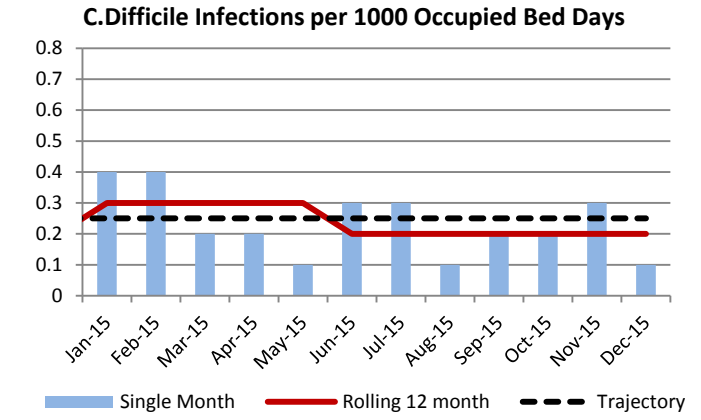
Commentary

The total number of SABs in December 2015 was 7; 1 hospital acquired, 6 healthcare acquired. The in month rate per 1000 acute occupied bed days for December is 0.2 cases, with the provisional 12 month rolling average, 0.31 against an agreed target of 0.24.

The Scotland position at quarter ending September 2015 is 0.32 cases per 1000 acute occupied bed days.

Every SAB continues to be fully investigated to identify the cause of the infection with a full root cause analysis performed with ward staff on all hospital and healthcare attributed SABs. This supports the identification of any issues that are, or may, potentially be related to the SAB acquisition.

Measure	Rate of Clostridium difficile infections in patients aged 15 & over is 0.25 cases or less per 1000 total occupied bed days
Current Performance	The December 2015 rolling year rate is 0.2 per 1000 total occupied bed days



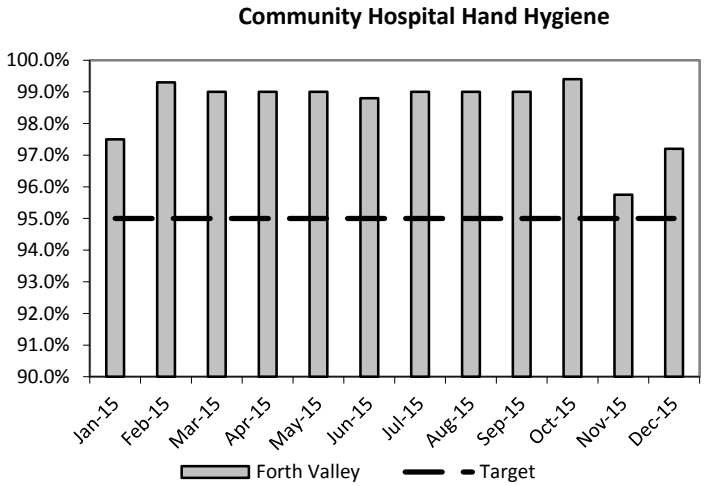
Commentary

The NHS Forth Valley rate of Clostridium Difficile Infections (CDI) in December 2015 is 0.1 per 1000 total occupied bed days. The rolling year rate is 0.2 per 1000 total occupied bed days against a target of 0.25. There were 2 CDIs in December 2015 both of which were healthcare acquired.

The Scotland position for quarter ending September 2015 is 0.35 per 1000 total occupied bed days.

Full enhanced surveillance is performed on all CDIs including healthcare and community acquired.

Measure	Community Hospital Hand Hygiene - % of staff undertaking hand hygiene practice as per infection control requirements
Current Performance	97.2% @ December 2015 against a target of 95%



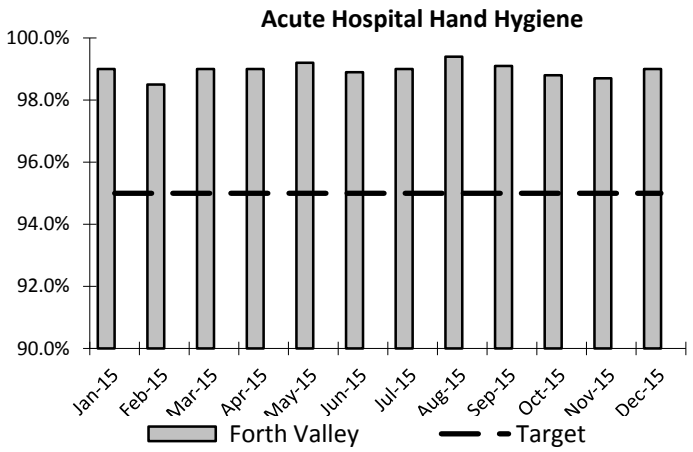
Commentary

The graph highlights that the December 2015 Scottish Patient Safety Programme average hand hygiene compliance is 97.2% within Community Hospitals.

This is broken down across the sites as:

- FCH – 95.6%
- SCH – 98.8%
- CCHC – 94.3%
- Bo'ness – 100%

Measure	Acute Hospital Hand Hygiene - % of staff undertaking hand hygiene practice as per infection control requirements – **Scottish Patient Safety Essential**
Current Performance	99% @ December 2015; ahead of the 95% target

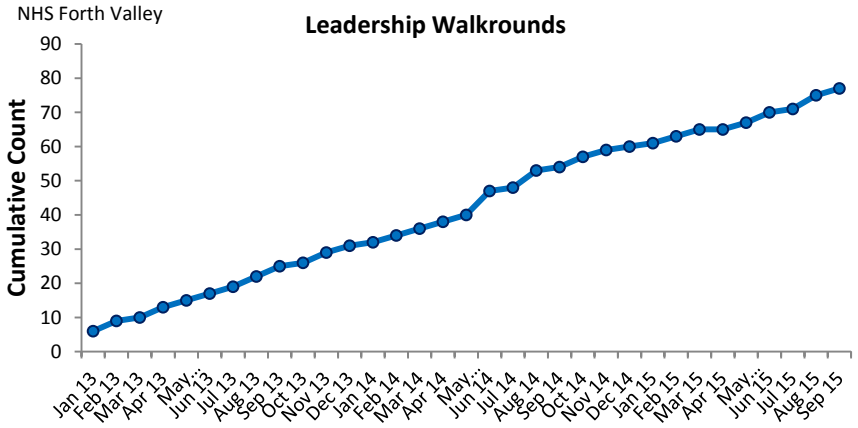


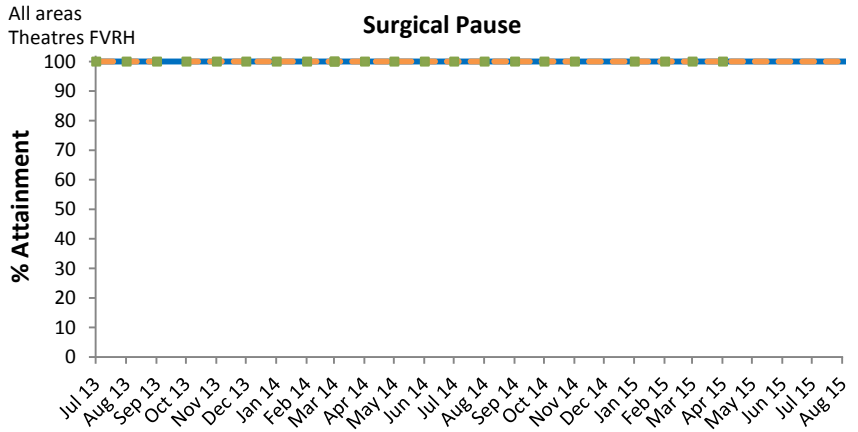
Commentary

Hand hygiene is monitored continually both by ward staff and by the Infection Prevention & Control Team (IPCT). Ward staff monitor 20 moments or opportunities of ward staff washing their hands appropriately every week as part of the Scottish Patient Safety Programme. These results are reported both locally to the ward and to the board on a bimonthly basis via the local Healthcare Associated Infection Reporting Templates (HAIRT). The information is reported at the Directorate reviews through balanced scorecards and review process.

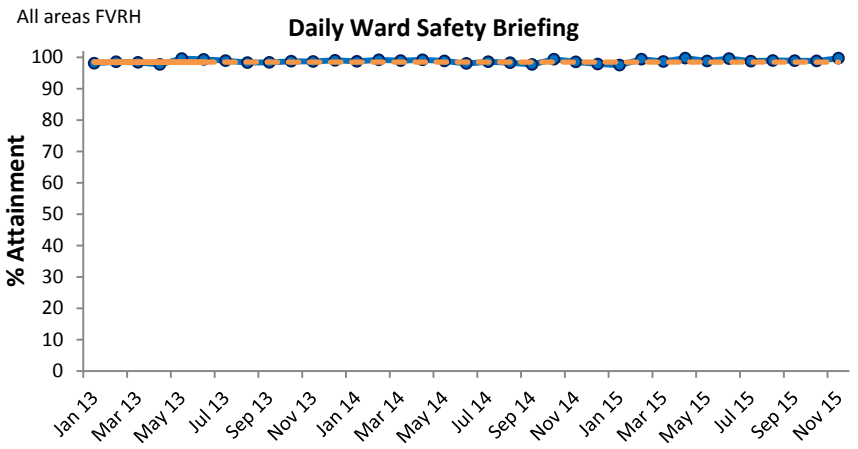
The graph highlights that the December 2015 acute hospital hand hygiene compliance is within target at 99%.

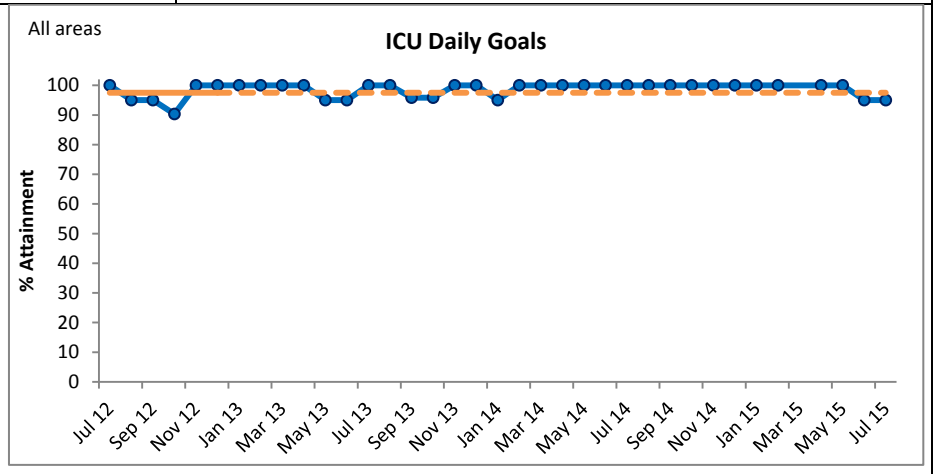
Scottish patient Safety Essentials			
Title	Leadership walkrounds	**Title**	Communications: Surgical Brief & Pause
Numerator	Number of walkarounds / month	**Numerator**	Total number of surgical cases which had a surgical briefing prior to the start of the surgical procedure
Goal	Aim: 4 week	**Goal**	≥ 95% reliability



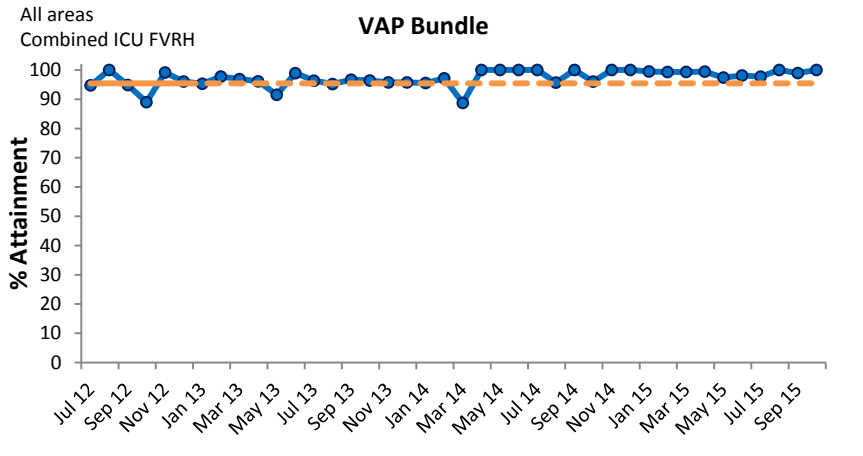


Title	Communications: General Ward Safety Brief	**Title**	Intensive Care Unit Daily Goals
Numerator	Total number of days in the month in which at least one safety briefing conducted	**Numerator**	Total number of patients who had daily goals agreed and documented in the case notes.
Goal	Minimum of daily safety briefing	**Goal**	≥ 95% reliability

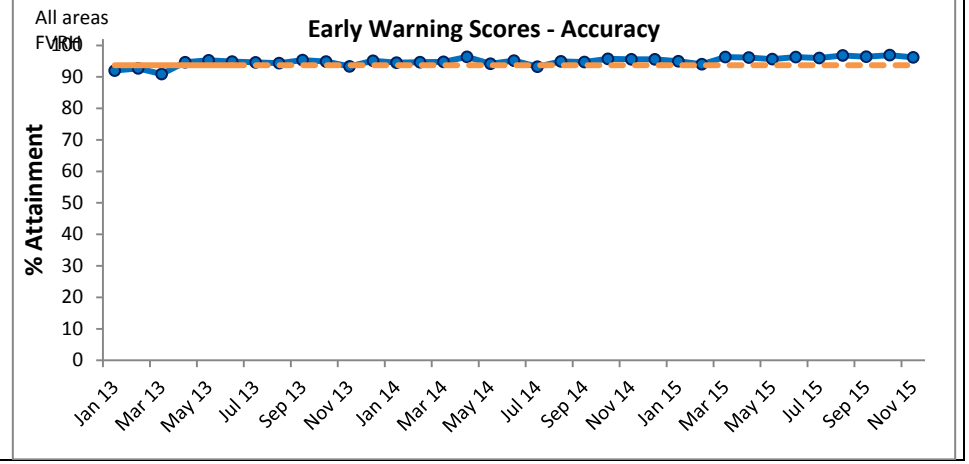




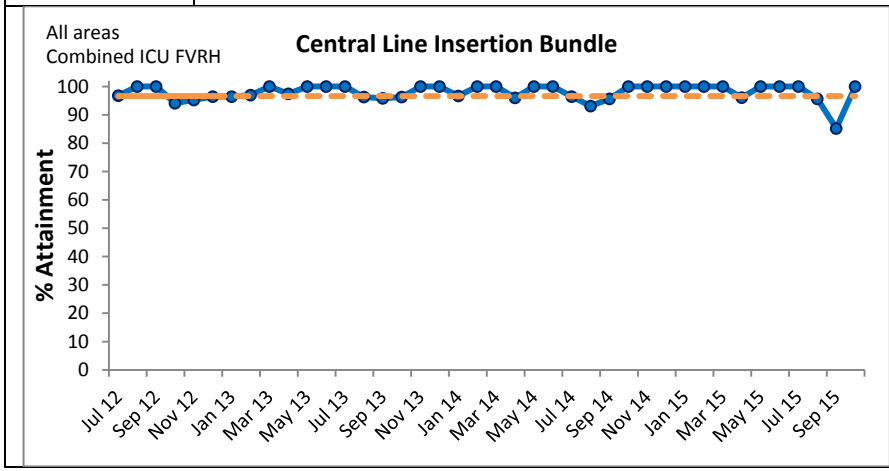
Title	Ventilator Associated Pneumonia Bundle
Numerator	Number of ventilated patients in the sample receiving all 5 components of the presenting VAP care bundle
Goal	≥ 95% reliability



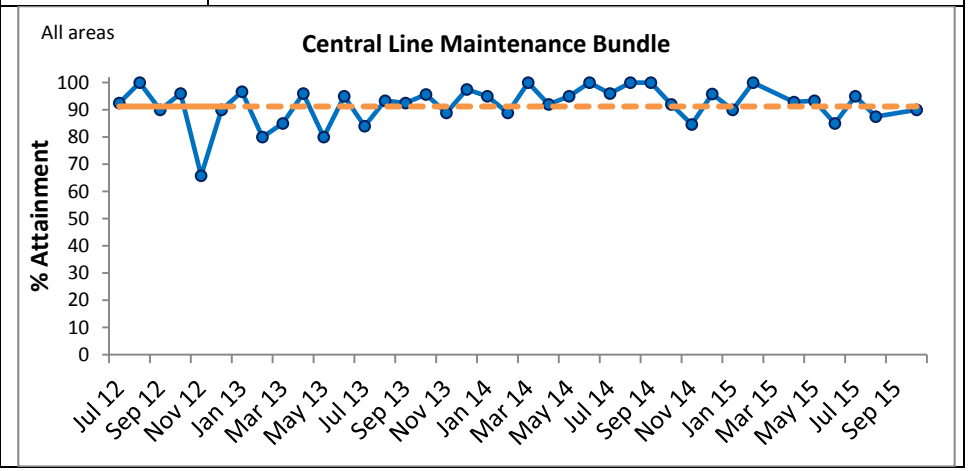
Title	Early Warning Scoring
Numerator	Number of Early Warning Scorings accurately completed – all areas FVRH
Goal	≥ 95% reliability



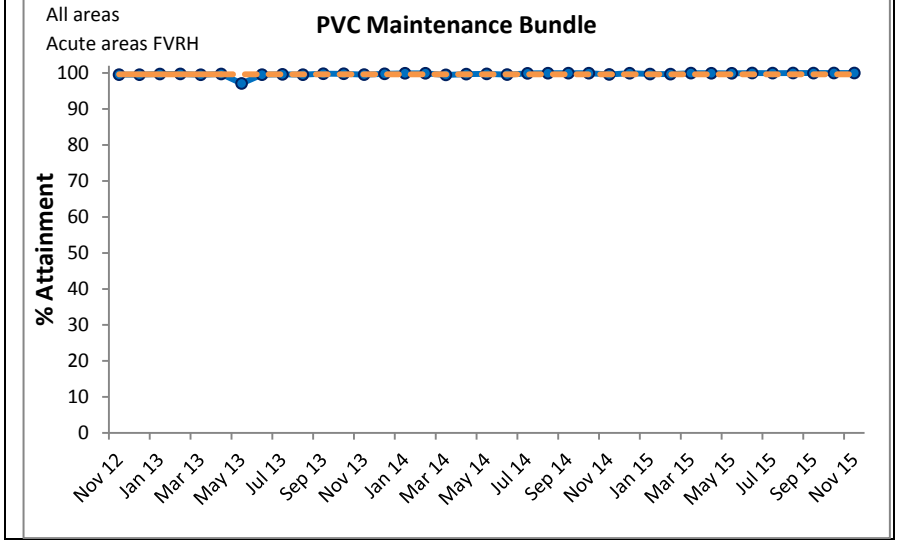
Title	Central Venous Catheter Insertion Bundle
Numerator	Number of patients receiving all elements of the CVC insertion bundle
Goal	≥ 95% reliability



Title	Central Venous Catheter Maintenance Bundle
Numerator	Number of patients receiving all elements of the CVC maintenance bundle
Goal	≥ 95% reliability



Title	Peripheral Vascular Catheter (PVC) Bundle
Numerator	Number of patients with optional PVC Care
Goal	**≥** 95% reliability



PERSON CENTRED

Context

Person Centred - Providing care that is responsive to individual personal preferences, needs and values and assuring that patient values guide all clinical decisions.

Clinical Quality Indicators (CQI)
Clinical Quality Indicators (CQIs) are evidenced based indicators that support the measurement of the quality, safety and reliability of care. The CQIs focus on quality improvement rather than a measure of performance. They are currently process indicators, which measure aspects of nursing care such as assessment and interventions. There is a 95% target in respect of CQIs. The December 2015 position is highlighted as Falls 97%, Pressure Area Care 95% and Food, Fluid & Nutrition 94%.

Areas that have been highlighted as having challenges in respect of overall compliance are supported by the Lead Nurses working with the teams to support the achievement of improvements within these areas.

The Performance & Resources Committee in December 2015 reviewed a broad range of measures in respect of the assessment of, and support to malnutrition issues within older people. Key small scale audits will be undertaken focussing on the commitment to ensure that those at risk are identified. NHS Forth Valley Food, Fluid & Nutritional Care (FFNC) steering group will oversee this activity and will report to the Performance & Resources Committee in due course.

Attendance Management
Work continues in respect of delivering the LDP standard of 4%. This remains a challenging target and is a high priority for the Board and managers across the organisation. The absence rate for November 2015 is highlighted as 5.39% for NHS Forth Valley with the Scotland position 5.22% at November 2015.

The NHS Forth Valley aim is to achieve continuous improvement year on year:

- to remain below 5% and routinely achieve the Scottish average or below
- to achieve the 4% standard

There is on-going focus on ‘hotspot’ areas with continued sharing of good practice across the organisation. A detailed report in respect of absence is considered by the Staff Governance Committee.

Stroke Care Bundle
The target is that 80% of patients with an initial diagnosis of stroke receive an appropriate bundle of care from December 2015 with 90% compliance from March 2016. The position at November 2015 is 72.5%.

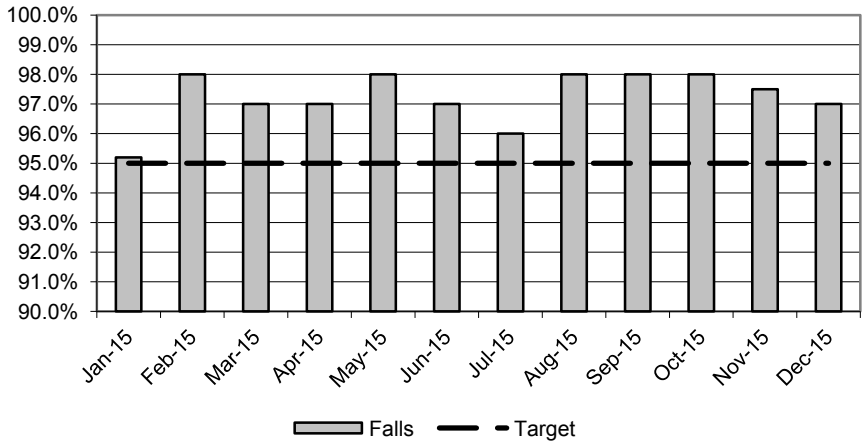
The Stroke Care Bundle has four key elements; access to a stroke unit within 1 day of admission, Aspirin administration within 1 day of admission, swallow screening on day of admission and brain scanning within 24 hours of admission. These elements are highlighted individually within the Balanced Scorecard.

Complaints
Complaint response times should be 20 working days with an overall 80% target in place. The NHS Forth Valley position for November 2015 is that 94.9% of complaints were responded to within 20 working days. The response rate to the end of November 2015 for complaints excluding prisons was 90.7% and 100% for prison complaints.

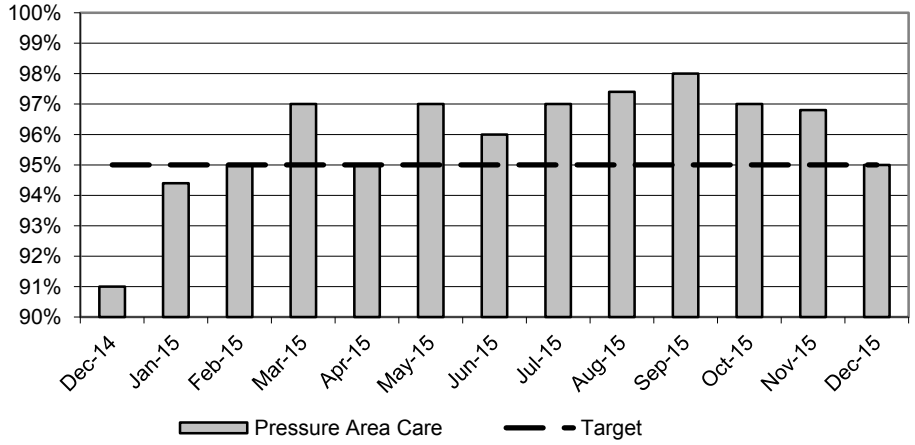
In addition, work to reduce the number of complaints by 20% across Forth Valley is on-going. A detailed Complaints Performance Report is presented to the Clinical Governance Committee as a standing item.

Measure	Clinical Quality Indicators – falls, nutrition, pressure area care
Current Performance	For December 2015 – Falls 97%, Pressure Area Care 95% and Nutrition 94%

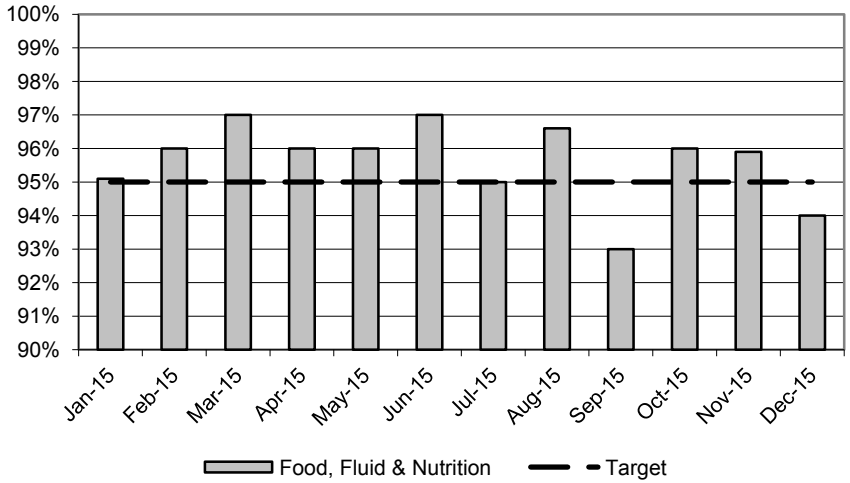
Clinical Quality Indicator - Falls



Clinical Quality Indicator - Pressure Area Care



Clinical Quality Indicators - Food, Fluid & Nutrition



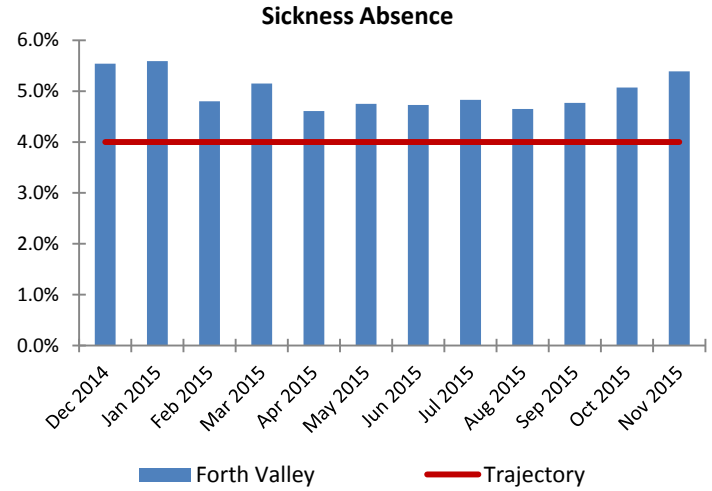
Commentary

Clinical Quality Indicators (CQIs) are evidenced based indicators that support the measurement of the quality, safety and reliability of care. The CQIs focus on quality improvement rather than a measure of performance. They are currently process indicators, which measure aspects of nursing care such as assessment and interventions.

The graphs represent NHS Forth Valley's compliance with the 3 National Clinical Quality Indicators. Areas that have been highlighted as having challenges in respect of overall compliance are supported by the Lead Nurses working with the teams to support the achievement of improvements within these areas.

The December 2015 position is highlighted as Falls 97%, Pressure Area Care 95% and Food, Fluid & Nutrition 94%.

Measure	To reduce sickness absence to 4% by March 2009
Current Performance	5.39% @ November 2015



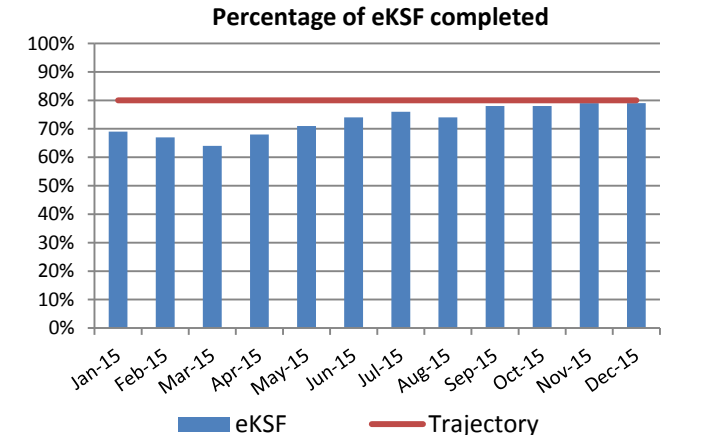
Commentary

The November 2015 position is highlighted as 5.39% with the position for Scotland 5.22%.

Long Term Sickness Absence calculations are based on days lost and available. These calculations assume that individuals can be absent and available for 365 days a year. Short Term absence for November 2015 is 1.99% (1.91% October) with long term absence 3.21% (2.83% October).

Note: The calculation varies between hours lost (overall rate) and days lost (long/short term absence).

Measure	Annual Knowledge Skills Framework development reviews completed and recorded on eKSF
Current Performance	79% at December 2015



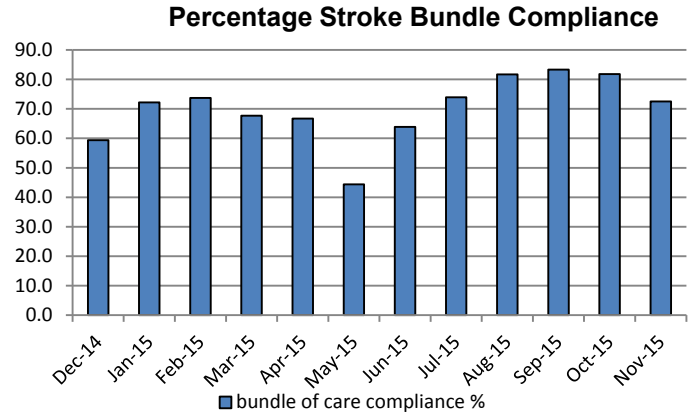
Commentary

The nationally accepted standard is 80%. The Forth Valley position for December 2015 is 79%.

The unit breakdown for December 2015 is:

- Corporate – 82% (November 83%)
- CHP – 77% (November 76%)
- Medical Directorate – 80% (November 81%)
- Surgical Directorate – 78% (November 77%)
- Women & Children and Sexual Health Services – 85% (November 80%)

Measure	Stroke Care Bundle – 80% of patients with an initial diagnosis of stroke to receive an appropriate bundle of care by December 2015 with 90% compliance from March 2016
Current Performance	72.5% @ November 2015 against a local trajectory of 80%



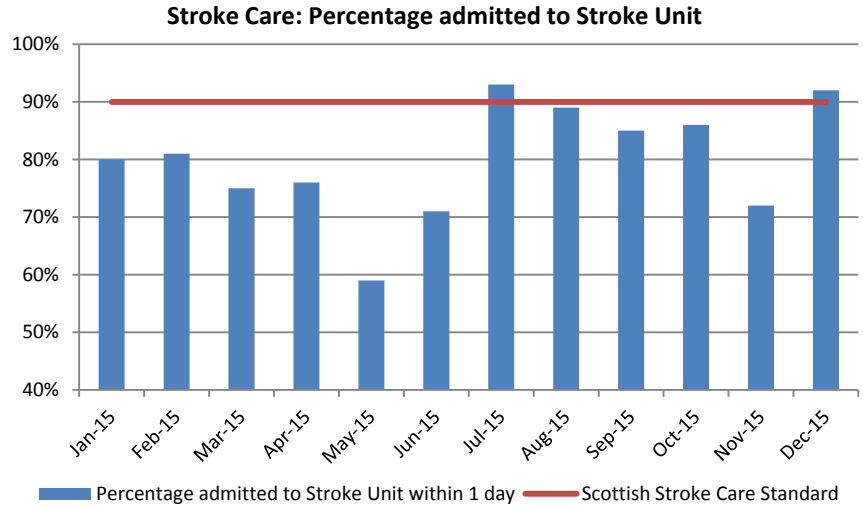
Commentary

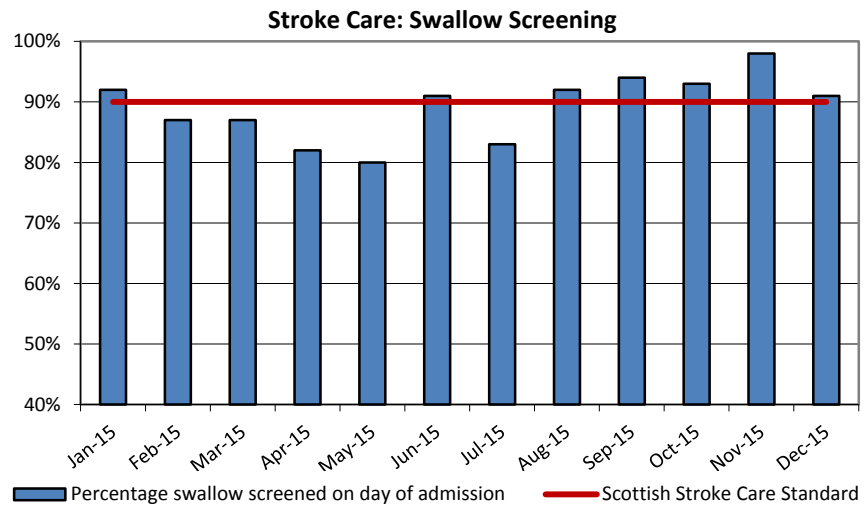
The target is 80% of patients with an initial diagnosis of stroke to receive an appropriate bundle of care from December 2015 with 90% compliance from March 2016. The position at November 2015 is 72.5%.

The Stroke Care Bundle has four key elements, access to a stroke unit, administration of Aspirin, swallow screening and brain scanning. NHS Forth Valley set a local trajectory of 80% of patients with an initial diagnosis of stroke to receive an appropriate bundle of care by December 2015, with 90% compliance from March 2016. This is a challenging target to maintain due to the complexities of the calculation.

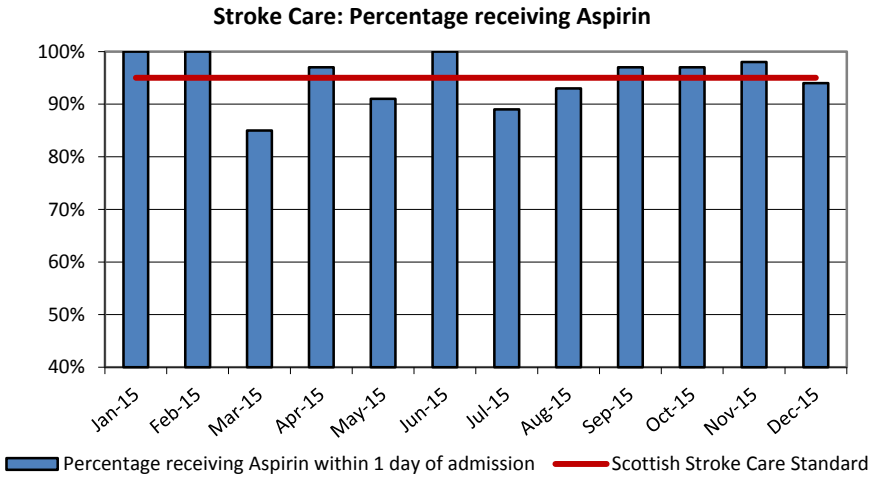
Key elements of the Stroke Care Bundle are highlighted below

Measure	Access to Stroke unit within 1 day of admission	**Measure**	Swallow screening on day of admission
Current Performance	92% @ December 2015 against a standard of 90%	**Current Performance**	91% @ December 2015 against a standard of 90%

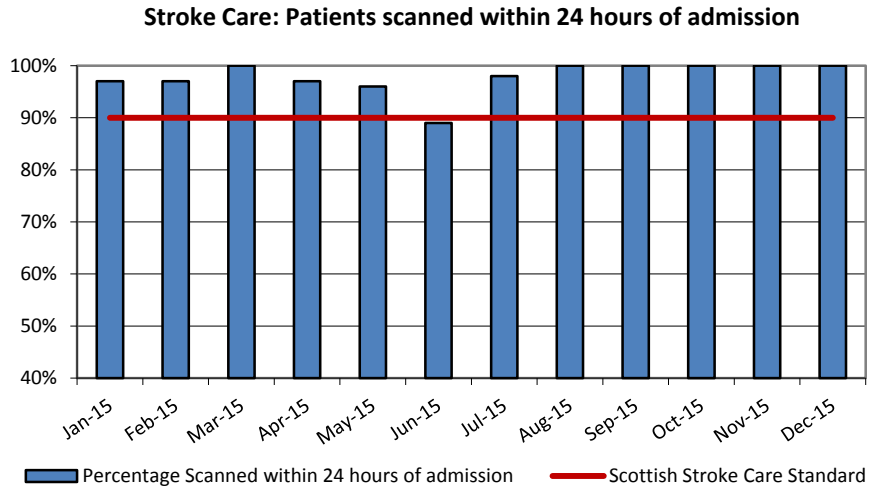




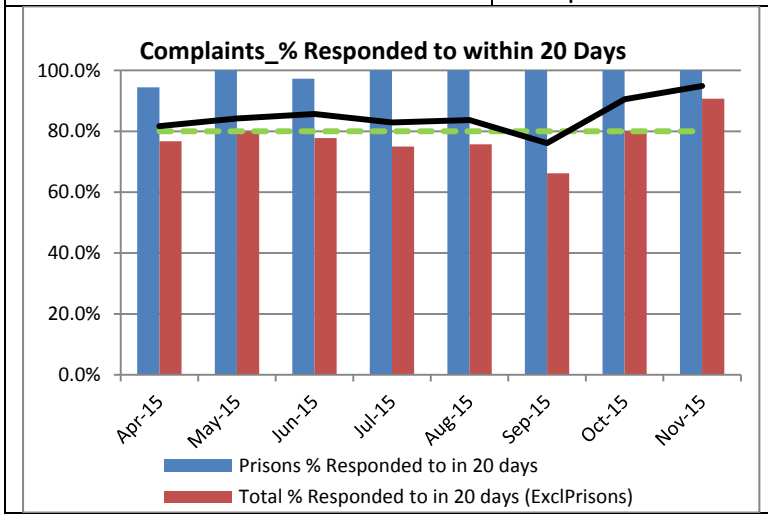
Measure	Aspirin administration within 1 day of admission
Current Performance	94% @ December 2015 against a standard of 95%



Measure	CT scanning within 24 hours of admission
Current Performance	100% @ December 2015 against a standard of 90%



Measure	20 day response rate to complaints – Local target of 80% target
Current Performance	Complaints excluding prisons 90.7% @ November 2015; Prison complaints 100% @ November 2015



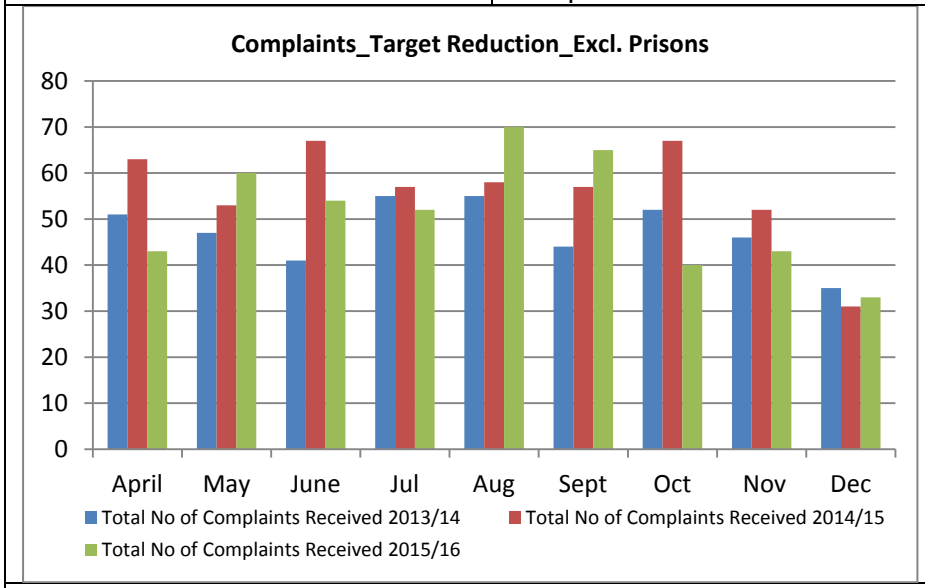
Commentary

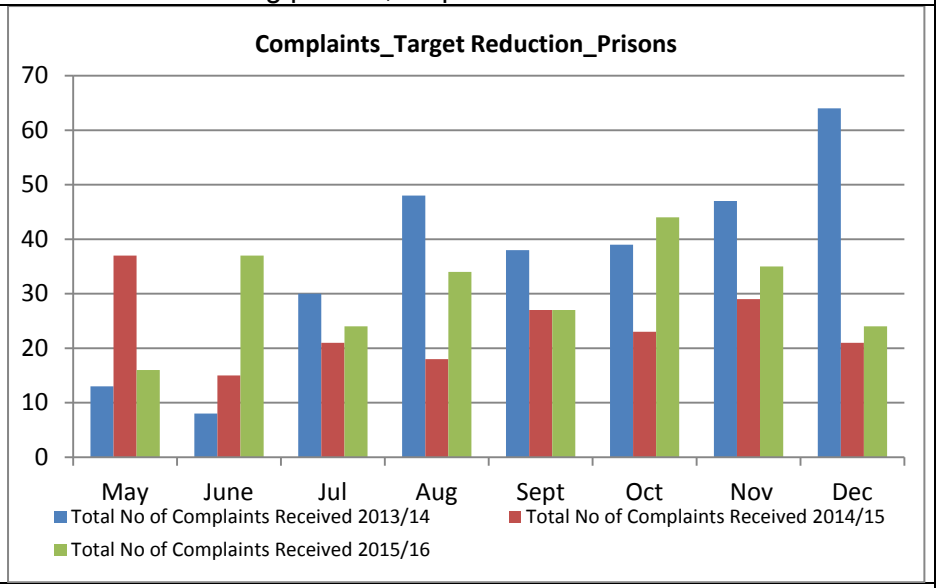
The graph highlights the 20 day response rate to the end of November 2015 as 90.7% for complaints excluding prisons and 100% for prison complaints. The overall position for Forth Valley is 94.9%

The top 3 issues raised in complaints remain Clinical Treatment, Attitude and Behaviour, and Waiting Time/ Date of Appointment. A detailed Complaints Performance Report is presented to the Clinical Governance Committee as a standing item.

NHS Forth Valley takes a person centred approach to the management of complaints with a focus on local resolution. There is on-going work across the organisation in support of complaints handling and resolution.

Measure	Reduction in the number of complaints received – Local target of 20% target
Current Performance	Complaints received at December 2015 – 33 excluding prisons; 24 prisons





Commentary

Work continues across NHS Forth Valley to support a reduction in the number of complaints received with a 20% reduction applied for 2015/16. In December 2015, 33 complaints were received excluding prisons, with 24 prison complaints received.

Work is on-going with the patient group in the prisons to locally resolve issues.

Performance in respect of complaints and complaints reduction are examined at the CEO Operational Group and through Directorate reviews.

Dimension of Quality:
EQUITABLE

Context

Equitable - Providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location or socio-economic status.

Smoking Cessation

The target is to sustain and embed successful smoking quits, at 12 weeks post quit, in the 40% most deprived SIMD areas. The full year target for NHS Forth Valley for 2015/16 is 219 successful 12 week quits in the 40% SIMD areas. The position for the second quarter to the end of September 2015 is that there were 57 successful quits against a trajectory point of 55. Data extract at 7 January 2016 highlights that 64% of the full year target has been achieved to date. In respect of the current activity it is anticipated that NHS Forth Valley will achieve the full year target of 12 week quits in the 40% most deprived SIMD areas by the end of March 2016.

New models of working are currently being undertaken by the Stop Smoking Service to provide outreach into services which support those smokers from Forth Valley's 40% most deprived SIMD areas including the following:

- A pilot Employability Project (you train) pop up clinic for apprentices/trainees
- Stop Smoking service in Forth Valley College Stirling Campus has commenced for both staff and students with a separate session for the public
- Pilot Paragon Housing Association stop smoking pop up service for tenants in Grangemouth
- As agreed with the Tobacco Action Group, support to those that pledged to stop smoking at New Year, with a 12 week celebration on No Smoking Day in March 2016

Child Dental Health

Following a presentation in respect of Child Dental Health at the Performance & Resources Committee in October it was agreed that Fluoride Varnish Applications, General Anaesthetics for Extraction and National Dental Inspection Programme information would be presented on a regular basis. This data was presented to the Performance & Resources Committee in December 2015 and is highlighted in the graph section below.

- *Fluoride Varnish Applications (FVAs)* - This is a process measure that provides information in respect of the number of FVAs provided to nursery and primary school children in targeted primary schools and nurseries across NHS Forth Valley.
- *General Anaesthetics for Extraction* - The majority of activity is for multiple extractions in young children with a small minority of activity being undertaken for dental treatment of children with special care needs and orthodontic extraction. A reduction in activity is therefore related to improvements in dental health; particularly a reduction in decay levels.
- *National Dental Inspection Programme* - The National Dental Inspection Programme has two levels: a Basic Inspection for all children, and a Detailed Inspection for a representative sample of a specific age group in alternate years. The Basic Inspection

involves a simple assessment of the mouth of each child. Each child is then placed into one of three categories depending on the level of dental health and a letter sent to their parents.
The letters are:

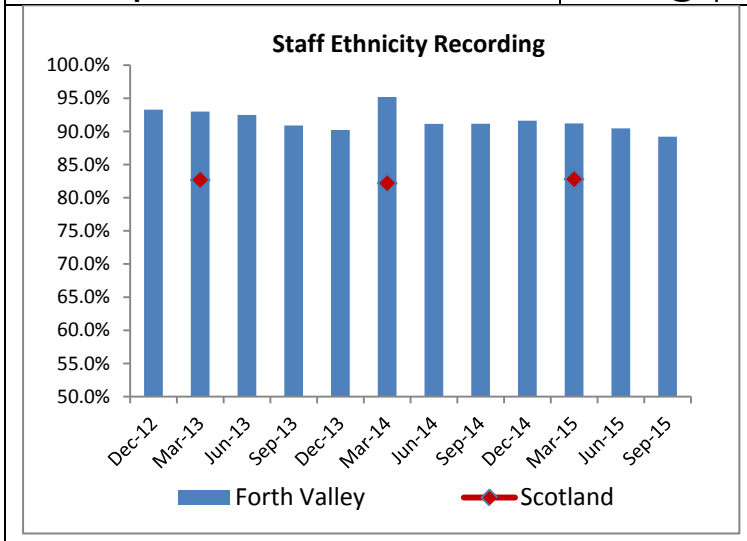
- Letter A (High Risk) - severe decay and should seek immediate dental care
- Letter B (Medium Risk) - some decay experience and should seek dental care in the near future
- Letter C (Low Risk) - no obvious decay but should continue to see the family dentist on a regular basis

As all P1 and P7 children undergo a basic examination each year this data can be used as a trend indicator, however due to the nature of the examination this data should not be over interpreted. A reduction in the A, B letters, and an increase in C letters would be indicative of an improvement.

Early access to maternity care

At least 80% of pregnant women in each SIMD quintile will have booked for antenatal care by the 12th week of gestation. Early access to antenatal services supports mothers-to-be to breastfeed, improving maternal and infant nutrition, reducing harm from smoking, alcohol and drugs, and improving healthy birth weight. These health behaviours are monitored through the maternity care quality indicators. The December 2015 management position for NHS Forth Valley highlights that 92.5% of pregnant women booked for antenatal care by 12 weeks, ahead of the 80% target.

Measure	Ethnicity recording - 95% of staff to have their ethnicity recorded
Current performance	89.2% @ quarter ending September 2015



Commentary

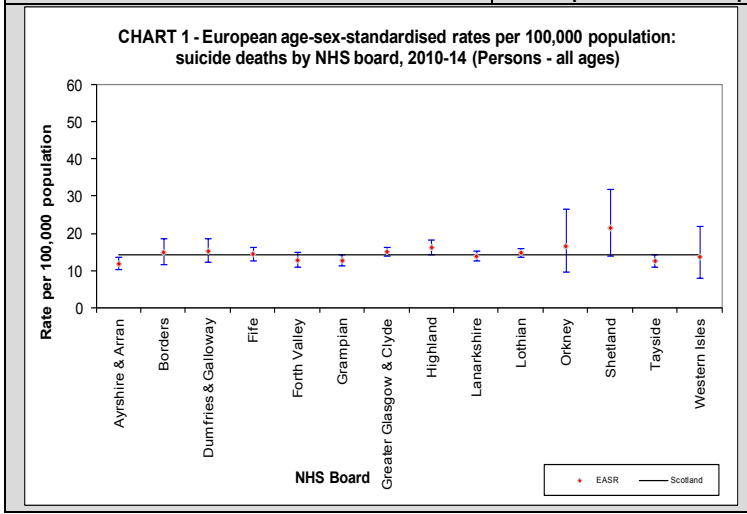
The graph shows that the quarterly position to the end of June 2015 for NHS Forth Valley is 89.2% of staff ethnicity is known. Staff do have the option of 'prefer not to say' with the total figure including those that declined to answer.

This data is updated on a quarterly basis with the December 2015 figure due for reporting in March 2016.

Work is on-going with the Equality and Diversity Manager, and the Workforce Team in respect of work aimed at increasing the percentage.

The annual publication in respect of the Scotland position at March 2015 highlights a position of 82.8%.

Measure	Suicide Rate – deaths caused by intentional self harm and events of undetermined intent
Current Performance	12.9 per 100,000 population @ December 2014 (2010 – 2015)



Commentary

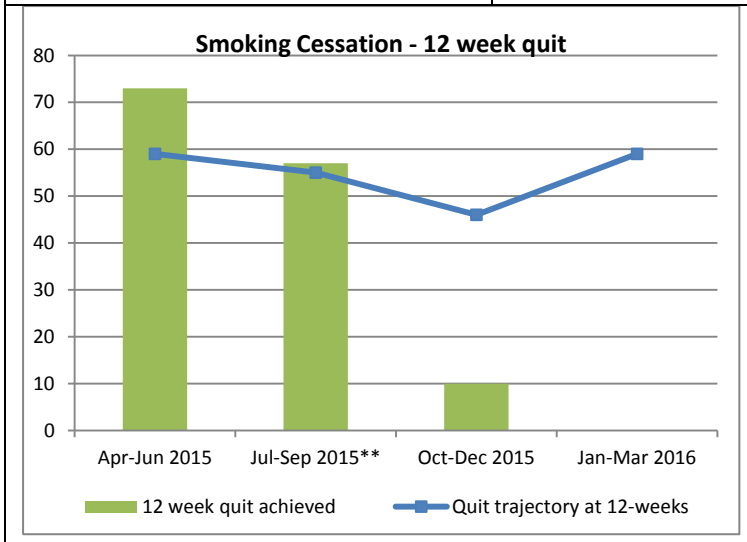
The graph shows that for NHS Forth Valley the 5 year rolling position to December 2014 is 12.9 per 100,000 population.

The Scotland position is 14.2 per 100,000 population.

The rate is European age-sex-standardised rate per 100,000 population, with a 95% confidence limits (LCL / UCL). A 95% confidence interval implies that 95 times out of 100 the interval will include the true underlying rate.

The next update is anticipated in August 2016.

Measure	NHS Scotland to deliver smoking cessation services to contribute to achieve at least 12,000 successful quits at 12 weeks post quit, in the 40% most deprived within-board SIMD areas over the 1 year ending March 2015
Current Performance	57 successful 12 week quits @ quarter ending September 2015 against a trajectory of 55



Commentary

The full year target for NHS Forth Valley for 201/16 is 219 successful 12 week quits in the 40% most deprived SIMD areas.

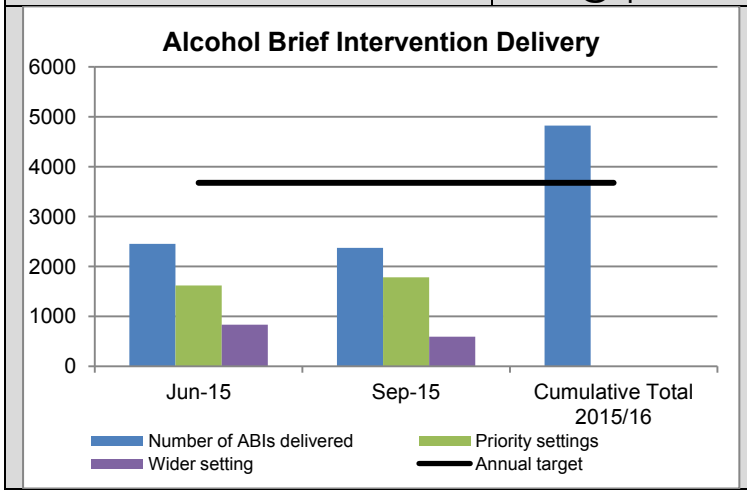
The position for the second quarter to the end of September 2015 is that there were 57 successful quits against a trajectory point of 55.

Data extract at 7 January 2016 highlights that 64% of the full year target has been achieved to date. In respect of the current activity it is anticipated that NHS Forth Valley will achieve the full year target of 12 week quits in the 40% most deprived SIMD areas by the end of March 2016.

Note:

- *Time lag in reporting due to the 12 week nature of the target and the ISD reporting cycle.*
- ***Final Quarter 2 data will not be available until 3rd February 2016.*

Measure	Sustain and embed Alcohol Brief Interventions (ABI) in primary care, A&E and antenatal, and broaden delivery in wider settings
Current Performance	2373 @ quarter ending September 2015

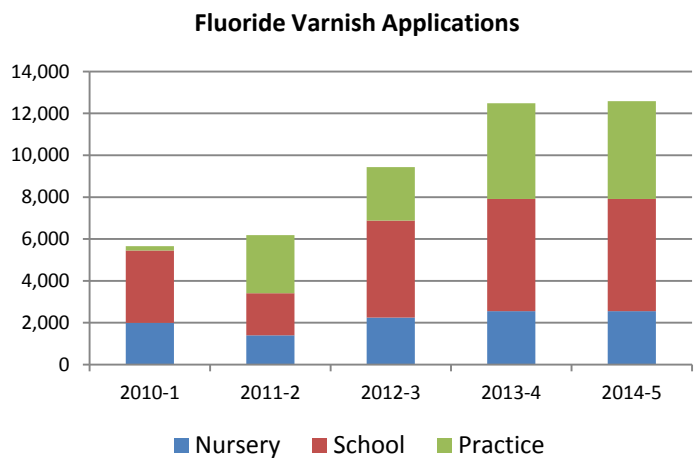


Commentary

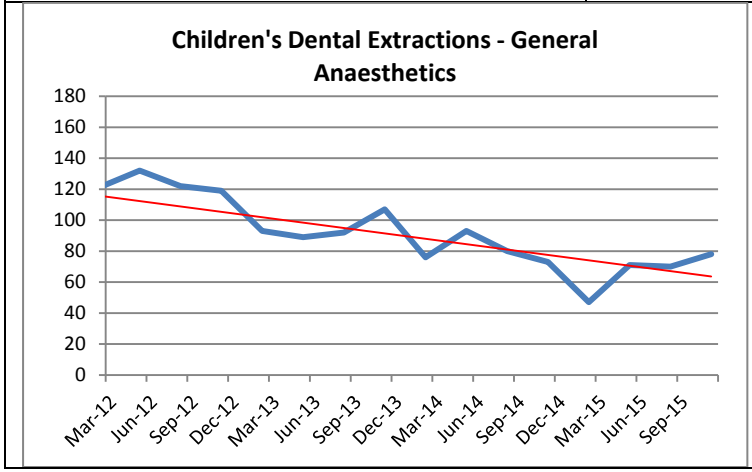
The standard is to sustain and embed Alcohol Brief Interventions (ABI) in primary care, A&E and antenatal, and to broaden delivery in wider settings. The annual target for Forth Valley remains the same as in previous years in terms of numbers with the delivery of 3676 ABIs.

Quarter 2, July – September 2015 saw delivery of a total of 2373 Alcohol Brief Interventions. Within the priority settings of Antenatal, A&E and Primary Care, 1782 ABIs were carried out, with 591 delivered in the wider settings e.g. Mental Health, Criminal Justice.

Measure	Achieve agreed completion rates for Child Healthy Weight interventions
Current Performance	100% uptake to March 2015
No graph data	**Commentary** The Child Healthy Weight programme continued throughout 2014/15 without a specific target. After a review with the 30 schools involved it was agreed to continue with the existing programme and therefore Max in the Middle (MiM) and Max in the Class (MiC) proceeded with : • MiM 46 classes (over 1000 participants) • MiC over 20 classes (over 500 participants) There was 100% uptake from the classes involved. Into 2015/16 the Max programme will continue.

Measure	**Child Dental Health** - To increase the total annual number of Fluoride Varnish Applications (FVAs) year on year in 3-4 year olds
Current Performance	12,584 Fluoride Varnish Applications carried out in the last 12 months
	**Commentary** The Childsmile programme is currently undertaking a programme review to coincide with 10 years of programme activity. The general dental practitioners participation in the Childsmile programme and the Fluoride Varnish aspect of the programme is variable across both Scotland and Forth Valley. The recent National Childsmile Board meeting in October 2015 concentrated on 'Prevention in Practice' and shared findings about factors that affect preventive treatments in general dental practice. A recent short-life working group, chaired by the Chief Dental Officer in 2015, discussed the possibility of Fluoride Varnishing activity being concentrated in the Public Dental Service, as well as continuing to support general dental practitioners through changing the Statement of Dental Remuneration to address possible barriers to treatments being carried out in practice. The Chief Dental Officer will communicate with the Programme Executive team as to her decisions about the way forward. Forth Valley continues support fluoride varnishing and the Childsmile programme in both the general dental services and the public dental services.

Measure	**Child Dental Health** - General anaesthetic (GA) for children's dental extractions – reduce to 200 GAs per annum by 2020 (50 per quarter)
Current Performance	78 GAs in the last quarter

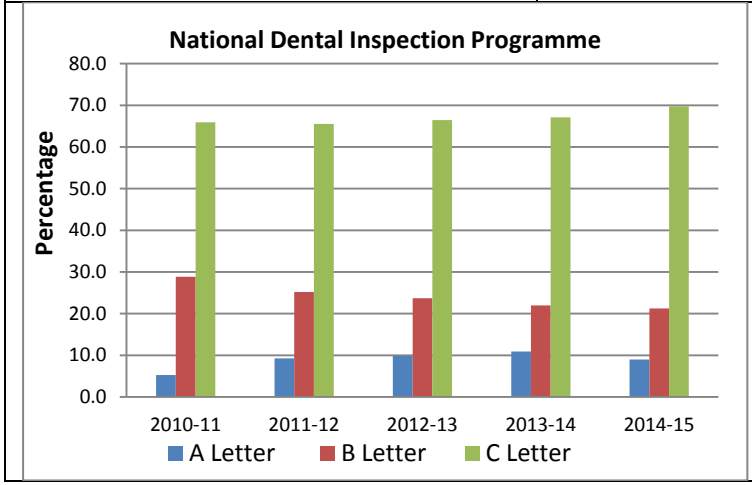


Commentary

The target is to reduce the rate of general anaesthetics for children's dental extractions to 50 per quarter.

A small increase is noted in the last quarter due to a number of additional sessions that were provided during the last quarter to offset session lost over the summer holiday period.

Measure	**Child Dental Health** - To reduce the number of children receiving high dental risk (A letter) from the Basic National Dental Inspection Programme inspection to < 2% by 2020.
Current Performance	In 2015 the proportion of Primary 1 pupils receiving a letters was 8.9%



Commentary

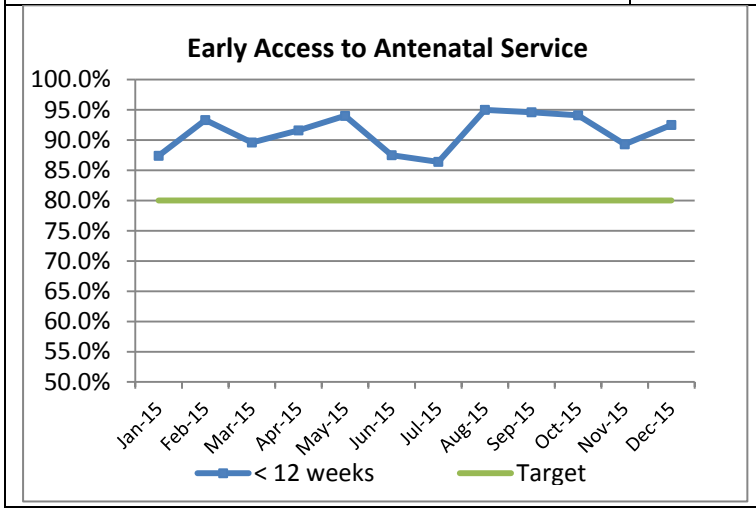
Child dental health is routinely monitored by the National Dental Inspection Programme (NDIP) with data published annually.

The percentage of A letters in Clacks, Falkirk and Stirling in 2015 was 10.2%, 8.7% and 8.8% respectively.

This represents an improvement on the previous year of 23%, 17% and 11% in Clacks, Falkirk and Stirling respectively.

The improvements are related to Childsmile programme activity.

Measure	At least 80% of pregnant women in each SIMD quintile will have booked for antenatal care by the 12th week of gestation.
Current Performance	92.5% at December 2015; ahead of target



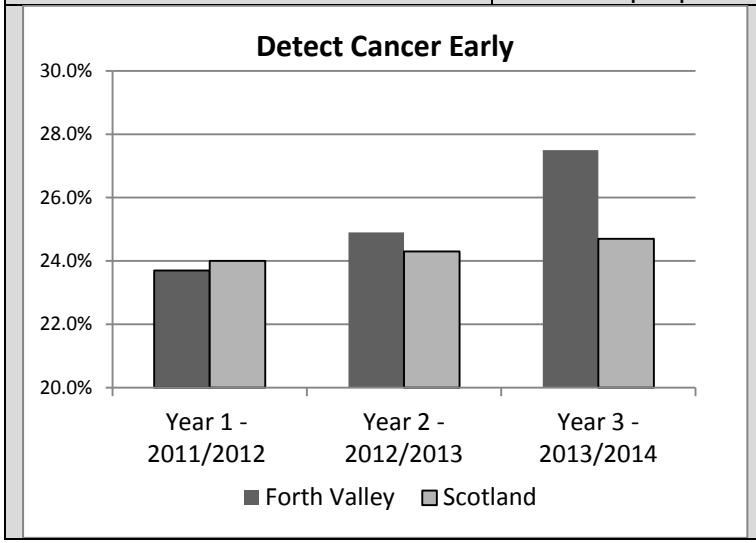
Commentary

Data highlights that NHS Forth Valley continues to perform well against this target.

The December 2015 management position for NHS Forth Valley highlights that 92.5% of pregnant women booked for antenatal care by 12 weeks. This remains ahead of the 80% target.

Early access to antenatal services supports mothers-to-be to breastfeed, improving maternal and infant nutrition, reducing harm from smoking, alcohol and drugs, and improving healthy birth weight. These health behaviours are monitored through the maternity care quality indicators.

Measure	To increase the proportion of people diagnosed and treated in the first stage of breast, colorectal and lung cancer by 25% by 2014/15. This refers to the two calendar years combined from January 2014 through to December 2015.
Current Performance	27.5% of people were diagnosed in the first stage throughout 2013/2014



Commentary

In 2010/2011, 23.0% of people with breast, colorectal and lung cancer in Scotland were diagnosed at stage 1 of the disease. This is the national baseline for the Detect Cancer Early (DTE) HEAT target and, as such, sets the national target of 28.8% of breast, colorectal and lung cancer to be diagnosed at stage 1 by 2014/2015.

The agreed target for NHS Forth Valley is 27% for 2013/2014, with this increasing to 29% for 2014/2015.

Published data highlights that 27.5% of people with breast, colorectal and lung cancer in Forth Valley were diagnosed at stage 1 of the disease in the period 01/01/2013 to 31/12/2014.

The next publication is anticipated in August 2016.

Dimension of Quality:
TIMELY

Context

Timely - reducing waits and sometimes harmful delays for both those who receive care and those who give care.

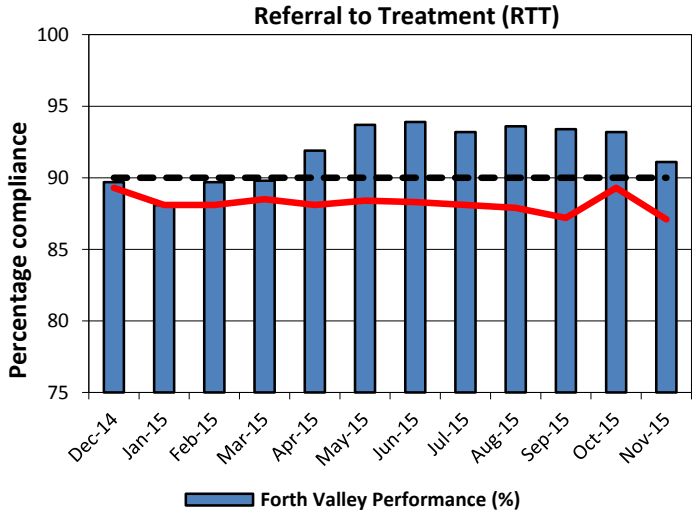
4 Hour A&E waits
The target is that 95% of patients will wait less than 4 hours from arrival to admission, discharge or transfer for accident and emergency treatment, with a stretch aim of 98%. The December 2015 compliance with the target is 97.8%; MIU 99.9%, ED 97.4% with 3, eight hour and no twelve hour breaches. There remains periods of variability in performance with patients waiting longer than the target due to 'wait for first assessment' as well as 'wait for a bed'. Significant activity continues with regard to improving consistency of performance.

Enhanced monitoring by the Scottish Government is currently in place in respect of the 4 hour emergency access standard. Focussed actions are in place to support delivery of the standard include actions to improve flow across the whole system, and actions to provide alternatives to admission to the acute setting.

In vitro fertilisation (IVF)
The position at December 2015 is that no one in Forth Valley who meets the eligibility criteria is waiting over 12 months.

- Detail in respect of Timely issues and targets will be discussed in the **Waiting Times Report - Agenda Item 7.3**

Measure	90% of planned / elective patients to commence treatment within 18 weeks of referral (RTT)
Current Performance	91.1% @ November 2015 against a standard of 90%



Commentary

In November 2015, 91.1% of patients were treated within 18 weeks of referral. The longest waiting patients are being treated in date order, unless otherwise clinically indicated.

19 out of 27 specialties achieved or bettered the 90% standard. Performance in 5 specialties was below 90% with the performance in Anaesthetics, Ophthalmology and Endocrinology requiring additional focus with performance below 80%.

The Scotland position at November 2015 was 87.1% compliance with the standard *(Note: November data excludes Ayrshire & Arran)*

Measure	Under the Patient Rights (Scotland) Act 2011, from 1st October 2012, all eligible patients will start to receive their day case or inpatient treatment within 12 weeks of the agreement to treat.
Current Performance	Five patient had an ongoing wait over 12 weeks at the end of December 2015

Treatment Time Guarantee Compliance				
	Quarter ending March 2015	**Quarter ending June 2015**	**Quarter ending September 2015**	**Quarter ending December 2015**
Number waiting >12 wks	**16**	**1**	**1**	**4**

*Note that the table highlights the number of patients who have completed waits over 12 weeks.

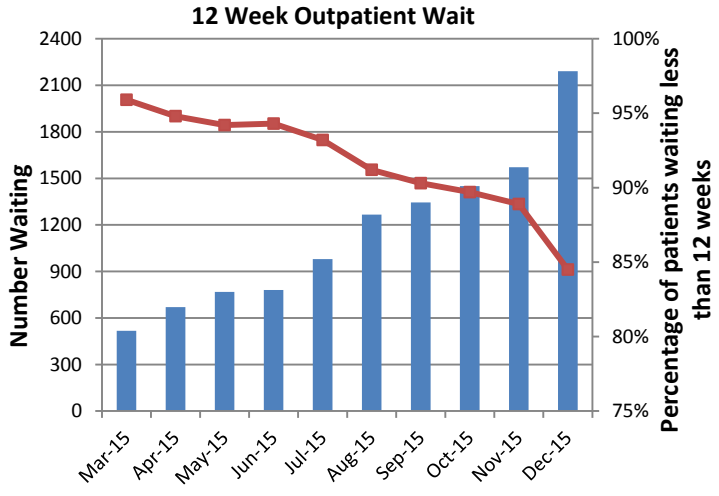
Commentary

Under the Patient Rights (Scotland) Act 2011, from 1st October 2012, all eligible patients will start to receive their day case or inpatient treatment within 12 weeks of the agreement to treat.

The provisional position for the quarter ending December 2015 highlights 4 patients waiting longer than the 12 week guarantee.

Five patients with an on-going wait over 12 weeks were highlighted at the end of December 2015.

Measure	No patient will wait longer than 12 weeks from referral (all sources) to a first outpatient appointment
Current Performance	2191 @ December 2015 against a standard of zero



Commentary

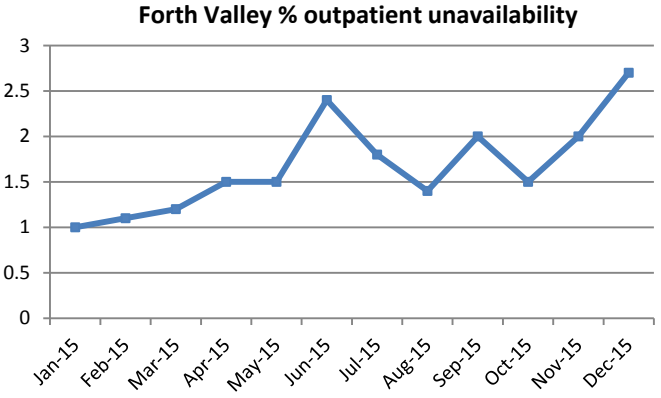
NHS Boards are being asked to deliver 95% of patients waiting under 12 weeks for a new outpatient appointment as a minimum standard, with a stretch aim of 100%. Waits over 16 weeks are to be eradicated.

At the end of December 2015 the number of patients exceeding the 12 week waiting time standard was 2191, with 793 waiting over 16 weeks.

84.5% of outpatients were waiting less than 12 weeks at the end of December 2015 with the Scotland position for September 86.1%.

The majority of patients waiting in excess of 12 and 16 weeks are within Anaesthetics, ENT, Ophthalmology, Orthopaedics, Dermatology, Neurology, OMFS and Gastroenterology.

Measure	Audit Scotland recommendation – Percentage outpatient unavailability as a proportion of the total waiting list size
Current Performance	2.7% @ December 2015



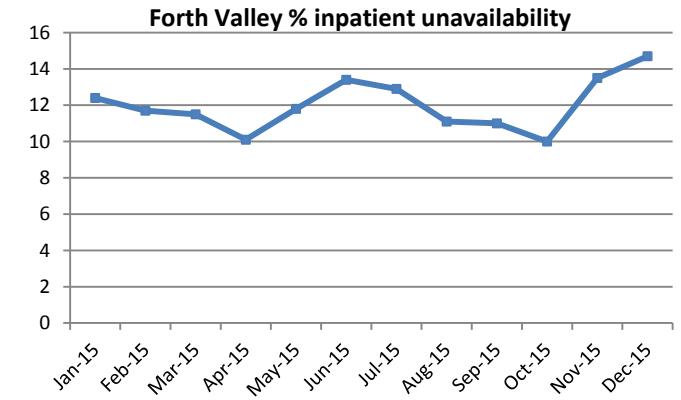
Commentary

The graph highlights the percentage of unavailable outpatients as a proportion of the total waiting list size. Rates are reported to comply with Audit Scotland recommendations. There is no agreed standard for unavailability rates however detailed monitoring is required.

At the end of December 2015 outpatient unavailability for NHS Forth Valley was 2.7%.

The Scotland position at September 2015 was 3.2%.

Measure	Audit Scotland recommendation – Percentage inpatient unavailability as a proportion of the total waiting list size
Current Performance	14.7% @ December 2015



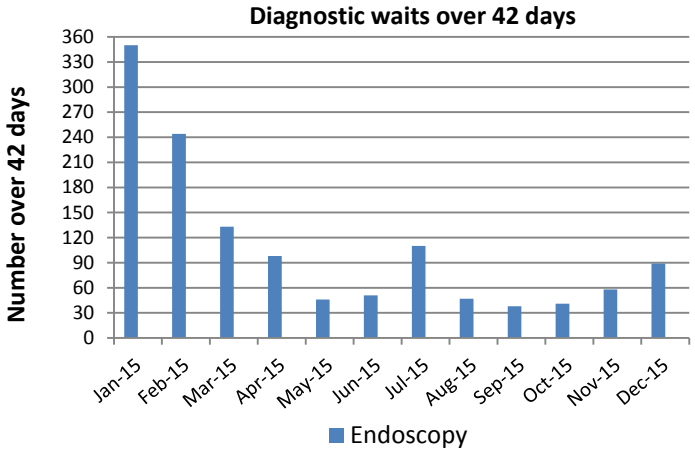
Commentary

The graph highlights the percentage of inpatient/day cases that are unavailable as a proportion of the total waiting list size. Rates are reported to comply with Audit Scotland recommendations. There is no agreed standard for unavailability rates however detailed monitoring is required.

At the end of December 2015 inpatient unavailability for NHS Forth Valley was 14.7%.

The Scotland position at September 2015 was noted as 18.9%.

Measure	Diagnostics - the maximum wait from referral to reporting of results should not be more than 42 days
Current Performance	89 patients waited over 42 days at December 2015



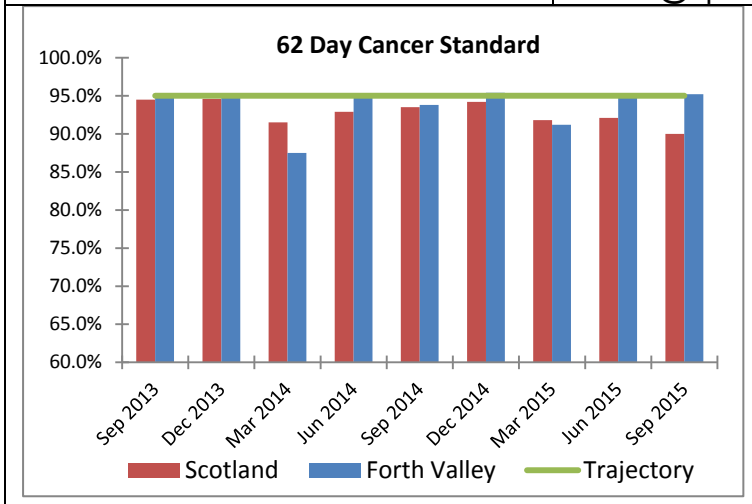
Commentary

At the end of December 2015 the total number of patients waiting over 42 days was 89. All the waits were within endoscopy.

Published data highlights that for quarter ending September 2015, across Scotland 90.3% of patients waiting for a key diagnostic test had been waiting less than six weeks with the Forth Valley position 97.9%.

In support of utilising capacity appropriately, the endoscopy booking team continue to phone all patients to confirm attendance.

Measure	95% of patients with suspicion of cancer treated within 62 days or less
Current Performance	95.2% @ quarter ending September 2015 against a target of 95%



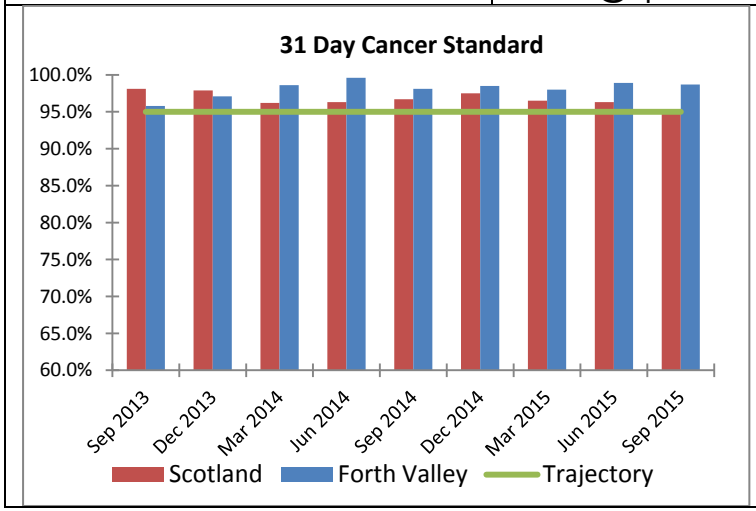
Commentary

For NHS Forth Valley the quarterly statistics to September 2015 highlight that 95.2% of patients with a suspicion of cancer were treated within 62 days.

In November 2015, the management report highlighted that 96.0% of patients were treated within 62 days.

The Scotland position for quarter ending September 2015 is 90.0%.

Measure	95% of patients with cancer treated within 31 days of decision to treat
Current Performance	98.7% @ quarter ending September 2015 against a target of 95%



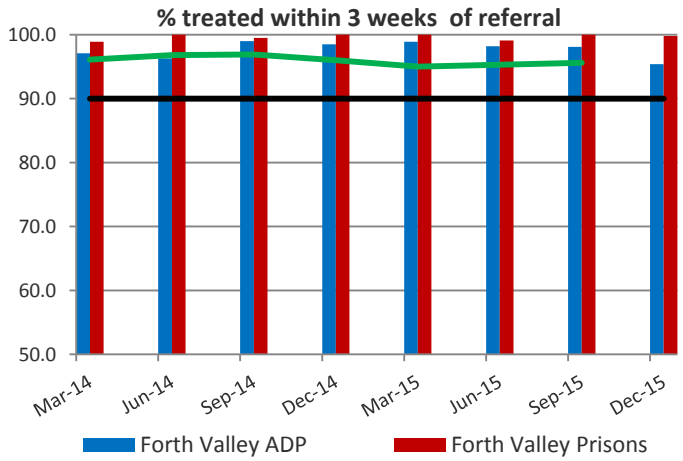
Commentary

Quarterly figures to September 2015 show that 98.7% of patients were treated within 31 days against a 95% Standard.

In November 2015, the management report highlighted that 98.6% of patients were treated within 31 days.

The Scotland position for quarter ending September 2015 is 95.2%.

Measure	By March 2013, 90% of clients will wait no longer than 3 weeks from referral received to appropriate drug or alcohol treatment that supports their recovery (combined Standard).
Current Performance	95.4% for quarter ending December 2015



Commentary

The pre-publication figures for the quarter ending December 2015 highlight that 95.4% of NHS Forth Valley clients started their first drug or alcohol treatment within 3 weeks of referral. The Scotland position at quarter ending September 2015 was 95.6%.

The pre-publication figures highlight that the position in respect of NHS Forth Valley prisons, to quarter ending December 2015, is that 99.8% of clients who have started first treatment waited less than 3 weeks. The Scotland position in respect of prisons to quarter ending September 2015 was 97.7%.

Publication of the quarterly position to the end of December 2015 is anticipated at the end of March 2016.

Measure	90% of eligible patients will commence in vitro fertilisation (IVF) treatment within 12 months by 31 March 2015.
Current Performance	At December 2015 no one meeting the access criteria was waiting over 12 months in Forth Valley

No graph data

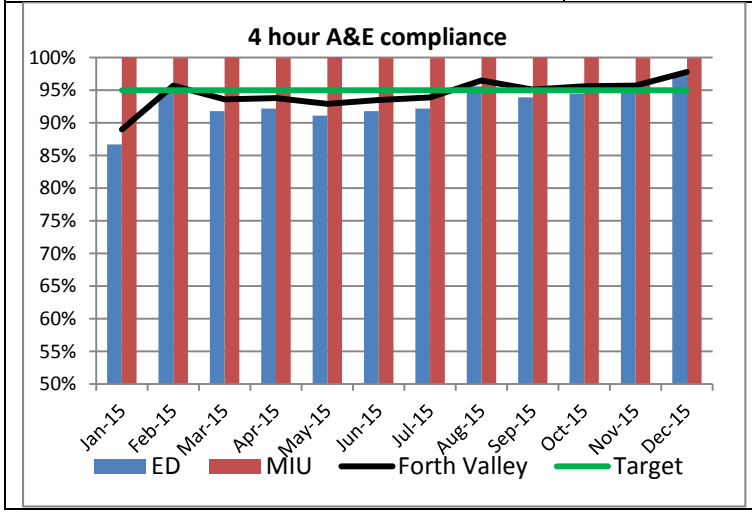
Commentary

The position for NHS Forth Valley at December 2015 is 100% compliance with the target, with no one meeting the eligibility criteria waiting over 12 months. The average wait from receipt of referral letter to pre-treatment screening is 6 months.

11 patients have deferred the start of treatment at their own request and 4 have been deferred for medical reasons. Medical reasons being that they do not fulfil certain aspects of the criteria in respect of e.g. raised blood pressure, obesity or gynaecological issues.

For the quarter ending September 2015, across Scotland 100% of eligible patients were screened for IVF treatment within 12 months.

Measure	95% of patients will wait less than 4 hours from arrival to admission, discharge or transfer for accident and emergency treatment
Current Performance	97.8% @ December 2015 against a target of 95%



Commentary

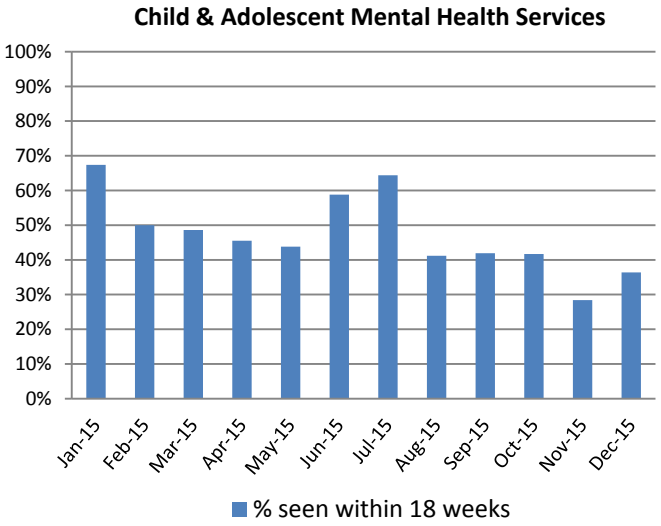
The Scottish Government requirement is that NHS Boards should achieve and maintain 95% with a stretch aim of 98%.

Compliance for December 2015 was 97.8%; MIU 99.9%, ED 97.4% with 3, eight hour and no twelve hour breaches. There remains periods of variability in performance with patients waiting longer than the target due to 'wait for first assessment' as well as 'wait for a bed'. Significant activity continues with regard to improving consistency of performance.

Focussed actions are in place to support delivery of the standard include actions to improve flow across the whole system, and actions to provide alternatives to admission to the acute setting.

The Scotland position at the end of November 2015 is 94.9%.

Measure	Faster access to Child & Adolescent Mental Health Specialist Services (CAMHS) by delivering 18 weeks Referral to Treatment – 90% target
Current Performance	36.4% @ December 2015



Commentary

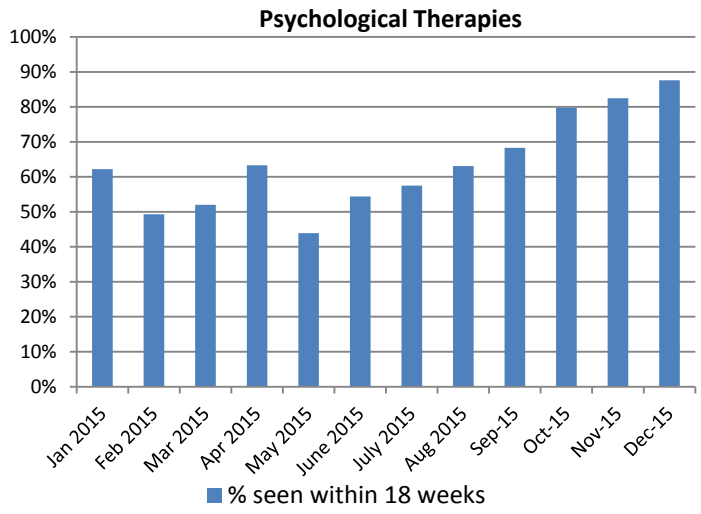
Management information highlights that compliance with the 18 week Referral to Treatment wait at December 2015 is 34.6%. This is likely the impact of seeing long waiting patients; a phenomenon seen in other specialties as we work through a backlog.

A review of processes and procedures has been undertaken to ensure efficient patient pathways along with work on reviewing referral pathways to support the implementation of new legislation, including review and audit of systems to assist the wider roll out of Named Persons.

Weekly meetings are on-going supporting implementation of a multi level action plan directly addressing the current waiting list. In addition, recent investment has seen the recruitment of new staff.

The Scotland position for September 2015 is 71.1% of patients were treated within 18 weeks of referral.

Measure	Deliver faster access to mental health services by delivering 18 weeks referral to treatment for Psychological Therapies from December 2014 - 90% target
Current Performance	87.6% @ December 2015



Commentary

Management information highlights that during December 2015, 87.6% of patients were seen within 18 weeks. The Scotland position for September 2015 is 71.1% of patients were treated within 18 weeks.

Actions are in place to support improvements across the service with an increased focus on treating people who have been waiting longest. Ongoing operational management improvements within psychology including internal restructure to create appropriate management arrangements.

Job plan reviews scheduled for all psychology staff to ensure required levels of clinical activity.

Service redesign with a draft outline service model and implementation plan is currently being developed with completion and steering group sign-off anticipated by the end of January.

Measure	Musculoskeletal (MSK) Physiotherapy Waits – NHS Boards are expected to deliver a maximum wait of no more than 4 weeks for AHP Musculoskeletal treatment from 1 April 2016.
Current Performance	Longest wait 26 weeks @ November 2015

No graph data

Commentary

The maximum wait for this service is 26 weeks at the end of November 2015. At the end of November 2015, 358 patients were waiting longer than 12 weeks with 33 waiting over 16 weeks.

NHS Forth Valley is one of six NHS Boards providing AHP Physiotherapy MSK data; Ayrshire & Arran, Borders, Dumfries & Galloway, Greater Glasgow & Clyde and Lanarkshire. Once all NHS Boards IT systems have been fully developed the data that will be reported. At the quarter ending September 2015, across these Boards, 48% of patients were seen within 4 weeks.

The number of referrals per 100,000 people across the 6 Boards was 2,015, with the Forth Valley position 2,050.

Dimension of Quality:
EFFECTIVE & EFFICIENT

Context
Effective - Providing services based on scientific knowledge.
Efficient - Avoiding waste, including waste of equipment, supplies, ideas, and energy.

Delayed Discharges 14 day wait and Bed Days Occupied
The target is that no one will wait more than 14 days to be discharged from hospital into a more appropriate care setting, once treatment is complete. The position for delays over 14 days at the December 2015 census is 26 against a zero standard. The local authority breakdown is Clackmannanshire zero delays, Falkirk 24, Stirling 1 and Fife 1.

Work is currently being taken forward in respect of measuring and monitoring delayed discharges over 72 hours. Initial calculations reviewing the December census position highlight that 44 patients were delayed in their discharge over 72 hours.

The total bed days lost to delayed discharge in December have decreased to 1095 from 1284 at the November 2015 census. Local authority breakdown for December is Clackmannanshire 14, a decrease of 73 from November; Falkirk 1019 up 169; and Stirling 33, a decrease of 200. For local authorities' out with Forth Valley there were 29 bed days lost, a decrease of 85 from November 2015.

There is also greater focus on those patients who are delayed in their discharge with Code 9 exemptions, which include issues in respect of Guardianship. The number of patients in this group delayed at the December 2015 census was 19, with the number of bed days occupied by this cohort at the December census point, 1929. Weekly meetings continue focussing on individual patient needs to ensure appropriate movement, placement and packages of care.

Key actions to support improvements are in relation to discharge processes, including new patient 'tracking' arrangements; re-inforcement of patient admission, discharge and transfer policy with hospital based staff; review and refocus of the Integrated Discharge Team; implement Adults with Incapacity/Guardianship Project to improve staff and public understanding of power of attorney and guardianship arrangements.

It is recognised across the Partnerships that significant effort is required to make and sustain improvements in respect of achieving the 2 week target. This remains a key priority on Integrated Joint Board agendas.

A&E attendances
The target is to achieve an agreed reduction in the number of attendances at A&E. The position for December 2015 is 2044 attendances per 100,000 population. The provisional Scotland rate per 100,000 at November 2015 is 2406.

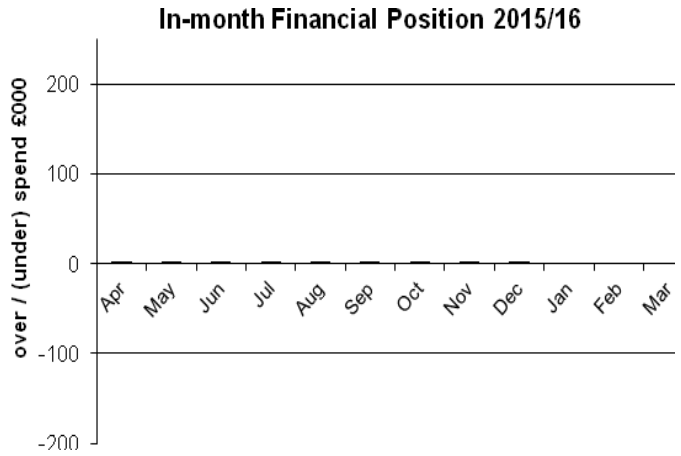
A reduction in the rate of A&E attendances is linked to the work in respect of Anticipatory Care Plans (ACPs) and Long Term Conditions. With an increase in the rate of A&E attendance over the summer period, the number of ACPs increasing and the bed days in respect of Long

Term Conditions decreasing the data requires to be considered collectively. A review of readmissions, led by the Medical Director, is being carried out. Initial work will ascertain the level of ACPs; this will be followed by a review of their utilisation.

New Outpatient appointment 'Did Not Attend' rates (DNA)
The DNA rate in respect of new outpatient appointments is 9.7% for the end of December 2015. The current NHS Forth Valley target is to remain below the Scotland position which for the quarter ending September 2015 is 10.3%. This will be reviewed on an on-going basis.

Finance
The current financial position will be discussed within the **Financial Monitoring Report - Agenda Item 7.2**

Measure	Finance – Financial balance
Current Performance	Breakeven as at 31st Dec 2015. Forecast outturn : £0.200m underspend



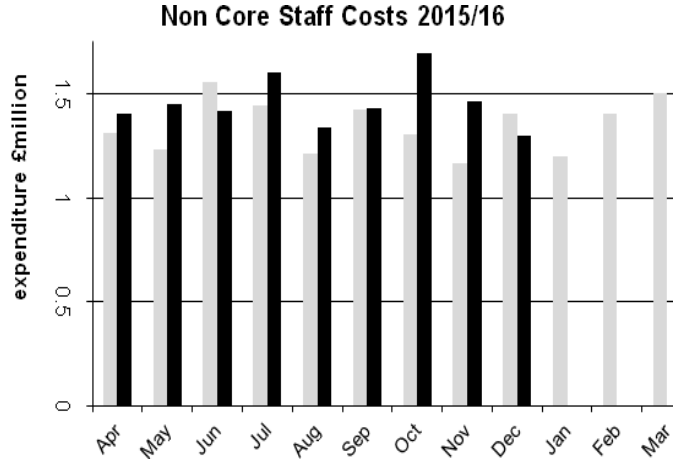
Commentary

NHS Forth Valley is reporting a balanced financial position to 31st December 2015 and forecasting a £0.200m underspend to 31st March 2016.

The main pressure areas are acute hospital prescribing costs, and access target delivery where additional bed capacity from winter remains open addressing current delayed discharge issues.

The current focus is on ensuring that financial plans for 2016/17 are supported by robust and deliverable savings plans.

Measure	Non Core Staff Costs
Current Performance	£13.099m spend for the 9 month period to 31st Dec 2015

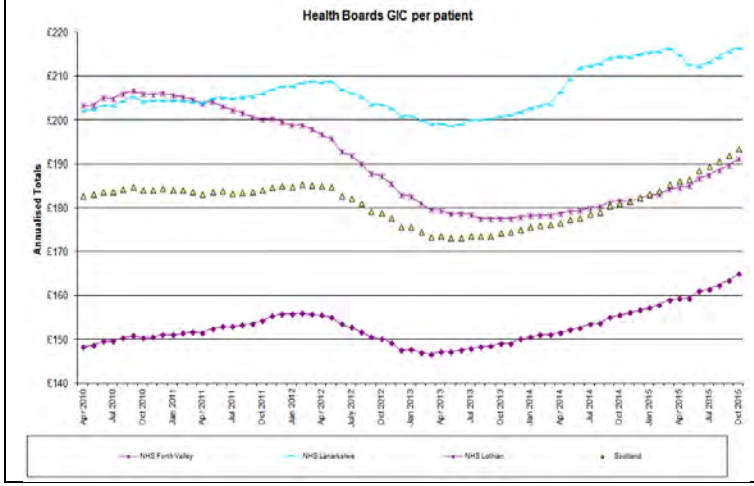


Commentary

Non-core staff costs include bank, agency, locum, and overtime costs.

Both Nurse bank and Medical agency costs have improved from October and November levels, however total non-core staff expenditure over the nine month period remains higher than the equivalent period last year.

Measure	To reduce GP prescribing cost per patient
Current Performance	£191.15 @ October 2015 (Scotland position = £193.41)



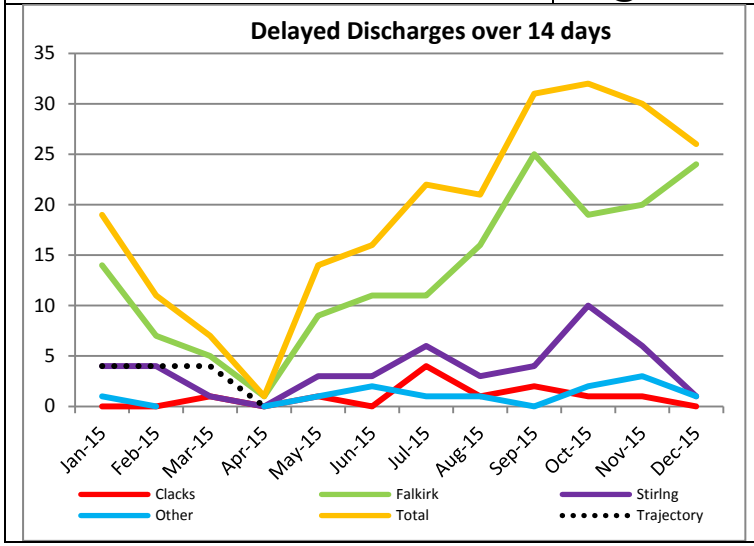
Commentary

The graph illustrates the cost per patient trends over the last 5 years for NHS Forth Valley and the Scottish average together with the two Boards currently reporting the highest and lowest cost per patient in Scotland (NHS Lanarkshire and NHS Lothian respectively).

The graph demonstrates the downward trend in Forth Valley's cost per patient from late 2010 onwards, before levelling out during 2013/14 and increasing slightly during 2014-15 mirroring national trends.

A modest increase is anticipated for 2015-16 which reflects the agreed uplift in the drug tariff as part of the community pharmacy contract settlement. However ongoing issues in relation to volume growth, short supply issues and uptake of new drugs are being experienced.

Measure	No one will wait more than 14 days to be discharged from hospital into a more appropriate care setting, once treatment is complete from April 2015
Current Performance	26 @ December 2015



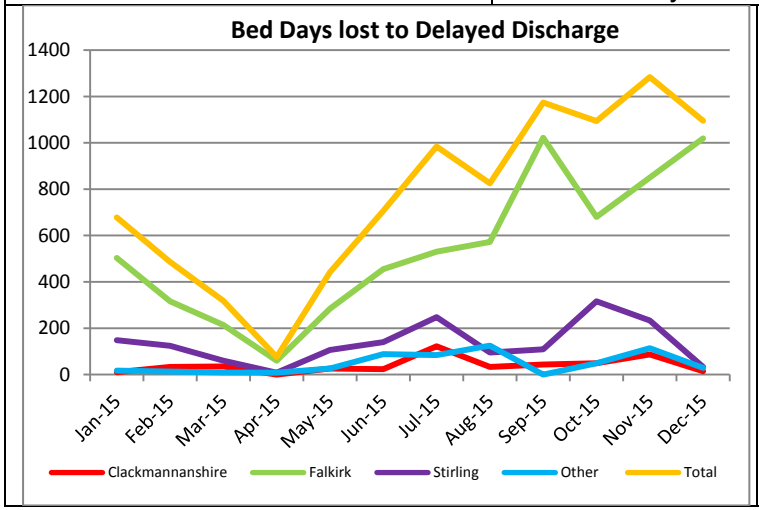
Commentary

At the December 2015 census 26 delays over 14 days were highlighted.

The local authority breakdown is Clackmannanshire zero delays, Falkirk 24, Stirling 1 and Fife 1.

Work is currently being taken forward in respect of measuring and monitoring delayed discharges over 72 hours. Initial calculations reviewing the December census position highlight that 44 patients were delayed in their discharge over 72 hours.

Measure	Reduction in the number of bed days lost due to delays in discharge
Current Performance	1095 bed days lost at the December 2015 census



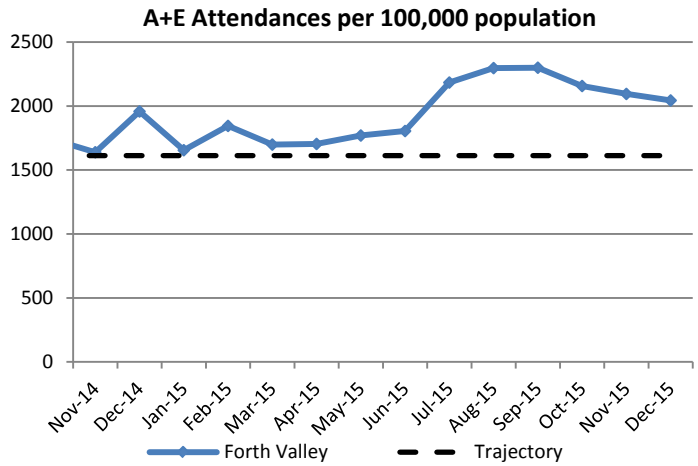
Commentary

The total bed days lost to delayed discharge in December have decreased to 1095 from 1284 at the November 2015 census.

Local authority breakdown for December is Clackmannanshire 14, a decrease of 73 from November; Falkirk 1019 up 169; and Stirling 33, a decrease of 200. For local authorities' out with Forth Valley there were 29 bed days lost, a decrease of 85 from November 2015.

Weekly meetings continue focussing on individual patient needs to ensure appropriate movement, placement and packages of care.

Measure	To achieve agreed reduction in rates of attendance at A&E (rate per 100,000 of population) between 2009/10 and 2013/14
Current Performance	2044 per 100,000 population @ December 2015



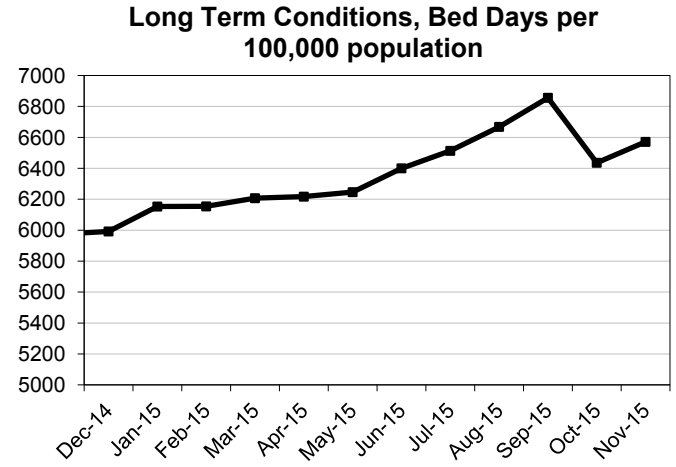
Commentary

The December 2015 position is 2044 attendances per 100,000 population.

A reduction in the rate of A&E attendances is linked to the work in respect of Anticipatory Care Plans (ACPs) and Long Term Conditions. With an increase in the rate of A&E attendance over the summer period, the number of ACPs increasing and the bed days in respect of Long Term Conditions decreasing the data requires to be considered collectively. A review of readmissions is being carried out. Initial work will ascertain the level of ACPs; this will be followed by a review of their utilisation.

The provisional Scotland rate per 100,000 at November 2015 is 2406.

Measure	Reduction in the number of bed days for long term conditions per 100,000 population
Current Performance	6571 @ November 2015 ahead of the Forth Valley standard of 7236



Commentary

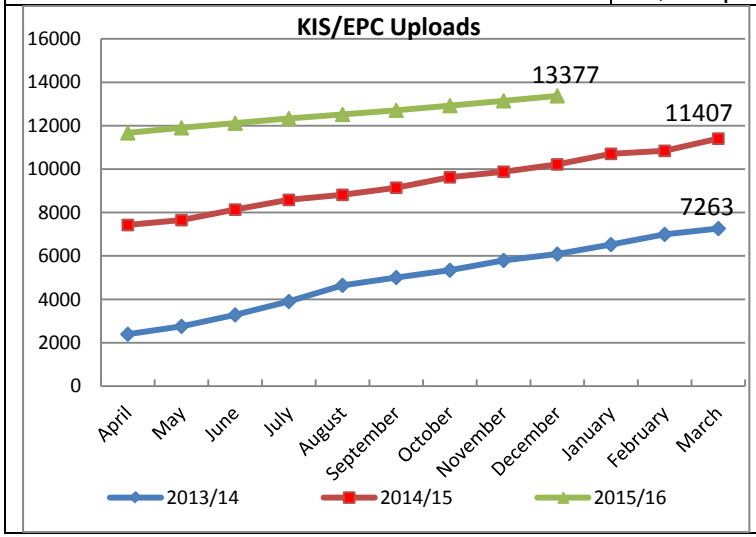
The target end point in respect of this historic HEAT target was 7236 bed days per 100,000 population. Work has continued in Forth Valley to maintain the position and gain further reduction against this.

Included in the long term conditions are Diabetes, Hypertension, Angina, Ischaemic Heart Disease, Chronic Obstructive Pulmonary Disease, Asthma and Heart Failure.

The in month position for November 2015 is 6571 bed days per 100,000 population.

This measure links to Acute Emergency Bed Days for over 75s, Anticipatory Care Plans, and rates of attendance at A&E.

Measure	Number of patients with an Anticipatory Care Plans
Current Performance	13,377 patients at December 2015



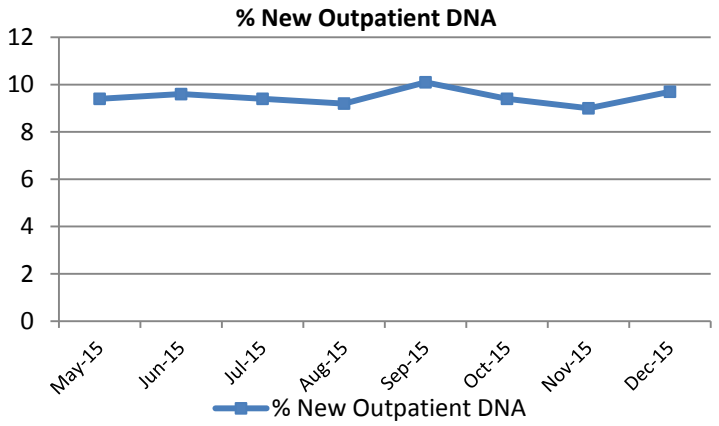
Commentary

The measure is the number of patients who have a Key Information Summary (KIS) or Electronic Palliative Care Summary (ePCS) uploaded to the Emergency Care Summary. The ECS provides up to date information about allergies and GP prescribed medications for authorised healthcare professionals at NHS24, Out of Hours services and accident and emergency.

The total number of patients with a KIS/ePCS record uploaded to the ECS system, and therefore could be considered to have an ACP is 13,377 at December 2015.

Total KIS uploads as a percentage of the board area list size is 4.25% of the total population, against a local target of 3%.

Measure	Reduce 'Did Not Attend' rates (DNA) for new outpatient appointments
Current Performance	9.7% @ December 2015



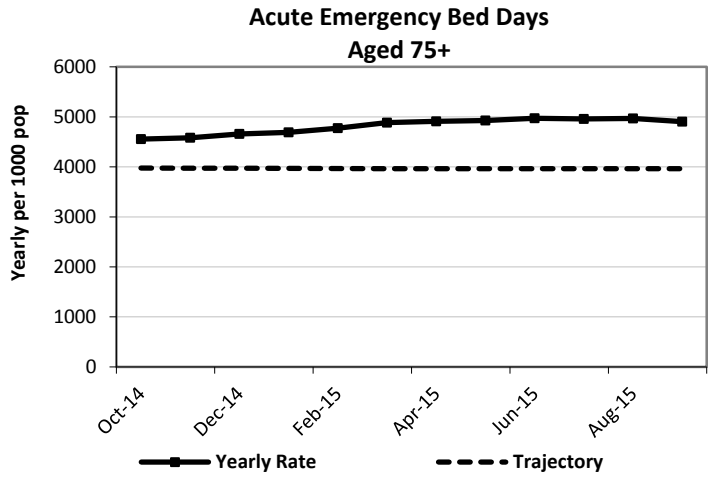
Commentary

The percentage DNA for new outpatients in December 2015 is 9.7%.

The current NHS Forth Valley target is to remain below the Scotland DNA position, with the Scotland position at quarter ending September 2015, 10.3%. This will be reviewed on an on-going basis.

There is active implementation and monitoring of Patient Access Policy in respect of 'Did Not Attend' patients.

Measure	To reduce Emergency Bed days in age 75+ per 1000 population by March 2015
Current Performance	4904 @ September 2015



Commentary

The September 2015 position is 4904 occupied bed days per 1000 population against a target of 3964.

A continual increase in the yearly position is highlighted, and this is in line with capacity pressures across the system.

The Scotland bed days rate per 1000 population at March 2015 was 4805 – data from NHS Scotland HEAT 2014/15 indicator reports.

Note: There is a time lag in this data of a minimum of 3 months due to the calculation being made using the SMR01 data which is processed and resubmitted to NHS Boards by ISD.

Measure	NHSScotland to reduce energy-based carbon emissions and to continue a reduction in energy consumption to contribute to the greenhouse gas emissions reduction targets set in the Climate Change (Scotland) Act 2009
Current Performance	Position for year ending March 2015 - See below

Energy target is a 1% year on year energy efficiency improvement

- The energy usage Variance v Target for NHS Forth Valley is **3.11% better** than target
- The Scotland position is highlighted as 0.28% better than target

CO_2 emissions target is a 3% year-on-year CO_2 emissions reduction target

- CO_2 emissions Tonnes v Target for NHS Forth Valley is **5.39% less** than the target
- The Scotland position is highlighted as 6.91% less than target

Commentary

The official figures are generated by the Environment Monitoring and Reporting Tool (eMART) and are amended by a weather compensation factor and adjusted for changes in estate floor area. The main purpose of this compensating factor is to 'even out' the vagaries of weather, allowing actual consumption to be viewed against a 'standardised' weather year.

A number of sites have performed below expectation for CO_2 emissions. Increased activity at Falkirk Community Hospital has had an impact while sites that have previously performed poorly have had Energy Surveys carried out. These surveys are now being analysed to identify areas for improvement.

Into 2015/16 targets have been set by individual Boards and reviewed by Health Facilities Scotland (HFS). These new targets form part of our Asset Management Strategy (AMS) and are reviewed annually as part of the overall AMS review process.

NHS LDP Standards 2015/16

Early diagnosis and treatment improves outcomes

- People diagnosed and treated in 1st stage of breast, colorectal and lung cancer (25% increase)
- 31 days from decision to treat (95%)
- 62 days from urgent referral with suspicion of cancer (95%)

Enable people to understand and adjust to a diagnosis, connect better and plan for future care

- People newly diagnosed with dementia will have a minimum of 1 years post-diagnostic support

Shorter waits can lead to earlier diagnosis and better outcomes for many patients as well as reducing unnecessary worry and uncertainty for patients and their relatives

- 12 weeks Treatment Time Guarantee (TTG 100%)
- 18 weeks Referral to Treatment (RTT 90%)
- 12 weeks for first outpatient appointment (95% with stretch 100%)

Antenatal access supports improvements in breast feeding rates and other important health behaviours

- At least 80% of pregnant women in each SIMD quintile will have booked for antenatal care by the 12th week of gestation

Shorter waiting times across Scotland will lead to improved outcomes for patients

- Eligible patients commence IVF treatment within 12 months (90%)

Early action is more likely to result in full recovery and improve wider social development outcomes

- 18 weeks referral to treatment for specialist Child and Adolescent Mental Health Services (90%)

Timely access to healthcare is a key measure of quality and that applies equally to mental health services

- 18 weeks referral to treatment for Psychological Therapies (90%)

NHS Boards are expected to improve SAB infection rates during 2015/16. Research is underway to develop a new SAB standard for inclusion in LDP for 2016/17

- Clostridium difficile infections per 1000 occupied bed days (0.32)
- SAB infections per 1000 acute occupied bed days (0.24)

Services for people are recovery focused, good quality and can be accessed when and where they are needed

- Clients will wait no longer than 3 weeks from referral received to appropriate drug or alcohol treatment that supports their recovery (90%)

Enabling people at risk of health inequalities to make better choices and positive steps toward better health

- Sustain and embed alcohol brief interventions in 3 priority settings (primary care, A&E, antenatal) and broaden delivery in wider settings
- Sustain and embed successful smoking quits, at 12 weeks post quit, in the 40% SIMD areas

Often a patient's first contact with the NHS is through their GP practice. It is vital, therefore, that every member of the public has fast and convenient access to their local primary medical services to ensure better outcomes and experiences for patients

- 48 hour access or advance booking to an appropriate member of the GP team (90%)

A refreshed Promoting Attendance Partnership Information Network Policy will be published in 2015

- Sickness absence (4%)

High correlation between emergency departments with 4 hour wait performance between 95 and 98% and elimination of long waits in A&E which result in poorer outcomes for patients

- 4 hours from arrival to admission, discharge or transfer for A&E treatment (95% with stretch 98%)

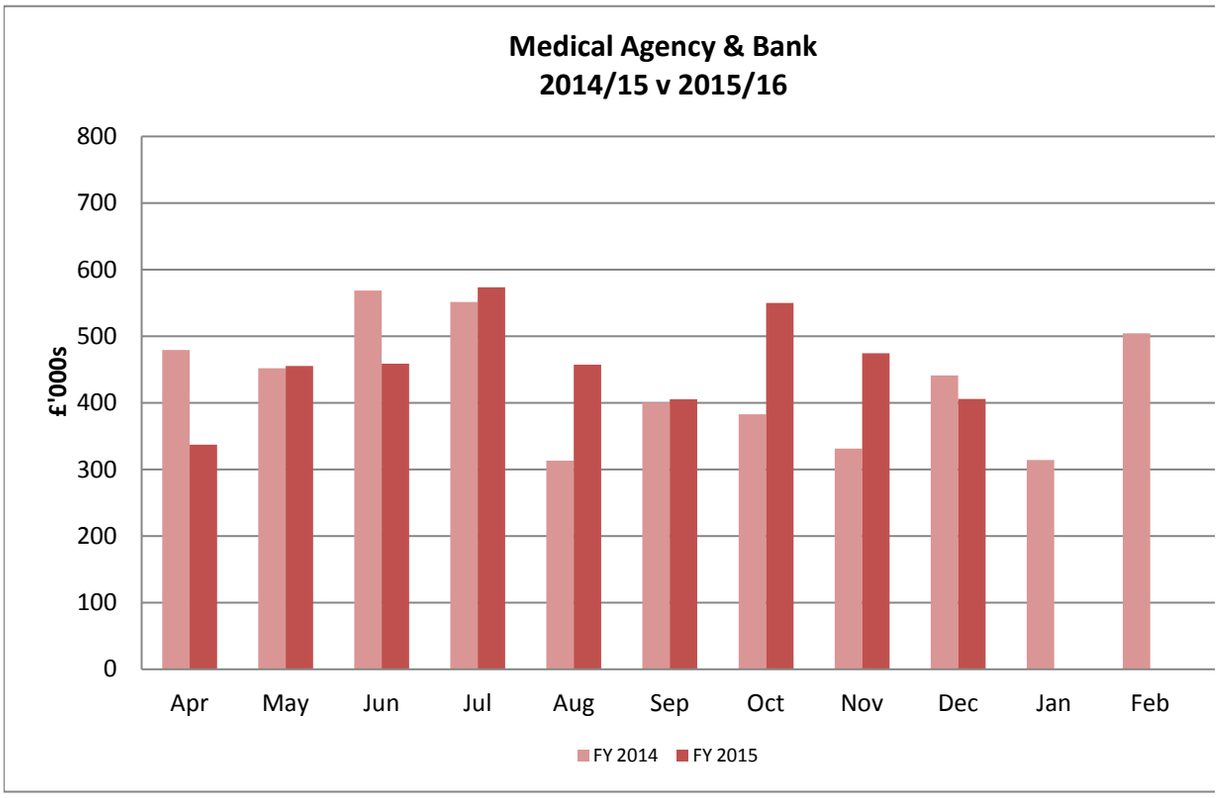
Sound financial planning and management are fundamental to effective delivery of services

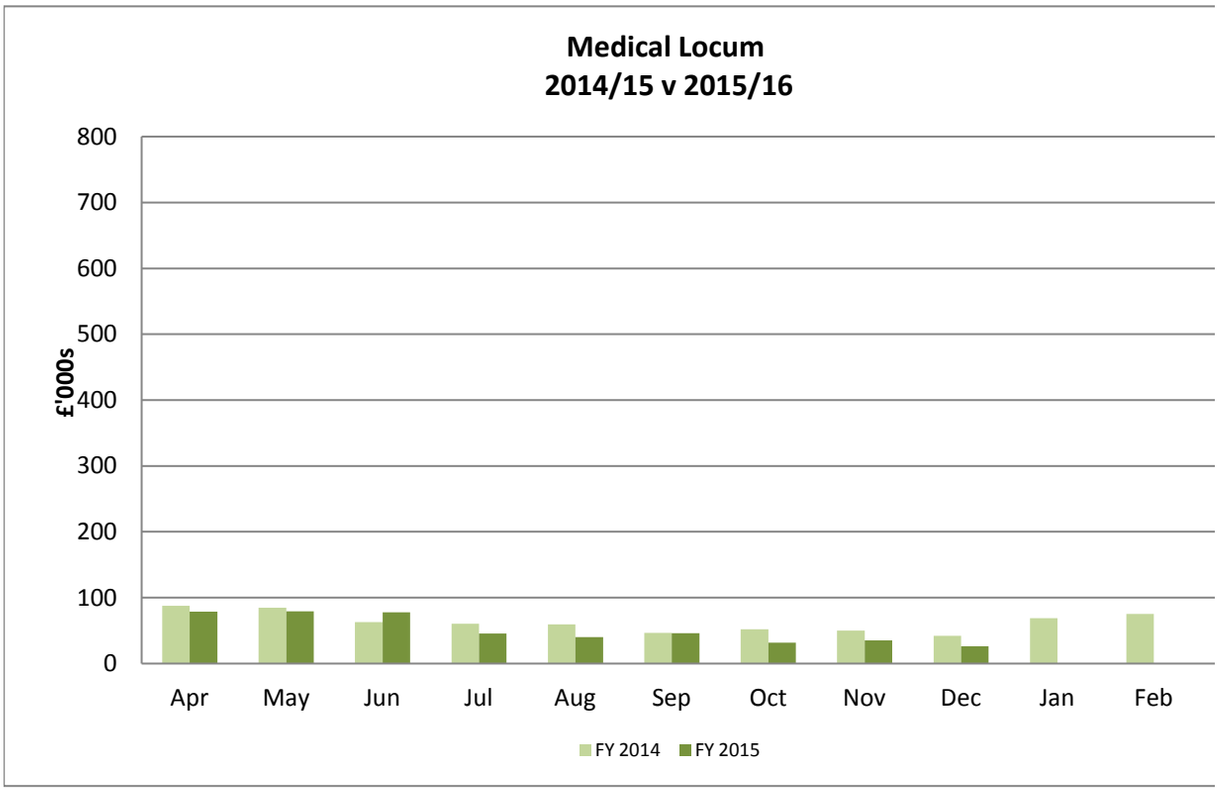
Operate within agreed revenue resource limit; capital resource limit; and meet cash requirement

NHS FORTH VALLEY **CAPITAL RESOURCE LIMIT** **As at 31st December 2015**	Position at 31st December 2015			Year end -Forecast		
	Plan £	Actual £	Variance £	Original Plan £	Forecast £	Variance £
SOURCES OF CORE FUNDING						
Scottish Executive Funding - Initial Allocation	3,853	3,853	0	6,725	6,725	0
SGHD - Project Specific Funding	9	9	0	600	600	0
SGHD - HUB Enabling Funding	20	20	0	20	20	0
SGHD - Asset Sales Retained	819	819	0	819	819	0
SGHD - Underspend 15/16	0	0	0	0	-819	-819
SGHD - Capital Grants to RRL	0	0	0	-170	-170	0
SGHD - Capital to Revenue Transfer	-542	-542	0	0	-1,415	-1,415
SGHD - Sales Receipts	-1,241	-1,241	0	-4,113	-1,866	2,247
Total Core Income	**2,918**	**2,918**	**0**	**3,881**	**3,894**	**13**
Planned Core Expenditure						
Regional Priorities						
HUB Initiative	26	26	0	20	180	160
Total	26	26	0	20	180	160
Strategic Priorities						
Mobile Device Coverage	0	0	0	500	0	-500
Corporate Accommodation Review	215	215	0	0	500	500
Demolitions	73	73	0	0	362	362
Total	288	288	0	500	862	362
Primary & Community Care Modernisation Programme						
Primary Care Premises Review	38	38	0	88	88	0
Bonnybridge HC	11	11	0	35	35	0
Clackmannan HC	14	14	0	35	35	0
Orchard House HC	46	46	0	48	48	0
Denny HC (Cap Grant)	0	0	0	170	170	0
Bannockburn HC	2	2	0	130	130	0
Balfron HC	14	14	0	14	14	0
Lochview Baths	14	14	0	14	14	0
Total	139	139	0	534	534	0
Community Hospitals						
FCH Wards 18 & 19	1,379	1,379	0	1,240	1,380	140
SCH OPD 1&2 and Foyer Area	0	0	0	0	0	0
FCH Exrternal Works	31	31	0	0	150	150
FCH Block 09 Showers	112	112	0	0	125	125
FCH Training Hut	37	37	0	0	35	35
FCH Signage	0	0	0	0	25	25
SCH Health Visitors (Former Ward 4)	41	41	0	0	35	35
SCH Conference Centre (V&A)	0	0	0	0	20	20
Total	1,600	1,600	0	1,240	1,770	530
Area Wide Expenditure						
IM & T Strategy	1,329	1,329	0	2,180	1,839	-341
Medical Equipment Replacement Programme	1,195	1,195	0	1,750	1,500	-250
Total	2,524	2,524	0	3,930	3,339	-591
Area Wide Other Expenditure						
Fire Safety / Statutory Standards / HEI Inspection	106	106	0	411	490	79
Site Surveys for EAMS System	8	8	0	50	50	0
HUB DB Capital Doune HC	9	9	0	811	120	-691
Total	123	123	0	1,272	660	-612
Other Capital Costs						
Capital Grants transferred to RRL	0	0	0	-170	-170	0
Capital to Revenue	-541	-541	0	0	-1,415	-1,415
Sales Receipts	-1,241	-1,241	0	-4,113	-1,866	2,247
Subordinated Debt Investment	0	0	0	668	0	-668
Total	-1,782	-1,782	0	-3,615	-3,451	164
Total Direct Core Expenditure	**2,918**	**2,918**	**0**	**3,881**	**3,894**	**13**
Savings/(Excess) Against Capital Resource Limit	**0**	**0**	**0**	**0**	**0**	**0**

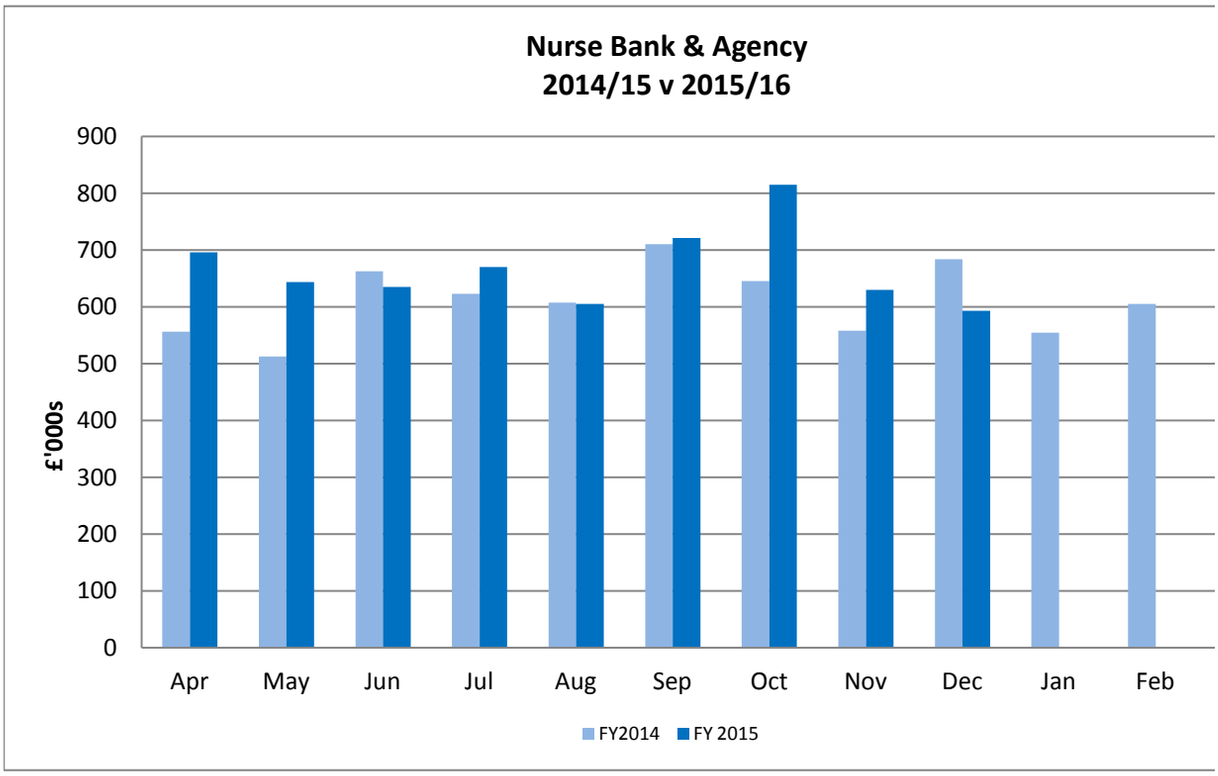
Forecast Property Sales						
Bellsdyke Development	1,241	1,241	0	1,068	1,241	173
Bannockburn Hospital Land	0	0	0	1,000	0	-1,000
Bonnybridge Hospital Land	0	0	0	800	0	-800
Kildean Hospital Land	0	0	0	780	0	-780
Gartcows Road Flats	0	0	0	225	275	50
Woodland Area old RSNH Site	0	0	0	160	0	-160
Surplus Land in Strathyre	0	0	0	33	0	-33
Surplus Land at Bellsdyke Road	0	0	0	47	0	-47
Dunrowan	0	0	0	0	350	350
Total Forecast Property Sales	**1,241**	**1,241**	**0**	**4,113**	**1,866**	**-2,247**

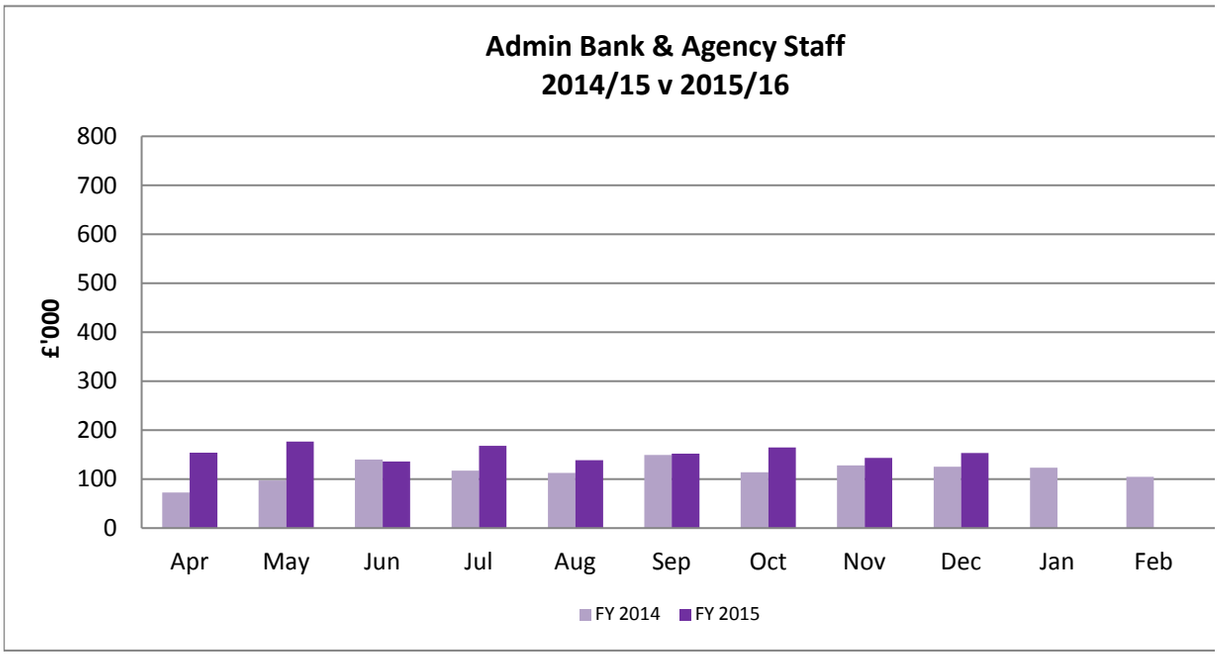
NHS FORTH VALLEY
NON-CORE STAFF COSTS





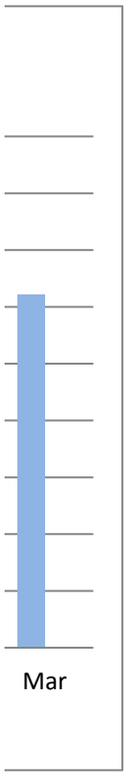
NHS FORTH VALLEY
NON-CORE STAFF COSTS





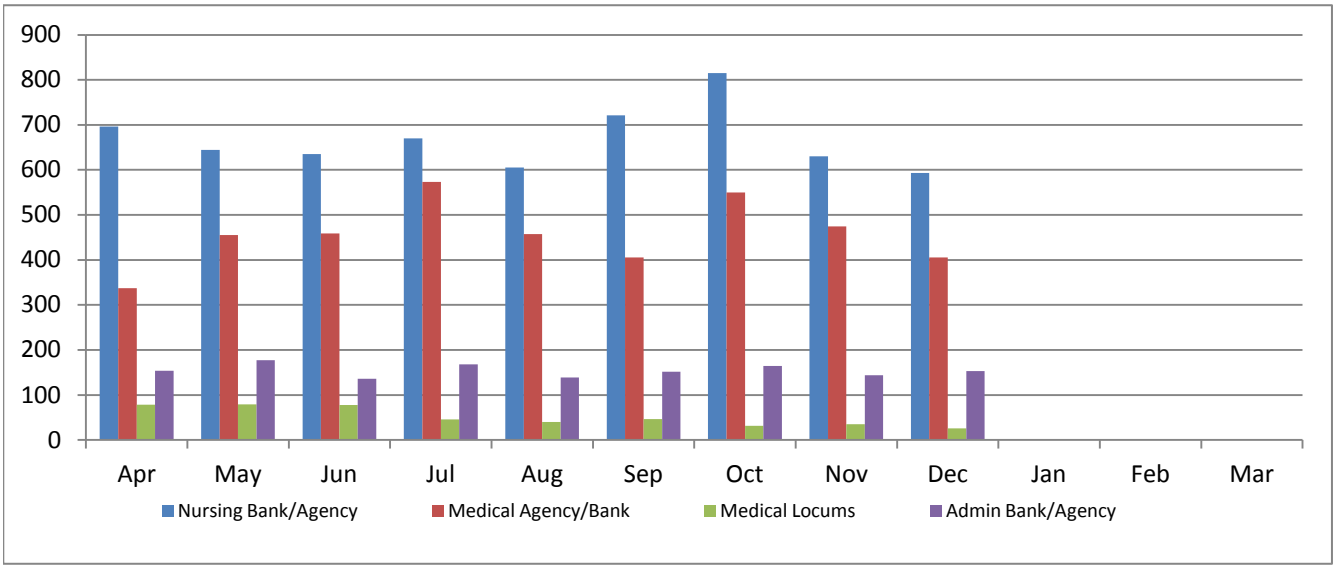
ANNEX 2

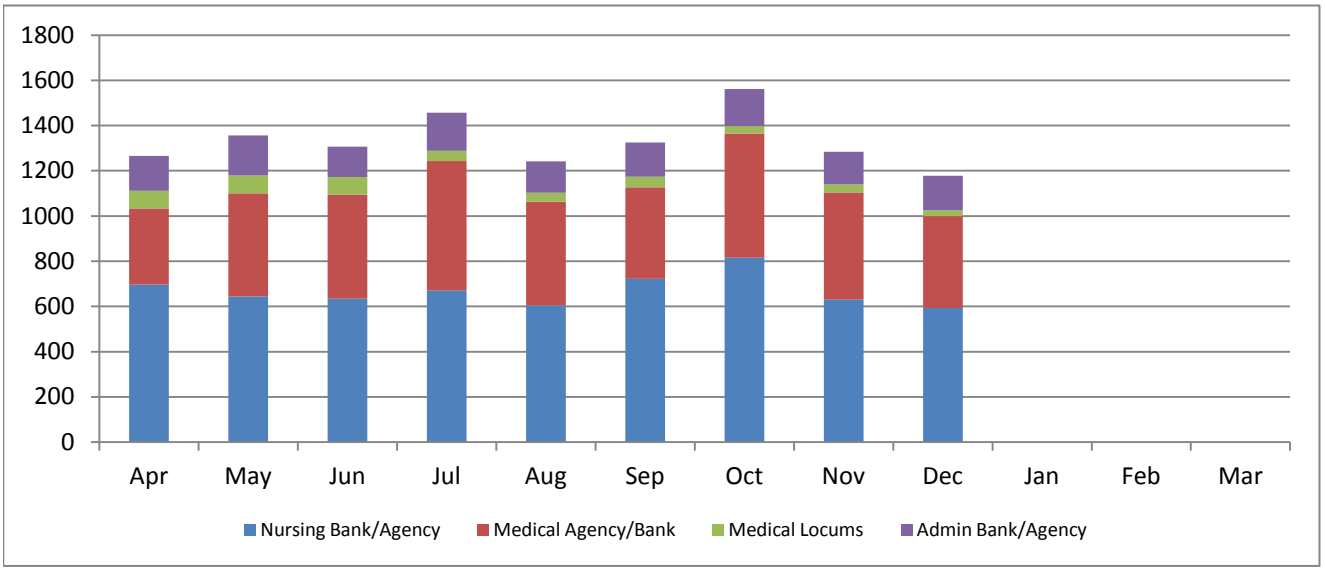
ANNEX 2



NHS FORTH VALLEY ANNEX 2

NON-CORE STAFF COSTS 2015/16





FORTH VALLEY NHS BOARD

26 January 2016

This report relates to
Item 7.2 on the agenda

Financial Monitoring Report

(Presented by Mrs Fiona Ramsay, Director of Finance)

For Noting

1. EXECUTIVE SUMMARY

1.1 This report provides a summary of the financial position for NHS Forth Valley to 31st December 2015.

1.2 There is a statutory requirement for NHS Boards to ensure expenditure is within the Revenue Resource Limit (RRL) and Capital Resource Limit (CRL) set by the Scottish Government Health and Social Care Directorate (SGHSCD). The revenue outturn position is summarised in Table 1 below:

Table 1 – Revenue Financial Outturn Position 31st December 2015

Service	Annual Budget £m	Budget to 31.12.15 £m	Actual to 31.12.15 £m	Variance £m	Forecast Outturn £m
Surgical Directorate	81.390	61.163	62.459	1.296	1.707
Medical Directorate	81.102	61.991	64.206	2.215	2.863
Women & Children	24.168	17.665	17.712	0.047	0.000
Community Health Partnerships	93.908	70.637	70.562	-0.075	-0.046
Estates and Facilities	81.895	59.436	59.447	0.011	0.000
Primary Care Prescribing	57.433	43.075	43.061	-0.014	0.000
Cross Boundary Flow	45.877	34.308	34.792	0.484	0.319
Primary Medical Services	42.015	30.071	30.078	0.007	0.000
Area-wide Corporate Services	31.169	22.269	22.166	-0.103	-0.069
Funding yet to be distributed inc Contingency	14.614	3.073	0.000	-3.073	-4.005
Income	-20.362	-15.192	-15.987	-0.795	-0.969
Total	**533.209**	**388.496**	**388.496**	**0.000**	**-0.200**
Family Health Services	32.075	24.287	24.287	0.000	0.000

1.3 Key issues to note are as follows:

- A balanced financial position is reported to the end of December 2015 for both revenue and capital.

- The forecast out-turn position remains a projected surplus of £0.200m for revenue. There are a number of key issues and risks in arriving at the out-turn:

    - Whilst funding has been provided for specific areas for the winter period as approved in the Winter Plan there remain capacity pressures in the system which may be exacerbated January to March.

    - Focus continues on cessation of waiting list initiatives and utilisation of the private sector. There are five areas where continuation to the year end has been agreed – E.N.T., orthopaedics, endoscopy, psychological therapies and Child and Adolescent Services. There will be an increasing risk in delivery of access targets as a consequence of this action.

- Overspends have continued in both Surgical and Medical Directorates. The Chief Executive and Director of Finance have met with the relevant General Managers to agree the actions required to address the overspend areas, and will continue to meet until in-month financial balance is achieved.

- Winter Plan funding, as approved at the October Performance and Resources Committee, has been transferred to relevant budgets in December.

- Due to full year effect of off patent drugs within primary care and increased income from rebates funding of £0.500m has been transferred from primary care prescribing to central reserves this month. There remains a risk that this is required to meet increased costs in the remaining months.

- NHS Forth Valley receives funding for partnership working including Transitional Funds, Delayed Discharges and Integrated Care Funding. Funding is transferred to relevant body as approved plans are implemented with NHS Forth Valley retaining responsibility to manage these funds between financial years.

- Current year cash savings requirements (CRES) are reflected in the financial position and overall savings delivery plans remain on track. There are however some areas which have not been achieved and alternatives found to ensure pressures met. It is important that every effort is made to identify recurrent cash savings for 2016/ 17 early given pressures anticipated in forthcoming year.

- Following discussion with SGHSCD, both property sales for Bonnybridge and Bannockburn will fall into next financial year. NHSFV Capital Resource Limit has been increased by £1.427m to assist with managing between financial years and local spending of £0.819m also moved to next year.

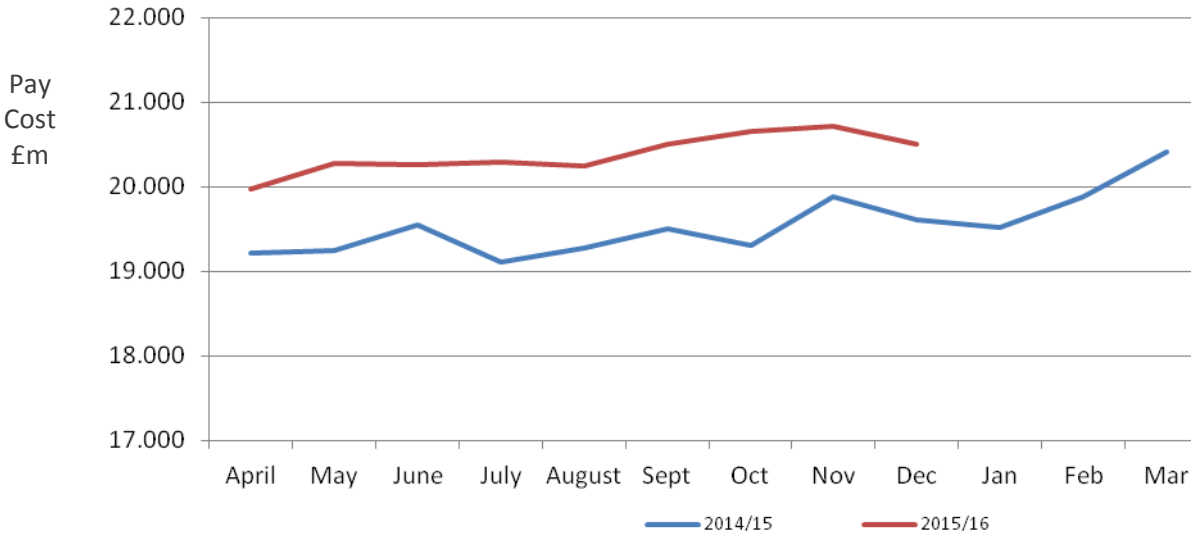
- The Scottish Government Spending Review was announced on 16th December 2015 and confirms an uplift of 1.7% for territorial Health Boards for 2016/17. A separate paper "Financial Plan" is on the Board Agenda outlining the significant issues arising from the draft Scottish Budget.

- Based on the outcome of the draft Scottish Budget the draft Board financial plan for 2016/17 estimates a requirement for approximately 6% recurrent cash savings (£27m) in 2016/17. All Directorates prepared plans for 3% cash savings and these are currently going through formal review process. The remaining 3% is Board targeted at area-wide cost reduction themes. A Board session to review progress to date will follow the January Board meeting.

- Guidance has been received from SGHSCD regarding the Local Delivery Plan (LDP). This requires submission of draft plans by 4th March 2016. To meet this deadline and to meet deadlines for budget allocation to the Integrated Joint Boards, delegated authority to approve the draft LDP including Financial Plan at the Performance and Resources Committee at the end of February 2016 will be required.

- 2.0 PAY COSTS AND WORKFORCE
-
- 2.1 Pay expenditure for the nine months to 31st December totals £183.431m.

Monthly Pay Cost Trend April – December 2015



Staff Group	April £m	May £m	June £m	July £m	August £m	Sept £m	Oct £m	Nov £m	Dec £m
Nursing & Midwifery	8.933	8.953	9.064	8.879	8.846	9.060	9.087	9.141	8.978
Medical & Dental	5.061	5.211	5.167	5.367	5.376	5.332	5.457	5.299	5.236
Admin & Clerical	2.396	2.445	2.428	2.470	2.415	2.459	2.438	2.562	2.523
AHPs	1.532	1.558	1.533	1.526	1.519	1.506	1.524	1.541	1.544
Support Services	0.644	0.676	0.659	0.622	0.651	0.668	0.675	0.645	0.685
Healthcare Sciences	0.585	0.597	0.581	0.577	0.581	0.582	0.573	0.578	0.583
Other Therapeutic	0.574	0.583	0.570	0.591	0.600	0.648	0.647	0.688	0.646
Senior Managers / Other	0.252	0.257	0.259	0.262	0.258	0.249	0.258	0.258	0.304
Total in-month	**19.977**	**20.280**	**20.261**	**20.294**	**20.246**	**20.504**	**20.658**	**20.713**	**20.498**
Total 2015/16 Cumulative	**19.977**	**40.257**	**60.518**	**80.812**	**101.058**	**121.562**	**142.220**	**162.933**	**183.431**

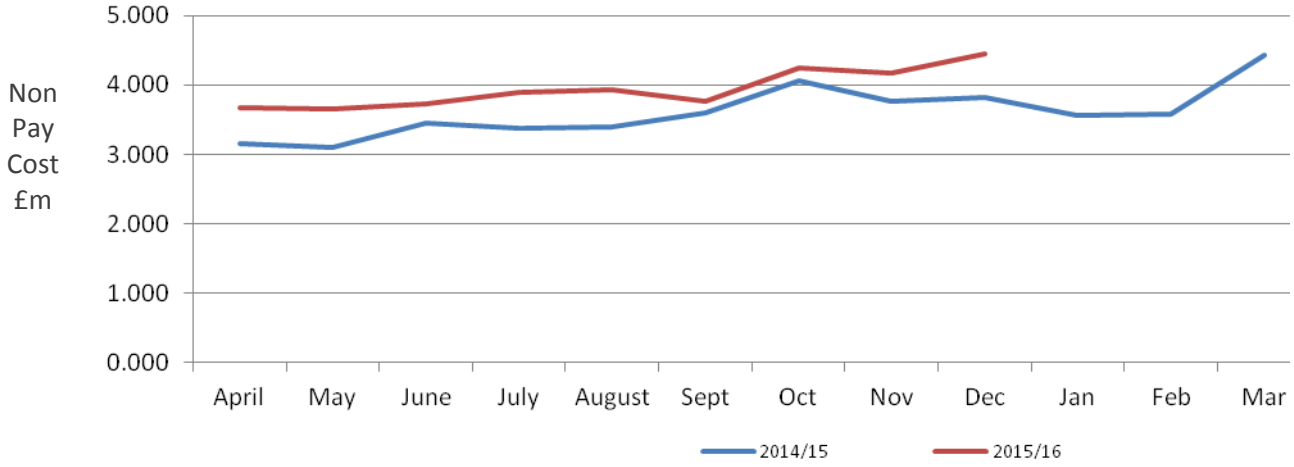
2.3 Expenditure on temporary non-core staff (bank, agency, locum and overtime costs) to 31st December is £13.100m, representing approx 7% of total staffing costs to date. Both Nurse bank and Medical agency costs have improved from October and November levels, however total non-core staff expenditure over the nine month period remains higher than the equivalent period last year. Revised control measures have been put in place for protocols governing the use of long and short term agency cover to ensure agency use is minimised, that requests are appropriately authorised, and that usage is regularly reviewed. The Controls process was outlined to the Performance and Resources Committee in December 2015.

2.4 The Director of Nursing has been working with senior nursing staff to identify consistent actions to reduce temporary nurse spend.

3.0 NON PAY COSTS

3.1 The table below shows cost of direct non-pay and supplies costs incurred in delivering clinical services during the year to date.

Monthly Non Pay Cost Trend April – December 2015



Supply Group	April £m	May £m	June £m	July £m	August £m	Sept £m	Oct £m	Nov £m	Dec £m
Hospital Prescribing Drugs	2.231	2.181	2.197	2.282	2.442	2.340	2.679	2.558	2.620
Surgical Sundries	1.054	1.079	1.068	1.172	1.087	1.019	1.155	1.162	1.356
Diagnostic Supplies	0.277	0.27	0.330	0.276	0.268	0.251	0.280	0.308	0.320
Other Therapeutic Supplies	0.119	0.125	0.129	0.167	0.137	0.159	0.124	0.152	0.147
Total in-month	**3.681**	**3.655**	**3.724**	**3.897**	**3.934**	**3.769**	**4.238**	**4.179**	**4.443**
Total 2015/16 Cumulative	**3.681**	**7.336**	**11.06**	**14.957**	**18.891**	**22.660**	**26.898**	**31.077**	**35.520**

3.2 Hospital based drugs costs, although showing a relatively stable position over the year to date, have increased significantly on the same period for the previous year. As previously indicated there are a number of factors contributing including price inflation, volume changes and the introduction of new drugs. The spend in the last quarter is significantly higher than the earlier months in the year.

3.3 The Medicines Resource Utilisation Group covering both primary and secondary care prescribing held its second meeting in December to reinvigorate approach to Medicines Management.

3.4 The New Medicines Fund provided nationally will provide some offset to the prescribing pressures this year but will only be available this year. This covers ultra orphan drugs and specified new medicines. £2.365m has been distributed in total this year.

3.5 A new pharmacy stock system was introduced at the end of September replacing the previous Ascribe system, preceding the planned roll out of the electronic prescribing system.

3.6 Surgical sundries cover a wide range of items in everyday use in clinical settings including single use instruments, dressings and other sundries.

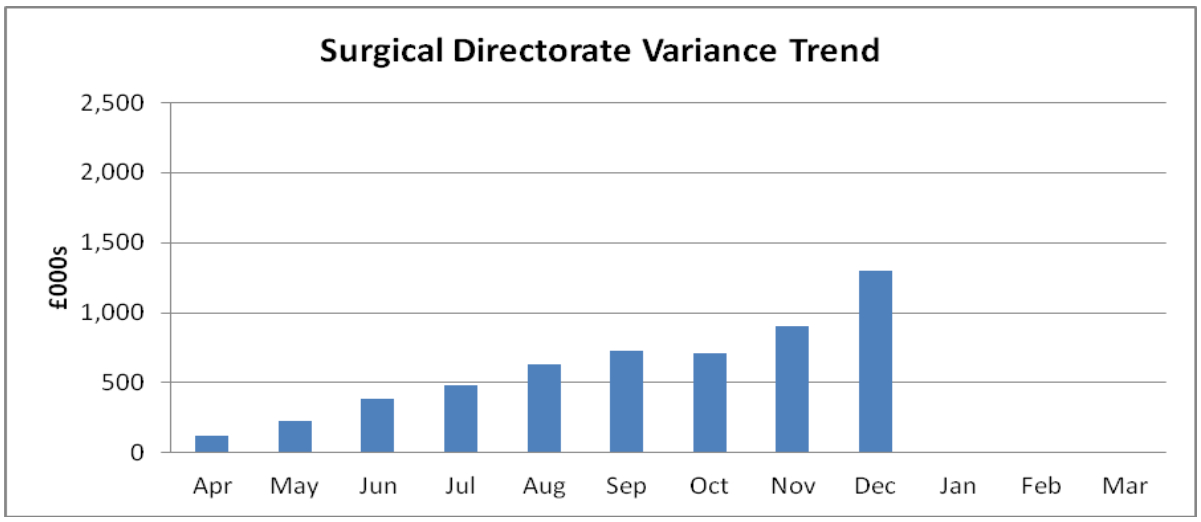
3.7 Diagnostic supplies include reagents used in lab tests, general consumables and other general lab supply costs. The majority of these costs are incurred within the Surgical Directorate.

3.8 Other therapeutic supplies include hearing aids, orthopaedic and surgical appliances, footwear, and dietetic supplies.

4.0 DIRECTORATE SUMMARY

4.1 Surgical Directorate

Service	Annual Budget £m	Budget to 31.12.15 £m	Actual to 31.12.15 £m	Variance £m
Ambulatory Care/ Cancer /Out Patients	23.924	17.996	18.711	0.715
Diagnostic Services	18.522	13.892	14.140	0.248
Theatres & Procurement	15.270	11.455	11.963	0.508
Surgical Wards	11.459	8.580	8.517	-0.063
Heads Of Department	9.511	7.076	6.957	-0.119
Waiting Times/ EVAR	1.764	1.608	1.655	0.047
Ambulatory Care Management	0.845	0.501	0.520	0.019
Access Support Team	0.199	0.151	0.094	-0.057
Clinical Simulator	-0.104	-0.096	-0.098	-0.002
Total	**81.390**	**61.163**	**62.459**	**1.296**



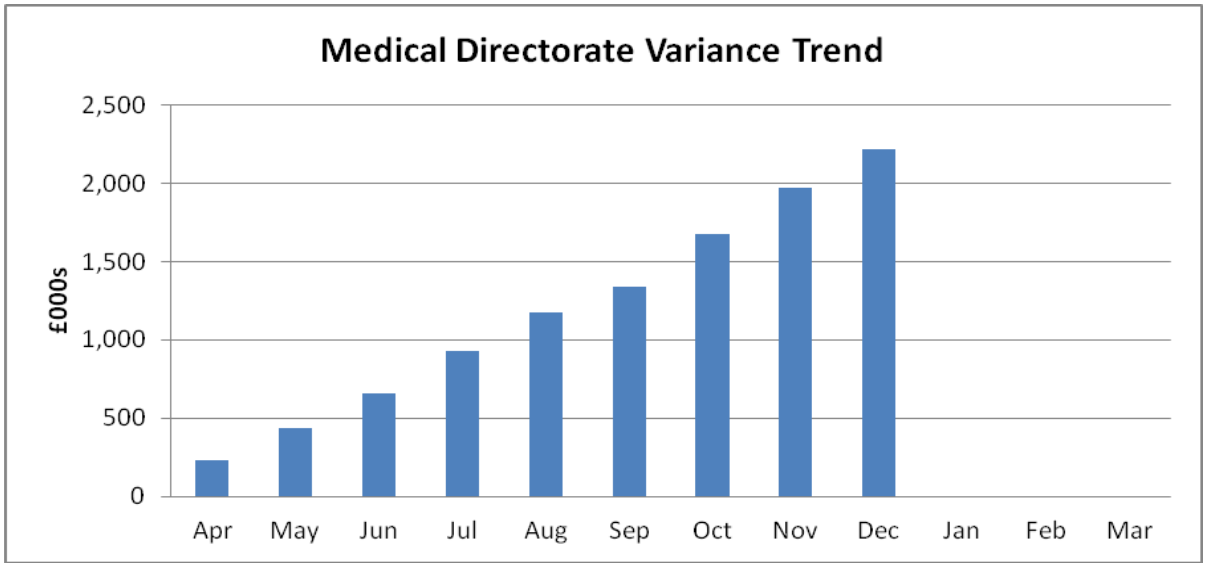
- Diagnostic Services (Labs and Radiology) overspend is a combination of pay and supplies factors. The pay pressures are largely attributable to Medical Agency and bank staff costs in ENT, Urology and Microbiology and vacancies in critical care areas. Actions are being taken to minimise costs going forward as part of the Directorate financial management plan. Supplies costs for reagents and consumables are impacted by rising activity levels in specific areas and pressures from capacity and access target challenges. There was a significant rise in spend in December for both oncology drugs and for theatre supplies.

- Savings plans are focusing on reducing bank staff in wards following appointment to substantive funded posts over June and July, improvements in antibiotic prescribing, and reducing medical agency staff costs. Ongoing meetings with General Manager to focus on in-month balance for 2015/16.

- Waiting time clinics have continued in 2015/16 but are planned to to cease as Sustainability Plan funding has been provided, albeit agreement is in place to continue a level of support for orthopaedics and E.N.T.

4.2 Medical Directorate

Service	Annual Budget £m	Budget to 31.12.15 £m	Actual to 31.12.15 £m	Variance £m
Ageing & Rehab	18.195	13.554	13.867	0.313
Medical Staffing	15.839	11.880	12.586	0.706
Front Door Services	13.495	10.064	10.199	0.135
Medical Specialties	13.653	10.719	10.840	0.121
Ambulatory Care	12.708	9.929	10.798	0.869
Management & Admin	3.313	2.520	2.603	0.083
Allied Health Professional Services	2.404	1.804	1.792	-0.012
Waiting Times & Other	1.495	1.521	1.521	0.000
Total	**81.102**	**61.991**	**64.206**	**2.215**



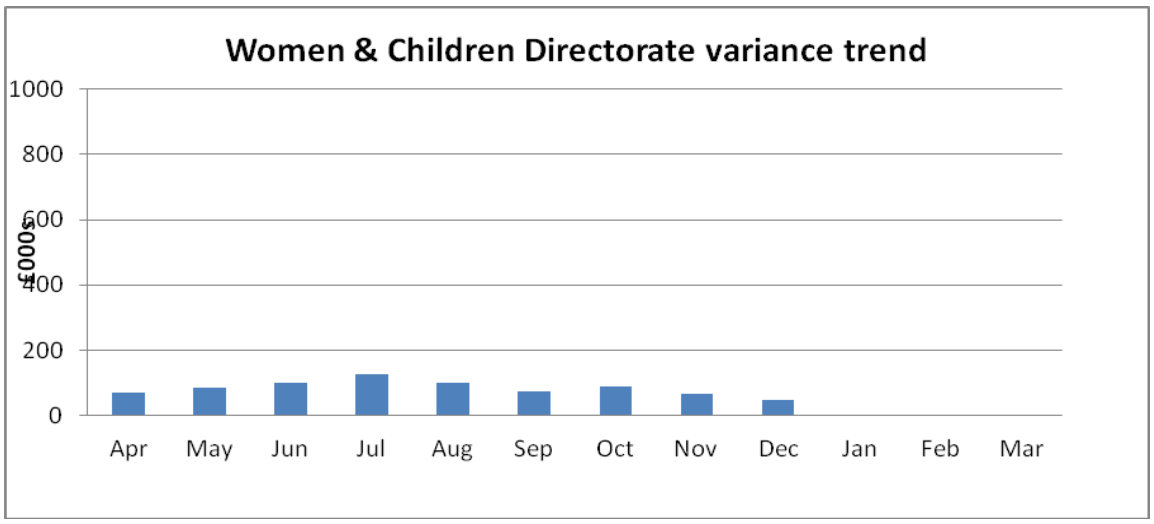
- The main pressure areas are driven by nursing and medical pay costs, including temporary bank and agency staff, to manage vacancies and absence and to meet capacity requirements, particularly within Front Door Services (A&E / Acute Care Team) and Ageing and Rehab areas.

- Non pay pressures include high spend on drugs within Ambulatory Care services (biologics and Healthcare at Home) as previously reported. Hospital prescribing costs are being targeted as part of the Directorate Savings Plan for 2015/16; however work remains at an early stage.

- Ongoing meetings with General Manager to focus on in-month balance for 2015/16. Actions have been taken with agency medical costs reducing in last two months and reduction in nurse bank in November albeit these actions have yet to stabilise the Directorate's position.

4.3 Women and Childrens and Sexual Health Services

Service	Annual Budget £m	Budget to 31.12.15 £m	Actual to 31.12.15 £m	Variance £m
Nursing	13.871	10.463	10.657	0.194
Medical Staffing	6.549	4.923	4.968	0.045
Management/Admin	1.651	0.734	0.655	-0.079
Sexual Health	1.710	1.264	1.168	-0.096
Vulnerable Children	0.349	0.256	0.249	-0.007
Waiting Times	0.038	0.025	0.015	-0.010
TOTAL	**24.168**	**17.665**	**17.712**	**0.047**



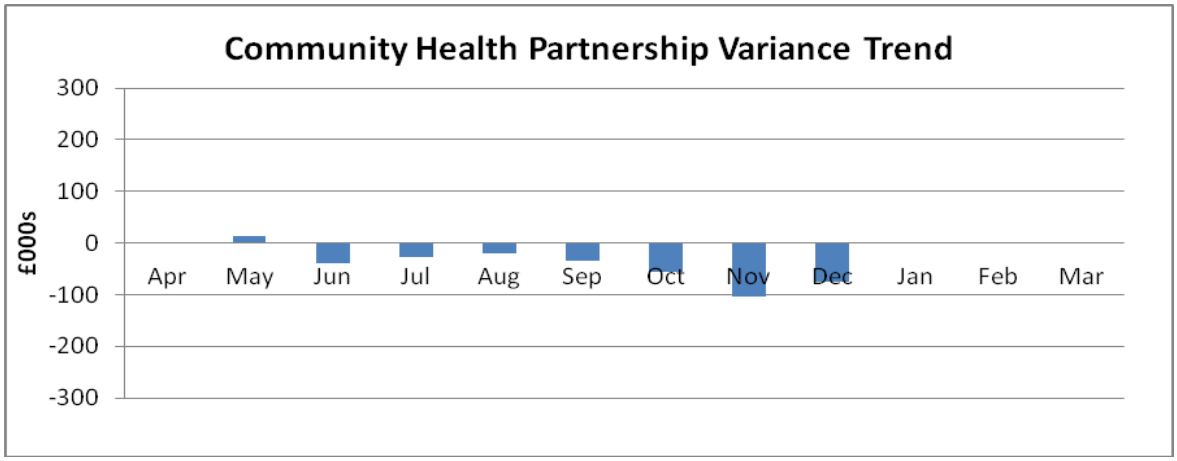
- This Directorate covers Women and Childrens Services and Sexual Health Services and is reporting an overspend of £0.047m to the end of December 2015.

- The majority of costs in the Directorate cover those outpatients and wards for gynaecology, obstetrics and paediatrics at FVRH. The overspend areas are in vulnerable children services, pay costs for nursing staff, cover arrangements for sickness absence and maternity leave within medical staff groups, partly offset by administration and sexual health underspends.

- The Directorate has confirmed actions are in place to ensure a balanced outturn is achieved at the year end.

4.4 Community Health Partnership

Service	Annual Budget £m	Budget to 31.12.15 £m	Actual to 31.12.15 £m	Variance £m
Resource Transfer	19.915	14.971	14.970	-0.001
Falkirk Partnership	14.537	11.103	10.784	-0.319
Stirling/ Clacks Partnership	13.736	10.140	10.092	-0.048
Specialist Mental Health Service	13.571	10.511	10.449	-0.062
Prisons & Specialist Community Services	7.323	5.487	5.464	-0.023
Lead Nurse (inc. Complex Care)	6.177	4.579	5.220	0.641
Substance Misuse Sector	5.672	4.337	4.169	-0.168
A.M.D. Mental Health	4.814	3.585	3.593	0.008
Health Improvement & Corporate Services	4.391	3.121	2.919	-0.202
Adult Clinical Psychology	1.792	1.281	1.285	0.004
Integrated Mental Health Services	1.364	1.013	0.971	-0.042
A.M.D. Primary Care	0.938	0.692	0.666	-0.026
C.H.P. Other	-0.322	-0.183	-0.020	0.163
TOTAL	**93.908**	**70.637**	**70.562**	**-0.075**



- The Community Health Partnership Directorate covers services including Learning Disability, Mental Health, Prison Services and Community Nursing / Health Visiting.

- Whilst there are a number of over and underspends within the Directorate which offset each other, the main overspend area relates to complex care services including mental health placements outwith the area. This covers agreed 'packages of care' for individuals often jointly with Local Authority Services to support care in their own home where their needs are ongoing and avoids hospital admission or supports discharge of those whose hospital stays would otherwise have been lengthy. A range of actions to mitigate costs have been agreed and areas of continued growth also identified which will link to the work of Clinical Services Review.

- A small underspend of £0.046m is projected.

4.5 Estates and Facilities

Service	Annual Budget £m	Budget to 31.12.15 £m	Actual to 31.12.15 £m	Variance £m
Unitary Charge (FVRH & CCHC)	43.880	32.368	32.368	0.000
Forth Valley Facilities	16.770	12.012	11.750	-0.262
Capital Charges	15.053	10.453	10.453	0.000
Property	4.952	3.670	3.709	0.039
Healthcare Strategy	0.880	0.663	0.666	0.003
Transport Hub Pilot	0.360	0.270	0.501	0.231
Total	**81.895**	**59.436**	**59.447**	**0.011**

- This Directorate covers estates, maintenance, transport and domestic services other than those covered by the FVRH Contract, management of the FVRH and Clackmannanshire Health Facility Contract and Capital Projects.

- The main risk area is the Transport Hub Pilot which is reporting an overspend offset by a underspends within the wider Facilities budget from a combination of lower energy prices, reduced fleet maintenance costs, and staff vacancies.

- A balanced financial out-turn is projected.

4.6 Primary Care Prescribing

Service	Annual Budget £m	Budget to 31.12.15 £m	Actual to 31.12.15 £m	Variance £m
Prescribing - Falkirk	29.023	21.757	22.644	0.887
Prescribing - Stirling	16.567	12.402	12.091	-0.311
Prescribing - Clackmannanshire	10.933	8.200	8.463	0.263
Pharmaceutical Discounts	-1.943	-1.457	-2.100	-0.643
Other	2.853	2.173	1.963	-0.210
Total	**57.433**	**43.075**	**43.061**	**-0.014**

- An underspend of £0.014m is reported for the nine month period ended 31st December 2015. (based on seven months actual data together with estimates for November and December).

- Pharmaceutical Discounts refer to the generic and proprietary discount rates which are applied to generic and branded drug prices. The discount rates are set as part of the community pharmacy contract settlement and reviewed on a quarterly basis to ensure the agreed level of retained profit margin is achieved by Community Pharmacy contractors

- Due to full year effect of off patent drugs within primary care and increased income from rebates funding of £0.500m has been transferred from primary care prescribing to central reserves this month. There remains a risk that this is required to meet increased costs in the remaining months.

- Other includes Childhood Immunisation, Stoma fees, Prescribing Incentive Scheme and other area wide GP prescribing.

- Following the anticipated budget transfer a balanced financial out-turn is projected.

4.7 Cross Boundary Flow

Service	Annual Budget £m	Budget to 31.12.15 £m	Actual to 31.12.15 £m	Variance £m
NHS Glasgow & Clyde SLA	20.297	15.223	15.154	-0.069
NHS Lothian SLA	11.394	8.545	8.605	0.060
UNPACS/Oats/Exclusions	5.850	4.288	4.811	0.523
Other NHS Scotland	4.498	3.374	3.261	-0.113
Other Healthcare Providers	1.966	1.474	1.655	0.181
Golden Jubilee Hospital	1.765	1.324	1.240	-0.084
Patients Travel	0.107	0.080	0.066	-0.014
TOTAL	**45.877**	**34.308**	**34.792**	**0.484**

- This budget covers patients travelling outwith NHS Forth Valley for their treatment including tertiary services i.e. those which require specific specialist care services such as oncology, neurosurgery, specialist medical health, and cardiac services.

- The position to the end of December is an overspend of £0.484m (£0.454m to end of November) due to small numbers of high cost individual patient treatments, and other non contracted activity. Funding for specific new high cost drugs added to budget from New Medicines Fund in October. This overspend is largely offset by income recovery that is reported separately.

- Final SLA values for 2015/16 are yet to be finalised with NHS Lothian. The outstanding risk relates to in-year marginal cost charges which are not yet confirmed.

4.8 Primary Medical Services

Service	Annual Budget £m	Budget to 31.12.15 £m	Actual to 31.12.15 £m	Variance £m
Global Sum Monthly Payment	26.257	19.692	19.679	-0.013
Quality & Outcomes Framework	5.144	2.823	2.719	-0.104
Enhanced Services	5.170	3.419	3.278	-0.141
Premises	3.240	2.476	2.455	-0.021
Other	2.204	1.661	2.091	0.430
Income	0.000	0.000	-0.144	-0.144
TOTAL	**42.015**	**30.071**	**30.078**	**0.007**

- Primary Medical Services covers payments to local GP practices to deliver services for their practice population. This area is ring-fenced i.e. funding can be added to but not removed from the budget.

- Risks also largely relate to Enhanced Services in terms of uptake rates beyond anticipated levels and available budget.

- Due to the contractual nature of these services the budget would be expected to breakeven each year.

4.9 Area-wide Corporate Services

Service	Annual Budget £m	Budget to 31.12.15 £m	Actual to 31.12.15 £m	Variance £m
Director of Finance, eHealth, IT	11.075	8.079	8.078	-0.001
Medical Director	6.372	4.431	4.336	-0.095
Director of Public Health	4.315	3.194	3.135	-0.059
Director of Human Resources	3.149	2.379	2.498	0.119
Director of Nursing	2.317	1.746	1.855	0.109
Chief Executive	1.992	1.428	1.260	-0.168
Area Wide Services	1.949	1.012	1.004	-0.008
TOTAL	**31.169**	**22.269**	**22.166**	**-0.103**

- This covers individual Directorate budgets Chief Executive, Medical Director, Nursing Director, Directors of Public Health, Human Resources, and Finance.

- The position to the end of December is an underspend of £0.103m which continues the trend from last year and is a combination of issues including vacancies within Public Health and Chief Executive budget areas, and close management of budgets. Projected out-turn is an underspend of £0.069m.

4.10 Family Health Services

Service	Annual Budget £m	Budget to 31.12.15 £m	Actual to 31.12.15 £m	Variance £m
General Dental Services	16.200	12.077	12.077	0.000
General Pharmaceutical Services	10.530	8.120	8.120	0.000
General Ophthalmic Services	5.345	4.090	4.090	0.000
TOTAL	**32.075**	**24.287**	**24.287**	**0.000**

- These services are "non-cash limited" i.e. budget provided matches spend and covers local dental services, local opticians and local pharmacist contract payments. These are delivered by national contracts.

5.0 CAPITAL

5.1 Overall Position

The forecast Net Capital expenditure for year-ended 31st March 2016 is currently £3.894m. Details can be seen at Annex 1 to this report.

5.2 Income

Within the allocation letter issued by the Scottish Government for December 2015/16, the anticipated allocation for HUB Enabling to the value of £0.020m was received. There was also an adjustment to the value of forecast Net Receipts made to the value of £2.247m as outlined in last month's report.

5.3 Expenditure

Gross expenditure to 31st December 2015 was £4.700m inclusive of an in-month increase during December to the value of £0.773m. There was also a deduction made to Gross expenditure to the value of (£1.782m) in relation to Capital to Revenue transfers and the Net Receipt for the Bellsdyke Development. Gross expenditure to date can be categorised as:

Regional & Strategic Priorities – as at 31st December 2015 £0.099m has been spent on professional fees relating to HUB enabling projects and decommissioning of Community Hospital sites. There has also been £0.215m spent on upgrades to sites required to house staff vacating the leased accommodation at Euro House, Stirling.

Primary & Community Care Modernisation Programme – to date £0.139m has been spent on minor upgrades to Health Centres based at Bonnybridge, Clackmannan, Denny, Balfron and Orchard House in Stirling. Within this total there have also been costs incurred on upgrades at the Lochview Community Learning Disabilities site.

Community Hospitals – as at 31st December 2015 £1.600m has been spent on refurbishments to blocks within Falkirk and Stirling Community Hospitals. Costs for upgrades to Wards 18 & 19 to accommodate Adult Mental Health are £1.379m and a further £0.143m has been spent on External works and upgrades to shower facilities in the Inpatient Unit. In addition, minor works have been progressed within the Training Hut at Falkirk Community Hospital to the value of £0.037m. With regard to the Ward 18 & 19 project being managed via the HUB Design & Build process, we still await a decision on the VAT recovery application made to Her Majesty's Revenue & Customs as initially reported in July. An update will be provided when available.

Area Wide Expenditure – as at 31st December 2015 £2.647m has been spent on Area Wide projects inclusive of £1.329m on the IM&T Strategy and a further £0.123m on Statutory Standards/HEI Inspection works and initial fees for the new Doune Health Centre. In addition the sum of £1.195m has been spent on the Medical Equipment Replacement Programme.

6.0 SAVINGS

6.1 Savings delivered to date are on track with planned phasing and trajectory. The following table provides a summary of progress against plan by category.

Description	2015/16 Annual Plan £'000	Actual Delivered At 31st Dec £'000	*Recurring* *£000*	*Non Recurring* *£'000*
Service Productivity	6,570	4,712	*4,515*	*197*
Drugs and Prescribing	1,210	802	*802*	
Procurement	571	400	*400*	
Workforce	3,313	1,241	*1,169*	*72*
Support Services (non-clinical)	614	436	*436*	
Estates and Facilities	1,076	540	*540*	
Savings - as yet unidentified	134	0	*0*	
Total Savings	**13,489**	**8,131**	***7,862***	***269***

6.2 The main savings and efficiency schemes underpinning the 2015/16 plan are as follows. Detailed monitoring of schemes is in place with individual Directorates:

- Primary Care Prescribing
  - Continuing to target those areas within GP practices where prescribing costs are higher than both Scottish average and NHS FV average. This is on track and savings are being delivered.
  - Work is also progressing on Hospital based prescribing to reduce drugs costs although this is in early stages.

- Waiting Times and Access
  - Reduction in waiting list premia costs and reducing reliance on short term waiting list initiatives with a focus on sustainable delivery plans.

- Reduction in Nurse bank spend
  - Targeted at five specific ward areas aiming to reduce reliance on bank by recruiting to substantive posts.

- Reduction in Medical Agency spend
  - Use of proleptic appointments and other measures in place during 2014/15 have stabilised expenditure levels into 2015/16 and further work is ongoing.

- Clinical efficiency and productivity
  - Using benchmarking information to target length of stay / new to return outpatient ratios which will bring efficiency benefits

- A range of smaller schemes including
  - New interpreting and Translation Service Contract across the area
  - Procurement savings across a number of products
  - Reduction in taxi / private ambulance usage
  - Energy efficiency

7.0 RISK

7.1 The detailed Finance Risk Schedule (initial risk schedule was included in Financial Plan) is updated monthly and at this stage of the year there are no new significant risks identified which would affect this year's out-turn.

7.2 There are four areas of major focus to reduce spending / manage rising costs:

- Use of temporary workforce spend i.e. bank and agency spend
- Management of prescribing including identification of issues and actions agreed
- Minimise private sector and waiting list initiatives to meet access targets
- Capacity and flow challenges to reduce variation in performance

8.0 CONCLUSION AND RECOMMENDATION

The Board is asked to note:

- the balanced revenue and capital positions to 31st December 2015, with a projected surplus of £0.200m for revenue and balanced for capital outturn to 31st March 2016.
- work commenced on 2016/17 – 2020/21 Financial Plan with significant financial challenge ahead

Fiona Ramsay
Director of Finance
19th January 2016

Forth Valley NHS Board

26 January 2016

This report relates to
Item 7.3 on the agenda

WAITING TIMES REPORT

(Paper presented by Mr David McPherson, General Manager)

For Noting

NHS Forth Valley Board Meeting

Reporting Period Ending 31st December 2015

Purpose of paper

It is essential that the Board is updated in sufficient detail around timely access to gain assurance on improvement and note action on areas of challenge. This paper outlines the Board's position in relation to a range of access targets established by the Scottish Government, the majority of which are NHS LDP Standards.

This paper covers the main elective targets, inpatients/daycases and new outpatients, both in terms of the stage of treatment targets and the combined 18 weeks Referral to Treatment position (RTT), unavailability, diagnostics, cancer, Drugs and Alcohol Treatment Services, Child & Adolescent Mental Health Services (CAMHS) and Psychological Therapies.

- In November 2015 the 18-week RTT performance was 91.1%.

- At 31st December 2015 census, the number of outpatients waiting over 12 weeks increased to 2205 from 1572 in November 2015. The number of patients exceeding 16 weeks was 799. The main challenge is within the specialties of Ophthalmology, Orthopaedics, Gastroenterology, Dermatology, Anaesthetics, ENT and Neurology.

- Since the start of the 2015-2016 Financial Year there have been 6 breaches of the Treatment Time Guarantee. Overall compliance remains high at 99%. The Board should be aware that TTG performance is expected to decrease in January 2016, in part due to winter pressures. At the time of writing (18th January 2016) there have been 48 breaches of the TTG (12 completed waits and 36 ongoing waits). It is anticipated that this pressure will continue into February 2016. Whilst locally this has become more challenging, Forth Valley remains much more positive than the national average.

- At 31st December 2015 NHS Forth Valley new outpatient unavailability was 2.7% The Scotland performance was 3.2% (September 2015 data).

- At 31st December 2015 NHS Forth Valley had 381 (14.7%) of inpatients/daycases unavailable for treatment. This is up from 345 (13.5%) in the previous month. Scotland's unavailability rate for inpatients and daycases at 30th September 2015 was 18.9%.

- Radiology has remained compliant with the 42 day diagnostic waiting time standard.

- In December 2015 the number of patients waiting over 42 days for endoscopy rose to 89 from 58 in November 2015.

- Management information for November 2015 highlights that compliance with the 62 day cancer waiting time standard was 96% and 98.6% for the 31 day cancer waiting time standard.

- Mental Health:
    - Drug and Alcohol misuse services continue to comply with the 21 day waiting time standard.
    - CAMHS and Psychological Therapies have an 18 week RTT standard. In December 2015 CAMHS treated 36.4% of patients within 18 weeks of referral and the Psychological Therapy service treated 87.6% of patients within 18 weeks of referral.

Contents

1. Referral to Treatment (RTT)

Waiting Time Standard: 90% of patients will be treated within 18 weeks of referral.

Compliance with standard

Table 1 provides information on the RTT performance by Directorate, for patients treated in NHS Forth Valley in November 2015.

Table 1

Table 1	NHS Forth Valley Referral To Treatment Performance Compared with Scotland Average for the Patients Treated in November 2015 (previous performances for July 2015 to October 2015 provided for trend analysis)							
Directorate	*FV Performance July -2015*	*FV Performance August -2015*	*FV Performance Sept -2015*	*FV Performance Oct -2015*	*FV Performance Nov -2015*	*Scotland Performance November-2015*	*Clock stops <= 18 weeks*	*Clock stops > 18 weeks*
Surgical Directorate Compliance	**91.3%**	**91.7%**	**91.6%**	**92.3%**	**89.9%**	86.0%	3767	425
Medical Directorate Compliance	**97.1%**	**97.5%**	**96.7%**	**94.6%**	**93.4%**	90.9%	1474	105
W&C Directorate Compliance	**96.5%**	**96.0%**	**96.5%**	**95.5%**	**93.6%**	87.8%	613	42
All Specialties	93.2%	93.6%	93.4%	93.2%	91.1%	87.1%	5854	572

Key issues and actions

- In November 2015 NHS Forth Valley treated 91.1% of patients within 18 weeks of referral.
- The national performance was 87.1%.
- Surgical Directorate
  - In November 2015 the Surgical Directorate treated 89.9% of patients within 18 weeks of referral. 8 of the directorate's 13 specialties delivered or bettered the 90% standard. 5 specialties were below the standard. Anaesthetics (75%), Ophthalmology (76%), OMFS (89.5%), Orthopaedics (89%) and Vascular Surgery (81.7%) were the specialties below 90%.
- Medical Directorate
  - In November 2015 the Medical Directorate maintained the 90% RTT standard and has done so since May 2014. 9 of 11 specialties delivered the standard**.** Neurology (84.4%) and Endocrinology (78.2%) were below 90%.
- Women & Children's
  - The W&C directorate has been above the 90% standard since March 2014. 2 specialties delivered the 90% standard whilst Paediatric Surgery performance was 62.5%.

2. Outpatient Stage of Treatment

Outpatient Waiting Time Standard: During 2015/16 Boards need to improve the 12 weeks outpatient performance to achieve a minimum 95% standard with a stretch aim to 100%. It is also essential that waits of over 16 weeks are eradicated.

Performance against the Outpatient Waiting Time Standard: Table 2 shows the number of ongoing outpatient waits over 12 and 16 weeks and the number over 12 weeks as a percentage of the total waiting. The information is provided per month for the period 31st July to 31st December 2015

Table 2

Table 2 — NHS Forth Valley
Specialty Level Compliance With The LDP Waiting Time Standard of 95% of New Outpatients to Wait Less than 12 Weeks And Number of Patients Waiting Over 16 Weeks.
Period Reported is July 2015 to December 2015

		Jul-15			Aug-15			Sep-15			Oct-15			Nov-15			Dec-15			
Directorate	Specialty	>12 Wks	%<12 Wks	>16 Weeks	>12 Wks	%<12 Wks	>16 Weeks	>12 Wks	%<12 Wks	>16 Weeks	>12 Wks	%<12 Wks	>16 Weeks	>12 Wks	%<12 Wks	>16 Weeks	Total Waiting	>12 Wks	%<12 Wks	>16 Weeks
Surgical	Anaesthetics	87	80.6%	10	132	72.7%	20	117	73.7%	21	146	68.1%	43	136	68.6%	28	398	138	65.3%	43
	Ear, Nose & Throat (ENT)	6	99.5%	4	141	89.5%	0	12	98.9%	3	22	97.9%	1	48	95.4%	0	1140	119	89.6%	9
	Fracture Clinic	0	100.0%	0	0	100.0%	0	0	100.0%	0	0	100%	0	0	100.0%	0	32	0	100.0%	0
	General Surgery	1	99.9%	0	0	100.0%	0	6	99.5%	3	4	100%	1	7	99.5%	1	1401	13	99.1%	7
	Haematology	0	100.0%	0	0	100.0%	0	0	100.0%	0	0	100%	0	0	100.0%	0	56	0	100.0%	0
	Neurosurgery	0	100.0%	0	0	100.0%	0	2	91.3%	2	1	83.3%	0	1	75.0%	1	1	1	0.0%	1
	Ophthalmology	400	78.8%	182	403	76.3%	185	441	74.2%	185	422	74.6%	166	435	73.6%	204	1729	544	68.5%	290
	Oral and Maxillofacial Surgery	9	98.5%	0	4	99.4%	1	0	100.0%	0	13	97.8%	0	48	92.6%	3	693	107	84.6%	11
	Orthodontics	0	100.0%	1	2	98.7%	0	3	98.1%	0	0	100%	0	1	99.4%	0	184	16	91.3%	2
	Orthotics	7	97.3%	1	11	94.8%	0	5	95.4%	0	1	98.9%	0	0	100.0%	0	70	1	98.6%	0
	Trauma and Orthopaedic Surgery	24	98.7%	5	41	97.7%	2	116	94.0%	26	85	95.5%	27	126	93.7%	21	2122	364	82.8%	57
	Urology	1	99.8%	1	3	99.5%	1	1	99.8%	0	1	100%	0	1	99.8%	0	620	18	97.1%	2
	Vascular Surgery	0	100.0%	0	0	100.0%	0	0	100.0%	0	0	100%	0	1	99.4%	0	144	0	100.0%	0
	Surgical Unit	535	93.7%	204	737	91.4%	209	703	91.4%	220	695	92%	238	804	90.3%	258	8590	1321	84.6%	422
Medical	Cardiology	7	98.4%	0	6	98.5%	1	0	100.0%	0	0	100%	0	0	100.0%	0	395	36	90.9%	1
	Clinical Oncology	0	100.0%	0	0	100.0%	0	0	100.0%	0	0	100%	0	1	97.3%	1	44	0	100.0%	0
	Dermatology	53	96.7%	8	83	94.8%	7	174	89.4%	7	235	85.6%	16	238	84.4%	39	1386	232	83.3%	49
	Diabetes	0	100.0%	1	1	98.9%	0	2	97.9%	0	2	98.0%	0	7	93.9%	2	113	4	96.5%	2
	Endocrinology	9	93.1%	0	26	82.6%	0	45	75.1%	21	62	69.0%	28	17	88.7%	6	163	42	74.2%	8
	Gastroenterology	256	68.4%	175	277	64.0%	189	260	66.6%	204	293	61.7%	159	341	58.2%	258	732	282	61.5%	219
	General Medicine	0	100.0%	0	0	100.0%	0	0	100.0%	0	0	100%	0	0	100.0%	0	34	3	91.2%	0
	Geriatric Medicine	0	100.0%	0	0	100.0%	0	0	100.0%	0	0	100%	0	0	100.0%	0	96	0	100.0%	0
	Neurology	110	82.8%	20	124	79.4%	13	139	78.8%	22	160	76.7%	42	142	77.4%	62	648	189	70.8%	92
	Renal Medicine	0	100.0%	1	0	100.0%	0	0	100.0%	0	0	100%	0	1	97.8%	0	50	0	100.0%	0
	Respiratory Medicine	9	97.3%	3	5	98.6%	0	7	97.9%	1	1	100%	0	10	96.9%	0	333	23	93.1%	5
	Rheumatology	0	100.0%	0	4	98.4%	0	2	99.0%	2	1	100%	0	1	99.7%	0	324	62	80.9%	0
	Medical Unit	444	90.4%	208	526	88.1%	210	629	85.9%	257	754	83%	245	758	82.9%	368	4318	873	79.8%	376
	Gynaecology	0	100.0%	0	0	100.0%	0	0	100.0%	0	0	100%	0	0	100.0%	0	717	0	100.0%	0
	Paediatric Surgery	1	97.7%	0	3	94.0%	1	13	68.3%	1	1	98.6%	0	10	86.1%	0	64	10	84.4%	1
	Paediatrics	0	100.0%	0	0	100.0%	0	0	100.0%	0	0	100%	0	0	100.0%	0	454	1	99.8%	0
	W&C Unit	1	99.9%	0	3	99.8%	1	13	99.0%	1	1	100%	0	10	99.3%	0	1235	11	99.1%	1
	Grand Total	980	93.2%	412	1266	91.2%	420	1345	90.3%	478	1450	90%	483	1572	88.9%	626	14143	2205	84.4%	799

Key issues and actions

- Table 2 demonstrates that at 31st December 2015 the number of NHS Forth Valley patients with ongoing waits over 12 weeks increased to 2205 from 1572 in November 2015.

  At 31st December 2015, 84.4% of NHS Forth Valley new outpatients were waiting less than 12 weeks. This has reduced from 88.9% in November

- 12 out of 28 specialties were compliant with the 95% standard. The majority of the long waiters over 12 and 16 weeks are within Anaesthetics , ENT, Ophthalmology, OMFS, Orthopaedics, Dermatology, Gastroenterology and Neurology

  - Neurology and Dermatology have recruited additional consultant capacity and planned improvement once staff in post.
  - Ophthalmology has not been able to recruit to vacant post and alternative staffing model is being explored.
  - Service managers are reviewing clinic lists to ensure they are optimised.
  - Capacity Planning for 2016/17 in progress

New Outpatient Did Not Attend (DNA) Rates:

New Outpatient DNA Standard: Following a detailed presentation and discussion at the April 2015 meeting, the Performance and Resources Committee set the national DNA rate as a target for NHS Forth Valley outpatient services

Performance against the Outpatient DNA Rate Standard: The latest management information for period July 2015 to December 2015 is detailed in Table 3. The full year rate for 2014/15 is provided for reference.

Table 3

Table 3	NHS Forth Valley Specialty Level DNA Rates: Previous Year's Rate and July 2015 to December 2015 Monthly rates (Excludes Mental Health and Community Specialties Migrated from PIMS)						
Specialty	2014-15	July 2015 %Age New DNA	August 2015 %Age New DNA	September 2015 %Age New DNA	October 2015 %Age New DNA	November 2015 %Age New DNA	December 2015 %Age New DNA
Diabetes	13.7	9.5	29.4	16.7	11.1	14.3	40.9
Orthoptics	24.6	28.6	26.2	17.1	33.3	18.1	31.7
Chiropody/Podiatry	n/a	18.0	15.5	22.5	18.9	15.1	19.9
Gastroenterology	15.9	19.1	16.0	18.7	19.0	18.0	19.8
Oral and Maxillofacial Surgery	14.4	17.1	15.5	18.6	14.4	13.8	19.7
Neurology	15.4	9.2	15.2	15.6	7.7	16.5	19.4
Anaesthetics	24.4	19.6	18.6	20.9	18.9	22.7	17.2
Paediatric Surgery	10.8	6.7	11.5	20.8	8.6	4.6	12.8
Dermatology	12.1	14.0	12.0	13.8	11.3	12.2	12.7
Vascular Surgery	6.2	7.1	3.6	4.6	7.3	7.0	10.9
Endocrinology	11.1	0.0	3.5	21.7	7.1	8.1	10.7
Ear, Nose & Throat (ENT)	12.4	11.9	11.4	13.4	13.9	10.9	10.6
Scotland DNA rate as at 31st December 2015							**10.3**
Paediatrics	13.8	20.8	13.4	15.4	11.6	7.6	10.2
Forth Valley	**10.1**	**9.4**	**9.2**	**10.1**	**9.4**	**9.0**	**9.7**
Trauma and Orthopaedic Surgery	9.4	7.8	7.2	9.2	7.2	6.3	9.6
Physiotherapy	8.1	8.2	8.3	7.6	7.1	6.6	8.8
Ophthalmology	8.9	10.0	9.2	9.6	11.8	9.4	8.6
Cardiology	7.8	8.2	6.6	4.2	6.8	8.1	8.5
Gynaecology	9.8	7.8	9.4	9.4	9.8	8.9	7.9
Geriatric Medicine	5.8	3.9	4.4	6.6	6.9	3.6	7.7
General Surgery	8.4	6.5	6.8	7.1	5.5	6.7	7.6
Urology	8.8	5.5	8.0	8.9	9.9	7.7	7.6
Orthodontics	13.1	13.6	19.2	7.9	7.9	8.3	7.3
Respiratory Medicine	12.5	8.9	6.3	10.8	8.6	8.1	6.0
Orthotics	0.0	3.8	6.1	6.6	6.3	8.1	5.8
Optometry	n/a	22.2	14.8	7.7	3.3	19.4	5.7
Haematology	9.7	2.8	5.7	6.1	0.0	14.0	4.8
Electrocardiography	5.0	5.1	5.0	4.2	5.7	3.9	4.3
General Medicine	5.8	3.4	3.4	4.5	8.2	4.1	3.9
Rheumatology	6.5	11.5	8.9	10.1	8.8	10.8	1.6
TRAUMA	4.5	2.8	0.3	0.2	0.0	0.6	0.3
Rehabilitation Medicine	2.9	33.3	0.0	0.0	0.0	0.0	0.0
Renal Medicine	14.6	0.0	0.0	100.0	0.0	0.0	0.0

Key issues and actions

- The NHS Forth Valley new outpatient appointment DNA rate for the month of December 2015 was 9.7% up from 9% in November 2015. The first outpatient appointment DNA rate for Scotland was 10.3%. NHS Forth Valley has 12 services above the national level.

3. Inpatients – Treatment Time Guarantee (TTG) Stage of treatment

Treatment Time Guarantee: All patients that agree to inpatient/daycase surgery should be treated within 12 weeks of the decision to treat. This is commonly referred to as the TTG and is a legal requirement under the Patients' Rights Bill.

Performance Against Guarantee

Table 4 shows waiting times information for inpatients and daycases seen by NHS Forth Valley and NHS Scotland per quarter year period. The reported period is from Quarter 4, 2014 (1st October 2014 to 31st December 2014) to Q4, 2015 (1st October 2015 to 31st December 2015). Note that the information for 1st October 2015 to 31st December 2015 is provisional.
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Table 4

Table 4 : Waiting Times for Inpatient Daycase Admission: Completed Waits for Patients Seen Per Quarter Period (Q4,2014 to Q4,2015).

		Published Information				Management Information			
NHS Board of Treatment	Indicator	Q4 (1st Oct 2014 to 31st December 2014)	Q1 (1st Jan 2015 to 31st March 2015)	Q2 (1st April 2015 to 30th June 2015)	Q3 (1st July 2015 to 30th Sept 2015)	Oct 15	Nov 15	Dec 15	Provisional Cumulative Performance for Q4 (1st Oct 2015 to 31st December 2015)
NHS Forth Valley	Number seen	3,258	3,437	3,435	3,090	948	1,086	990	3,024
	Median (days)	55.0	57.0	58.0	59.0	57.0	61.0	64.0	n/a
	90th Percentile (days)	82.0	82.0	80.0	80.0	82.0	82.0	83.0	n/a
	Number who waited over 12 weeks	2	16	1	1	1	2	1	4
	% Compliance With TTG	99.94%	99.5%	99.97%	99.97%	99.89%	99.82%	99.90%	99.87%
NHS Scotland	Number seen	81,905	81,476	78,846	78,546	n/a	n/a	n/a	n/a
	Median (days)	38.0	41.0	41	41	n/a	n/a	n/a	n/a
	90th Percentile (days)	77.0	81.0	80	80	n/a	n/a	n/a	n/a
	Number who waited over 12 weeks	2,376	4,318	4,053	4,255	n/a	n/a	n/a	n/a
	% Compliance With TTG	97.1%	94.7%	94.9%	94.6%	n/a	n/a	n/a	n/a

Key issues and actions

- Table 4 shows that since the start of the 2015/2016 financial year NHS Forth Valley has had 6 breaches of the Treatment Time Guarantee.

- NHS Forth Valley compliance with TTG since the 1st of April to 30th Sept 2015 is 99.9%. The most up to date compliance information available for Scotland is for the quarter period ending 30th September 2015 which is 94.6%.

- With regard to ongoing waits, at 31st December 2015 there were five inpatients in Forth Valley with ongoing waits over 12 weeks.

- Since the start of the 2015-2016 Financial Year there have been 6 breaches of the Treatment Time Guarantee. Overall compliance remains high at 99%. The Board should be aware that TTG performance is expected to decrease in January 2016, in part due to winter pressures. At the time of writing (18th January 2016) there have been 48 breaches of the TTG (12 completed waits and 36 ongoing waits). It is anticipated that this pressure will continue into February 2016. Whilst locally this has become more challenging, Forth Valley remains much more positive that the national average.

4. Unavailability

As outlined within the Audit Scotland recommendations, NHS Boards are required to monitor the unavailability levels for inpatient/daycase and new outpatient services. Tables 5 and 6 describe the level of unavailability by specialty for Outpatients and Inpatients respectively at 31st December 2015 census.

New Outpatient Unavailability: Table 5 describes the level of unavailability for Outpatients at 31st December 2015 census. Information from July to November 2015 is provided for reference.

Table 5

Table 5 :	NHS Forth Valley, Number of Available and Unavailable New Outpatients at Each Month-End Census 31st July 2015 to 31st December 2015. Data is at Specialty Level (Expressed as % of Total Waiting).							
	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15		
Specialty	% of Patients Unavailable	% of Patients Unavailable	% of Patients Unavailable	% of Patients Unavailable	% of Patients Unavailable	Number Available	Number Unavailable	% of Patients Unavailable
ANAESTHETICS	0.4%	0.2%	1.3%	0.2%	1.2%	396	2	0.5%
EAR, NOSE & THROAT (ENT)	1.2%	0.8%	0.5%	0.4%	0.2%	1,132	8	0.7%
FRACTURE CLINIC	0.0%	1.7%	0.0%	0.0%	0.0%	32	0	0.0%
GENERAL SURGERY	1.6%	0.9%	2.0%	2.6%	3.0%	1,309	92	6.6%
HAEMATOLOGY	3.3%	0.0%	0.0%	0.0%	1.6%	56	0	0.0%
OPHTHALMOLOGY	2.2%	1.8%	2.0%	1.6%	1.2%	1,702	27	1.6%
ORAL AND MAXILLOFACIAL SURGERY	0.5%	0.2%	0.9%	0.8%	0.6%	687	6	0.9%
ORTHODONTICS	0.0%	0.7%	3.1%	1.9%	1.8%	182	2	1.1%
ORTHOTICS	0.8%	0.0%	0.9%	3.3%	1.1%	68	2	2.9%
TRAUMA AND ORTHOPAEDIC SURGERY	1.5%	1.4%	2.4%	1.2%	0.8%	2,088	34	1.6%
UROLOGY	8.2%	6.5%	10.8%	8.6%	9.5%	568	52	8.4%
VASCULAR SURGERY	6.8%	7.2%	5.8%	6.5%	8.2%	138	6	4.2%
NEUROSURGERY	0.0%	0.0%	0.0%	0.0%	0.0%	1	0	0.0%
Surgical Unit	2.1%	1.7%	2.6%	2.0%	2.0%	8,359	231	2.8%
CARDIOLOGY	1.6%	1.8%	1.4%	1.3%	1.4%	391	4	1.0%
CLINICAL ONCOLOGY	0.0%	0.0%	0.0%	0.0%	0.0%	44	0	0.0%
DERMATOLOGY	1.4%	1.0%	1.6%	0.8%	0.7%	1,352	34	2.5%
DIABETES	1.0%	0.0%	0.0%	0.0%	0.0%	113	0	0.0%
ENDOCRINOLOGY	0.8%	0.7%	0.0%	0.0%	0.0%	161	2	1.2%
GASTROENTEROLOGY	0.6%	1.0%	1.0%	0.4%	0.5%	721	11	1.5%
GENERAL MEDICINE	0.0%	0.0%	2.9%	0.0%	0.0%	34	0	0.0%
GERIATRIC MEDICINE	0.0%	0.0%	2.0%	0.0%	1.1%	96	0	0.0%
RENAL MEDICINE	0.0%	0.0%	0.0%	0.0%	0.0%	50	0	0.0%
NEUROLOGY	1.1%	0.3%	0.3%	0.9%	0.5%	644	4	0.6%
RESPIRATORY MEDICINE	2.4%	2.6%	5.1%	2.4%	3.4%	324	9	2.7%
RHEUMATOLOGY	0.6%	0.8%	0.5%	2.4%	1.4%	318	6	1.9%
Medical Unit	1.2%	1.0%	1.4%	0.9%	0.9%	4,248	70	1.6%
GYNAECOLOGY	2.1%	0.5%	1.3%	1.1%	4.9%	681	36	5.0%
PAEDIATRICS	1.6%	0.6%	0.6%	0.8%	7.4%	404	50	11.0%
PAEDIATRIC SURGERY	2.3%	2.0%	0.0%	0.0%	0.0%	64	0	0.0%
W&C Unit	2.0%	0.6%	1.0%	0.9%	5.9%	1,149	86	7.5%
Grand Total	1.8%	1.4%	2.0%	1.5%	2.0%	13,756	387	2.7%
Scotland Position as at 30th Sept 2015								3.2%

Key issues & actions

- Table 5: at 31st December 2015 there were 387 new outpatients unavailable for appointment which is 2.7% of the total waiting list.
- At 30th September 2015 published Information on ISD website shows 3.2% of NHS Scotland outpatients were unavailable.
- The following specialties were above the 3.2% national average: General Surgery 6.6%, Urology 8.4%, Vascular 4.2%, Gynaecology 5.0% and Paediatrics 11.0%.

Inpatient Unavailability:
Table 6 describes the level of unavailability for Inpatients and daycases at the 31st December 2015 census.

Table 6

Table 6 :	NHS Forth Valley, Number of Available and Unavailable Inpatients/Daycases at Specialty Level as at Month-end Census 31st July 2015 to 31st December 2015 (Expressed as % of Total Waiting)											
	Jul-15	Aug-15	Sep-15	Oct-15			Nov-15			Dec-15		
Specialty	% Unavailable	% Unavailable	% Unavailable	Number Available	Number Unavailable	% Unavailable	Number Available	Number Unavailable	% Unavailable	Number Available	Number Unavailable	% Unavailable
ANAESTHETICS	4.2%	5.9%	**14.6%**	46	1	2.1%	38	1	2.6%	41	2	4.7%
CARDIOLOGY	3.7%	6.5%	0.0%	39	0	0.0%	42	1	2.3%	31	0	0.0%
DIAGNOSTIC RADIOLOGY	0.0%	0.0%	0.0%	0	0	0.0%	0	0	0.0%	0	0	0.0%
EAR, NOSE & THROAT	8.9%	6.0%	8.1%	321	11	3.3%	303	34	10.1%	297	49	14.2%
GENERAL SURGERY	11.5%	12.7%	**13.3%**	436	75	14.7%	422	72	14.6%	445	65	12.7%
GYNAECOLOGY	11.0%	7.7%	8.9%	210	16	7.1%	154	16	9.4%	190	20	9.5%
OPHTHALMOLOGY	8.4%	7.9%	5.4%	407	27	6.2%	331	36	9.8%	333	46	12.1%
ORAL MAXILLIOFACIAL	15.0%	6.1%	6.5%	172	10	5.5%	137	13	8.7%	136	15	9.9%
ORTHOPAEDICS	20.9%	18.2%	**16.6%**	637	100	13.6%	529	129	19.6%	464	150	24.4%
PAEDIATRIC SURGERY	10.0%	7.1%	4.0%	27	3	10.0%	8	3	27.3%	25	1	3.8%
UROLOGY	11.5%	9.0%	**11.4%**	156	21	11.9%	157	26	14.2%	170	16	8.6%
VASCULAR SURGERY	13.3%	6.1%	7.0%	100	20	16.7%	92	14	13.2%	82	17	17.2%
Grand Total	12.9%	11.1%	11.0%	2551	284	10.0%	2213	345	13.5%	2214	381	14.7%
Scotland Position as at 30th September 2015												**18.90%**

Key Issues and actions

- At 31st December 2015 NHS Forth Valley had 381 (14.7%) inpatients/daycases unavailable for treatment. This is up from 345 (13.5%) in the previous month.
- Scotland's unavailability rate for inpatients and daycases at 30th September 2015 was 18.9%.
- At 31st December Orthopaedics had an unavailability rate higher than the Scottish average.

5. Key Diagnostic Tests

5.1 Imaging

Waiting Time Standard: The maximum waiting time from referral to reporting of results for the 4 key diagnostic Imaging tests should be no more than 6 weeks (42 days).

Performance against Standard: At 31st December 2015, the imaging service was fully compliant with the 42 day waiting time standard.

Key Issues and Actions:

- At 31st December 2015 there were no patients waiting over 42 days.

5.2 Endoscopy

Waiting Time Standard: The maximum waiting time from referral to reporting of results for the 4 key diagnostic tests within Endoscopy should be no more than 6 weeks (42 days).

Performance against Standard: Table 7 provides information on the compliance with the 42-day target for the 4 key diagnostic endoscopy tests for the period 31st July to 31st December 2015 .

Table 7

Table 7: NHS Forth Valley. Trend in the Number of Patients Breaching the Key Diagnostic Waiting Time Standard for Endoscopy. Month-end Census 31st July to 31st December 2015

Service	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15
Upper Endoscopy	51	28	19	17	8	9
Lower Endoscopy (excl. Colonoscopy)	43	1	2	2	27	41
Colonoscopy	12	18	17	22	23	39
Cystoscopy	4	0	0	0	0	0
All Endoscopy	**110**	**47**	**38**	**41**	**58**	**89**

Key issues and actions

- At 31st December 2015 there were 89 patients waiting over 42 days for the Endoscopy service. This is up from 58 in November 2015.
- The longest ongoing wait at end of December was 12 weeks
- Endoscopy have advertised for additional nurse endoscopist and supporting nursing staff.

Endoscopy Surveillance

Whilst there are no specific targets around endoscopy surveillance, NHS Forth Valley makes a monthly data submission to ISD and Scottish Government on the waiting times for surveillance. Table 8 provides information on the number of patients over their surveillance recall dates and Table 9 shows the range of wait beyond the surveillance date. The reporting period is 31st July 2015 to 31st December 2015.

Table 8

Table 8	NHS Forth Valley Endoscopy Surveillance. Trend in Number of Patients Waiting Over Target Surveillance Date Month-end Census 31st July 2015 to 31st December 2015							
	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Month on Month Change	% Month on Month Change
Number of Patients Waiting Over Target Surveillance Date	243	164	175	223	212	187	-25	-11%

Table 9

Table 9	Number of Patients Waiting For Endoscopy Surveillance Month end Census 31st July 2015 to 31st December 2015							
		Number Waiting Greater than Due Date						
	Number Waiting Less than Due Date	*Up to 4 weeks (28days)*	*Up to 8 weeks (56days)*	*Up to 12 weeks (84days)*	*Up to 18 weeks (126days)*	*Up to 26 weeks (182days)*	*>26 weeks (>182days)*	***Totals***
Dec-15	4,022	64	73	46	4	0	0	4,209
Nov-15	3,947	103	72	31	4	1	1	4,159
Oct-15	3,913	105	57	49	8	2	2	4,136
Sep-15	3,895	61	59	42	6	5	2	4,070
Aug-15	*3,930*	*49*	*59*	*43*	*10*	*3*	*0*	4,094
Jul-15	*3,831*	*74*	*76*	*56*	*21*	*13*	*3*	4,074

Key issues and actions

- Table 8 shows that at 31st December 2015 the number of patients beyond their recall date for surveillance was 187. This is a reduction of 25 patients (11%) on November 2015 position.

- Table 9 shows that there were no patients waiting longer than 18 weeks for their surveillance appointment.

6. Cancer Waiting Times

Cancer Waiting Time Standards

- 95% of patients with suspicion of cancer should be treated within 62 days or less.
- 95% of patients with cancer should be treated within 31 days of decision to treat**.**

Performance against waiting time standards

Table 10 provides information on the published performance for Cancer services for the quarter periods Q3 2014 to Q3 2015. The Monthly management information for October 2015 and November 2015 is also provided.

Table 10

Table 10: NHS Forth Valley Cancer Services Performance for 62 and 31 Day Targets By Quarter Year Periods from 1st July 2014 to 30th September 2015.
The Monthly Management Information for October 2015 and November 2015 is also provided

		Quarterly Data					Monthly Management Information	
Waiting Time Standard	NHS Board	Qu 3 July-14 to Sept-14	Qu 4, Oct-14 to Dec-14	Qu 1, Jan-2015 to Mar -2015	Qu 2, April-2015 to June -2015	Qu 3 July-15 to Sept-15	Oct-15	Nov-15
62 Day Target	FV	93.8%	95.4%	91.2%	95.2%	95.2%	96.4%	96.0%
	Scotland	93.5%	94.2%	91.8%	92.1%	90.0%	n/a	n/a
31 Day Target	FV	98.1%	98.4%	98.0%	98.9%	98.7%	98.5%	98.6%
	Scotland	96.7%	97.5%	96.5%	96.3%	95.2%	n/a	n/a

Key issues and action

- Monthly management information for the Month of November 2015 shows that NHS Forth Valley continues to deliver the 62 day and 31 day standard.

7. Mental Health Targets

7 .0 Mental Health Targets

7.1 Drug and Alcohol Services

Waiting Time Standard: 90% of clients will wait no longer than 3 weeks from referral received to appropriate drug or alcohol treatment that supports their recovery.

- **Compliance with Standard:** The data for quarter ending December 2015 highlights that NHS Forth Valley continues to meet the standard with 95.4% of clients treated within 3 weeks. The standard does not include prison services however the management information highlights that the position in respect of Forth Valley prisons performance was 100% bringing the combined performance to 97.9% for the quarter 1st October 2015 to 31st December 2015. The Scotland position at September 2015 was 95.6%.

Key issues and actions: There are no key issues within Drugs and Alcohol services waiting times.

7.2 Psychological Therapies

Waiting Time Standard: At least 90% of people waiting for Psychological Therapies should start treatment within 18 weeks of referral.

Compliance with Target
Table 11 highlights the monthly compliance with the RTT target for period July 2015 to December 2015.

Table 11

Table 11 Psychological Therapies Waiting Time at Specialty Level - % patients seen within 18 weeks in each month July 2015 to December 2015

	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15
Behavioural Psychotherapy	55.1	69.2	87.7	86.1	85.7	75.6
Adult Clinical Psychology	58.1	55.8	61.3	77.8	81.2	90.7
Dynamic Psychotherapies	100	100	100	100	100.0	100.0
Overall Performance (All Services)	**57.1**	**63.1**	**68.3**	**79.8**	**82.5**	**87.6**

Key issues and actions

- In December 2015, 87.6% of patients were treated within 18 weeks.
- In September 2015 NHS Scotland treated 81.2% of patients within 18 weeks of referral.

7.3 Child and Adolescent Mental Health Service (CAMHS)

Waiting Time Standard: At least 90% of people waiting for CAMHS services should start treatment within 18 weeks of referral.

Compliance with Standard: Table 12 highlights the CAMHS RTT performance for NHS Forth Valley against the RTT standard from July 2015 to December 2015.

Table 12

Table 12: NHS Forth Valley CAMHs Waiting Times: % of Patients Treated Within 18 Weeks of Referral (RTT). Performance by Month Treated: July 2015 to December 2015						
NHS Board of Treatment	**NHS Forth Valley**			**Scotland**		
	% 0-18 weeks	Median (weeks)	90th Percentile (weeks)	% 0-18 weeks	Median (weeks)	90th Percentile (weeks)
Dec-15	36.4	n/a	n/a	n/a	n/a	n/a
Nov-15	28.4	n/a	n/a	n/a	n/a	n/a
Oct-15	41.7	n/a	n/a	n/a	n/a	n/a
Sep-15	41.9	27.0	32.0	71.1	9.0	30.0
Aug-15	45.3	21.0	31.0	71.3	9.0	29.0
Jul-15	64.4	8.0	30.0	75.1	8.0	32.0

Key issues and actions

- The data for the month of December 2015 highlights that 36.4% of NHS Forth Valley patients were treated within 18 weeks of referral. In September 2015 Scotland treated 71.1% of patients within 18 weeks of referral.

- The Board have made a significant financial commitment in the past 12 months to enhance the clinical capacity of the service but the full impact of this has not yet been realised in terms of waiting list reduction. This is mainly due to recruitment difficulties and staff sickness/ maternity leave.

8. Conclusion:

NHS Forth Valley continues to deliver the 18 week Referral to Treatment standard. Going forward the RTT performance will be affected by the increasing trend in volumes of outpatients waiting over 12 and 16 weeks. Since the start of the 2015-2016 Financial Year there have been 6 breaches of the Treatment Time Guarantee. Overall compliance remains high at 99%. The Board should be aware that TTG performance is expected to decrease in January 2016, in part due to winter pressures. At the time of writing (18th January 2016) there have been 48 breaches of the TTG (12 completed waits and 36 ongoing waits). It is anticipated that this pressure will continue into February 2016. Whilst locally this has become more challenging, Forth Valley remains much more positive that the national average.

Radiology, Cancer services, Drug and Alcohol services continue to deliver their waiting time standards and Psychological Therapies had a significant improvement in performance against their RTT target with 87% compliance. CAMHS and Endoscopy services continue to work through their recruitment plans and waiting list backlog.

NHS Forth Valley unavailability rates and DNA rates remain lower than the Scottish.

Forth Valley NHS Board

26 January 2016

This report relates to
Item 7.4 on the agenda

Communications Quarterly Update Report
September – December 2015

(Presented by Elsbeth Campbell, Head of Communications)

For Noting

SUMMARY

1. NHS Forth Valley Communications Quarterly Update Report (September – December 2015)

2. PURPOSE OF PAPER

This paper aims to provide an update on the ongoing work to develop and improve internal and external communications across the organisation in line with the plans and priorities set out in NHS Forth Valley's Communications Strategy (2015 – 2017). It also provides an overview of some of the key work undertaken to raise awareness of a wide range of service developments, campaigns, events and initiatives across Forth Valley during September – December 2015.

3. KEY ISSUES

Effective communications plays an increasing role in raising awareness, educating and informing patients and the public on a wide range of health developments, services and changes both locally and nationally. It also plays a vital role in protecting and enhancing an organisation's reputation, providing reassurance and encouraging greater uptake of services such as vaccination and screening.

High levels of media interest and public scrutiny along with rising patient expectations, also means accurate, timely communication is more important than ever.

4. FINANCIAL IMPLICATIONS

The Communications Strategy highlights the importance of cost-effective communications that build on the organisation's existing tools as well as working collaboratively to make use of the resources available in partner agencies – locally, regionally and nationally.

5. WORKFORCE IMPLICATIONS

Every member of staff has a responsibility for communication and managers have a specific responsibility for ensuring that their staff have access to information and are kept updated on key changes, developments and issues that affect them.

6. RISK ASSESSMENT AND IMPLICATIONS

Both internal and external communication activities can carry risk however, accurate, timely and relevant communications, tailored to the needs of specific audiences can help reduce the level of risk associated with specific plans, changes or announcements.

7. RELEVANCE TO STRATEGIC PRIORITIES

The Communications Strategy supports NHS Forth Valley's key priorities and overall strategic vision.

8. EQUALITY DECLARATION

An Equality Impact Assessment has been carried out on the Communication Strategy and specific work is also undertaken to raise awareness and promote work carried out across the organisation to meet the requirements of relevant national legislation.

□ Paper is not relevant to Equality and Diversity

x Screening completed - no discrimination noted

□ Full Equality Impact Assessment completed – report available on request.

9. CONSULTATION PROCESS

The Communications Strategy reflects feedback from a number of consultations, reviews and audits carried out across the organisation. Communication plans for specific projects and initiatives are developed in partnership with relevant staff and other key stakeholders, as appropriate.

10. RECOMMENDATION(S) FOR DECISION

The Forth Valley NHS Board is asked to: -

Note the update and progress which has been made during the period to raise awareness of a wide range of service developments, campaigns, events and initiatives across Forth Valley, in line with NHS Forth Valley's Communications Strategy

11. AUTHOR OF PAPER/REPORT:

Name:	***Designation:***
Elsbeth Campbell	**Head of Communications**

Approved by:

Name:	***Designation:***
Jane Grant	**Chief Executive**

Communications Quarterly Update Report

Key Activity Highlights

- Issued over 70 proactive media releases and statements
- Generated over 250 news stories - 93% of the resulting coverage was either positive or neutral
- Continued to build our audience on social media – our Facebook audience has tripled in one year and we are now ranked 3rd amongst NHS Boards in Scotland

Campaign Highlights

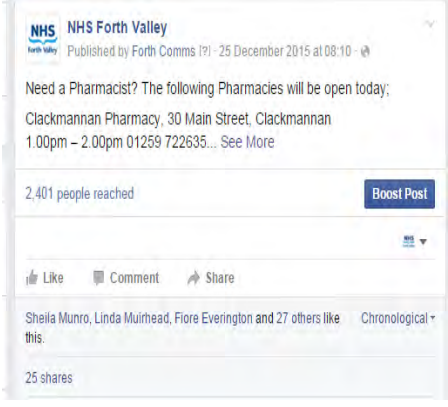
'Be Health-Wise this winter'

One of the main priorities for the Communications Department in the last quarter of 2015 was to support the Board's winter plans, encourage people to prepare ahead for the winter period and highlight where people can access local health treatment and advice over the festive period.

- A local launch was organised to coincide with the national launch of NHS Scotland's 'Be Health-Wise this winter' campaign. This featured a local GP and community pharmacist who were joined by some real life wise owls from the Little Critters centre in Stirling.
- A dedicated Winter Zone was developed on the NHS Forth Valley website with key local health information, details of where to access services and video clips of frontline staff providing health advice.
- Social media was used extensively to reinforce key health messages and give details of services available over the festive period.
- As part of the 'Think Norovirus' campaign, work was undertaken to encourage the public to stay away from hospitals and other NHS facilities
- A new campaign was launched to promote the Minor Injuries Unit (MIU) at Stirling Community Hospital using external Billboard advertising at key sites, local radio advertising, posters, a new video featuring local staff and social media. Council partners also shared information externally and internally and letters were sent to the parents of local school children across Forth Valley.

Results

- The raido campaign reached around 46,000 adults each week
- Articles and campaign images appeared in all local newspapers
- During December 2015 posts reached more than 19,000 people on Facebook alone
- Attendances at the MIU increased by around 8%, compared with December 2014
- The new video, which featured local nursing staff, generated positive feedback and comments from patients



Publicity

Throughout the period, the Communications Department promoted a wide range of service developments and initiatives across the organisation. These included highlighting that NHS Forth Valley had been named by trainee doctors as one of the top places in the UK to work following a national survey by the General Medical Council. In November 2015, NHS Forth Valley became the first health board in Scotland to support a campaign to help people with dementia in all its hospitals. John's Campaign encourages hospitals to allow family members and carers to stay with patients with dementia so they can be surrounded by familiar faces. The ALFY advice line for older people, which was successfully piloted in Bo'ness, was rolled out across Forth Valley on 1st December 2015 backed by a local communications campaign. A number of key appointments were also announced during this period including a new Chief Officer for the Falkirk Health and Social Care Partnership and a new Non-Executive member of the Forth Valley NHS Board.

In October 2015, BBC Scotland filmed a live broadcast from the atrium of Forth Valley Royal Hospital for Reporting Scotland. The main focus of the programme was the Scottish Government's national conversation on the future of health and social care services and it included live interviews with Shiona Robison, Cabinet Secretary for Health and Wellbeing and Sister Ann Myles, a Senior Charge Nurse at Forth Valley Royal Hospital. Dr Craig Sayers, Clinical Lead for Prison Health Services in NHS Forth Valley was also interviewed for a series 'Prison First and Last 24 hours', which aired in December 2015 on Sky 1. Dr Sayers spoke of a number of health issues affecting prisoners including the effect of so-called legal highs.

A wide range of events were promoted in the run up to the festive period. These included the switching on of the Christmas tree lights at Forth Valley Royal Hospital by the Rt. Hon. Sir George Reid, former Presiding Officer of the Scottish Parliament; a month long programme of musical entertainment and events in the atrium. The Children's Ward received a number of visits from local businesses and organisations who were keen to donate presents. These included Falkirk Football Club, Forth Valley College and a number of local supermarkets. Santa was joined by his elves and the cast of Frozen to help provide entertainment at the Children's Ward Christmas party. Serco staff also kindly donated a number of gifts to patients in Ward A22. The Midwives Choir staged a 'flash mob' in Starbucks at Forth Valley Royal Hospital and the Nurses Choir featured on the front page of the Nursing Standard's Christmas issue. Forth Valley Royal Hospital also welcomed its first Christmas and New Year babies and the Communication Team worked closely with ward staff to publicise the first deliveries in Falkirk, Stirling and Clackmannanshire.

A new STOPATHON campaign, asking individuals who wish to stop smoking to pledge to quit in January 2016, was launched to encourage local people to quit smoking and live a healthier lifestyle in time for National No Smoking Day on 9th March 2016. In return for signing the pledge the local Stop Smoking Service offers a variety of free support and treatment. A new partnership was also launched with Artlink Central to harness the

experience of local ex-servicemen and women. Up to ten volunteers are being sought for the Workshop Project to create new artwork which can then be enjoyed by patients, staff and visitors across Forth Valley. This is Artlink's first creative programme with veterans and it aims to give those taking part an opportunity to develop new skills, build new social networks and leave a lasting legacy.

Awards

During the period NHS Forth Valley's Audiology and Volunteer Service won the 2015 British Academy of Audiology's (BAA) Team of the Year Award. Serco, in partnership with NHS Forth Valley, won the prestigious Golden Services Award 2015 for the cleanest healthcare premises with more than 250 beds. The Clackmannanshire Integrated Mental Health Service (IMH), a partnership between NHS Forth Valley and Clackmannanshire Council, retained its Customer Service Excellence accreditation following a recent inspection. A number of staff from NHS Forth Valley were selected as finalists at the 2015 Scottish Health Awards 2015 and Deirdre Anderson was also a finalist in the IHM Manager of the Year award. Nine S3 and S4 pupils from Clackmannanshire High Schools celebrated their successful completion of the Play Mentor programme after studying child development at Forth Valley College and completing work placements.

Events

The Communications Department were involved in a number of events including the Annual Review for 2014/15. Work was undertaken to encourage local people, patient representatives, community groups and local organisations from across Forth Valley to attend and this ensured a good attendance at the meeting on 16th Sept 2015. Filming, photography and live tweeting was also undertaken to promote the NHS Forth Valley 2015 Staff Awards which took place prior to the Annual Review. Details of the event and photographs were sent to local media and the winners were also promoted internally and externally. In addition, film clips from both events were posted online to enable anyone who could not attend to view key highlights.

The Communications Department also produced a new video and presentation to showcase the work of local volunteers. These were shown at a special reception held in December 2015 to thank the hundreds of volunteers who support NHS Forth Valley. In addition, work was undertaken to promote a number of community events, including an engagement event to update on plans for the new health centre in Doune, ALFY information sessions and local consultation events on draft health and social care strategic plans.

Internal Communications

Work continued to ensure staff were updated on key developments and changes across the organisation. This included briefing updates which were circulated after each NHS Board meeting and the Winter 2015 Staff Newsletter which attracted more than 25,000 online views throughout the period. Regular staff briefs were also issued to update staff on key issues and the staff intranet continued to be updated on a daily basis to raise awareness of events, training opportunities and news across the organisation. Filming was undertaken to promote the organisation's Long Service Awards. The Communications Department interviewed staff with 20, 30 and

40 years NHS service about their time with the NHS and the changes they had seen during their careers. The short films were shown at the award ceremony held in December 2015 and promoted via the website, intranet and social media channels.

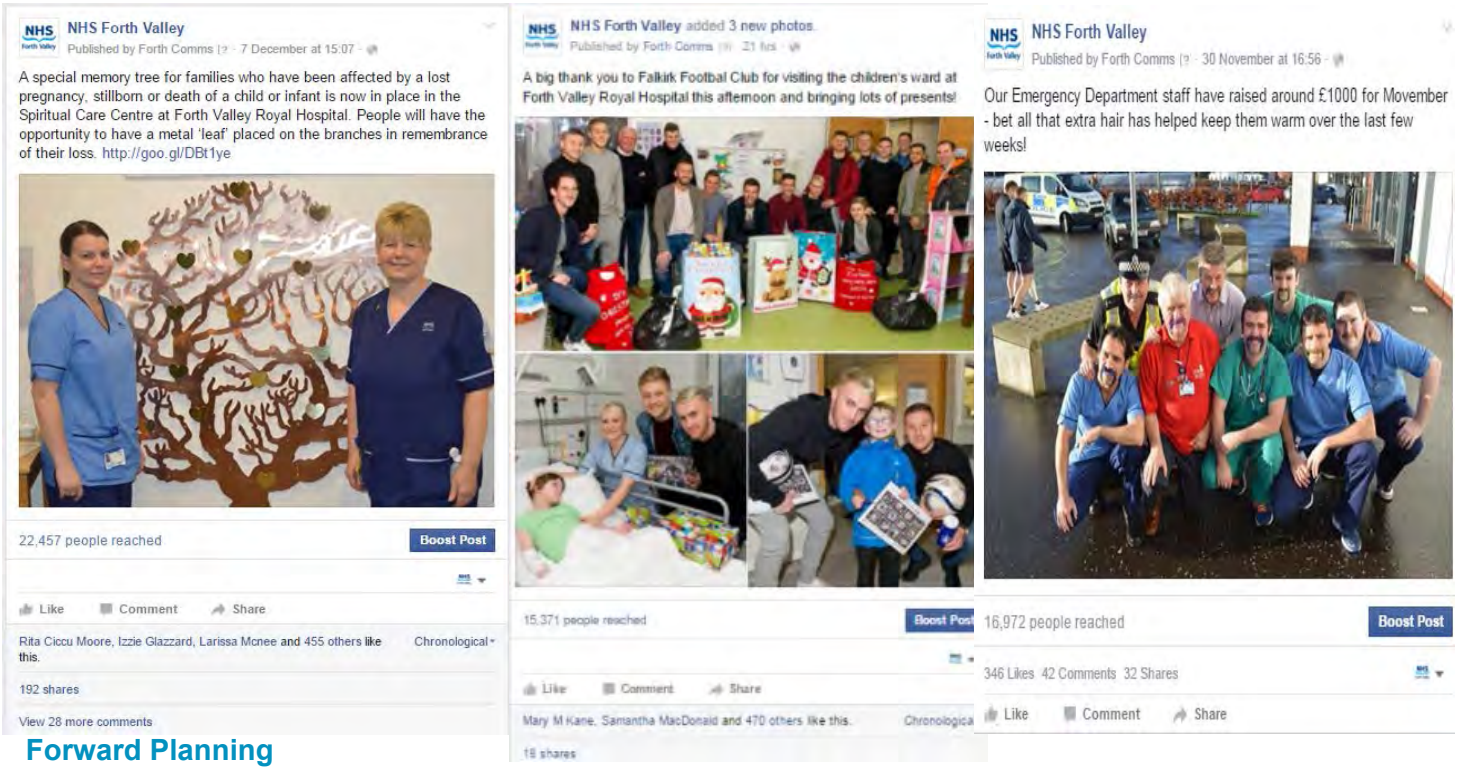
Media Management

The Communications Department dealt with a number of high profile media issues during the period. These included patient complaints, winter planning, the Forth Road Bridge Closure, local GP recruitment issues and the dismissal of a member of staff from Signpost Recovery which provides a range of alcohol and drug support services on behalf of NHS Forth Valley.

Web and Social Media

Continuing use was made of social media to provide information, advice and updates on a wide range of events, initiatives and health issues. We now have more than 5,800 followers on Twitter with many posts being regularly re-tweeted by our followers. The NHS Forth Valley Facebook account has seen a large increase in activity over the last quarter and now has more than 3,550 likes and much more interaction with users. Work continues with staff from a number of services, including dietetics and stop smoking services, to promote a range of local services and health advice. Between September and December 2015, there have been more than 345,464 page views on our website. Mobile and tablet usage continues to rise with 55% of people viewing our website through a mobile phone or tablet device. These increases are largely due to our more responsive website design, which makes it far easier to navigate the website from a phone or tablet.

A few of the top performing posts from the last quarter are shown below and work continues to monitor the response to different content, themes and messages on social media.



Forward Planning

Communication priorities for the next four months include the development of plans to promote our draft Healthcare Strategy, work to highlight progress in health and social care integration and raise awareness of key plans, priorities and challenges for 2016/17.

BOARD MEETING

26th January 2016

This report relates to
Item 8.1 on the agenda

Financial Plan

(Presented by Mrs Fiona Ramsay,

Director of Finance)

For Noting

SUMMARY

1. PURPOSE OF PAPER

This paper highlights the key messages and planning parameters for Health arising from the 2015 Scottish Government Spending Review.

2. SUMMARY OF KEY ISSUES

The Scottish Government Spending Review 2015 indicates that NHS Territorial Boards will receive a 5.5% uplift. This uplift includes a £250m investment to be directed to Health and Social Care Partnerships, to ensure improved outcomes in social care.

For NHS Forth indicative figures have been provided as follows:-

Recurrent Baseline	£ 464.033m	
Indicative Budget Uplift	£ 7.889m	1.7%
Indicative Social Care Allocation	£ 13.400m	2.9%
Indicative 2016/17 Baseline	£ 485.322m	4.6%

The remaining health uplift comprises NRAC funding which has been provided to NHS Grampian and NHS Lothian.

National dialogue continues regarding the Indicative Social Care Allocation.

There are three further issues to highlight :-

- A New Outcomes Framework will cover those allocations currently provided within 'Bundles Allocations' - these resources will have 7.5% cash savings applied to them.

- Resources for Alcohol and Drug Partnerships will be solely managed through Health.from 2016/17. In 2015/16 resources totalled £ 69.2m across health and justice. For 2016/17 £ 53.8m has been indicated as funding to be distributed to Boards with the letter also indicating an expectation that a total of £15m to support efforts and maintain overall spend will come from increased Board baseline budgets.

- Indication that the New Medicines Fund for 2016/17 will be approximately £60m (app £85m in 2015/16)

Three areas of investment identified :-

- Primary and Community Care
- Mental Health
- Transformational Change

Based on estimated costs for Pay (including National Insurance changes in 2016/17), Prices and Prescribing combined with known service pressures and commitments this indicates real cash savings of approximately 6% (£27m) will be required in 2016/17.

The draft Local Delivery Plan including the Financial Plan is required to be submitted by 4th March 2016 with final Plan required by the end of May 2016.

4. SUMMARY OF ACTIONS TO DATE

An initial Draft Financial Plan has been prepared for 2016/17 and will be subject to further discussion at an NHS Board session following the January NHS Board meeting.

All Directorates have submitted cash savings plans of 3% and these are currently subject to managerial review. The Area-wide themes are being used to identify the remaining 3%.

5. FINANCIAL IMPLICATIONS

As outlined in the paper.

6. WORKFORCE IMPLICATIONS

Workforce implications will be incorporated in the Local Delivery Plan / Financial Plan considerations.

7. RISK ASSESSMENT AND IMPLICATIONS

Risk assessment is incorporated into the Local Delivery Plan / Financial Plan.

8. RELEVANCE TO STRATEGIC PRIORITIES

Statutory requirement to deliver services within revenue and capital resource limit.

8. EQUALITY DECLARATION

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

Further to an evaluation it is noted that:
☒ Paper is not yet relevant to Equality and Diversity (see above)
☐ Screening completed - no discrimination noted
☐ Full Equality Impact Assessment completed – report available on request.

9. CONSULTATION PROCESS

Consideration will be given to any consultation requirements arising from the Local Delivery Plan / Financial Plan.

10. RECOMMENDATION(S) FOR DECISION

The Board is asked to:

- Note the outline planning parameters arising from the 2015 Scottish Government Spending Review
- Approve delegated authority to the Performance and Resources Committee to approve the draft Local Delivery Plan including the draft Financial Plan noting that the draft Financial Plan will include the proposed budgets for the Integrated Joint Boards

11. AUTHOR OF PAPER/REPORT:

Name:	***Designation:***
Fiona Ramsay	**Director of Finance**

NHS Forth Valley Board

26 January 2016

This report relates to
Item 8.2 on the agenda

Primary Care Workforce Challenges

(Paper presented by Mrs Fiona Ramsay, Director of Finance)

For Noting

SUMMARY

1. Primary Care Workforce Challenges.

2. PURPOSE OF THE PAPER

To update the Board on the position as regards actions taken to help address the local implications of the national challenge in respect of the primary care workforce, in particular General Practitioners.

This paper provides a short summary of the current position.

3. **KEY ISSUES**

The Board will be aware that in recent months there have been five Practices under management of the Board. The Westburn Practice reverted to independent practitioner status in August 2015, with Drymen following in early December 2015. These are extremely positive developments in the current workforce climate and we will continue to work with the Practices to ensure ongoing sustainability.

Practices which remain managed by the Board are:-

Slamannan - long-standing arrangement with no plans to change.

Bannockburn and Kersiebank - model of care supported by a team of GPs (salaried posts, long term/short term locum provision and support from local Practices via GP Sustainability Local Enhanced Service) Advance Nurse Practitioners, Pharmacists and Primary Mental Health Workers.

The Patient Relations Manager continues to work with the Practice Managers to identify issues that arise. Work continues to review lessons learned and to help identify changes required.

There are no further issues to highlight in respect of the Practice based at **CCHC** (Clackmannan Community Health Centre), although patient transfers to the Clackmannan Practice have not been as high as anticipated.

There are a further two practices where discussions are in progress or where there remains a vulnerability due to single handed GP cover at present.

- **Stenhouse Practice** (Stenhousemuir)
    - Meeting scheduled towards end of January 2016 to discuss sustainability options.
- **Wallace Practice** (Stirling)

GP Sustainability Group chaired by the Medical Director retains an overview of the position, including any “at risk” Practices.

4. FINANCIAL IMPLICATIONS

Funding from General Medical Services for the relevant Practices has been used to resource the new models of care. Based on current information this funding is sufficient for 2015/16. Additional pharmacy staff and salaried general practitioner staff recruited will be recharged to Practices who are using these services.

The Board approved £0.500m to support the challenges in primary care and this funding is likely to be required in 2016/17.

5. WORKFORCE IMPLICATIONS

Additional pharmacy staff, advanced nurse practitioners, primary mental health workers and salaried GPs have been appointed. It is likely, given changing model of primary care services, that further staff in these areas will be required.

The ongoing work with Practices has also identified support for the role of Practice Nurse and specific area-wide training needs and work is in progress regarding this.

6. RISK ASSESSMENT AND IMPLICATIONS

Primary Care Workforce remains one of the top risks on the Corporate Risk Register.
This paper provides an update on actions taken to mitigate the risk.

7. RELEVANCE TO STRATEGIC PRIORITIES

Resilient primary care services are an essential pre-requisite of future service provision.

8. RELEVANCE TO DIVERSITY AND / OR EQUALITY ISSUES

Due to the need for immediate change Equality and Diversity impact assessment has not yet been completed.

9. CONSULTATION PROCESS

Due to the need for immediate change it was not possible to consult in advance of changes. The Patient Relations Manager is working with the Practice Managers to highlight and address issues as they arise.

10. RECOMMENDATION(S) FOR DECISION

The Board is asked to note progress in addressing Primary Care Workforce Challenges

11. AUTHOR OF PAPER/REPORT:

Name:	***Designation:***
Fiona Ramsay	**Director of Finance**

Forth Valley NHS Board

26 January 2016

This report relates to
Item 8.3 on the agenda

Health and Social Care Integration

(Presented by Mrs Kathy O'Neill, General Manager)

For Noting

SUMMARY

1. TITLE: Health and Social Care Integration: Progress Report

2. PURPOSE

2.1 The purpose of this paper is to update Forth Valley NHS Board on progress with the implementation of Health and Social Care Integration in Forth Valley.

3. INTRODUCTION & BACKGROUND

3.1 Arrangements are progressing to establish two Health and Social Care Partnerships in Forth Valley on the basis of a body corporate partnership model, both partnerships to be fully established by April 2016.

4. FORMAL ESTABLISHMENT OF THE FALKIRK HEALTH & SOCIAL CARE PARTNERSHIP

4.1 As reported at the November Forth Valley NHS Board meeting, the orders to establish the Integration Joint Boards for Falkirk and for Clackmannanshire and Stirling came in to place on 3rd October 2015.

4.2 The first meetings of the Integration Joint Boards have now taken place with the full membership of voting and non voting members including elected members, non executive members of NHS Forth Valley, clinical and professional representatives, staff side representatives and representative of third sector, unpaid carers and service users.

4.3 The first Falkirk Integrated Joint Board met 6th November 2015. Board meetings and Papers are now available to the public

4.4 The first Clackmannanshire and Stirling Integrated Joint Board met on 27th October 2015. Meetings will be open to the public from 26th January 2016.

4.5 Work continues to complete the work necessary to ensure the delegation of responsibility from the Health Board and local authorities is in place from 1st April 2016. This will include agreement on budgets and services as well as the underpinning frameworks required by the Integration Scheme including for example Clinical and Care Governance Framework, Risk and Performance Frameworks and Housing Contribution Statements.

5. STRATEGIC PLAN & STRATEGIC NEEDS ASSESSMENT

5.1 Strategic Needs Assessments have been produced for each Partnership. A further iteration of this work will be to produce locality level needs assessments for the six locality areas that have been agreed across the two Partnerships.

5.2 Significant work has been undertaken to produce draft strategic plans for consultation. As part of the consultation process, these were presented to the Health Board at its last meeting as formal consultees.

5.3 Consultation periods on both draft Strategic Plans have now concluded. The revised draft Strategic Plans will now be developed through the respective Strategic Planning Groups before formal presentation to the Integration Joint Boards for approval to publish before 1 April 2016.

5.4 It is only when the Strategic Plan is agreed by the Integration Joint Board that functions and resources can be delegated to the Integration Authority. To meet the statutory requirements this means that the Plan must be agreed and published prior to 1 April 2016.

6. CHIEF OFFICER & FINANCE OFFICER ARRANGEMENTS.

6.1 Chief Officers are in post for both Partnerships. Shiona Strachan has been in post in Clackmannanshire and Stirling since July 2015 and Patricia Cassidy took up post in Falkirk in December 2015.

6.2 The recruitment process for the Falkirk Chief Officer Finance Officer was unsuccessful. There is ongoing discussion on the recruitment to the post.

6.3 Ewan Murray, the Chief Finance Officer for the Clackmannanshire and Stirling Partnership took up post in November 2015.

7. PROGRAMME BOARD AND WORKSTREAMS UPDATE

7.1 A range of work is ongoing to ensure that the new Partnerships are able to fulfil their legal responsibilities from April 2016.

7.2 This programme of work is overseen by a Programme Board, chaired by the Chief Officers. A number of workstreams are undertaking detailed work in the following areas:-

- Finance (including two sub groups)
- Governance
- Risk
- Clinical and Care Governance
- Performance
- Data Sharing Partnership
- Organisational Development & Workforce Development
- Work Force
- Participation & Engagement

7.3 The programme of work will ensure the delivery and implementation of a range of task that are required to support new integration arrangements and to ensure the Partnerships meet their statutory obligations from April 2016.

7.4 The outputs from each work stream, will be presented to Integration Joint Boards over the coming months. Some require to be in place ahead of April 2016, others are part of a longer term programme of work. All partners are contributing significant resources to the completion of this work.

8. ENGAGEMENT & PARTICIPATION

8.1 A Forth Valley wide Staff Forum has been established and has now held an initial development session to confirm the terms of reference and the operating framework. It involves membership drawn from the Human Resources teams, staff side and trade union representation from local authority partners.

9. FINANCE

9.1 The individual funding settlements have just been provided to partners and it will not be clear what level of resource is available to the Integration Authority until the Councils and NHS Forth Valley are clear about their own budget positions.

9.2 Discussions are ongoing with both partnerships to complete the due diligence work required on the initial draft budgets.

10. AUDIT SCOTLAND REPORT

10.1 On 3 December 2015, Audit Scotland issued the first report in respect of three planned audits of the Health & Social Care Integration national reform programme. Subsequent audits will look at Integration Authorities ("IAs") progress after the first year of being established and their longer term impact in shifting resources to preventative services and community based care and in improving outcomes for the people who use these services.

10.2 This first audit provided a progress report during this transitional year. Audit Scotland have reviewed progress at this relatively early stage to provide a picture of the emerging arrangements across Scotland for setting up, managing and scrutinising Integration Authorities as they become formally established. Their report highlights generic risks that Audit Scotland considers need to be addressed across Scotland as a priority to ensure the reforms succeed.

10.3 The main recommendations by Audit Scotland relate to concerns over how local arrangements will work in practice (including governance arrangements, differences over organisational costs, managing conflicts of interests, the independence of Integration Joint Boards, the accountability for service delivery, and the effective scrutiny), how budgets for the new Integration Authorities are to be agreed, the development of strategic plans, and establishment of supporting strategies for areas such as work force, risk management, and data sharing.

10.4 The recommendations contained in the report will be considered by Integration Joint Boards.

11. RECOMMENDATIONS

The Forth Valley NHS Board is asked to note progress with Health Social Care Integration in Forth Valley.

12. AUTHOR OF PAPER/REPORT:

Name:	***Designation:***
Kathy O'Neill	**General Manager – FV CHPs**

DRAFT

Outline Business Case for Investment in Facilities to Deliver Integrated Primary and Community Care in Doune

Draft Version: 12
Date: 12 January 2016

Contents

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1.0 Executive Summary

1.1 Introduction

This Outline Business Case (OBC) has been developed by NHS Forth Valley supported by community planning partners, third and independent care sectors, carers and representatives of the Doune community.

The purpose of the Outline Business Case is to identify a preferred option for delivering the preferred way forward that was identified in the Initial Agreement for the project. The OBC demonstrates that the preferred option provides value for money; sets out the likely deal; demonstrates its affordability; details the supporting procurement strategy and the management arrangements for the successful delivery of the project.

The investment in facilities sought through this Outline Business Case is a crucial element of a larger programme of work to design and deliver healthcare services fit for the future. The investment supports and enables the Board's approach to delivering future services based on the following principles:

- Provision of consistently high quality, safe and sustainable services across the whole system, integrating care in partnerships appropriately.
- Ensuring all care is patient focussed while planning and delivering care in partnership with our population.
- Increased focus and pace on shifting the balance of care - develop community and primary care services through facilitating supported self-management, anticipatory care planning, integrating care pathways, locality planning and workforce development.
- Minimise time spent in acute care and focus acute care on complex, unscheduled emergency care, specialist elective care with day surgery /23hr surgery the norm, minimising length of stay and ensuring the majority of service provision is as close to home as possible.
- Collaborative working should be focussed on reducing inequalities, prevention through an asset based approach and on early years.

In applying these principles the Board will take into account the 'Health and Wellbeing Outcomes (Joint Public Bodies Act 2014) which are set out below:

- People are able to look after and improve their own health and wellbeing and live in good health for longer.
- People, including those with disabilities, long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.
- People who use Health and Social Care services have positive experiences of those services, and have their dignity respected.
- Health and Social Care services are centred on helping to maintain or improve the quality of life of service users.
- Health and Social Care services contribute to reducing health inequalities

- People who provide unpaid care are supported to reduce the potential impact of their caring role on their own health and well-being.
- People who use Health and Social Care services are safe from harm.
- People who work in Health and Social Care services are supported to continuously improve the information, support, care and treatment they provide and feel engaged with the work they do.
- Resources are used effectively in the provision of Health and Social Care services, without waste.

Since 2004 NHS Forth Valley's vision has been to invest in Primary and Community Care, Community Hospitals and to streamline Acute Services. In 2012 the final phase of the new Forth Valley Royal Hospital was completed which was a major step toward achieving this vision. The focus now is on fully embedding the new and integrated models of care across the range of care settings from acute through to the network of community hospitals and other primary and community care facilities. Investment in facilities in Doune has been identified as a high priority for delivering the new and integrated model of care in primary and community setting.

The investment proposed in this OBC will enable more services to be provided locally, facilitate integrated working between a wide range of primary and community health professionals and social care professionals, deliver services that respect individual needs and values and which demonstrate compassion.

The key focus of the proposed investment is to enable and facilitate the redesign of services from a service user's point of view. Services will be shaped around the needs of users through the development of partnerships and co-operation between them, their carers and families; between the local health and social care services; and between the public sector, voluntary organisations and private service providers.

NHS Forth Valley and its partners in care and service delivery recognise that the workforce is the key to delivering these proposed changes. A key part of the vision that underpins this Outline Business Case is the resolute desire to harness the energy, creativity and dedication of the local workforce for the benefit of service users.

1.2 Background

The project described in this Outline Business Case has been the subject of previous work to make the case for change and investment in facilities and infrastructure in Doune. It was this previous work which, when assessed as part of a capital programme prioritisation exercise undertaken by NHS Forth Valley, led to this project being identified as a priority for taking forward to delivery stage.

In 2014 further work was done to develop an Initial Agreement for the project including the development and evaluation of a long list of options which led to the identification of a Preferred Way Forward for the project.

1.3 How this document has been produced

This document brings together all of the previous and historical work undertaken on the project including the work done in 2014 to develop an Initial Agreement, updates it and presents it in an OBC format compatible with the Scottish Capital Investment Manual (SCIM) – Business Case Guide.

The work of updating the information for this Outline Business Case has involved a range of stakeholders including representatives from the Doune community. The purpose of this was to engage with the stakeholders and community in gathering current relevant information/issues and to explore the options for change. In doing so, it has also provided stakeholders with an opportunity to influence the direction of the project and to contribute to this Outline Business Case document.

1.4 Public engagement

Many of the stakeholders and community representatives have been involved in extensive public engagement and stakeholder exercises over recent years as part of the development of NHS Forth Valley's Integrated Healthcare Strategy 2011-2014 "Fit for the Future". This involved stakeholders and members of the public in determining how the health system for their own area should be shaped in the future. The public dialogue for this project has sought more detailed input from the Doune community on how the overall system and in particular this project should be shaped to respond to the many pressures and opportunities that exist. The method of involvement has included the community planning structures of the local Authority to ensure that there is a high level of consistency with all the partners' approaches to planning and service change.

A rigorous appraisal of the shortlisted options for the project was undertaken as part of the development of this OBC. This exercise included a workshop involving a range of stakeholders including General Practitioners, clinicians, service managers and members of the local community and involved an appraisal of the non-financial benefits and risks of the short-listed options.

1.5 Structure of the Outline Business Case

The Outline Business Case has been prepared using the agreed standards and format for Business Cases, as set out in the SCIM – Business Case Guide. The SCIM guidance states that the primary purpose of an Outline Business Case is the identification of a preferred option and the assessment of value for money, affordability and achievability.

The document follows the approved format of the well-established "Five-Case Model" for business cases and explores the project from five perspectives:

- **The Strategic Case** explores the case for change – whether the proposed investment is necessary and whether it fits with the overall local and national strategy.

- **The Economic Case** asks whether the solution being offered represents best value for money – it requires alternative solution options to be considered and evaluated.

- **The Commercial Case** tests the likely attractiveness of the proposal to developers – whether it is likely that a commercially beneficial deal can be struck.

- **The Financial Case** asks whether the financial implication of the proposed investment is affordable.

- **The Management Case** highlights implementation issues and demonstrates that the Health Board and its partners in this project are capable of delivering the proposed solution.

1.6 The Strategic Case

This Outline Business Case clearly demonstrates that there is a strong Strategic Case for the investment in facilities to support the delivery of integrated care in Doune.

For most people their first and perhaps only ongoing contact with the NHS is within primary care. This covers a wide range of professional staff including general practitioners, dentists, optometrists and community pharmacists as well as community and specialist nursing and rehabilitation teams. Shifting the balance of care away from reactive episodic care in an acute setting to team based anticipatory care closer to people's homes is a vital part of implementing NHS Forth Valley's strategy and is consistent with current national policy. This is why NHS Forth Valley is continuing to develop a single system which integrates both primary and secondary healthcare services as well as increasingly looking for opportunities to integrate with partner agencies. The proposed new integrated model of service delivery is fully in line with national and local policies and the strategic direction of NHS Forth Valley and Stirling Council in the delivery of health and social care.

This Outline Business Case proposes investment to support an integrated model of care for the Doune community which aims to deliver services as close to home as possible, placing less reliance on acute inpatient beds and with a clear focus on responding to individuals' needs.

The proposed changes are a crucial part of the way forward for the configuration of health and social care integration and the development of community based service groupings across Forth Valley. This will see the consistent development of health and social care groupings as the focus for integration within communities. These groupings will also integrate with acute services with the

aim of managing pressures more effectively within the system, and developing clinical pathways in a proactive way.

The case for change is driven by inadequacies in the current model of care and the current facilities. The main problems are:

- The current system of health and social care for Doune is fragmented and disjointed from a service user and professional perspective.
- There are gaps in service provision and inequities in access to services.
- The existing building is generally overcrowded, not fit for purpose, inefficient and not capable of expansion to support the increasing demand for services locally.

The recent report by the Clinical Work Stream for Long Term Conditions and Multiple Morbidity (part of the NHS Forth Valley Clinical Services Review) highlights the need for the right resources (premises, IT and workforce) in the community to ensure capacity and capability to manage more people independently in the community and support ways of working to avoid hospital admissions. The Strategic Case within this OBC is closely aligned with the key recommendations in the report for:

- A Resilient Locality Working Model
- Effective Anticipatory Care Planning
- Effective and Efficient Management of People with Long Term Conditions and Multiple Morbidity
- Supported Self-Management
- Integrated Care Pathways Closer to Home
- Embedding Technology in the Pathway

The proposals in the OBC will ensure progress is made on the above recommendations and are essential if we are to deliver a sustainable way of delivering appropriate and holistic care to individuals with long term conditions and multiple morbidity.

Looking forward to health & social care integration and the operation of Health & Social Care Partnerships, the proposals can be viewed in light of the Draft Strategic Plan for Clackmannanshire & Stirling which at the time of writing has recently been to consultation. The project aligns to the priority to reduce the number of unplanned admissions to hospital and acute services by supporting community based services.

1.7 The Economic Case

The Economic Case in this Outline Business Case sets out how the Project Group has selected the preferred option for delivering the preferred way forward for the project. Previously, work on the Initial Agreement generated options for

the project using the SCIM Options Framework approach. This required the group to systematically work through the available choices for the project in terms of scope, service solution, service delivery, and implementation and funding options.

The long list of options was reduced to a shortlist through a rational assessment process which involved assessing options against a set of investment objectives and critical success factors which had previously been developed for the project. The reference project is essentially the preferred way forward given that it is predicated upon the best assessment at this stage of the possible scope, service solution, service delivery, implementation and funding choices. In addition to the reference project, a more ambitious project and a less ambitious project were constructed from some of the "carried forward" options in each category of choice. These three projects, together with the "Status Quo/Do Minimum" project formed the shortlist of options shown below which were the subject of a rigorous option appraisal for this Outline Business Case.

	Shortlisted Options			
	Option 1 Status Quo/ Do Min	**Option 2 Preferred Way Forward (Reference Project)**	**Option 3 (Less ambitious)**	**Option 4 (More ambitious)**
Scope	Status Quo/Do minimum	Expanded range of local Health & Social Care Services for the Doune community - More GPSI services, diagnostic & treatment, near patient testing etc. Emphasis on preventative and self-help services - Diabetes, COPD, Long Term Conditions, Smoking Cessation, and Healthy Eating, Old Age Psychiatry/Dementia	As Option 2 but with some of the expanded range of diagnostic and treatment services in Option 2 necessarily provided in Callander or Stirling.	As Option 2 but with increased capacity to provide services to a wider geographic catchment population outwith Doune
Service Solution	Status Quo/Do minimum	Integrated Primary and Community Health teams located in Doune working closely with visiting Health and Social Care professionals. Capacity designed to anticipate projected increases in demand for services as the local population grows.	As Option 2 but with teams increased in size in stages to reactively respond to increases in demand for services locally as and when the population increases i.e. reactively.	As Option 2 but services further expanded in range and designed to maximise the impact of the new model on reducing hospitalisation.
Service Delivery	Status Quo/Do minimum	Integrated Primary and Community Health teams co-located. Capacity within facilities for visiting Health and Social Care services	Additional teams with additional, separate facilities	Fully integrated Health & Social Care teams – part of network with Callander.

Implementation	Gradual Expansion of teams and facilities – reacting to increased demand on services	Development of a new Health Centre based on a single site and implemented as a single scheme	Step Changes by creating new teams with separate facilities as required to meet increases in demand.	Integrated Health Centre developed on a single site and implemented as a single scheme.
Funding	NHS Capital	NHS Capital	NHS Capital	NHS Capital

1.8 The Commercial Case

The purpose of the Commercial Case is to set out the planned approach that the project partners will be taking to ensure there is a competitive market for the supply of services and facilities. This in turn will determine whether or not a commercially beneficial deal can be done and achieve the best value for money for the project.

It is intended that the Doune Health Centre will be delivered via the hub initiative, in partnership with Hub East Central Scotland Ltd (hubco).

The hub route has been established to provide a strategic long-term programme approach to the procurement of community-based development through joint local venture arrangements.

The East Central HubCo can deliver projects through one of the following options:

- Design and Build contract (or build only for projects which have already reached design development) under a capital cost option;
- Design, Build, Finance and Manage under a revenue cost option (land retained model); or
- Lease Plus model for a revenue cost option under which the land is owned by hubco.

The first option, Design and Build, using NHS Capital is the most suitable for this project. The relatively small size of this project means that the other two options are not effective delivery models for this project.

1.9 The Financial Case

The Project will be delivered under a Design and Build Development Agreement with hub East Central Scotland Ltd (hubco), governed by the terms and conditions of the East Central Territory Partnering Agreement and following the hub process.

Net Additional Revenue Costs to the NHS Board have been estimated @ £0.071m per annum including £0.047m of additional capital charges. These figures are net of additional non-reimburseable costs which require to be met by the Doune GP practice. The practice has provided confirmation that the financial implications are affordable to them and are keen to proceed with the development.

With regard to the Board's balance sheet, the asset would initially be capitalised at £2.420m and will be impaired by £0.605m following valuation to a carrying value of £1.815m. This estimate is based on experience of similar projects.

The equipment and IT procured separately will be accounted for by NHS Forth Valley as a non current asset.

1.10 The Outline Management Case

Under the hub initiative, NHS Scotland has provided an exclusivity arrangement which requires NHS Forth Valley to consider hub as the procurement option for all community based projects in excess of capital construction value of £750.000. Only if the project does not demonstrate value for money is there the option to consider other procurement options.

Template project agreements have been developed by the Scottish Futures Trust for Design and Build contracts. These template agreements are designed to be applicable for use by all of the public sector organisations as participants in the National Hub Programme as a basis for improved efficiency in contract procurement and delivery.

NHS Forth Valley has a strong track record of effectively managing both capital projects and change programmes to ensure that investment objectives and benefits are successfully delivered. This Outline Business Case describes the project governance structure that has been established for this project using a programme and project management approach (PPM) which will be applied to the project to ensure maximum control, quality and financial benefit. This will ensure that:

- A process and audit control framework is applied to all aspects of the project
- Project risks are being managed effectively
- Learning and good practice from the project can be transferred to other projects in the NHS Forth Valley capital programme.

The following table provides indicative timescales for completion of key milestones for delivery of the project.

Activity	Date
Stage 1 Completion	**January 2016**
Stage 2 Completion	**June 2016**
Financial Close	**July 2016**
Construction	**July 2016-March 2017**

The Strategic Case

2.0 Strategic Context

The Scottish Government has set out its objectives for addressing inequalities and prevention with an emphasis on the following main areas:

- Addressing health inequalities with plans focussed on those communities where deprivation is greatest.
- Health improvement and prevention activity based on the needs of the local population.
- NHS procurement policies should support employment and income for people and communities with fewer economic levers.
- Actions relating to employment policies that support people to gain employment or ensure fair terms and conditions for all staff.

The project described in this OBC demonstrates that NHS FV is committed to building on health improvement actions to promote healthy living including preventing obesity, promoting a healthy diet, tobacco related health inequalities, uptake of smoking amongst young people, protecting children from second-hand smoke, supporting smokers to quit and promoting physical activity through workforce and the Health Promoting, Health Service, as well as in the wider community. NHS FV will also continue to work in partnership across the Alcohol and Drug Partnership to target alcohol brief interventions on harder to reach communities including those in deprived areas, and to sustain access to drug and alcohol treatment and to continue to promote recovery from substance misuse as set out in the local FV ADP Strategy and ADP Delivery Plans.

The Board is working within Community Planning Partnerships to meet outcomes within Single Outcome Agreements (SOAs) which will impact on health. There is a contribution from NHS Forth Valley to each Community Planning Partnership, including the development of health inequalities as a cross-cutting issue across all theme groups, the development of an Equality and Diversity Impact Assessment (EQIA) process for CPPs and the application of health impact assessment.

The Strategic Case for this Outline Business Case is closely aligned to these Scottish Government priorities for action. It focuses on delivering care as close to home as possible, placing less reliance on acute inpatient beds and with a clear focus on responding to individuals' needs.

The changes proposed in this Outline Business Case are designed to 'pull' patients from the acute sector, particularly those using A&E and outpatient services, into the community to enable people to be treated and cared for as close to home as possible, for as long as possible, by the right staff. To enable this to happen, the Outline Business Case presents a case for change for service redesign, which requires investment to deliver the new service model and to provide facilities which support and enable the required changes to be implemented locally within the Doune community.

The overall purpose of the project is contribute to NHS Forth Valley's wider vision to enable and facilitate fundamental change in the way in which health and social care is delivered to the people in the local communities, the underlying aims being to redesign services from a patient's point of view. Health and social care services will be shaped around the needs of patients and clients through the development of partnerships and co-operation between patients, their carers and families; between the local health and social care services; and between the public sector, voluntary organisations and private providers to ensure a patient-centred service. Overall, the project aims to substantially increase the delivery of health and social care in the local community.

The recent report by the Clinical Work Stream for Long Term Conditions and Multiple Morbidity (part of the NHS Forth Valley Clinical Services Review) highlights the need for the right resources (premises, IT and workforce) in the community to ensure capacity and capability to manage more people independently in the community and support ways of working to avoid hospital admissions. The Strategic Case within this OBC is closely aligned with a number of the key recommendations in the report for:

- A Resilient Locality Working Model
- Effective Anticipatory Care Planning
- Effective and Efficient Management of People with Long Term Conditions and Multiple Morbidity
- Supported Self-Management
- Integrated Care Pathways Closer to Home
  Embedding Technology in the Pathway

The proposals in the OBC will ensure progress is made on the above recommendations and are essential if we are to deliver a sustainable way of delivering appropriate and holistic care to individuals with long term conditions and multiple morbidity.

Looking forward to health & social care integration and the operation of Health & Social Care Partnerships, the proposals can be viewed in light of the Draft Strategic Plan for Clackmannanshire & Stirling which at the time of writing has recently been to consultation (extract attached at Appendix C) . The proposed new health centre is in line with the Key Themes and Ambitions in the Clackmannanshire and Stirling Draft Strategic Plan (numbered 1 to 7) namely those in relation to early intervention and prevention (1); supporting service users to self manage and plan care pro-actively (2) and improving access to services and building capacity (7). Further, this aligns the project to the priority to reduce the number of unplanned admissions to hospital and acute services by supporting community based services.

Although the project described within this Outline Business Case is relatively small, the effect that it will have on the ability to deliver the strategic vision should not be underestimated. This project provides a vehicle for implementing key strategies that provide the capacity and capability to achieve significant benefits of strategic and operational importance for patients and staff in the Doune community.

Local Context

Doune Medical Practice has had a longstanding challenge in meeting an expanding population. The Practice, currently has 4000 registered patients. Around 180+ new homes/flats have been built in Doune and Deanston over the last two years and this has led to an increase in the practice list size of approximately 600 patients. It is envisaged that an expected further 100 patients will register when the house building is complete. Furthermore, there is also a further new housing development under construction in Thornhill at present, and planned developments in Dunblane over the next 5 years. This is putting increased pressure on the practice which must respond to the challenge of the needs of an increasing population.

The existing accommodation in Doune is too small for the current population and has very limited scope for extension. This physically limits the capacity to deliver the full range of services needed by the community. The building requires significant investment in terms of backlog maintenance, creation of appropriate privacy, changing areas and office accommodation.

In addition to providing the facilities capacity to meet current needs, the proposals in this Outline Business Case recognise the importance of being able to respond to the ageing local population and the rise in dementia sufferers. The new premises will enable Old Age Psychiatry Services to be provided to the local population through Doctor and CPN clinics and Dementia Link Services. Similarly, Adult Mental Health Services and Dermatology Services can be expanded from the new premises.

The proposed replacement of the existing Doune Health Centre would result in significant saving (cost avoidance) in relation to backlog maintenance and future building and engineering lifecycle replacement costs.

The existing site is in the middle of residential area of Doune and is owned by NHS Forth Valley. A capital receipt will be forthcoming when the building is sold on occupation of the proposed new Health Centre.

3.0 Organisational Overview

The Forth Valley covers a geographic area from Killin and Tyndrum in the North and Strathblane to the west and Bo"ness in the South. The Forth Valley NHS Board controls an annual budget of around £500 million, employs around 8000 staff and is responsible for providing health services for and improving the health of the population of Forth Valley. NHS Forth Valley is a single integrated system comprising acute hospital services, and a range of community based services which are delivered currently through the Forth Valley Community Health Partnerships (CHPs) in Clackmannanshire, Falkirk and Stirling, co-terminus with the corresponding local authorities

Doune is part of the Stirling locality which has a population of 88,740 people and delivers health and social care services in partnership with GP practices and the local authority social care team.

4.0 Business Strategy and Aims

The way healthcare is delivered across Forth Valley has been transformed over the last decade and, in 2011; NHS Forth Valley completed major service and infrastructure changes towards achieving the vision with the opening of Forth Valley Royal Hospital. The creation of fully Integrated Joint Boards for Health & Social Care this year presents a new and exciting opportunity to redefine, recreate, and fundamentally improve how health and social care services are provided, to ensure a coordinated and complementary approach is taken

The focus now is to continue efforts to deliver high quality, safe and efficient services and fully embed the new ways of working across the organisation. This will require further changes to the way services are designed, organised and managed, building on the redesign and improvement work which has already been carried out in many areas. It will also require the commitment and contribution of staff across the organisation to ensure NHS Forth Valley will continue develop and deliver affordable services which not only meet the needs of today's patients, but are also fit for future generations.

NHS Forth Valley is are now entering a new and exciting chapter of driving quality improvement throughout the organisation, streamlining patient pathways and achieving greater consistency of care, continuing to design and deliver healthcare services fit for the future. The focus now is to fully embed the new and integrated models of care across the range of care settings from acute through to the network of four community hospitals, based in Bo"ness, Clackmannanshire, Falkirk and Stirling and other primary and community care facilities. This links very closely the joint interests of the NHS and its partners in not only delivering new models of care and facilities but in improving population health and reducing inequalities. The continued focus on partnership working and working towards greater integrated service provision with improved outcomes is one of the cornerstones of the new Integrated Joint Boards for Health and Social Care.

NHS Forth Valley has developed a Property & Asset Management Strategy (PAMS) to bring together a range of proposals that support and enable NHS Forth Valley to respond to the challenges and drivers for change and grasp the opportunities that these create for improving the quality, effectiveness and efficiency of its services and physical assets. The project described in this OBC is a key priority within the PAMS.

The investment proposed in this Outline Business Case fits within, supports and promotes a number of existing business strategies and aims of which this project is an integral part:

- **The Scottish Government's 2020 Vision -** everyone is able to live longer healthier lives at home, or in a homely setting. NHS FV has embarked on a strategic Clinical Services Review (CSR) with the aim of producing a Healthcare Strategy for 2015-2020 that reflects the NHS Scotland 2020 Vision. During 2015/16 the development of Strategic Plans with Integration Joint Boards (IJB) will be an important part of the local planning agenda and the CSR will also ensure that NHS FV is ready to engage fully in this undertaking to deliver the outcomes expected in local Single Outcome Agreements.

- **Forth Valley Health Plan:** The Plan sets out the overall strategy and guidance for the development of the health system in Forth Valley.

- **NHS Forth Valley Property & Asset Management Strategy (PAMS)** which aims to ensure that assets are used efficiently, coherently and strategically to support the future clinical and corporate needs of the Board consistent with our forecast for service need.

- **NHS Forth Valley's Service Strategies** which set clear quality requirements for services and care, and are based on the best available evidence of what treatments and services work most effectively for patients.

5.0 Other organisational Strategies

A number of other organisational strategies have influenced the development of this Outline Business Case:

The 2020 Workforce Vision

NHS Forth Valley is fully engaged in the developing 2020 Workforce vision. Building on the current workforce framework "A Force for Improvement", the 2020 workforce vision is currently being developed. Integration of health and social care is a thread that runs through all of the 2020 workstreams which are underpinned by:

- Staff governance and engagement

- Leadership and capability

- Capacity and modernisation.

Telehealth and Telecare Strategy

The role of telehealthcare in supporting the delivery of strategic initiatives such as *Reshaping Care for Older People* and *Shifting the Balance of Care* has been increasingly recognised within the Scottish Government and with Health and Social Care Partnerships. The Scottish Centre for Telehealth and Telecare launched " A National Telehealth and Telecare Delivery Plan for Scotland to 2015: "Driving Improvement Integration and Innovation" in Dec 2012.

6.0 Investment objectives

6.1 Investment Objectives

A robust case for change requires a thorough understanding of what the organisation is seeking to achieve (the investment objectives); what is currently happening (existing arrangements); and the associated problems (business needs).

In developing this project, the Project Group has been mindful of the fact that procuring an asset or service, or putting in place a scheme is never an investment objective in itself. It is what the organisation is seeking to achieve in terms of measurable returns on the investment that is important.

The setting of robust investment objectives is an iterative process which involves revisiting them as the project progresses. Further appraisal has been undertaken for this OBC and similarly will be re-visited as part of the development of the Full Business Case. The investment objectives agreed by the Project Team and ranked in order of priority, are as follows:

1. **Person Centred Care -** provide care that is responsive to individual personal preferences, needs and values and assuring that patient values guide all clinical decisions.

2. **Service Integration -** deliver joint working between the NHS, local authorities and other partners.

3. **Improved access to treatment and services -** extend the access for the new model of care to include all those living within the Doune area

4. **Improved service effectiveness and efficiency -** achieve more effective use of resources across the public sector, particularly within the NHS and with local authorities and other partners. These resources include staff, buildings, information, and technology.

6.2 Design Quality Objectives

The design quality objectives for the scheme have been set out in the attached Design Statement (Appendix D). The Design Statement has been prepared to ensure that implementation in terms of the design and construction of the physical premises meets the needs and objectives of stakeholders.

7.0 Existing Arrangements

Whilst the primary driver for change in project in this Outline Business Case is service modernisation and redesign, these changes simply cannot take place without investment in the accommodation that will enable and facilitate the required changes in service delivery. The table that follows provides information on the current condition and performance of the properties within the scope of the project.

Name	Building floor area sq.m		Current condition & performance of the Estate based on National Standards (EstateCode Appraisals)			
	Existing	Required	Physical Condition	Statutory Standards	Space Utilisation	Functional Suitability
Doune Health Centre	267	605	Investment required to bring back to satisfactory condition	Satisfactory	Very overcrowded	Poor – not fit for purpose

The table shows that the main problems with the existing property are due largely to the lack of space and poor functional suitability. Since the existing health centre was originally built the list sizes, workload and general level of service activity have

significantly increased as a result of increased catchment populations and the expanded primary and community care services needed to support the community in Doune. Hence, the services have now simply outgrown the buildings and reached a state where they present a serious constraint on both the continuation and further development of services. There is very little potential for developing either existing or new services within the existing facilities due to the physical limitations of extending buildings on their existing sites. Furthermore, the current design and functional suitability seriously compromise the provision of modern health and care services from these buildings.

In addition to the space utilisation and functional suitability problems, the existing buildings are in unsatisfactory physical condition and it is estimated that the backlog maintenance expenditure requirement for these buildings is in excess of £120k (project costs). It should be borne in mind that this backlog maintenance expenditure requirement is associated with the structure and physical condition of the buildings and even if these monies were expended it would do little to address the space utilisation and functional suitability issues which currently exist in the buildings.

Without investment in modern facilities which facilitate integrated and new working practices, the essential changes required in service models to meet the challenges associated with delivering national and local policy simply will not happen. Furthermore, the retention and recruitment of general practitioners, primary and community care professionals, appropriately skilled nursing, allied health professionals, social workers and support staff is becoming increasingly more difficult as the facilities become progressively more inadequate. This lack of fit for purpose accommodation will exacerbate the ability to retain and recruit the necessary staff to provide health and social care services in the future. The existing facilities can, at times, compromise clinical standards and effectiveness and have been identified as risk management issues in areas such as cross-infection and health and safety. The existing accommodation also compromises the achievement at times of basic quality standards in terms of patients' privacy and dignity.

8.0 Business needs – Current and Future

This section identifies the 'business gap' in relation to existing arrangements. In other words, the difference between 'where we want to be' (as suggested by the Investment Objectives) and 'where we are now' (in terms of existing arrangements for the service). This highlights the problems, difficulties and inadequacies associated with the status quo. The following table outlines the existing arrangements in respect of each Investment Objective and describes the problems with these existing arrangements in order to identify 'business need'. It then further describes what is needed to overcome these problems.

Note: the detailed information used to describe the existing arrangement will form the benchmark from which the future achievement of the Investment Objectives can be measured.

Investment Objective	Existing Arrangements	Business Need
Person Centred Care - provide care that is responsive to individual personal preferences, needs and values and assuring that patient values guide all clinical decisions.	A lack of resources and facilities limits the ability to anticipate patient needs and provide specialist planned care close to home and often results in unplanned admissions to hospital. Telehealth and telecare technologies are not sufficiently currently established as a key part of the health and social care support.	Care at home or in a patient's community provided by the most appropriate person with the right skills with the unequivocal aim of having the most appropriate person with the right skills delivering the care. Patients and staff work alongside each other to identify problems that can be practically overcome and to develop implementable solutions that benefit everyone. Long-lasting change that genuinely makes a difference to patients' experience, along with many wider benefits that result from participating in designing individual care and self-care. The care provided should respect individual needs, values and preferences and should be based on shared decision making.
Service Integration - deliver joint working between the NHS, local authorities and other partners.	Many people find the maze of health, social care and housing services, benefits and procedures confusing. People with more than one long term condition, often with complex needs, may be visited or contacted by a number of different people from different departments in different organisations who may not fully understand the individual's holistic needs. Clinicians and health and social care professionals in one part of the system often do not have a stake in the other parts of the service. Joint and "joined up" working between the NHS, local authorities and other partners is not fully developed and even in a relatively small community such as Doune, there are multiple points and locations for accessing services.	To provide care and treatment by working in partnership with other organisations (LA, voluntary & independent sectors), through extended community teams, with professionals, patients, carers and communities as full partners in improving health and managing conditions. Groups of aligned clinicians to support the development and delivery of pathways and protocols providing a mechanism for communication, information sharing and feedback on referral rates, clinical practice and the deployment of resources.

Investment Objective	Existing Arrangements	Business Need
Improved access to treatment and services - extend the access for the new model of care to include all those living within the Doune area.	Many people travel to Stirling Community Hospital and Forth Valley Royal Hospital for traditional return outpatients, in some cases involving a long bus journey, and to see a clinician for only a very short time.	Improved access to care and treatment through changes in the location of services, reduced travel time/distance and shorter waiting times. Decentralised access to acute clinics and specialist clinical advice accessible from patients' homes and local community locations. Using telemedicine or telephone consultations for an increasing numbers of return and routine outpatients.
Improved service effectiveness and efficiency - achieve more effective use of resources across the public sector, particularly within the NHS and with local authorities and other partners. These resources include staff, buildings, information, and technology.	A high degree of variation in the way that primary care and community hospital resources are used is evident from recorded activity information. The current lack of service integration results in less than optimal use of resources across the health and social care economy.	Services provided that have strong evidence of clinical effectiveness based, as far as possible, on relevant rigorous science and research evidence supported by evidence of plans for carrying out audits/evaluations of effectiveness. Patients not occupying acute inpatient beds who could have been cared for in other, non-inpatient, settings. Audits have identified that 25%-40% of inpatients did not require the specialist services provided by an acute hospital bed. Shared services and resources across the health and social care economy offer opportunities for improved effectiveness and efficiency.

9.0 Desired Scope and Service Requirements

The services included within the scope of the project are intended to deliver a number of service outputs:

Preventive care

Services will be designed to provide a growing range of products and services that empower local people to adopt healthier lifestyles – signposting/advice on diet and exercise, helping patients manage their medicines, encouraging the wider community to support vulnerable people to ensure that they are supported and safe. Registers of those at greatest risk from serious illness will be maintained so that they can be offered preventive treatment. Some examples of these would be Diabetes/COPD/Long Term Conditions/|Smoking/Healthy Eating clinics etc.

Self-care

The frontline for health and social care is the home. Most care starts with people looking after themselves and their families at home. Local services will focus on becoming a resource which people can routinely use every day to look after themselves. Easily accessible information on a wide range of conditions will be provided through a range of media and technologies. Similarly, services will be designed to provide seamless and easy access to patient and self-help groups.

Primary care

Primary care services will be designed as a one-stop gateway to health and care services. The project will provide access for all patients in the community to an appropriate and safe range of modern, integrated health and care services delivered from local buildings suitable for contemporary needs and with good access to more specialised services when these needs cannot be met locally. Local GPs will be working in a team from modern multi-purpose premises alongside health visitors, nurses, practice pharmacists (not dispensing pharmacists), podiatrists, allied health professionals, midwives and social care staff.

Programmed investigation and care

Programmed investigation and care, aimed at maximising the services provided locally, will be developed through innovative clinical protocols, tailored staffing policies and the ability to take full advantage of digital technology. Wherever possible, an investigation and treatment option will be provided which is attractive to patients. This will require services to be tightly organised around the needs of patients including minimising the number of unnecessary attendances and streamlining processes. The integrated health and social care model will offer GPs the opportunity to deliver services appropriate to population needs but also provides significant opportunities for the wider health and social care services to benefit from improved collaboration, communication and integration. The benefits from this are not limited to older people's services but closer working with other community hospital based services such as Allied Health Professionals, Maternity Services, Mental Health Services and Children's Services.

Staff

Delivering the change required to bring about a modern, integrated health and social care service will require continued staff engagement– the doctors, nurses, AHPs, social care workers and support staff. Modern models of health and social care rely on flexible teams of staff working across traditional skill boundaries. If we are to deliver the service gains needed by patients in the community then there will need to be investment in the environment in which we expect staff to work, both physically and culturally: facilitating recruitment and retention, training and development and flexible working patterns.

The proposed new model of service delivery with teams working flexibly across health and social care will significantly contribute to facilitating the right work-life balance, improved job satisfaction and career fulfilment for staff.

10.0 Benefit Criteria

The investment proposed in this Outline Business Case is crucial to the transformation and development of health and social care services in the area in line with the national and local strategy. It will bring benefits to a wide range of stakeholders and these are set out for each investment objective in the tables that follow.

Investment Objective: Person Centred Care			
Benefit	**Relative value**	**Relative timescale**	**Type of Benefit**
Positive experience of health and social care	High	Medium term	Qualitative
Services which provide personalised care and support designed to optimise well-being through an enabling approach	High	Medium term	Qualitative
People can stay independent and well at home and without need for care and support	High	Medium term	Qualitative
Greater potential to avoid hospital admission	High	Medium term	Financially quantifiable to patients through less travel time/ Costs
Greater equity of service provision	High	Medium term	Qualitative
Significantly improved facilities providing a positive experience of the environment in which services are provided	Medium	Medium term	Qualitative
An increase in the self-assessed General Health indicator	Medium	Longer term	Qualitative
One point of contact for signposting to all health services	Medium	Longer term	Qualitative

Investment Objective: Improved access to treatment			
Benefit	**Relative value**	**Relative timescale**	**Type of Benefit**
Maximised range of health and social care services available locally	High	Medium term	Qualitative
Increased and improved access to local services, with less dependence on centralised acute hospital services	High	Medium term	Qualitative
Specialist clinical advice accessible from patients' homes, health centres and a wide range of community locations	High	Medium term	Qualitative
Reduced travel time and cost for patients	High	Medium term	Qualitative & cost saving for patients
Easier journey through health and social care system with a single point of access	High	Medium term	Qualitative
More timely and therefore more effective interventions	High	Medium term	Qualitative & cash and resource releasing

Investment Objective: Service Integration			
Benefit	**Relative value**	**Relative timescale**	**Type of Benefit**
Service integration and greater efficiency in the use of resources	High	Medium & longer term	Cash releasing
Aligned partnership resources to achieve policy goals	High	Medium term	Potential cash releasing
As many services as possible should be available at each visit especially for those with chronic disease, combined with recognition that each patient contact should be the only contact needed to access all the services needed.	High	Medium term	Qualitative & cash and resource releasing
Improved working arrangements and facilities for staff resulting in greater job satisfaction and less turnover/sickness	Medium	Medium term	Qualitative & cash and resource releasing

Investment Objective: Improved service effectiveness and efficiency			
Benefit	**Relative value**	**Relative timescale**	**Type of Benefit**
Everyone gets the best start in life – early years collaborative	High	Medium term	Qualitative & potential cash and resource releasing
People are able to live a longer, healthier life	High	Long term	Qualitative & potential cash and resource releasing

Lower premature mortality rate	High	Longer term	Qualitative & potential cash and resource releasing
Reducing emergency hospital admissions	High	Medium term	Qualitative & potential cash releasing
Reduced lengths of stay in hospitals	High	Medium term	Qualitative & potential cash releasing
Reduced adverse events	High	Medium term	Qualitative & potential cash releasing
Improved resource indicator	High	Medium term	Potential cash releasing
Streamlined management arrangements	High	Medium term	Potential cash releasing
Integrated information systems and records management across health and social care organisations	High	Medium	Qualitative & potential cash and resource releasing

Some the above benefits can be quantified financially and have therefore been included in the economic appraisal within this Outline Business Case. Others cannot be quantified financially and these have been brought together as a set of non-financial benefit criteria used in a rigorous appraisal of the shortlisted options for the project. This appraisal of non-financial benefits included a workshop on 7 November 2014 involving a range of stakeholders including General Practitioners, clinicians, service managers and members of the local community. The workshop ranked and weighted the criteria as shown in the table that follows and then scored each option against the benefit criteria.

Benefit Criteria	Rank	Weight	Normalised Weight
Effective Service Delivery	**1**	**100**	**14.4**
Positive User Experience	**2**	**95**	**13.7**
Safety of Service Provision	**2**	**95**	**13.7**
Access to Care/Services	**4**	**90**	**13.0**
Flexibility	**5**	**80**	**11.5**
Service Integration	**6**	**80**	**11.5**
Best Use of Resources	**7**	**78**	**11.3**
Quality of Accommodation	**8**	**75**	**10.8**
	Total	**693**	**100**

The results from the non-financial benefits appraisal are shown in section 18 of this Outline Business Case.

11.0 Strategic Risks

Numerous national and international studies have shown that one of the main reasons for change projects being unsuccessful in terms of cost and time overruns and/or failing to deliver the expected benefits is as a result of the failure to properly identify and manage risk within the projects. This OBC has included an assessment of the key risks that could impact on the successful delivery of the project and sets out what actions the partners in the project will take to ensure risk is minimised and managed. The process of risk management will continue through the development of the Full Business Case and throughout the life of the project and then transfer to the operational management of the organisations. The following table sets out the high level early stage assessment of risks associated with the project.

Risk No	Risk Description	Risk Level	Proposed Mitigation
1	Delay in implementing the project will result in insufficient capacity in existing services to cope with the increased demand arising from increasing catchment populations in the Doune area covered by the scope of the project.	High	NHSFV has identified the project as a priority for development of a business case and implementation.
2	The workforce age profile is such that retirals could have a significant impact over the next five years on the workforce's capacity to cope with demand.	High	Workforce planning to ensure that the retention and recruitment of the staff will match service demand.
3	For the proposed new model of service delivery to be effective and to maximise the benefits, full commitment and "buy in" to the new service model and the project from all partners and stakeholders is essential.	High	NHSFV working closely with the GP Practice to ensure full commitment and input to the development of this Outline Business Case and subsequent FBC.
4	Affordability – capital and revenue costs	Medium	Clear accountability will be established across the organisations for the systems-wide changes in resource allocation and service transformation.
5	Capital Cost estimates are indicative only at this stage and therefore could escalate.	Medium	The construction cost estimates have been provided by hubco and tested by the Tier 1 Contractor, however, unknowns remain.

6	Building Warrant risk – the implementation of the new Building Regulations could lead to more onerous/expensive design in relation to energy and/or emissions requirements.	Medium	Designers au fait with the new regulations, dialogue with Health Facilities Scotland in relation to similar projects and Building Control.
7	Planning risk – issues relating to planning permission or planning constraints for the required facilities developments	Low	Early engagement with Local Authority planning Department.
8	Procurement and contractual risks are inherent in the procurement of the new facilities included in all shortlisted options.	Low	Early involvement of suppliers (hubco) will minimise this risk and ensure the right balance of risk transfer between parties.
9	Lack of flexibility in the project to respond to the uncertainty of the extent and rate of population growth in the Doune community.	Low	NHSFV party to the LA Local Development Plan re housing developments and the outcomes. .

12.0 Constraints and Dependencies

Constraints

Currently, the introduction of the new model of care for the local population is constrained by the current model of care delivery and the existing facilities which are unfit for purpose.

Capital Funding

This project has been identified as a priority for NHS Forth Valley and has been included in the Board-wide Capital Programme. However, the overall capital programme is oversubscribed with many programmes/schemes competing for scarce funding. Therefore the availability of capital funding must be regarded as an absolute constraint and reflected in this Outline Business Case and the subsequent FBC document. All options have been tested for value for money as part of the economic appraisal in the OBC.

Revenue Funding

Equally there are pressures on revenue funding. The revenue consequences associated with the proposals in this Outline Business Case mean that this project will cost more than it does now to provide services from existing facilities in revenue terms. The demonstration of the affordability of this scheme will be tested fully through the overall programme management to implement the new model of care. A fully detailed revenue model has been developed for this OBC.

Timescale

The new facilities required to support the proposed new model of health and social care services must be available for use in early 2017 due to the known issues with the available space within and physical condition of the existing building.

Site availability / Accessibility

The new facilities required to support the new model of service delivery must be provided within Doune in order to best serve the needs of the service users of this catchment population.

Doune is a small village, with all the surrounding land owned by a private company, Moray Estates. The GP Practice with the help of Stirling Council had been searching for a suitable site since 1995. It was only when Moray Estates agreed to sell some land on the North side of Doune for housing, a potential site for a health centre became available with Moray Estates agreeing to sell the land. There were no other suitable, available sites in Doune.

The current site was allocated for healthcare purposes within a Section 75 Agreement with Miller Homes. The period of this Agreement was due to expire at the end of March 2013 and the Board utilised hub enabling funds to purchase it at that time.

The new site is accessible on foot, has good road provision with access from the north by road not having to pass through the village , and a bus stop is within 100m of the proposed health centre. The access is considerably improved compared to the current health centre site which has poor parking provision, difficult ambulance access and is further from bus stops at >250m.

It is clear that the existing site cannot accommodate a development of the required size, it is also constrained in terms of location and accessibility.

A map of Doune indicating the existing and new health centre sites is included at Appendix A, the proposed site plan for the new development is included at Appendix E. Further, a map indicating the wider catchment area of the GP Practice is included at Appendix B.

Dependencies

This project is part of a wider transformational change programme across Forth Valley intended to radically change the system of health and social care in the area. Whilst this project will have great value on its own, when it is taken together with the other elements of implementing the NHS Forth Valley and Stirling Council's strategies and plans it will provide essential and fundamental support for service change and redesign across the region. Since this project is an enabling one which supports the wider transformational change agenda across the Health Board and Council it is dependent on the integration of operating systems and workforce redesign, to deliver the full benefits of the new model of service delivery.

Clearly, the project described in this Outline Business Case cannot be considered in isolation from the significant challenges known to be faced by NHS Forth Valley and Stirling Council over the next few years in relation to demography, public health,

finance, workforce and the condition of the facilities and buildings used for the delivery of health and social care services. Whilst this project is dependent upon the partner organisations successfully dealing with the challenges in a positive and proactive way, it is also a significantly contributing action that is part of the overall approach to dealing with these issues through:

- Promoting people's shared responsibility for prevention, anticipation and self-management

- Improved integration across the NHS and other public and third sector bodies by incorporating multi-use space within the proposed new health centre which can be used by visiting health and social care professionals

- Recognition, promotion and development of the roles of healthcare professionals outwith hospitals, such as community pharmacists and practice nurses

- Support to stay at home/in the community as local as possible, through the development of better co-ordinated and right-focused community teams

- Improved understanding and more normalised use of technology in pre-hospital and community based care, e.g. tele-healthcare.

- Care in a hospital as an inpatient as a last resort

- Fewer hospital beds and potentially fewer hospitals, but with each delivering reliably high quality treatment.

This project, like the whole of partner organisations' plans for service modernisation and redesign, is totally dependent on the successful participation of the people of Doune, together with local authority and third sector partners.

The Economic Case

The Economic case asks whether the solution being offered represents best value for money. It has examined and appraised alternative solutions in terms of benefits, costs and risks.

13 Critical success factors

In addition to the Investment Objectives set out in the previous section of this Outline Business Case, the Project Group identified a number of factors which, while not direct objectives of the investment, will be critical for the success of the project, and are relevant in judging the relative desirability of options.

The agreed Critical Success Factors, ranked and weighted in order of importance are shown in the table below.

Critical Success Factor	The extent to which the option:	Weight
Strategic Fit	takes forward the national policy and local strategy priorities, particularly in relation to integration of health and social care, NHS Forth Valley's Integrated Healthcare Strategy and Health Plan	22
Acceptability	will be acceptable to all stakeholders and the Doune community	20
Flexibility	can be adopted to meet the changing needs of the local population and the developing service model over time	18
Achievability	can be achieved within the overall planning timescale for the project.	15
Value for money	is expected to achieve a good balance of cost, benefit and risk	15
Affordable	is expected to be affordable within the overall Forth Valley health and social care economy	10
		100

14 Main business options

The Project Group has identified a range of possible options that meet the investment objectives, scope and key service requirements for the project. This generation of options was undertaken using the Options Framework approach in accordance with the SCIM guidance which required the group to systematically work through the available alternatives for the project in terms of five categories of choice as shown in the table below.

Category of choice	Description
Scope	How big/small is the project? What is included, what is not included, boundaries, services
Service Solution	How do we deliver the scope? Models of service delivery, use of technology, new ways of working, centralised/de-centralised etc.
Service Delivery	Who does the delivery? In-house, outsourced, mixed economy model etc.
Implementation	How do we make the change happen? Roll out, big bang, phased delivery etc.
Funding	How do we fund it? Capital, Hub revenue, lease etc.

Scope Options

In terms of the scope options, it was agreed that the following services should be considered as potentially within the scope of the project.

- Services provided by Doune Medical Group
- Primary & Community Care Services for the Doune area (including parts of Dunblane and Deanston)
- Social Care Services for the Doune area provided by Stirling Council – visiting using shared multi-use rooms.

Therefore, the development of scope options has inherently considered all of these services as potentially within options. The rationale for the inclusion of these services within the scope of the project stems from the clear policy requirement to ensure more effective partnership working between the primary and secondary care professionals and other partners in the delivery of health and social care to communities.

For a multi-dimensional project such as this which spans a wide range of health and social care services, it became clear that there are a large number of options that can be formed by different combinations of scope. Therefore, in order to provide a manageable list of options, high level descriptions of the options have been developed which incorporate the following elements of scope:

- Geographical area/catchment population to be served
- Level of service functionality
- Capacity assumptions/issues

The scope of services considered for inclusion within the project can be summarised by the three main scope options shown in the table that follows.

Scope 1	Scope 2	Scope 3
Status Quo/Do Minimum – The range of services provided and the geographic areas and catchment population remain as existing	**Expanded Range of Services** - The range of services provided to the Doune community is expanded to include more GPSI services, diagnostic and treatment capacity and a wider range of visiting consultant/nurse/AHP led outpatient clinics. An expanded range of preventative/anticipatory/self-help programmes	**Expanded Range of Services and Extended geographic Area** - Expanded range of services beyond that in Scope Option 2 and to cover a wider geographic area.

Service Delivery Options

In relation to service solution, the options for Service Delivery were identified as shown in the table that follows.

Service Delivery 1	Service Delivery 2	Service Delivery 3
Status Quo/Do Minimum – Existing service delivery teams i.e. GP Practice, PC teams, Hospital teams and Social Services teams. It is recognised that given the expected increases in population in Doune then the existing teams will need to be increased in size.	**Additional Teams** – Whilst retaining the existing service delivery teams, this option assumes that new, separate teams will be formed to cope with the expected increases in populations and activity	**Integrated Health & Care Teams –** Fully integrated teams formed across existing Health, Local Authority, Voluntary and independent sector organisations

Implementation Options

The options for implementation of the proposed changes were identified as shown in the table that follows.

Implementation 1	Implementation 2	Implementation 3
Gradual Expansion – Existing teams and facilities will be expanded/reconfigured to meet service needs as demand increases.	**Step Changes** – this option assumes that new teams and supporting facilities will be developed to cope with the expected increases in population and demand for services as required. In practice this will be a series of step changes which will have to be planned in anticipation of expected increases in service need.	**Develop an Integrated Health Centre –** this option assumes that the required changes in service solution and delivery will be implemented through the development of a new health centre on a single site.

Funding Options

The options for funding the proposed developments are shown in the table that follows.

Funding 1	Funding 2	Funding 3
NHS Capital	**hubco revenue funding solution**	**Cost Rent Scheme –** Use of the existing Cost Rent Scheme to fund the capital development, NHSFV and LA would be tenants.

15 Preferred way forward

Using the Options Framework approach, the following actions were undertaken:

- The options within the first category of choice (scope) were assessed in terms of how well each option met the evaluation criteria (investment objectives and CSFs) and whether each option was 'out', 'in' or a 'maybe'. In other words, whether it should be discounted immediately; or carried forward, either as the preferred choice in the category or a possibility for consideration.

- The options for the delivery of the preferred choice (scope) in relation to the next category of choice (service solution) were considered and again, options were identified either as the preferred choice or as carried forward or discounted.

- The process was repeated for all other five categories of choice.

Adopting the Options Framework approach led to the construction of a reference project from the preferred choice in each category i.e. an amalgamation of the preferred choice for the scope, service solution, service delivery, implementation and funding. The reference project is essentially the preferred way forward given

that it is predicated upon the best assessment of the available options in each category of choice.

16 Short listed options

In addition to the reference project, a more ambitious project and a less ambitious project were constructed from some of the "carried forward" options in each category of choice. The short list of options that will be taken forward for detailed appraisal in this Outline Business Case are described in the table that follows.

	Shortlisted Options			
	Option 1 Status Quo/ Do Min	**Option 2 Preferred Way Forward (Reference Project)**	**Option 3 (Less ambitious)**	**Option 4 (More ambitious)**
Scope	Status Quo/Do minimum	Expanded range of local Health & Social Care Services for the Doune community - More GPSI services, diagnostic & treatment, near patient testing etc. Emphasis on preventative and self-help services - Diabetes, COPD, Long Term Conditions, Smoking Cessation, and Healthy Eating, Old Age Psychiatry/Dementia	As Option 2 but with some of the expanded range of diagnostic and treatment services in Option 2 necessarily provided in Callander or Stirling.	As Option 2 but with increased capacity to provide services to a wider geographic catchment population outwith Doune e.g Dunblane
Service Solution	Status Quo/Do minimum	Integrated Primary and Community Health teams located in Doune working closely with visiting Health and Social Care professionals. Capacity designed to anticipate projected increases in demand for services as the local population grows.	As Option 2 but with teams increased in size in stages to reactively respond to increases in demand for services locally as and when the population increases i.e. reactively.	As Option 2 but services further expanded in range and designed to maximise the impact of the new model on reducing hospitalisation.
Service Delivery	Status Quo/Do minimum	Integrated Primary and Community Health teams co-located. Capacity within facilities for visiting Health and Social Care services	Additional teams with additional, separate facilities	Fully integrated Health & Social Care teams – part of network with Callander.
Implementation	Gradual Expansion of teams and facilities – reacting to increased demand on	Development of a new Health Centre based on a single site and implemented as a single scheme	Step Changes by creating new teams with separate facilities as required to meet increases in demand.	Integrated Health Centre developed on a single site and implemented as a single scheme.

	services			
Funding	NHS Capital	NHS Capital	NHS Capital	NHS Capital

17 NPC/NPV Findings

An economic appraisal of the short listed options has been undertaken to identify the Net Present Cost (NPC) of the options. This appraisal takes into account the full capital and revenue costs of the options over 60 years using Discounted Cash Flow techniques. Hence, the economic appraisal enables the options to be compared in terms of their total costs (NPC). In accordance with SCIM and HM Treasury Guidance the NPCs have been calculated using the Treasury's Generic Economic Model (GEM) which uses a discount rate of 3.5% for the first 30 years of the appraisal and 3% thereafter. The results are shown in the table that follows.

Option No	Option	Net Present Cost (NPC) £millions over 60 years
1	Status Quo/Do Minimum	0.982
2	Reference Project (Single new build HC)	3.538
3	Less Ambitious (existing HC + new HC)	4.125
4	More Ambitious (Larger HC serving larger population)	4.588

18 Benefits Appraisal

The results from the non-financial benefits appraisal are summarised in the table that follows. The overall weighted benefit scores have been computed by multiplying the consensus score for each option on each criterion by the weight given to each criterion and then summating these weighted scores to arrive at an overall weighted benefit score for each option.

Option No	Option Description	Weighted Benefits Score	Rank
1	**Status Quo/Do Minimum**	**551**	**4**
2	**Reference Project (Single new build HC)**	**841**	**1**
3	**Less Ambitious (existing HC + new HC)**	**593**	**3**
4	**More Ambitious (Larger HC serving larger population)**	**839**	**2**

A number of conclusions can be drawn from these results:

- Both option 2 and Option 4 have relatively high overall weighted benefits scores (the maximum possible weighted benefit score using this system is 1000). This indicates that the workshop delegates considered that both of

these options could be expected to perform well in terms of meeting the criteria and delivering the benefits required from the investment in the project. The closeness of the weighted benefits scores for these two option indicates that there is little to choose between them in terms of the expected non-financial benefits.

- The relatively low weighted benefits scores of Option 1 and Option 3 reflect the workshop group's concern that these two options are unlikely to fully deliver the required benefits from the project. The workshop delegates had serious concerns that Option 1: Status Quo/Do minimum will constrain the ability of the service providers to introduce new models of service delivery, new ways of working and will significantly limit the extent to which new and extended services can be developed. Similarly, they were concerned that Option 3: Less Ambitious would result in a fragmentation of the services due to split site working and would be unlikely to facilitate and enable optimisation of services.

- The relatively large difference between the weighted benefits scores between Option 1: Do Minimum/Status Quo and Option 3: Reference Project confirms that the proposed investment in the Reference Project is expected to produce a step change in the non-financial benefits delivered to patients, service users and staff. Hence, it confirms that the project is a worthwhile one with an expected significant return on investment in terms of non-financial benefits.

19 Risk Assessment

The majority of risks associated with the short listed options have been measured and quantified in monetary terms and included in the calculated Net Present Cost of each option. Hence, the costs used in the economic appraisal shown in this OBC have been risk adjusted to reflect the main business, operational and project implementation risks including:

- Planning, design and construction risks
- Commissioning risks
- Operational risks
- Service risks
- Business risks
- Optimum bias

Non-financial Risks

Recognising that not all risks can be quantified in monetary terms, the non-financial risks associated with the shortlisted options were identified and appraised at the

workshop on the 7 November 2014. This appraisal was similar to that used for the non-financial benefits and involved.

- Reviewing each of the shortlisted option to identify potential non-financial risks.
- Assessing each risk in terms of its likelihood and impact
- Computing a risk score for each option by multiplying the likelihood and impact scores

The results from the appraisal of non-financial risks is summarised in the table that follows.

Non-financial Risks	Likelihood Score (0-10)				Impact Score (0-10)				Overal Risk Score			
	Option				Option				Option			
	1	2	3	4	1	2	3	4	1	2	3	4
	Do Min	Less Amb	Ref Proj	More Amb	Do Min	Less Amb	Ref Proj	More Amb	Do Min	Less Amb	Ref Proj	More Amb
Operational problems - service managment, logistics, car park managment etc	10	2	5	5	10	7	8	8	100	14	40	40
Risk of demand not being met	10	2	2	1	10	5	7	3	100	10	14	3
Risk of over provision of capacity	0	1	1	4	0	2	2	5	0	2	2	20
Short term implementation risk	0	2	2	2	0	3	3	3	0	6	6	6
Long term risk of model not being effective	8	2	7	5	10	7	8	8	80	14	56	40
					Total Overall Risk Score				280	46	118	109

These results show that the workshop group considered that all the options were relatively low risk (maximum possible risk score is 500) but that Option 1: Do Minimum/Status Quo is considerably higher than the other options. This reflects the workshop delegates concerns that the existing facilities simply cannot support the service provider's requirement to continue to develop and improve services over the medium and longer term.

20 Sensitivity Analysis

Sensitivity analysis is fundamental to option appraisal since it is used to test the robustness of the ranking of options and the selection of a preferred option. It examines the vulnerability of options to changes in underlying assumptions and future uncertainties. For this project it has been undertaken in two stages:

- **Scenario Analysis** – examining the impact of changing scores, weights and net present costs through a number of scenarios
- **Switching Values** – computing the change required to bring about a change in the ranking of the options

Scenario Analysis - Scoring Scenarios

This analysis has examined the impact on the weighted benefit scores of more optimistic or pessimistic scoring scenarios. The optimistic and pessimistic scores from the workshop have been used to re-calculate weighted benefit scores and these are shown in the table below. The weighted benefits score derived from the

consensus scores are also shown in the table for comparative purposes.

		Scoring Scenario					
		Optimistic		Consensus		Pessimistic	
Option No	Option Description	WBS	Rank	WBS	Rank	WBS	Rank
1	Status Quo/Do Minimum	551	4	551	4	524	3
2	Reference Project (Single new build HC)	878	1	841	1	841	1
3	Less Ambitious (existing HC + new HC)	604	3	593	3	512	4
4	More Ambitious (Larger HC serving larger population)	864	2	839	2	827	2

It can be seen from the table that the ranking of options does not significantly change as a result of adopting more optimistic and more pessimistic scoring.

Scenario Analysis - Weighting Scenarios

The weighted benefit scores shown early in this report have been calculated using the weights developed by the workshop delegates to reflect their views of the relative importance of each criterion. The impact on the overall weighted benefit scores of changing these weights has been examined through adopting two further weighting scenarios:

- **Equal weights** applied to the criteria - This is a reasonable and plausible scenario to examine since experience from other workshops has frequently shown this to be a scenario that broadly represents a wide body of public opinion i.e. all the criteria are equally important.
- **Increased importance given to Access to Services –** Again, this is a reasonable scenario to examine since it is a widely held view that access to services is crucial to service uptake and effectiveness.

The table that follows shows the weights applied in these two scenarios and compares them with those developed by the workshop.

	Weighting Scenarios		
	No1	No2	No3
Benefit Criteria	Workshop	Equal	Priority on Access
Service Integration	11.5	12.5	13.0
Positive User Experience	13.7	12.5	13.0
Access to Care/Services	13.0	12.5	15.0
Effective Service Delivery	14.4	12.5	13.0
Flexibility	11.5	12.5	10.0
Best Use of Resources	11.3	12.5	11.0
Quality of Accommodation	10.8	12.5	11.0
Safety of Service Provision	13.7	12.5	14.0
	100	100	100

The impact on the overall weighted benefit scores of adopting these weighting scenarios is shown in the table that follows.

		Weighting Scenario					
		No 1		No 2		No 3	
Option No	Option Description	Workshop Weights		Equal Weights		Weights reflecting priority on Access	
		WBS	Rank	WBS	Rank	WBS	Rank
1	Status Quo/Do Minimum	551	4	538	4	547	4
2	Reference Project (Single new build HC)	841	1	838	1	838	1
3	Less Ambitious (existing HC + new HC)	593	3	588	3	594	3
4	More Ambitious (Larger HC serving larger population)	839	2	838	1	838	1

It can be seen that the ranking of options does not materially change as a result of adopting the two different weighting scenarios.

Scenario Analysis - Net Present Cost Scenarios

The net present costs used earlier in this report are the expected outturn costs for the options taking account of the expected impact (monetised) and probability of all risks. It is calculated by determining optimistic and pessimistic outturn costs and the probability of each of these outcomes occurring. An assumption has been made that the optimistic outturn costs has a probability of 0.05 and pessimistic outturn cost has a probability of 0.15 i.e. the pessimistic outturn cost is more likely than the optimistic one. These outturn costs are shown below.

		Net Present Cost (NPC) £millions over 60 years		
Option No	Option	Optimistic	Expected	Pessimistic
1	Status Quo/Do Minimum	0.73	0.98	1.25
2	Reference Project (Single new build HC)	2.8	3.54	4.2
3	Less Ambitious (existing HC + new HC)	3.6	4.12	4.8
4	More Ambitious (Larger HC serving larger population)	3.9	4.59	5.3

The optimistic and pessimist outturn cost scenarios have been used to re-examine the value for money comparisons and the results are shown in the table that follows

		Outturn Cost Scenarios					
		Optimistic Outturn Cost		Expected Outturn Cost		Pessimistic Outturn Cost	
Option No	Option	Cost per Unit of Weighted Benefit Score £	Marginal Cost per extra unit of Weighted Benefit Score (Compared to Do Minimum) £	Cost per Unit of Weighted Benefit Score £	Marginal Cost per extra unit of Weighted Benefit Score (Compared to Do Minimum) £	Cost per Unit of Weighted Benefit Score £	Marginal Cost per extra unit of Weighted Benefit Score (Compared to Do Minimum) £
1	Status Quo/Do Minimum	1,325		1,783		2,269	
2	Reference Project (Single new build HC)	3,329	7,134	4,206	8,807	4,993	10,166
3	Less Ambitious (existing HC + new HC)	6,070	68,139	6,955	74,604	8,093	84,283
4	More Ambitious (Larger HC serving larger population)	4,649	11,007	5,469	12,519	6,317	14,063

The results in the table show that Option 2: Reference Project remains best value for money in both the optimistic and pessimistic cost scenarios.

Switching Values

The table below shows the percentage change required on the weighted benefits scores, net present costs and the two vfm measures for the less ambitious and more ambitious options to equal the Reference Project option.

Switching Values				
Percentage change required in current values to equal the Reference Project value				
Option	Weighted Benefit Score	Net Present Cost £m	Cost per Unit of Weighted Benefit Score £000	Marginal Cost per extra unit of Weighted Benefit Score (Compared to Do Minimum) £
Less Ambitious	42%	-14%	40%	88%
More Ambitious	0.3%	23%	23%	30%

The results in the table show:

- The Net Present Cost of the Less Ambitious Option is higher than that of the Reference Project and it's significantly inferior Weighted Benefit Score means it offers poor value for money.
- Although the Weighted Benefit Score of the More Ambitious Option would only need to change by 0.3% to the equal that of the Reference Project, it's significantly higher Net Present Cost means that very substantial change would be required to improve its two vfm measures to those of the Reference Project.

21 Preferred Option

The results from the five appraisals of the short listed options i.e. benefits, risks, costs, and value for money are brought together in the table that follows which shows the ranking of each option in each appraisal. (1 is highest ranking i.e. best, 4 is lowest ranking i.e. worst).

		Ranking of Options by Appraisal			
	Option No/Description	1	2	3	4
		Status Quo/Do Minimum	Reference Project (Single new build HC)	Less Ambitious (existing HC + new HC)	More Ambitious (Larger HC serving larger population)
Non-Financial Benefits Appraisal	WBS (consensus)	551	841	593	839
	Rank	4	1	3	2
Non-Financial Risks Appraisal	Overall NF Risk Score	280	46	118	109
	Rank	4	1	3	2
Economic Appraisal	Net Present Costs (60 years) £m	0.98	3.54	4.12	4.59
	Rank	1	2	3	4
Value for Money	Cost per Benefit Point £	1,783	4,206	6,955	5,469
	Rank	1	2	4	3
	Marginal Cost per Extra Benefit Point compared to Do Minimum £	NA	8,807	74,604	12,519
	Rank	NA	1	3	2

The table shows that Option 2: Reference Project is ranked highest in three of the five appraisals indicating that overall it is the preferred option since it is the one most likely to maximise the non-financial benefits required from the project, provides best value for money and has an acceptable level of risk.

22 Value for Money Scorecard

In line with the guidance issued in 2013 in relation to primary healthcare premises, a Value for Money Scorecard is included at Appendix F of this document.

The summary diagram shows a variable picture in relation to space utilisation and cost with elements above the metric (total cost at +6%) and below it (area per GP at -2%, support space ratio at -11%). The scorecard will be further interrogated and will remain under review and be updated for the Full Business Case.

The Commercial Case

The Commercial Case sets out the planned approach that the project partners will be taking to ensure there is a competitive market for the supply of services and facilities. This in turn will determine whether or not a commercially beneficial deal can be done and achieve the best value for money for the project.

23 Potential Scope & Services

It is intended that the new Doune Health Centre will be delivered via the hub initiative, in partnership with hub East Central Scotland Ltd (hubco). The hub route has been established to provide a strategic long-term programme approach to the procurement of community-based development through joint local venture arrangements.

The hub contract with NHS Forth Valley will be a Design & Build Development Agreement (DBDA) form of contract.

At Outline Business Case stage, the Participants Brief has been developed and has informed the developing design, to RIBA Stage 2 Concept Design, with general layout drawings and site plan.

24 Potential Risk Allocation

The Territory Partnering Agreement (to which NHS Forth Valley form is a signatory) requires Participants to enter into a Design Build Development Agreement (the Standard form Project Agreement) for Approved Projects. The Template Standard Project Agreement is contained as a Schedule to the Territory Partnering Agreement and must be entered into in substantially the form set out in that Template. All changes to the Standard Project Agreement require SFT approval, which will only normally be given to changes required for project specific reasons or to reflect changing guidance or demonstrable changing market circumstances.

It has been agreed that NHS Forth Valley will enter into the Standard Project Agreement.

In respect of allocation of risk this has been addressed in a transparent manner. The key features of the Hub Initiative are:

- The parties are encouraged to work together as partners in an open and transparent approach and to ensure that this partnering ethos is maintained
- A clear and transparent system is in place
- A level of cost certainty is determined
- A quantitative and qualitative analysis is used

Risk owners are clearly identified to ensure that whoever is best placed to manage, mitigate and control specific risks is responsible to do so.

25 Potential Charging Mechanism

As noted, the project is being procured through hub East Central Scotland under a DBDA form of contract, with design being led by the Tier 1 Contractor and their design team. As such there is no concession period and therefore no charging mechanism applied.

The project will upon completion be handed over to NHS Forth Valley to manage and operate.

It is worth noting that during the design & construction process cognisance shall be given to the whole life costs of the facility in order that the project achieves a sensible balance between Capital and Lifecycle costs to provide best value.

26 Potential Key Contractual Arrangements

The hub route has been established to provide a strategic long-term programme approach to the procurement of community-based development through joint local venture arrangements. SCIM guidance states that this route should be the default for community based new builds over £750,000.

The East Central hubco can deliver projects through one of the following options:

- Design and Build contract (or build only for projects which have already reached design development) under a capital cost option;
- Design, Build, Finance and Manage under a revenue cost option (land retained model); or
- Lease Plus model for a revenue cost option under which the land is owned by hubco.

The first option, Design and Build, using NHS Capital is the most suitable for this project. The relatively small size of this project means that the other two options are not effective delivery models.

27 Potential Personnel Implications

At present, it is anticipated that there will be few implications for personnel. The process of assessing and managing the impact of any changes to staffing brought about by implementing the proposals contained within the OBC will be robustly managed by the GP Practice in their role as independent contractors, by NHS Forth Valley separately in terms of the anticipated NHS service provision and by the two jointly should the need arise. This will include an assessment of the following areas:

- The factors that affect the workforce plan.
- How the future staffing requirements will be identified.
- How the change process will be managed

A number of national drivers impact on the approach to workforce planning.

- The 20:20 Workforce Vision
- The Healthcare Quality Strategy for NHS Scotland (2010)
- Integration of Adult Health and Social Care in Scotland

A continuation of current workforce development plan will be a crucial element in delivering the new model of care and ensuring a safe, skilled and effective workforce. Future focus will be on the continued development of team working between the GP Practice and NHS Forth Valley.

In moving forward through the various stages of the development of this project, it will be essential to ensure full compliance with the staff governance standards and to utilise the benefit of the project to ensure that staff are:

- Well informed
- Appropriately trained and developed
- Involved in decisions
- Treated fairly and consistently, with dignity and respect, in an environment where diversity is valued
- Provided with a continuously improving and safe working environment, promoting the health and wellbeing of staff, patients and the wider community

It is fully envisaged that at the appropriate milestones in the project timetable, colleagues will be fully involved in agreeing processes for the transfer of staff to the new facilities and how that will be facilitated for all staff groups. It will be imperative that these working relationships with colleagues are positive as they will assist with the process of implementing change, supporting staff and ensuring all processes are fair and equitable.

28 Potential Implementation Timescales

The key dates for progressing and delivery of the project are set out in the table that follows.

Activity	Date
Stage 1 Completion	**January 2016**
Stage 2 Completion	**June 2016**
Financial Close	**July 2016**
Construction	**July 2016-March 2017**

The programme is under continual review and will be again in Stage 2/FBC in relation to meeting the projected Financial Close date.

The Financial Case

The Financial Case sets out clearly the financial impact of the investment proposals in this OBC.

29 Potential Capital Requirement

The capital requirements for the options are set out in the table below.

Option	1 Status Quo / Do Minimum £m	2 Reference Project (Single New Build HC) £m	3 Less Ambitious (Existing HC + New HC) £m	4 More Ambitious (Larger HC serving larger population) £m
Forecast Construction/Associated Costs	0.349	2.420	2.572	2.761
Furniture Fixtures and Equipment, Telecoms & IT	0.000	0.197	0.197	0.239
TOTAL CAPITAL REQUIREMENT	0.349	2.617	2.769	3.000

30 Potential Impact on Balance Sheet and Accounting Treatment

NHS Forth Valley will recognise the value of the property as a non-current asset on its Balance Sheet. The asset will initially be capitalised at full cost, and following a valuation by the Valuation Office Agency, the carrying value will be based on their assessment of the Depreciated Replacement Cost.

The impact on the Board's balance sheet for the options are set out in the table below.

Option	1 Status Quo / Do Minimum £m	2 Reference Project (Single New Build HC) £m	3 Less Ambitious (Existing HC + New HC) £m	4 More Ambitious (Larger HC serving larger population) £m
Forecast Construction/Associated Costs	0.349	2.420	2.572	2.761
Forecast Impairment on Completion	(0.087)	(0.605)	(0.643)	(0.690)
Forecast Carrying Value	0.261	1.815	1.929	2.071

Therefore, for the reference project, the asset would initially be capitalised at **£2.420m** and will be impaired by **£0.605m** following valuation to a carrying value of **£1.815m.** This estimate is based on experience of similar projects.

The equipment and IT procured separately will be accounted for by NHS Forth Valley as a non current asset.

31 Revenue Costs & Overall Affordability

This Outline Business Case has been prepared on the assumption that the project is procured through hubco using NHS Capital.

The projected revenue costs of the options are detailed in the table below.

Option	1 Status Quo / Do Minimum £m	2 Reference Project (Single New Build HC) £m	3 Less Ambitious (Existing HC + New HC) £m	4 More Ambitious (Larger HC serving larger population) £m
Capital Charges	0.009	0.050	0.052	0.059
Utilities, Cleaning, Rates and Maintenance	0.032	0.074	0.094	0.082
Income From GP Practice	(0.006)	(0.022)	(0.025)	(0.025)
Net Additional Cost to NHS Board Per Annum	**0.005**	**0.071**	**0.091**	**0.085**

The NHS Board will provide for the revenue consequences of this business case within its financial plan. These figures are net of additional costs which require to be met by the Doune GP practice. The practice has provided confirmation that the financial implications are affordable to them and are keen to proceed with the development.

For the reference project the projected net additional revenue costs per annum to the NHS Board can be summarised as follows:

Capital Charges	£0.047m
Other Revenue Costs Net of Income	£0.024m
TOTAL	**£0.071m**

It should also be recognised that the investment in this project will reduce the backlog maintenance expenditure requirement (£120k) in relation to the existing Health Centre. Therefore, the project will enable NHS Forth Valley to avoid expenditure on a proportion of this backlog maintenance over the next decade or so.

The Management Case

The Management Case describes how the organisation will ensure the project will be managed effectively and the investment objectives and benefits will be delivered successfully.

32 Procurement Strategy

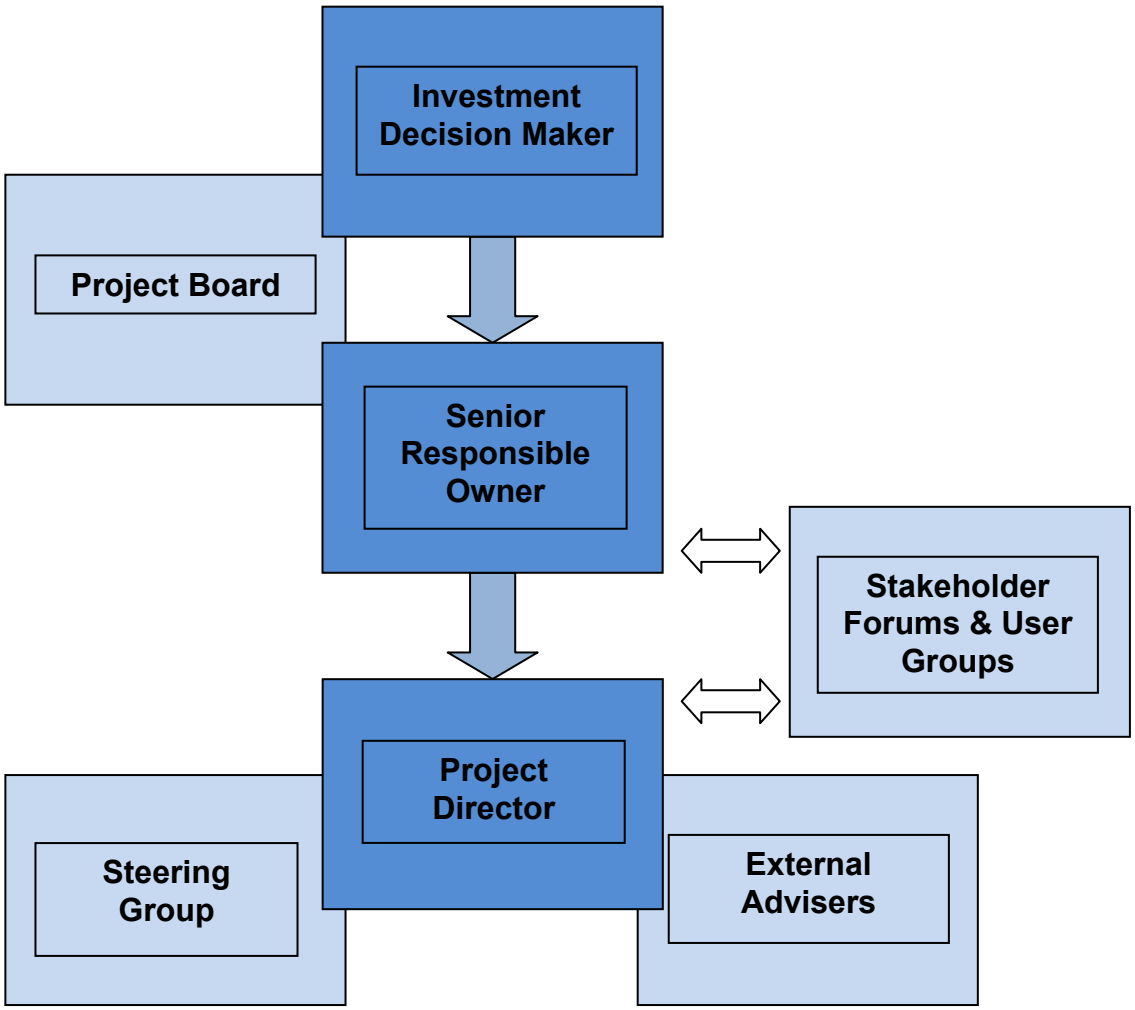
Under the hub initiative, NHS Scotland has provided an exclusivity arrangement which requires all Health Boards to consider hub as the procurement option for all community based projects in excess of capital construction value of £750.000. Only if the project does not demonstrate value for money is there the option to consider other procurement options. One of the benefits which hub will deliver is improved procurement efficiency. The Procurement legislation requirements have been met in the procurement for the Private Sector Development Partner and the associated contract documents. This means that projects procured through the hubco will not be required to undertake these stages saving cost and time.

Standard form project agreements have been developed by the Scottish Futures Trust Design and Build contracts. These template agreements are designed to be applicable for use by all of the public sector organisations as participants in the National Hub Programme as a basis for improved efficiency in contract procurement and delivery.

33 Project Management

NHS Forth Valley has a strong track record of effectively managing both capital projects and change programmes to ensure that investment objectives and benefits are delivered successfully.

In compliance with the Scottish Capital Investment Manual, this project will deploy a Programme & Project Management Approach (PPM) with a structure as shown below.



The PPM approach will be applied to this project to ensure that:

- A process and audit control framework is applied to the project
- Project risks are being managed effectively
- Learning and good practice points can be transferred to other projects across Forth Valley

The roles and responsibilities allocated across the structure are shown in the table that follows.

Role	Responsibility
Investment Decision Maker	Collective and final responsibility for the approval of the Investment Proposal
Senior Responsible Owner	Personal accountability and overall responsibility for the delivery of the successful outcome
Project Director	Leading, managing and co-ordinating the Project Team on a day to day basis
Project Board	Provides the SRO with stakeholder and technical input to decisions affecting the project
Steering Group	Takes forward the decisions of the Project Board and develops the operational elements of the project
Stakeholder forums and User groups	Provides the Project Board with further insight and advice on the detailed requirements of the project

The nominated officers for this programme are shown in the table that follows.

Investment Decision Maker	Forth Valley NHS Board
Senior Responsible Owner	Kathy O'Neill, General Manager Forth Valley CHPs
Project Director	Morag Farquhar, Programme Director

34 Change Management

The partners in the project have developed a series of principles that will underpin the change process:

- Recognise the need to maximise the benefits of the change for patients and service users, who are at the heart of the changes made
- Take advantage of the time available to complete the new facilities to start the change process and thereby avoid risks related to a 'big bang' approach
- Test and prove the changes through careful piloting of any aspects of the new models and processes that can be implemented before the new facility is finally commissioned
- The change management philosophy and principles will be communicated to all staff.
- Work in partnership with staff and other stakeholders to engage all those involved in the delivery of care in the change process
- Focus on staff skills and development required so that staff are both capable and empowered to deliver care effectively and to a high quality standard in the new facility

35 Benefits Realisation

The benefits envisaged from the project and as set out this OBC will require active management if they are to be fully realised. Benefits Realisation is the overarching process which incorporates the Benefits Realisation Plan (BRP) as part of a process of continuous improvement. It takes due account of changes in the project during the delivery phase which impact on, or alter the anticipated benefits. As such the benefits management approach is a cycle of identification, planning, execution and review.

In developing the BRP the Partners have sought to ensure that stakeholders are at the centre of the benefits realisation process. A number of stages have been identified for the development of the BRP, namely:

- How benefits will contribute to the Board's local strategies and to National Strategies
- How benefits will be delivered
- The owner's roles and responsibilities for defining, realising and managing benefits
- The mechanism for monitoring benefits and identify corrective actions, if required
- The arrangements for transition to the operational phase
- The schedule for benefit reviews and identification of further benefits

As part of the further development of BRP the partners will agree baseline measures reflecting the current status of each benefit area and the timeline for attaining the anticipated full realisation of the benefits. This will also be linked to the Change Management Plan to provide assurance on delivery.

The benefits of each Investment Objective have been reviewed and updated throughout the development of this OBC and the Draft BRP is included at Appendix G. This draft will be subject to further review at Full Business Case stage and consolidation against the developing performance framework for the Health & Social Care Partnership and further alignment to the national health & wellbeing outcomes.

36 Risk Management

The key high level risks associated with this project have been identified and these have formed the basis of a more detailed risk register, utilising the standard hub format, which has been regularly reviewed and updated as the OBC has been developed.

The philosophy for managing risks considers effective risk management to be a positive way of achieving the project's wider aims, rather than a mechanistic exercise, to comply with guidance. Inadequate risk management would reduce the potential benefits to be gained from the project.

The partners recognise the value of an effective risk management framework to systematically identify, actively manage and minimise the impact of risk. This is done by:

- Having strong decision making processes supported by a clear and effective framework of risk analysis and evaluation
- Identifying possible risks before they crystallise and putting processes in place to minimise the likelihood of them materialising with adverse effects on the project
- Putting in place robust processes to monitor risks and report on the impact of planned mitigating actions
- Implement the right level of control to address the adverse consequences of the risks if they materialise.

The risks have been allocated across a range of categories depending on where these risks would apply within the overall structure of the project. These include:

- The phase of the project to which they apply
- Those that would have a major impact on the cost of the project
- The ownership of the risks including those which can be transferred to the hubco (Tier 1) contractor or retained by NHS Forth Valley

Each risk has subsequently been assessed for its probability and impact, and where relevant its expected value.

The risk register is maintained as a dynamic document will continue to be reviewed and updated as the project progresses and will be a standing item at the regular project meetings. An extract from the Risk Register as at development of the OBC is attached at Appendix H.

37 Post Project Evaluation

The partners in the project are committed to ensuring that thorough and robust post-project evaluation is undertaken at key stages in the process to ensure that the expected benefits from the project are realised and that positive lessons can be learnt from the project.

Scottish Government has published guidance on PPE, which supplements that incorporated within the Scottish Capital Investment Manual (SCIM). The key stages applicable for this project are set out in the table below:

Stage	PPE Evaluation Undertaken	Timing
1	Develop PPE Plan with benefits measures	On completion of OBC
2	Monitor progress and evaluate project outputs	On completion of facilities
3	Evaluation of Service Outcomes	6 months after commissioning of the new facilities

4	Post occupancy evaluation	2 years after commissioning of the new facilities

Within each stage, the following issues will be considered:

- The extent to the project objectives have been achieved
- The extent to which the has progressed against the PPE plan
- Where the plan was not been followed, what were the reasons
- Where relevant, how plans for the future projects should be adjusted

The Project Owner will be responsible for ensuring that the arrangements have all been put in place and that the requirements for PPE are fully delivered. The Project Director will be responsible for day to day oversight of the PPE process, reporting to the Project Owner and Project Board. The Project Owner and the Project Director will set up an Evaluation Steering Group (ESG), which will:

- Represent interests of all relevant stakeholders
- Have access to, professional advisers who have appropriate expertise for advising on all aspects of the project.

The Project Manager will coordinate and oversee the evaluation. The key principle is that the evaluation is objective. The Evaluation Team will be multi-disciplinary and include the following professional groups, although the list is not exhaustive:

- Clinicians including nursing staff, clinical support staff, Allied Health Professionals and social workers
- Healthcare Planners, Estates professionals and other specialists that have an expertise on facilities
- Accountants and finance specialists, IM&T professionals, plus representatives from any other relevant technical or professional grouping
- Patients and service users and/or representatives from patient and public groups.

Appendices

A – Map of Doune: location of existing and new sites
B – Map of GP Practice Catchment Area
C – Extract from Clackmannanshire & Stirling Draft Strategic Plan
D – Design Statement
E – Value for Money Scorecard
F – Draft Benefits Realisation Plan
G – Extract from Risk Register
H – Letter of Stakeholder Support

Appendix A – Map of Doune: location of existing and new sites

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World • United Kingdom • Scotland • Stirling • Doune
Site of Proposed New Building
Existing Health Centre
Balkerach Street
Fir Road
Beech Court
Rowan Court
Elm Court
Larch Crescent
A84
A820
North Lea
Moray Street
Hall Lane
Margaret Lockart
Red Kite Community Nursery
Taste Of The Trossachs
The Woodside Hotel
George Street
Graham Street
Castlehill
Queen Street
Muir Crescent
Doune Nursery
Secret Scotland Tours
Leitch Driving School
Edward Shaw Investments LTD
250 feet
100 m
Scottish Water
© 2013 Microsoft Corporation © 2013 Nokia

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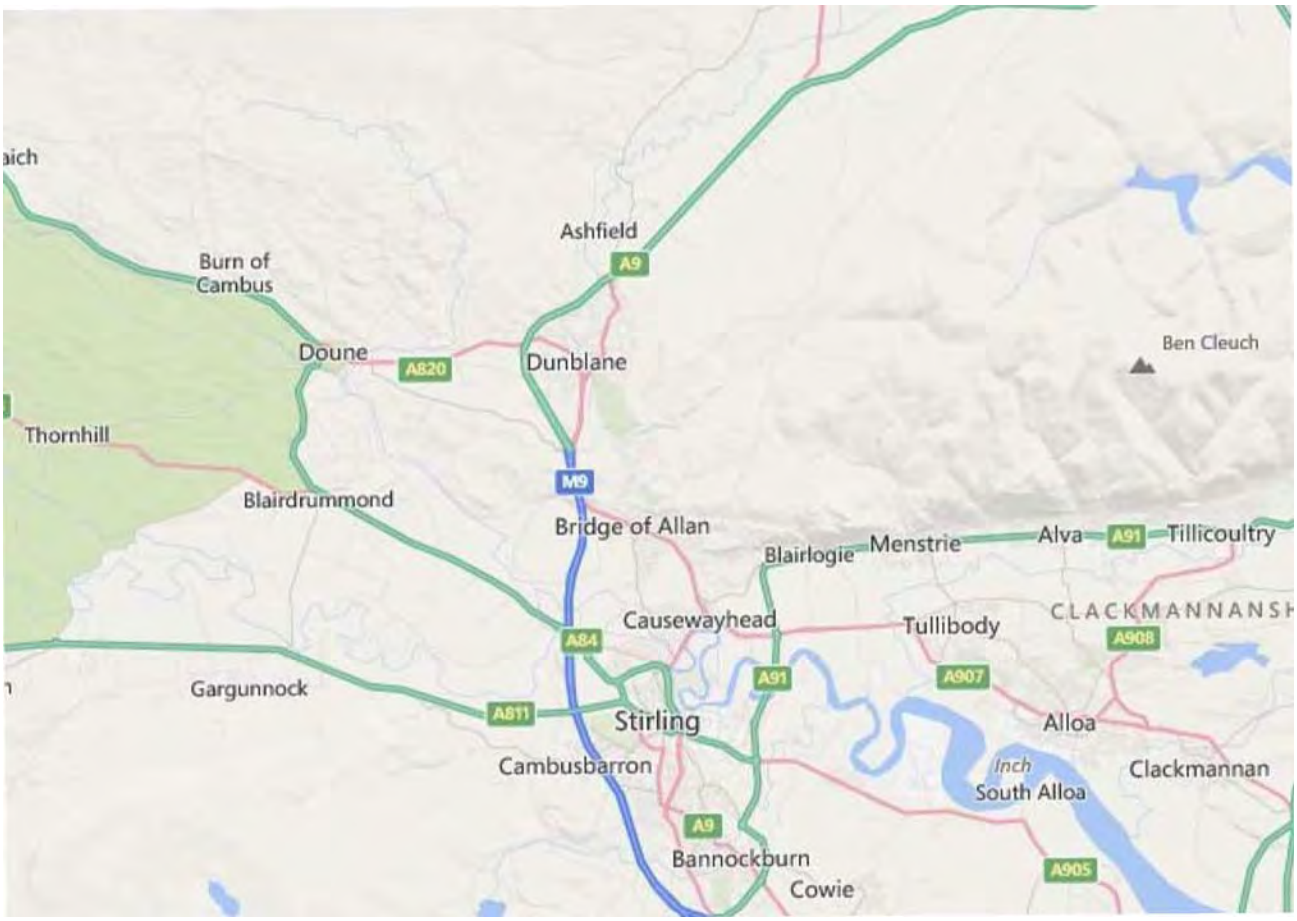
Appendix B – Map Including GP Practice Catchment Area



Doune, Dunblane, Thornhill

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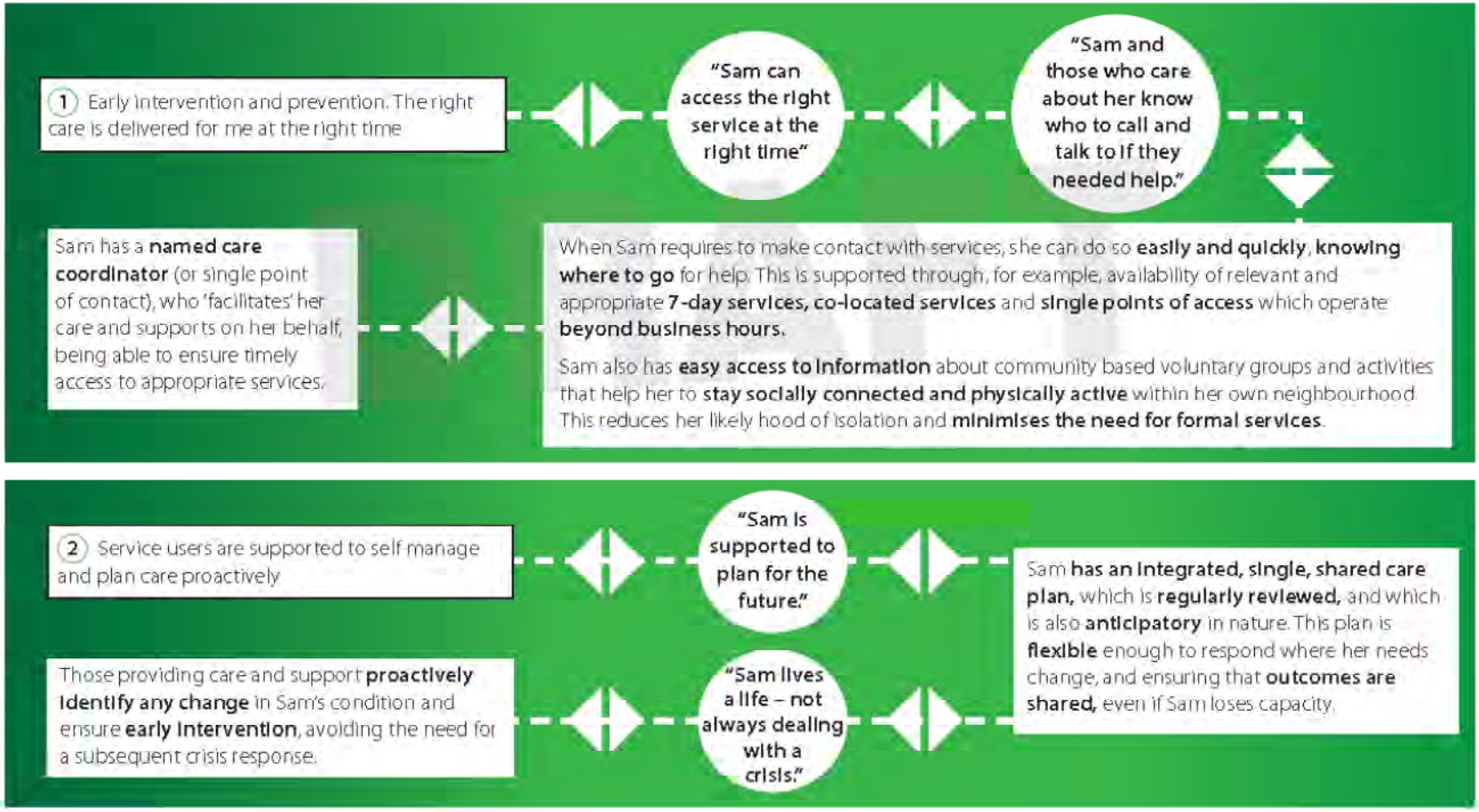
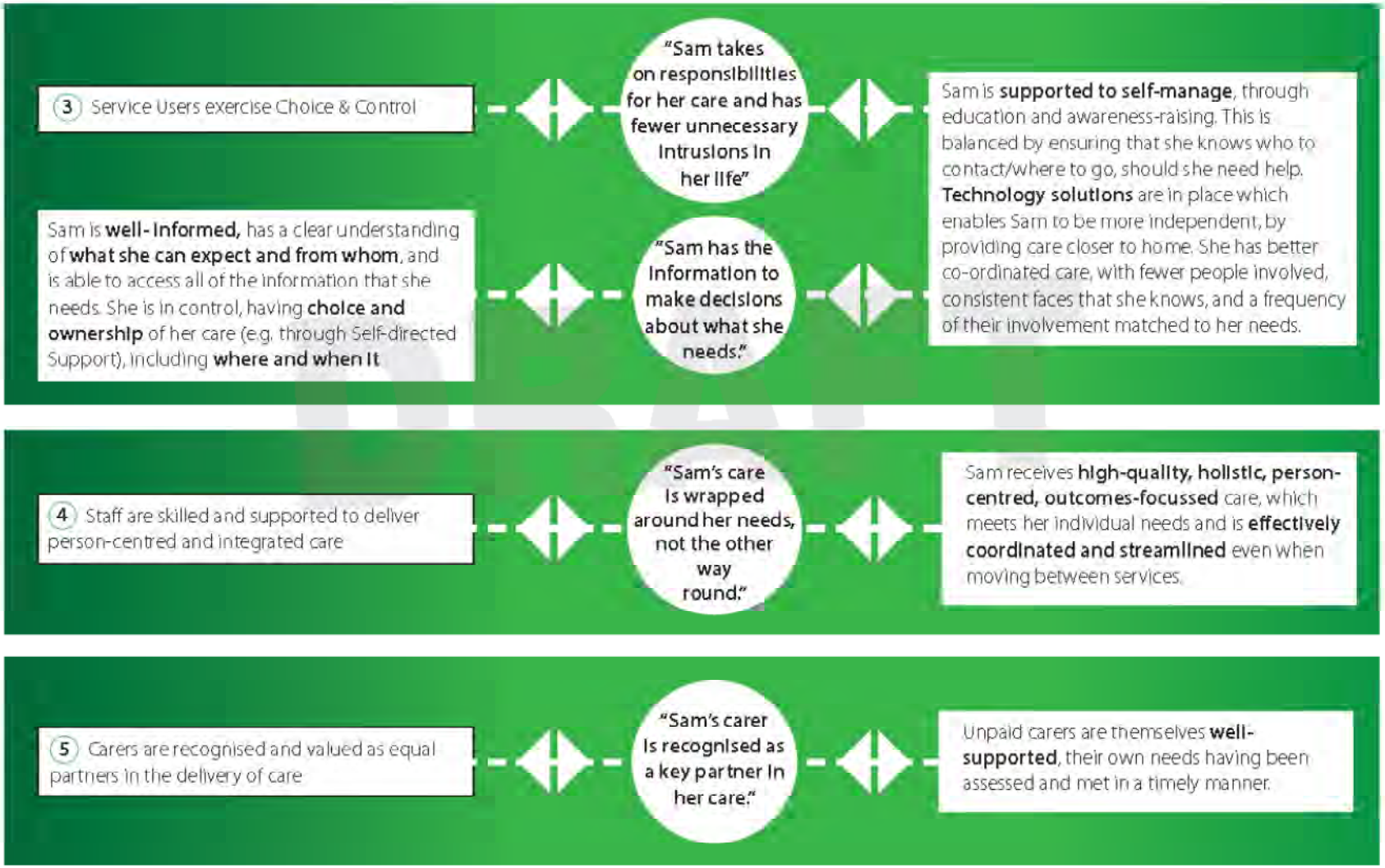
Appendix C – Extract from Clackmannanshire & Stirling Draft Strategic Plan

Key Themes and Ambitions

Keeping SAM at the centre and using material gathered as part of the engagement sessions and from other events, we have identified our ambitions for what an 'integrated future' should look like for each Theme:




3 Service Users exercise Choice & Control
"Sam takes on responsibilities for her care and has fewer unnecessary intrusions in her life"
Sam is supported to self-manage, through education and awareness-raising. This is balanced by ensuring that she knows who to contact/where to go, should she need help. Technology solutions are in place which enables Sam to be more independent, by providing care closer to home. She has better co-ordinated care, with fewer people involved, consistent faces that she knows, and a frequency of their involvement matched to her needs.
Sam is well-informed, has a clear understanding of what she can expect and from whom, and is able to access all of the information that she needs. She is in control, having choice and ownership of her care (e.g. through Self-directed Support), including where and when it
"Sam has the information to make decisions about what she needs."
4 Staff are skilled and supported to deliver person-centred and integrated care
"Sam's care is wrapped around her needs, not the other way round."
Sam receives high-quality, holistic, person-centred, outcomes-focussed care, which meets her individual needs and is effectively coordinated and streamlined even when moving between services.
5 Carers are recognised and valued as equal partners in the delivery of care
"Sam's carer is recognised as a key partner in her care."
Unpaid carers are themselves well-supported, their own needs having been assessed and met in a timely manner.

6 There is a focus on Rehabilitation Recovery and Reablement across all services. There are fewer avoidable admissions and discharge planning is effective and efficient.

"Sam does not require unplanned, emergency, hospital care"

If Sam is admitted to hospital; effective joint planning takes place to ensure a **smooth, safe and timely discharge. Rehabilitation and reablement** services are in place which help Sam to remain at home, or to return home quickly, but safely following a period in hospital.

7 Services work together with communities to improve access to services and build capacity – working with third sector, community groups across and within localities. This reduces health inequalities within and across our communities.

"Sam is able to stay at home and participate in community activities"

"Sam has access to additional, targeted information and advice to support her to manage her health care needs"

This is supported through improved availability and use of **assets within her community**.

Our Priorities

In order to address the key themes presented on the previous pages and to achieve our ambitions for Sam **we will**:

- **Further develop systems to enable front line staff to access and share information** across professions and organisations. This will enable people receiving services, named care coordinators, and other relevant staff to minimise the time spent duplicating assessment and maximise opportunities to create 'seamless' personal outcomes focused care.
- **Support more co-location of staff from across professions and organisations** to enable working in an integrated way where this facilitates the best quality of care, support, and enablement/independence to be achieved.
- **Develop single care pathways** which recognise that there are many more conditions than services available. While one size doesn't fit all there are benefits to be had from providing consistent and predictable processes.
- **Further develop anticipatory and planned care serves** for people with multiple long term conditions. This will include people with dementia and will be tailored to meet people's preferred personal outcomes and maximises their ability to be actively involved in managing their own conditions.
- **Provide more single points of entry to services** where named care coordinators help people receive more holistic services. Internal links will be made to any other services and supports needed rather than service users approaching each service anew.

- **Deliver the Stirling Care Village** to realise many of the expected benefits of greater levels of Health & Social Care Integration. This will include improved personal outcomes and reduced numbers of assessments by demonstrating many of the innovations noted above.
- **Develop seven-day access to appropriate services** to maximise quality of care; the potential for rehabilitation and recovery; and flow through acute and community services.
- **Take further steps to reduce the number of unplanned admissions to hospital and acute services** by supporting more prevention, early intervention, and community based services. This includes medical and social forms of prevention that could impact on future health such as providing information about local groups and activities that can help people stay socially connected and physically active along with more 'Keep Well' style health screening and support.

The decisions associated with our priorities identified in this section of the Strategic Plan will be based on the efficient and effective use of available resources, what we already know works well in this area, and from the evidence base and findings of well conducted local, national, and international research.

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Appendix D - Design Statement

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Doune Health Centre: SCIM DESIGN STATEMENT
Introduction

The objectives the project seeks to achieve are outlined in the Initial Agreement, namely:

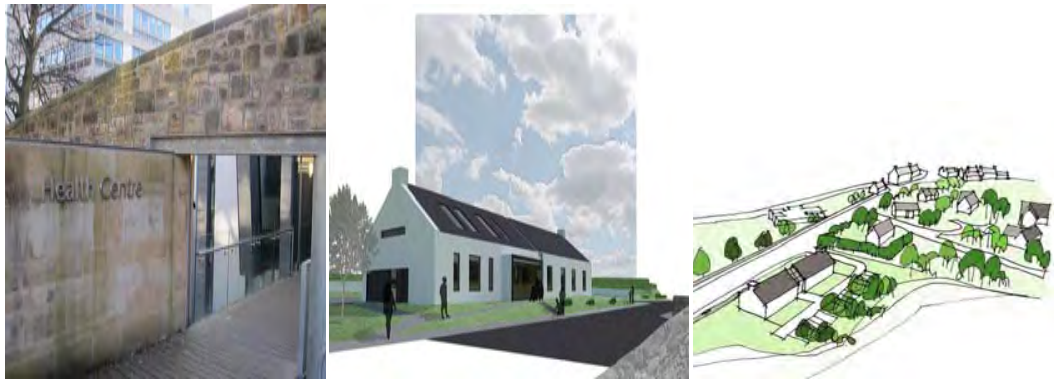
- Care at home or in a patient's community provided by the most appropriate person with the right skills.
- Greater equity of service provision, positive experience of health and social care and of the environment in which services are provided.
- The care provided should respect individual needs, values and preferences and should be based on shared decision making.
- Improved access to care and treatment through changes in the location of services, reduced travel time/distance/cost and shorter waiting times.
- Easier journey through health and social care system with a single point of access.
- As many services as possible should be available at each visit.
- Using telemedicine or telephone consultations for an increasing numbers of return and routine outpatients.
- To provide care and treatment by working in partnership with other organisations (LA, voluntary & independent sectors), through extended community teams, with professionals, patients, carers and communities as full partners.
- Improved service effectiveness and efficiency, greater efficiency in the use of resources including staff time.
- Improvements for staff resulting in greater job satisfaction and less turnover/sickness.

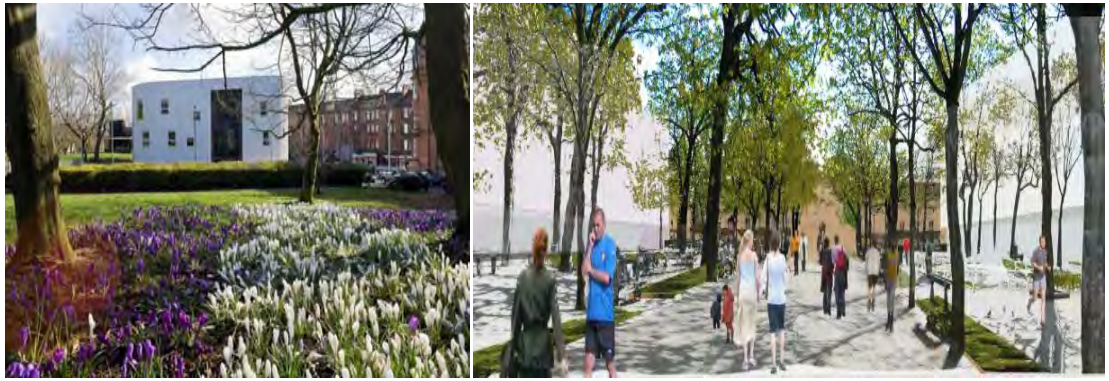
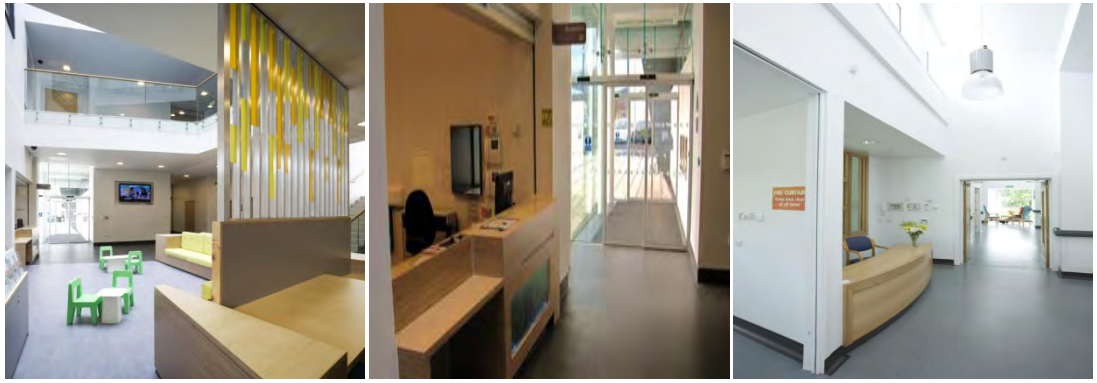
Therefore, in order to realise the above objectives through investment in facilities, the resultant facility must possess the following attributes:

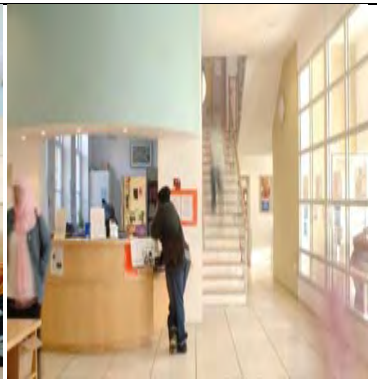
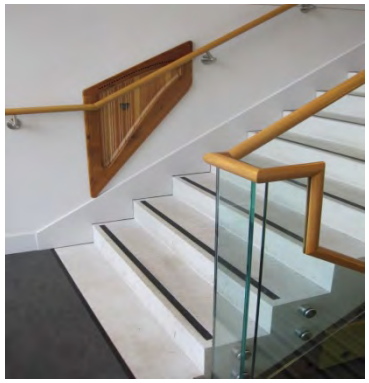
1 Non-Negotiables for Patients

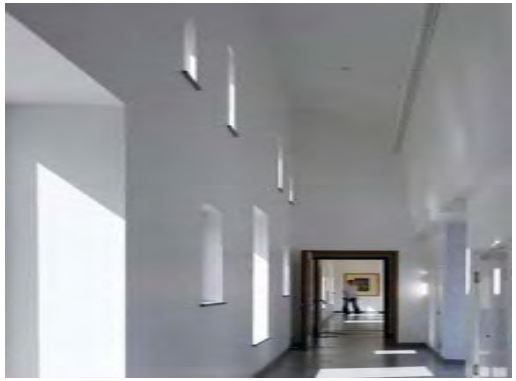
Physical accessibility to the site and into and around the building is paramount. There is a need to ensure Equality Act compliance including wheelchair user accessibility – appropriately designed, barrier-free paths, automatic entrance doors to be provided, corridor doors to be appropriate (either easy to manipulate or held open). Equally important to design for those with physical impairment is that for those with cognitive difficulties and attention must be paid to designing for dementia etc.

Agreed Non-Negotiable Investment Objective	Benchmark Standard – The criteria to be met and/or some views of what success might look like
1.1 The facility must improve access for people coming from remote locations by car, but be no	• Within the village of Doune, well connected to main pedestrian routes by level/gently sloping paths. • Clear signposting from A84 and/or A820 for pedestrian and vehicle routes.

harder for those walking from the village or using buses. Its location must be clear for infrequent and 'one-off' patients such as tourists.	• Pedestrian on site routes to be attractive and well lit, with a 'nature walk' feel. • Entrance within 5 minutes walk of a bus-stop • Off-street parking provision available for patients • You can see where you go to park on entering the site.
1.2 The facility should not feel 'out of place' in its setting, but familiar and comfortable for patients with the landscape (paving, plants , vehicle areas) an integral part of public routes and the building being of a similar scale and nature to other buildings in Doune. It should have a professional, but not overly harsh, feel. The entrance must be obvious from arrival routes.	 Images: Robin House, Waterford Health Park, Stratheden Hospital  Images: Chalmers Health Centre, Dunscore Health Centre (x2) (Anderson Christie Architects) Pedestrian routes to make good use of existing and new planting (including

	views to mature trees etc) to provide some shelter and be more like a nature walk.  Images: Plean St Centre, Springfield Village
1.3 On entering, there must be a direct view to a single 'place' to check in irrespective of the service being accessed, though individuals personal needs and preferences must be accommodated at check-in. The design must project the 'friendly atmosphere' of the practice/service.	• Reception facilities offering the choice of face-to-face and electronic check in. • Reception areas designed to provide some privacy to conversations, being a step away from circulation routes and waiting areas  Images: The West Centre (x2), Migdale Hospital

	   Images: Plean Street Centre, Villa Street Medical Centre (x2)
1.4 Patient's routes around the facility must be short (particularly routes from waiting to consulting/treatment), pleasant and clear. The route from consulting/treatment must not put patients immediately 'on show' but allow a moment to compose themselves.	   Images: The West Centre, Dumfries Dental Centre, The Waldron Health Centre

	  Images: The Bamburgh Clinic, St Nicholas Hospital, Stratheden Hospital
1.5 The waiting area (including any immediately accessible external areas) must cater for the different needs of patients, considering age and personal preferences, a pleasant place providing: • opportunities for social interaction and support, and areas of a more private nature, • positive distractions – something interesting to look at and a place for children to play, • clear connection to staff for assistance and call to appointments.	• Clear view to patient call system, • Good daylighting and a view to nature • not overlooked by housing • access to health information and support through the use of printed material and ICT • flexibility in layout to allow visiting services and third sector to hold promotion events (see also 2.3 below)    Images: The West Centre (x2), Dumfries Dental Centre

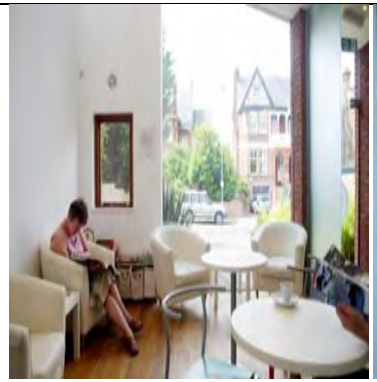
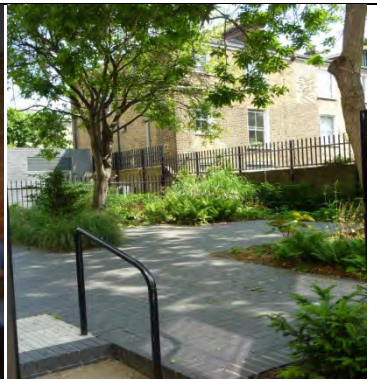
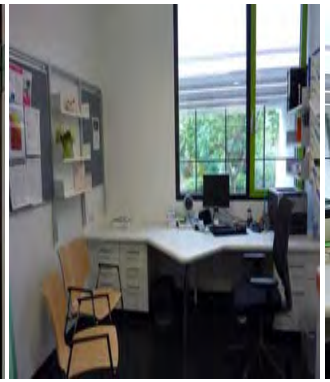
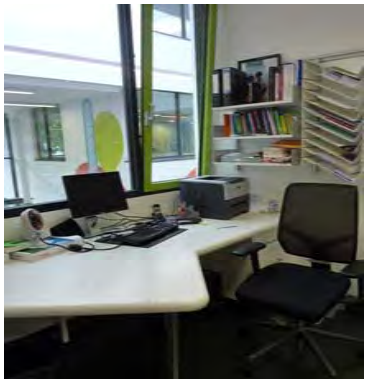
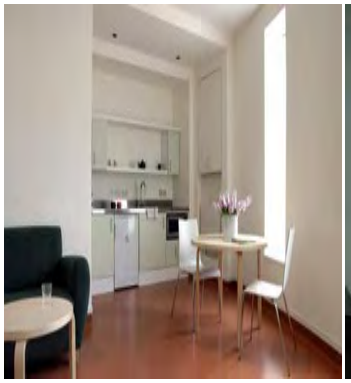
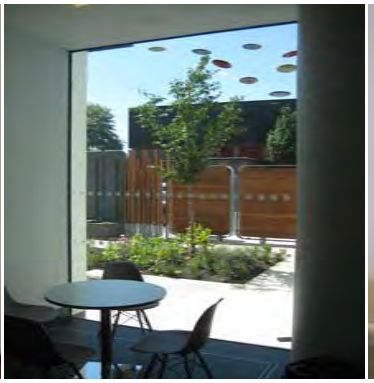
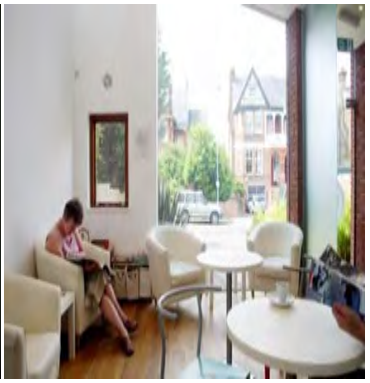
	   Images: Advance Dental Centre, New Stobhill Hospital, Kentish Town Centre
1.6 The design and location of consulting and treatment rooms must provide good daylight while retaining adequate visual and audio privacy.	   Images: The Waldron Health Centre, Kentish Town Centre (x2)

	 Image: Kelso Health Centre

2 Non-Negotiables for Staff

Agreed Non-Negotiable Investment Objective	Benchmark Standard – The criteria to be met and/or some views of what success might look like
2.1 The layout of the site must provide: • safe and reliable access for staff (both resident and visiting) in daylight and darkness. • for deliveries and storage/transfer of waste materials to be managed discretely	• All staff routes on site to be well lit, with casual observation from occupied areas of the facility and/or adjacent properties. • Parking must be provided conveniently to a discrete entrance with easy route for those handling large items of equipment etc. • Routes for visiting professionals must allow them to 'check in' with resident staff on entry • Bin/recycle stores and delivery entrance placed out of sight of main public routes and spaces.
2.2 The layout of the facility must promote team working across all service providers.	• Staff routes around the facility to be shared , not separate, allowing impromptu meetings and conversations • Like functions (like administrative space or consulting rooms) should be provided together • The layout of activities and routes should make it easier to talk to a colleague face to face than to send e-mails.

	 Image: Renfrew Health & Social Care Centre
2.3 The facility must support the education and continuing development of staff.	Space for group learning and accessing IT based education material should be provided. This should be designed and located so that it can be used (on its own and in conjunction with other spaces) for other purposes, including by community groups and the public for events and to support access to information and support.
2.4 The layout of public areas (consult/treatment/meeting/waiting) must provide flexibility in use for visiting services and for additional activities such as health promotion, support groups, fundraising.	• Bookable consulting and treatment rooms provided alongside rooms intended for GP use and served from the same reception/circulation. • Meeting rooms/education areas and waiting areas designed to be used individually and as a suite for special events and out of hours activities
2.5 The facility must support the introduction and use of telehealth.	IT/E-Health infrastructure to meet applicable standards to be installed with flexibility for adaptation in the future, including internet connectivity and v/c capability. Consideration to be given to wireless installation to promote flexible working/use of mobile equipment.
2.6 There must be a place staff to be able to rest, socialise and make food/refreshments convenient to work areas, to encourage use by all.	Attractive space, placed away from public view to all staff to be 'off duty'. An external area should also be provided to ensure that staff have the opportunity for a breath of fresh air in their day.

	   Images: Brent Birth Centre, The West Centre, Advance Dental Centre

3 Non-Negotiables for Visitors/Carers/Dependents

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

Agreed Non-Negotiable Investment Objective	Benchmark Standard – The criteria to be met and/or some views of what success might look like
No additional needs identified	

4 Alignment of Investment with Policy

Agreed Non-Negotiable Investment Objective	Benchmark Standard – The criteria to be met and/or some views of what success might look like
4.1 The development would be a significant investment in Doune, and must contribute positively the appearance of the village and the amenity of routes and spaces.	• With the preferred site sitting between the established areas of the village and consented/planned developments in housing and amenity green space. The layout must provide easy and pleasant pedestrian connections between these areas encouraging access to green exercise. • The development must take cognisance of the surrounding area and foster good relationships with neighbours – ensuring that traffic impacts during construction and operations are minimised and that sufficient parking is provided on-site to prevent on-street parking becoming a nuisance.

	• The released site is on a key route from the high street to the school, and adjacent to the fire service. Long term vacancy on this site would be detrimental to the appearance of the village. Opportunities will be sought to work with partners in the public sector to ensure the early redevelopment of this plot into an attractive and appropriate amenity, or ensure any sale for private use results in a visually attractive development.
4.2 The development strategy must identify how services could be expanded on the site should additional housing be consented or other demographic changes increase demand in the immediate locality.	• Flexibility of structure and services needs to be built into the design of the building. Types of accommodation to be located logically to allow for flexibility between uses/types of care eg clinical areas and office areas and specifications to be such to allow use by all on an ad hoc or more permanent basis. In general 10% expansion space to be allowed.
4.3 The development must be resource efficient and easy to clean and maintain	• BREEAM accreditation – Excellent rating to be achieved. • Every opportunity to be taken to implement sustainable building solutions, particularly where these are linked to carbon reduction and energy saving measures • Surfaces/finishes to be durable and easy to clean: use of the HAI-Scribe process and input from Infection Control advisors is essential. • Service routes to be planned appropriately with safe access and to allow maintenance/replacement without undue disruption to service users/providers. FM routes should be separate from public ones. • M&E systems to be specified with due attention to lifecycle costs, ease of maintenance, replacing fittings etc.

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

Doune Health Centre GP Practice
Representation from the GP Practice Patient Forum
Stirling Community Healthcare Partnership
NHS Forth Valley Estates & Facilities

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SELF ASSESSMENT PROCESS – V1 AT INITIAL AGREEMENT STAGE

Decision Point	Authority of decision	Additional skills or other perspectives	How the above criteria will be considered at this stage and/or valued in the decision Information needed	Information needed to allow evaluation
Site Development Strategy	Decision by NHS with advice from the Steering Group		Analysis considering the capacity of the proposed site to deliver the required development including fulfilling the above criteria	Feasibility study based on the best available information to be developed.
Completion of brief to go to market	Decision by the NHS with advice from the Project Director	Stakeholders including service providers and internal technical advisors	Inclusion of the Design Statement in the brief	Early engagement with hubco and their process to assess the affordability/ deliverability of the brief
Selection of Delivery/Design team	Decision by the NHS with advice from the Project Director	Stakeholders including service providers and internal technical advisors as appropriate	Selection process per hubco method statements to be applied, with quality and cost considerations, to ensure that the best design team for the development is chosen from the hubco Supply Chain. Designers will have already been through a qualification process to become part of the Supply Chain. 'Participant' will be involved in the selection process for the project and can influence the outcome including, if necessary, nomination of other designers for consideration.	Previous experience/ examples of the designers' work on similar commissions. Interview process to include presentation/ questions regarding design approach and potential to fulfil the set criteria. Careful consideration will be given to the quality criteria set.

Selection of early design concept from options delivered	Decision by the NHS with advice from the Project Director		AEDET or other assessment of options to determine whether they meet the criteria	Proposals developed to Stage 3 with sufficient detail to allow distinction between the main uses of the building(s) including circulation and external space. Elevations/3D visuals.
Approval of design proposals to be submitted to planning authority	Decision by the NHS with advice from the Project Director	NDAP Assessment	AEDET or other assessment of the proposals to determine whether they meet the criteria	Selected design to Stage 4 with elevations etc.
Approval of detailed design proposals to allow construction	Decision by the NHS with advice from the Project Director		AEDET or other assessment of the proposals to determine whether they meet the criteria	Design developed to Stage 5 with agreed specification.
Post occupancy evaluations	Consideration by appropriate internal governance groups with report to SGHD	Independent analysis by service providers, potential third party evaluation.	Assessment by stakeholders to determine whether the completed development met the set objectives.	

SELF ASSESSMENT PROCESS

REVIEWED AT OUTLINE BUSINESS CASE STAGE

Decision Point	Authority of decision	Additional skills or other perspectives	How the above criteria will be considered at this stage and/or valued in the decision Information needed	Information needed to allow evaluation
Site Development Strategy	Decision by NHS with advice from the Steering Group		Analysis considering the capacity of the proposed site to deliver the required development including fulfilling the above criteria.	Feasibility study based on the best available information to be developed.
OBC Review *Project Director advice following stakeholder engagement on the form of the building, confirmation of the Schedule of Accommodation, site analysis etc – site capacity confirmed with future development zone, horizontally at the 'courtyard'. Initial Site Plan developed including parking, waste, external access.*				
Completion of brief to go to market	Decision by the NHS with advice from the Project Director	Stakeholders including service providers and internal technical advisors	Inclusion of the Design Statement in the brief	Early engagement with hubco and their process to assess the affordability/ deliverability of the brief
OBC Review *Design Statement issued as part of New Project Request Process to hubco and Tier 1 Contractor and Affordability Cap calculated in liaison with Hub East Central Scotland and used in the OBC.*				

Selection of Delivery/Design team	Decision by the NHS with advice from the Project Director	Stakeholders including service providers and internal technical advisors as appropriate	Selection process per hubco method statements to be applied, with quality and cost considerations, to ensure that the best design team for the development is chosen from the hubco Supply Chain. Designers will have already been through a qualification process to become part of the Supply Chain. 'Participant' will be involved in the selection process for the project and can influence the outcome including, if necessary, nomination of other designers for consideration.	Previous experience/ examples of the designers' work on similar commissions. Interview process to include presentation/ questions regarding design approach and potential to fulfil the set criteria. Careful consideration will be given to the quality criteria set.
OBC Review *Participant involvement in the Supply Chain selection process for the project from issue of information through evaluation of responses and interview/selection. Previous experience considered, eg selected Architect has recent experience of small scale health centre development delivered via hub.*				
Selection of early design concept from options delivered	Decision by the NHS with advice from the Project Director		AEDET or other assessment of options to determine whether they meet the criteria	Proposals developed to Stage 3 with sufficient detail to allow distinction between the main uses of the building(s) including circulation and external space. Elevations/3D visuals.

OBC Review *Initial proposals developed. Stakeholder review taken place, clinical and technical of proposals (internal layout and site plan with externals), also presentation at public stakeholder event. AEDET process ongoing with workshop 15 January 2016, further workshops will take place at appropriate milestones.*				
Approval of design proposals to be submitted to planning authority	Decision by the NHS with advice from the Project Director	NDAP Assessment	AEDET or other assessment of the proposals to determine whether they meet the criteria	Selected design to Stage 4 with elevations etc.
OBC Review N/A				
Approval of detailed design proposals to allow construction	Decision by the NHS with advice from the Project Director		AEDET or other assessment of the proposals to determine whether they meet the criteria	Design developed to Stage 5 with agreed specification.
OBC Review N/A				
Post occupancy evaluations	Consideration by appropriate internal governance groups with report to SGHSCD	Independent analysis by service providers, potential third party evaluation.	Assessment by stakeholders to determine whether the completed development met the set objectives.	
OBC Review N/A				

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Appendix E – Proposed Site Plan

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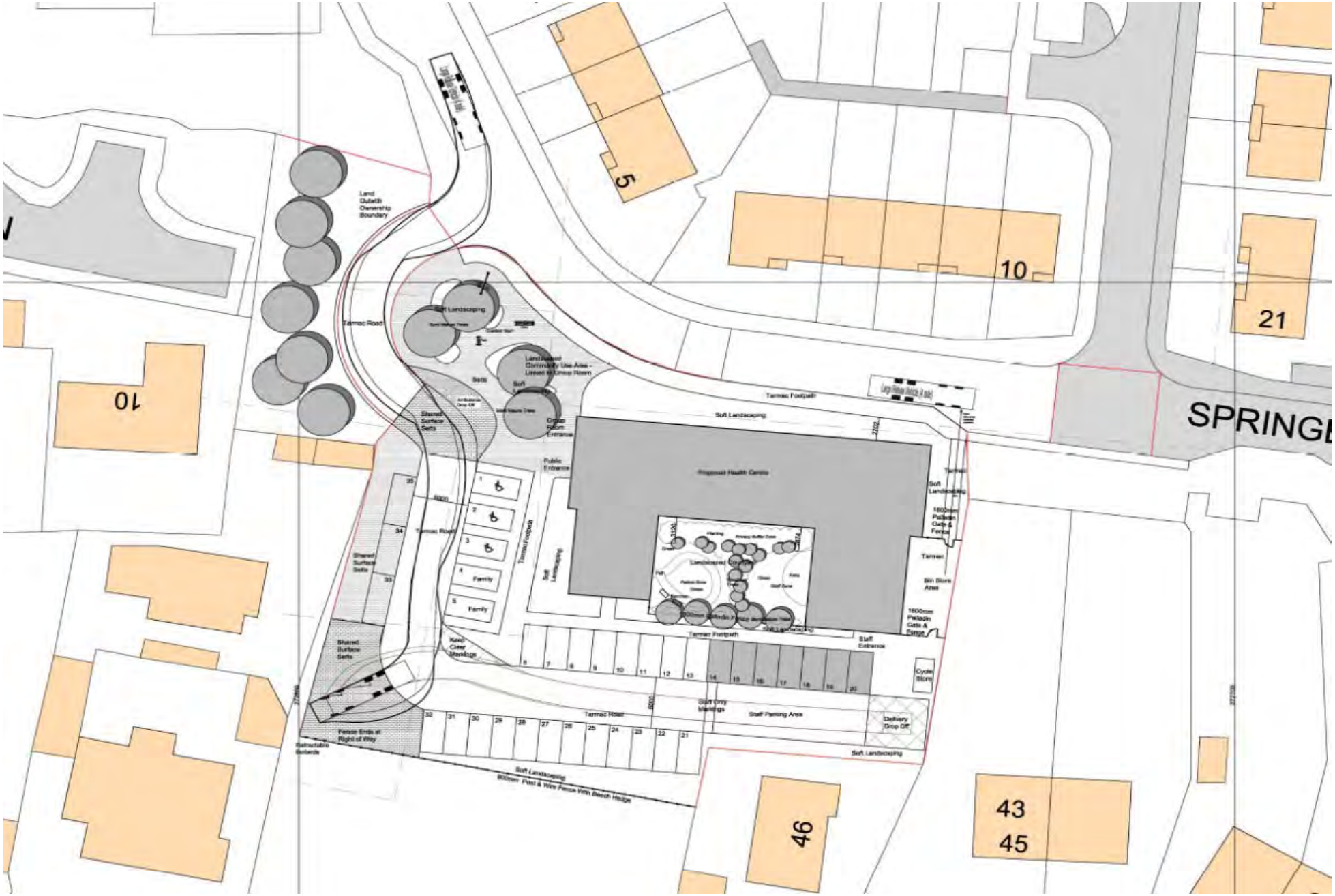
Land Outwith Ownership Boundary
Tarmac Road
Soft Landscaping
Shared Surface Setts
Group Room Entrance
Public Entrance
Tarmac Footpath
Soft Landscaping
Proposed Health Centre
Tarmac
Bin Store Area
1800mm Palisade Gate & Fence
Staff Entrance
Cycle Store
Staff Only Markings
Staff Parking Area
Delivery Drop Off
Kerb Clear Markings
Family
Tarmac Road
Tarmac Footpath
Soft Landscaping
Retractable Bollards
Timber Post & Wire Fence With Beech Hedge
5
10
21
SPRINGF
10
46
43
45

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Appendix F – Value for Money Scorecard

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VALUE FOR MONEY SCORECARD

Doune Health Centre

Version 1.0

18 January 2016

PROJECT SUMMARY

Project Name:	Doune Health Centre	
Health Board:	NHS Forth Valley	
Local Authority:	N/A	
Total Project Cost:	£1,944,614	(Incl NHS Direct Costs)
Hubco Affordability Cap:	£1,792,473	
Hubco Current Project Cost:	£1,792,473	(Equivalent to the Affordability Cap)
Site Abnormals:	£0	
Gross Internal Area:	569	m2
Nr of GP's:	3	nr
Car Parking Spaces:	35	nr
Storey's:	1	nr

1.0 SUMMARY OF METRICS	Upsized Metric	New Project (Excl Abnormals)	Diff +/-
Total Project Cost *(£/m2)*	£3,222	£3,421	£199
Prime Cost *(£/m2)*	£1,895	£1,487	-£408
Area Per GP *(m2/GP)*	160	156.87	-2.73
Ratio Support Space *(Ratio)*	1:3	2.7	-0.34
Life Cycle *(£/m2)*	£18.00	£18.00	£0.00

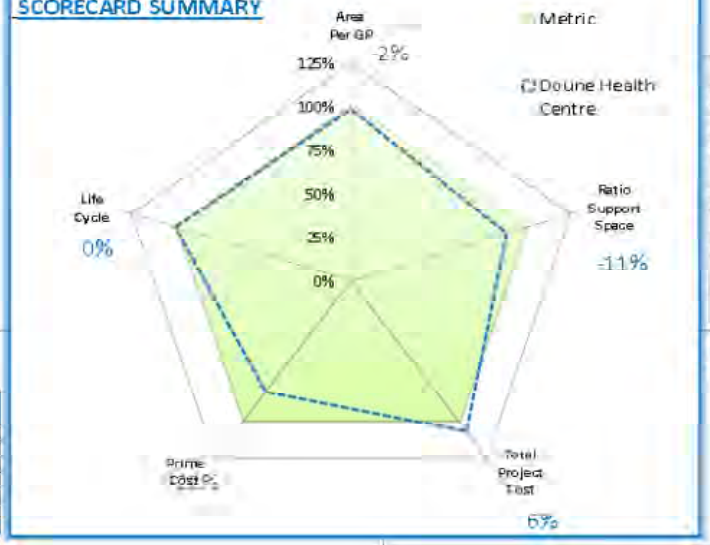
PERFORMANCE METRICS

5.0 Cost Metric	Metric at 4Q 2012		Updated Metric at FC	
	Base	4Q2012	FC Date	2Q 2016
	Project Cost £/m2	Prime Cost £/m2	Project Cost £/m2	Prime Cost £/m2
<1000m2	£2,550	£1,500	£3,222	£1,895
1,001 – 5,000m2	£2,350	£1,460	£2,969	£1,832
5,001m2>	£2,250	£1,400	£2,843	£1,769

Inflation Uplift:	26.84%
Area Metric B	1:3

6.0 Area Metric A	
Nr of GP	Area/GPm2
3	160
4	152
5	137
6	130
7-9	123
10-11	116
12-16	109
17-20	105
21>	100

SCORECARD SUMMARY



Description Of Scorecard

Area Per GP - Area per GP's based on banding listed within table 6. This refers to the Nr of GP's and not practices. This measures the space efficiency of the new project.

Ratio Of Support Space - Ratio of Clinical provision versus circulation and support space. Metric of 1m2 of clinical equal to 3m2 of support space. Metric equal to 1:3. Refer to table 7.0 below. This measures the space efficiency of the new project.

Total Project Cost - £/m2 rate for total cost for new project. Metric rates outlined in table 5.0 above.

Prime Cost (Excl Abn) - £/m2 rate for total cost for work packages for the project excluding external works. Metric rates outlined in table 5.0a above.

Life Cycle Cost - Metric of £18/m2 against new project based on standard service spec

FINANCIAL ASSESSMENT

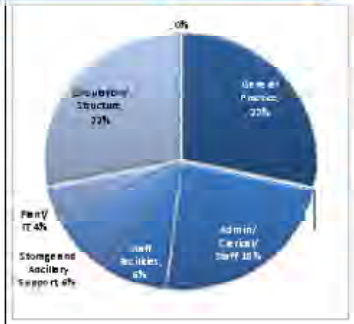
2.0 Abnormals	Elem	Prime	Fee's	Total Adjustment
				£0
				£0
				£0
				£0
				£0
				£0
Total		£0	£0	£0

3.0 Total Project Cost Breakdown	Total (Incl Abnormals)	Rate £/m2	Total (Excl Abnormals)	Rate £/m2
Substructure	£66,687	£116	£66,687	£116
Superstructure	£361,462	£635	£361,462	£635
Finishes	£69,974	£123	£69,974	£123
Fittings & Furnishing	£76,495	£135	£76,495	£135
M&E	£271,679	£478	£271,679	£478
Prime Cost	£845,296	£1,487	£845,296	£1,487
External Works	£303,286	£533	£303,286	£533
Project Fees (Design, surveys, Hubco fee)	£643,891	£1,133	£643,891	£1,133
Hubco Affordability Cap	£1,792,473	£3,153	£1,792,473	£3,153
NHS -Decant/Management	£10,000	£18	£10,000	£18
NHS - Contingency	£142,141	£250	£142,141	£250
TOTAL PROJECT COST	£1,944,614	£3,421	£1,944,614	£3,421

4.0 FM & LCC	Metric	Actual	Diff
Life Cycle Cost	18	18	0.00
Hard Facilities Management	19	19	0.00

Items	%	£
Post FC Risk	1.8%	£13,893
Pre FC Risk	0.0%	
NHS Cost	7.6%	£150,926

NHS Board Commentary on Financial Assessment



AREA METRIC ASSESSMENT

7.0 Functional Area	Area	%
General Practice	127	22%
Other Health Services	29	5%
Local Authority	0	0%
Patient Interface	94	16%
Admin / Clerical/ Staff	105	19%
Staff Facilities	34	6%
Storage and Ancillary Support	34	6%
Plant/ IT	21	4%
Circulation/ Structure	126	22%
Total GIA	569	100%
Omit Abnormals		
GP & Other Health Services	-156	
LA Facilities (Incl circ/plant)	0	-
Nett Support Space	412	Diff
Ratio Clinical vs Support Space	1: 2.7	0.3

Nr of GP	Metric (m2/GP)	Actual (m2/GP)
3	160	157

NHS Board Commentary on Area Provisions

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Appendix G – Draft Benefits Realisation Plan

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Doune Health Centre – DRAFT Benefits Realisation Plan

This Benefits Realisation Plan (BRP) is a fundamental part of this project, running from the project's beginning to its end, and beyond. The aim is to ensure that the intended benefits from the project are delivered and that the resources allocated to the project are fully utilised. The BRP is also intended to demonstrate how the investment in this project is contributing to overall service improvement for the partners in the project. By focusing on benefits realisation planning, the partners will be able to track whether intended benefits have been realised and sustained after the end of the project. Furthermore, it helps to ensure a clear signposting of who is responsible for the delivery of those benefits.

The benefits realisation plan will be reviewed and updated through the development of the Full Business Case and at regular intervals once the project has been completed. This will help to monitor the changes made as a result of the project and if necessary enable corrective action to be taken to ensure that the original benefits are being achieved.

Investment Objective: **Service Integration -** deliver joint working between the NHS, local authorities and other partners						
Benefit	**Stakeholders impacted**	**Enablers required to realise benefit**	**Outcomes displayed if benefit realised**	**Current baseline measure**	**Who is responsible**	**Target Date**
Delivery of more effective care with improved user outcomes	Patients /Service users/Unpaid Carers	Deliver service redesign influenced by public involvement	Network enabling access to high quality, safe and cost effective services as locally as possible. More people supported to live well in their own home	Percentage of population living at home.	Integration Joint Board *	Annual Report
Greater collaboration between partner organisations to improve effectiveness of preventative and intermediate care	Patients/ Service users/Unpaid Carers All Health and Social Care Providers	Deliver service redesign influenced by public involvement	People are able to look after and improve their own wellbeing/living for longer. People are able to live independently and at home.	Emergency admission rates Achievement of delayed discharge target Rate of admission to Care Homes	Integration Joint Board *	Annual Report

Investment Objective: **Service Integration** (continued) - deliver joint working between the NHS, local authorities and other partners						
Benefit	**Stakeholders impacted**	**Enablers required to realise benefit**	**Outcomes displayed if benefit realised**	**Current baseline measure**	**Who is responsible**	**Target Date**
Improved staff engagement & communication between partner organisations	Staff	Co-location, joint and integrated working,	Enabled partnership culture & care coordination. Effective coordination of care	Staff surveys Evidence of staff engagement. Provision of staff communications	Registered Manager Practice Managers/ Service Manager	Annual Report
Shared use of partner resources	NHS Board and partners in delivery of Health and Social Care	Co-location of service providers Flexible working arrangements	Facilitate new ways of working and delivery of care between partners	Evidence of integration: (a)Workforce (b) Management (c) Pooled budgets (d) Facilities.	Integration Joint Board *	Annual Report
Improved working arrangements and facilities for staff resulting in greater job satisfaction and less turnover / sickness	Staff	Modern, good quality accommodation.	Lower staff turnover and sickness rates. Number of staff in training and development.	Percentage of staff who would recommend their workplace as a good place to work.	Integration * Joint Board	Annual Report

Investment Objective: **Person Centred Care -** provide care that is responsive to individual personal preferences, needs and values and assuring that patient values guide all clinical decisions						
Benefit	**Stakeholders impacted**	**Enablers required to realise benefit**	**Outcomes displayed if benefit realised**	**Current baseline measure**	**Who is responsible**	**Target Date**
Positive experience of health and social care	Patients/Service Users/Unpaid Carers	Increased involvement in management of own condition(s).	Delivery of service redesign influenced by public involvement.	Percentage of users who feel respected, involved and consulted (Health and Social Care Experience Survey)	Integration Joint Board *	Annual Report
More people able to access care from their preferred location	Patients/Service Users/Unpaid Carers	Systematic support for long term conditions	Access to community resource and services	Proportion of care delivered locally	Integration Joint Board *	Annual Report
Better transition through each care journey	Patients/Service Users/Carers/Unpaid Carers	Implementation of continuity of care in all care pathways	Increase involvement in management of own condition(s).	Percentage of users who feel respected, involved and consulted (Health and Social Care Experience Survey)	Integration Joint Board *	Annual Report
Positive experience of the environment in which services are provided	Patients/Service Users/Unpaid Carers	Provision of good quality buildings and environment	Environment created where excellence & safety can flourish efficiently	6 Facet Survey information	Director of Estates & Facilities	PAMS review, annual

Investment Objective: **Improved access to treatment and services -** extend the access for the new model of care to include all those living within the Doune area						
Benefit	**Stakeholders impacted**	**Enablers required to realise benefit**	**Outcomes displayed if benefit realised**	**Current baseline measure**	**Who is responsible**	**Target Date**
More people able to access care from their preferred location	Patients/Service Users/Unpaid Carers	Systematic support for long term conditions	Enabled and convenient access to modernised services. Access to community resource with acceptable accommodation.	Percentage discharged home from Intermediate Care Proportion of care delivered for local population in Doune	Integration Joint Board *	Annual Report
Better transition through each care journey	Patients/Service Users/Unpaid Carers Service Provider Organisations	Implementation of continuity of care in all care pathways	Speedy access to modernised services Integrated service provision Increased “one stop” service provision	Percentage of users who feel respected, involved and consulted (Health and Social Care Experience Survey) GP Health & Care Experience Survey	Practice Managers	Annual Report
Maximised range of health and social care services available locally	Patients/Service Users/Unpaid Carers Service Provider Organisations	Integrated health and social care model of service provision	Service provision closely matched to needs	Demonstrable shifts in balance of care and use of resources and range of services available locally	Integration Joint Board *	Annual Report

Investment Objective: **Improved service effectiveness and efficiency -** achieve more effective use of resources across the public sector, particularly within the NHS and with local authorities and other partners. These resources include staff, buildings, information, and technology						
Benefit	**Stakeholders impacted**	**Enablers required to realise benefit**	**Outcomes displayed if benefit realised**	**Current baseline measure**	**Who is responsible**	**Target Date**
Affordable service delivery	NHS Board and partners in delivery of Health and Social Care	Integrated Health and Social Care Model implemented	Facilitating the use of technology to support both care and administrative processes.	Cost as measured by key financial performance indicators. IRF Cost Indicators	Finance Manager	Annual Report
Meeting service user preferences is more cost effective	NHS Board and partners in delivery of Health and Social Care	Efficient and effective service model	Increased service provision at same or lower costs	Cost as measured by key financial performance indicators	Finance Manager	Annual Report
Reduced demand for more expensive care pathways	NHS Board and partners in delivery of Health and Social Care	Shift in the balance of care	Shift in balance of care	Rate of admission and length of stay in Care Homes and hospital. Percentage of population with anticipatory care plans	Integration Joint Board *	Annual Report
Operational cost of building reduced	NHS Board	New more energy efficient construction, fittings etc, reduction in maintenance burden	Reduced running costs	Costs as reported in the Cost Book/PAMS	Director of Estates & Facilities	PAMS Review/ SAFR, annual

*Integration Joint Board or whichever group or individual is given delegated authority/function.

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Appendix H – Extract from Risk Register

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AmberBlue

Hubco Risk Register

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Ref No:	Risk Description	Risk Category Ref	Risk Category	Prior to Mitigation			Action Plan Completed?	Time / Cost Impact	Mitigation	Post Mitigation			
				Probability (1-5)	Impact (1-5)	Risk Rating (1-25)				Probability (1-5)	Impact (1-5)	Risk Rating (1-25)	Time / Cost Impact
1	May fail to identify appropriate Stakeholders	A	Clarity and Understanding of Client Brief and Objectives	3	4	12		T&C	Develop communications and engagement plan to determine all relevant stakeholders	1	4	4	T&C
2	May fail to engage with Stakeholders	A	Clarity and Understanding of Client Brief and Objectives	3	3	11		T&C	Implementing project governance structure and implement communications plan to ensure regular communication	1	3	3	T&C
3	Different Stakeholders with contradictory aspirations	A	Clarity and Understanding of Client Brief and Objectives	3	4	12		T&C	Implementation of engagement plan and consensus on an agreed brief and stakeholder	2	4	8	T&C
4	May not involve appropriate Professional expertise to develop the design (Design, Commercial, Clinical/Educational)	A	Clarity and Understanding of Client Brief and Objectives	5	5	25		T&C	Selection of design consultants with relevant appropriate experience to deliver project of similar nature	1	4	4	T&C
5	May fail to adequately determine the overall programme	E	Programme, Information Release, Decision Making, Timing and Adequacy	5	5	25		T&C	Continual agreement on programmes with Client, Tier 1 and design team on ability to deliver programme dates	3	4	8	T&C
6	Securing Funding from Scottish Government to deliver the project	D	Funding and Business Case Issues	5	5	25		T&C	Within NHS Boards plan to deliver, submitted to Government for review. Issue of revised initial agreement to outline case for project delivery	2	5	10	T&C
7	May fail to acquire Planning Permission	G	Planning, Statutory Approvals and Health & Safety	3	5	15		T&C	re-engage with Planning and maintain dialogue to ensure satisfactory design for planning approvals.	1	5	5	T&C
8	The Requirement Statement may fail to keep abreast with future Clinical Practices & Legislation	A	Clarity and Understanding of Client Brief and Objectives	3	4	12		T&C	Right people involved with initial development of brief and horizon scanner and consideration of future proofing and potential adaptation within the design	2	3	6	T&C
9	The Requirement Statement may be subject to uncontrolled Scope Creep	A	Clarity and Understanding of Client Brief and Objectives	3	3	9		T&C	Ensure brief is correct first time and implement management/change control measures to minimise changes to scope. Initial meeting with Estates to define initial scope of M&E design, look to freeze scope of design at earliest opportunity.	2	3	6	T&C
~~10~~	~~Changes to Building Regulations~~	~~G~~	~~Planning, Statutory Approvals and Health & Safety~~	~~3~~	~~3~~	~~9~~		~~T&C~~	~~Identify key dates for changes to regs implementations and manage programme dates to suit. Meeting dates dependent on OBC approvals and NRR submission. Current 2-4 month window of Building Reg changes. Risk increased post mitigation 02.02~~	~~3~~	~~3~~	~~9~~	~~T&C~~
11	The Options may fail to identify and address Site constraints, (environmental concerns, ground conditions).	M	Design and Specification	5	5	25		T&C	Carry out initial screening, obtain information in relation to site services. Develop scope of Ground investigations for site. Early results from SI indicate contamination on site. Develop strategy to deal with once full results known.	3	4	12	T&C
12	Delay to programme affecting Construction Inflation calculations within the affordability cap	D	Funding and Business Case Issues	3	3	9		T&C	Develop realistic programme for delivery. Obtain consensus for delivery of objective by project team. Allow for additional inflation percent within cost planning for any potential programme slippage. Programme developed accounting for	1	3	3	T&C
13	There may be a lack of resource (Funds, time or people) to complete the Business Case Document effectively	D	Funding and Business Case Issues	3	4	12		T&C	Identify relevant people and key dates for delivery of Business Case document. Secure support to produce documentation. Consider timescales for third party processes and programme target dates.	2	3	6	T&C
14	Road mouth is out with red line boundary on title deeds	F	Third Party and External Disruption to Operations	5	5	25		T&C	Identify landowner, obtain permissions to undertake work and identify within title report what prior rights there are. CLO to consider options for additional ownership of land assessing the site	5	5	25	T&C
15	Heras fence to rear of neighbouring business James Innes & Son appears to encroach on NHS land? Risk of disagreements over works access and extent of work on site	F	Third Party and External Disruption to Operations	3	3	9		T	Discussion with neighbouring stone mason to establish correct site boundaries. Consider provision of access during construction and beyond	3	4	12	T
16	Planning conditions are onerous and fall out with expected scope for dealing with site abnormals (traffic calming measures/observations area etc.)	G	Planning, Statutory Approvals and Health & Safety	3	3	9		T&C	Early discussions with Planning to ensure planning conditions are identified and are proportionate to the development. Meeting with planning indicated that no onerous conditions likely to be applied.	2	3	6	T&C

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				Prior to Mitigation						Post Mitigation			
Ref No.	Risk Description	Risk Category Ref	Risk Category	Probability (1-5)	Impact (1-5)	Risk Rating (1-25)	Action Plan Completed?	Time / Cost Impact	Mitigation	Probability (1-5)	Impact (1-5)	Risk Rating (1-25)	Time / Cost Impact
17	Right of way on site - interference with proposed development on the site	G	Planning, Statutory Approvals and Health & Safety	2	4	8		T&C	Develop site proposals to allow right of way to remain	1	3	3	T&C
18	No build zones from mains utilities - restriction of development in nearby area	H	Construction, Site Conditions, Ground and Weather	3	4	12		T&C	Consult with utilities to establish requirements and advise on proposed areas for development. Medium pressure main at north side of Boundary. Hand dig with 0GN to took place 05.02.15 to establish exact location, with results proving inconclusive. Further information identified Gas Main at 1.5m depth further hand digging required	3	4	12	T&C
19	Risk of contamination from previous use of site	H	Construction, Site Conditions, Ground and Weather	4	3	12		T&C	Carry out initial screening, obtain information in relation to site services. Develop scope of Ground Investigations for site. Early results from SI indicate contamination on site. Develop strategy to deal with once full results known.	4	3	12	T&C
20	Identify nature of future expansion; scope and type of service provision; failure to incorporate client requirements and time!	A	Clarity and Understanding of Client Brief and Objectives	3	3	9		T&C	Highlight future expansion provision within design. Stakeholder and Participant approval on provisions. MF advised that expansion to account for 2 additional consulting rooms. Arch to develop as part of design.	1	3	3	T&C
~~21~~	~~Overhead cables crossing site - diversions~~		~~#N/A~~	~~5~~	~~4~~	~~20~~		~~T&C~~	~~identify cables on site and requirement to manage any required diversions~~	~~5~~	~~4~~	~~20~~	~~T&C~~
22	Dialogue with NHS estates to inform the design preventing abortive design work	A	Clarity and Understanding of Client Brief and Objectives	1	1	1		T&C	Early engagement with NHS Estates and define scope of works to ensure compliance. Meeting held 20th Jan with Ian Minloch. Proposals to be further developed for feedback by NHS Estates. Further engagement scheduled to review design proposals.	1	1	1	T&C
23	hub support to meet key dates for submission of Business Cases and external approvals	D	Funding and Business Case Issues	2	1	2		T&C	Continual engagement with Participant and Stakeholders to identify resources and target key dates	1	1	1	T&C
24	Buried services at western perimeter of the site.	H	Construction, Site Conditions, Ground and Weather	4	4	16		T&C	Undertake further trial pits and trace to establish services and exact locations; GPR survey located existing services, action to be taken to determine whether these are active and potentially need to be	3	4	12	T&C
25	Wayleave Requirement for existing services - risk that no agreed wayleaves in place affecting time and programme	G	Planning, Statutory Approvals and Health & Safety	3	4	12		T&C	Establish what wayleaves in place and commence any required process at earliest opportunity. Place early order for incoming utilities and ensure that	2	4	8	T&C
26	Existing Drainage layout - risk that current assumptions differ resulting in additional drainage design requirements.	H	Construction, Site Conditions, Ground and Weather	3	4	12		T&C	As built information from DR Murray with DIA information to inform capacity requirements. Early contact to be made with Scottish Water	2	3	6	T&C
27	BREEAM - Time sensitive credits, risk that these are missed meaning lost credits affecting BREEAM rating	D	Funding and Business Case Issues	3	4	12		T&C	Discussion ongoing with Hulley & Kirkwood to clarify time sensitive credits at what stages and activities to be undertaken.	2	3	6	T&C
28	Potential Design, Time & cost implications as a result of implementation and compliance with Section 6 (Energy) of current Building Regulations as of Oct 2015	G	Planning, Statutory Approvals and Health & Safety	4	4	16		T&C	Engage with design team to implement an options appraisal of viable solutions to adhere to Building Regulation. Research existing solutions being	3	4	12	T&C
29	Potential design changes as a result of the energy strategy impacting on the planning and environmental design resulting in a chimney from the Biomass heating solution	G	Planning, Statutory Approvals and Health & Safety	4	4	16		T&C	Engage with design team to implement an options appraisal of viable solutions to satisfy planning and environmental health requirements.	3	4	12	T&C
30	Location of Gas Main and the designated exclusion zone of min 3m impacting on the position of the building	H	Construction, Site Conditions, Ground and Weather	5	5	25		T&C	Further information identified Gas Main at 1.5m depth further hand digging required to establish exact location provisionally scheduled for Jan	5	5	25	T&C
31	Impacts on programme from adjacent RSHA construction site using Doune HC site for access	H	Construction, Site Conditions, Ground and Weather	3	2	6		T&C	Close liaison with both developments to ensure that programmes are co-ordinated, continual communication between all parties	1	2	2	T&C

DRAFT

Appendix I – Letter of Stakeholder Support

DRAFT

Doune Health Centre

Doune

10th Nov 2015.

Re A New Health Centre for Doune.

In my capacity as Senior Partner at Doune, I write in support of NHS Forth Valley's project to build a new health centre in Doune.

General Practice is changing with a new GP Contract planned for Scotland in 2017. A model framework is already in discussion and this is aiming to introduce an expansion of the primary health care team, to include pharmacists, advanced nurse practitioners and more practice nurse support. In order to have any possibility of moving with the new direction for general practice we would need expanded new premises. Also the New Contract will address the need to work more closely with secondary care, to keep patients out of hospital with more care in the community. An expansion of services for this will be required, and space and facilities will be needed, a new health centre will enable us to offer more services locally. There would be facilities available for visiting secondary health care personal to use the new premises , for example, with the rise in the ageing population dementia care will need large expansion for the future and Doune has the potential to be a local base , allowing less travel for patients and more local services. This is just one example, other services could include physiotherapy, dermatology, dietetics, psychology and counseling.

In addition, the practice area has seen a large rise in new housing in the last 2 years. The list size has gone up from 3,200 patients to 4,000 patients, adding further pressure to our current inadequate premises.

Our current premises were built in 1972 and were designed for one doctor working at a time with one nurse. The practice now has 3 partners and 1 trainee at all times, and other periods 2 trainees, with 2 practice nurses and a full complement of district nurses and health visitor working out of the current premises. As a consequence, the current premises are very cramped , there is often standing room only in the waiting room, and a marked lack of patient privacy. There is a long term damp problem in one of the portacabins which leads to a constant odour. There are issues with infection control, patient access, parking and health and safety for staff and patients.

I, the practice team, and patient representatives have worked closely with the Health Board through the planning case, and design over the last 2 years, and we have agreed on a design of a new building which will meet our needs, and the patients needs for general practice care for the future. The practice is willing to accept the future costs which would accrue to the practice, as estimated and to be confirmed at financial close. I would urge full support for the proposed New Health Centre.

Dr Philip Rose

Forth Valley NHS Board

26 January 2016

This report relates to
Item 8.4 on the agenda

Proposed New Build Doune Health Centre
Draft Outline Business Case

(Presented by Mrs Fiona Ramsay, Director of Finance)

For Approval

SUMMARY

1. PROPOSED NEW BUILD DOUNE HEALTH CENTRE

2. PURPOSE OF PAPER

To present the Outline Business Case for the proposed new health centre in Doune for approval and, subject to completion of the required external assurance processes, submission to the Capital Investment Group.

3. KEY ISSUES

- The investment in facilities sought through this Outline Business Case is an important element of a larger programme of work to design and deliver healthcare services fit for the future consistent with NHS Forth Valley's previous and developing Healthcare Strategy. Investment in facilities in Doune has been identified as a priority.

- The existing health centre is generally overcrowded, not fit for purpose, inefficient and not capable of expansion to support the increasing demand for services.

- An Initial Agreement was developed for the project previously which identified a Preferred Way Forward for the project with a recommended direction of travel of a new building, following the initial assessment of the long list of options that were considered for the project. Although not formally approved by the Capital Investment Group, following submission of the Initial Agreement, the Board were asked to develop an Outline Business Case, including full option appraisal. The Outline Business Case concludes that a new building is the preferred option that should be taken forward.

- In line with business case requirements, a Design Statement has been developed and is appended to the Outline Business Case. Development of the Statement was facilitated by Architecture and Design Scotland (A&DS) and had input from the GP Practice, the CHP and a patient representative. The Design Statement has been through the formal assessment process and received 'supported' status at Initial Agreement Stage, it requires to be updated for the Outline Business Case and the next stage of the Design Assessment Process completed.

- Also in line with business case requirements, the 'value for money scorecard' has been updated and this is also appended to the Outline Business Case. This will require further interrogation and to be reviewed by and agreed with the Scottish Futures Trust.

- Both of the above 'assurance' processes (Design Assessment, vfm scorecard) require to be completed prior to the document being considered by the Capital Investment Group

- Net Additional Revenue Costs to the NHS Board have been estimated @ £0.071m per annum including £0.047m of additional capital charges. These figures are net of additional non reimburseable costs which require to be met by the Doune GP practice. The practice has provided confirmation that the financial implications are affordable to them and are keen to proceed with the development.

- The draft Outline Business Case was presented to the Corporate Management Team on 17 December 2015 and the Performance & Resources Committee on 22 December 2015 where it was supported for onward submission. Comments have been taken on board, in particular relation to health & social care integration, and the revised document is presented to the NHS Board. Further changes include the updated Risk Register and value for money scorecard.

4. FINANCIAL IMPLICATIONS

Indicative capital and revenue costs are as per the Outline Business Case, namely.
Capital : £2.4m projected construction costs plus £0.2m for Furniture, Fittings and Equipment
Revenue : Net Additional Revenue Costs of £0.071m per annum.

5. WORKFORCE IMPLICATIONS

None anticipated

6. RISK ASSESSMENT AND IMPLICATIONS

A Risk Register is in place for the project and an extract included within the Outline Business Case. The main risks at this time relate to programme and site issues (services and the access route).

7. RELEVANCE TO STRATEGIC PRIORITIES

The proposed new health centre is in line with national and local priorities in relation to the provision of care local to communities. In particular, it reflects the focus in NHS Forth Valley's strategic intent, away from the acute setting to primary and community care.

The proposed new health centre is in line with the Key Themes and Ambitions in the Clackmannanshire and Stirling Draft Strategic Plan (numbered 1 to 7) namely those in relation to early intervention and prevention (1); supporting service users to self manage and plan care pro-actively (2) and improving access to services and building capacity (7). The project thus aligns to the priority to reduce the number of unplanned admissions to hospital and acute services by supporting community based services.

The proposed development is also in line with the Board's Property & Asset Management Strategy, in which the existing premises in Doune are highlighted as a priority for improvement/investment.

8. EQUALITY DECLARATION

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

Further to an evaluation it is noted that: *(please tick relevant box)*
√ Paper is not relevant to Equality and Diversity
□ Screening completed - no discrimination noted
□ Full Equality Impact Assessment completed – report available on request.

9. CONSULTATION PROCESS

Consultation has taken place with the GP Practice and Community Health Partnership and with Finance Directorate colleagues. Engagement has taken place with the local Community Council in the form of meetings and written updates and with the Scottish Health Council. A public meeting was held in Doune on 6 January 2016, presenting the initial design proposals and updating on the progress of the project, which were received positively.

A general update on the project is to be presented at the Clackmannanshire & Stirling Integration Joint Board at their meeting on 26 January 2016 with a view to further engagement as the project progresses.

Consultation has also taken place with hub East Central Scotland Ltd, East Central Territory and Scottish Futures Trust in relation to the project in general and completion of the 'vfm scorecard' in particular in the case of the latter.

Architecture & Design Scotland facilitated the workshops in relation to the development of the Design Statement and they and Health Facilities Scotland formally assessed it at Initial Agreement stage and will be engaged in the next stage of the Design Assessment Process.

10. RECOMMENDATION(S) FOR DECISION

The NHS Board is asked to: -

- Approve the draft Outline Business Case for the proposed new build Doune Health Centre for onward submission to the Capital Investment Group, subject to completion of the outstanding assurance processes (Design Assessment and vfm scorecard).
- Agree to remit to the Director of Estates & Facilities completion of the assurance processes prior to consideration of the Outline Business Case by the Capital Investment Group.

11. AUTHOR OF PAPER/REPORT

Name:	***Designation:***
Morag Farquhar	Programme Director

Approved by:

Name:	***Designation:***
Tom Steele	Director of Estates & Facilities

Forth Valley NHS Board

26 January 2016

This report relates to
Item 9.1 on the agenda

Procurement Strategy 2015 - 2018

(Presented by Mrs Fiona Ramsay, Director of Finance)

For Approval

SUMMARY

1. DRAFT PROCUREMENT STRATEGY 2015-2018

2. PURPOSE OF PAPER & BACKGROUND

The proper management of procurement is an important factor contributing towards the efficient operation of NHS Forth Valley and the attainment of corporate objectives. In order to support steps already underway to deliver better healthcare, it is vital to staff and patients that products and services are delivered at the highest quality and optimum value, within systems tested as fit for purpose at point of delivery, whilst managing risk and due diligence.

NHS Forth Valley first introduced a Procurement Strategy in 2012 and this paper seeks to update the Strategy.

Contextually Procurement is governed by the Scottish Public Sector Procurement Directorate and in Health through NSS National Procurement and on to Local Health Board Procurement. In this context the strategy seeks to acknowledge the requirements of the national procurement structures but importantly renew our local focus on efficiency and effective management of procurement spend.

The refreshed strategy also takes into account CEL 05 (2012) dealing with Key Procurement Principles, the recent The Procurement Reform (Scotland) Act 2014 along with New Public Contracts Regulations 2015 which will come into force from April 2016.

3. KEY ISSUES

The refreshed Strategy picks up NHS Forth Valley's efficiency plans and the renewed focus on the key elements of the new Legislation and Regulations which include:-

- Financial and efficiency plans
- The requirement for a robust NHS Forth Valley ordering, deliver and payment process – end to end
- Requirements for Public procurement processes to be transparent, streamlined proportionate, standardised and business friendly. Making it easier for businesses, particularly newer businesses, Small and Medium sized Enterprises (SMEs) and the Third Sector to access public contract opportunities and sub-contracting requirements
- Smarter use of public procurement to encourage innovation and growth
- Taking account of social and environmental sustainability issues through public procurement
- Target of 85% of undisputed invoices paid within 10 days and 100% of paid invoices 30 days
- A focus on Information to support efficient procurement
- A requirement to maximise the use of nationally negotiated contracts

4. FINANCIAL IMPLICATIONS

The Strategy will support the overall financial and efficiency strategy of the NHS Board by focussing on efficient and effective buying and consumption of non pay items.

5. WORKFORCE IMPLICATIONS

None

6. RISK ASSESSMENT AND IMPLICATIONS

Assessed as part of the operational plan of the Procurement Department

7. RELEVANCE TO STRATEGIC PRIORITIES

Part of the NHS Board's Financial Strategy as well as supporting the National Strategy and Regulatory Requirements.

8. RELEVANCE TO DIVERSITY AND / OR EQUALITY ISSUES

These areas are covered in the strategy to provide a positive impact.

9. CONSULTATION PROCESS

Approval by the NHS Forth Valley Procurement Steering Group, as well as National Consultation on Strategy contents and implementation requirements.

Corporate Management Team reviewed the draft strategy and endorsed for onward approval by the NHS Board.

10. RECOMMENDATION(S) FOR DECISION

The Forth Valley NHS Board is asked to:-

- Approve the Procurement Strategy 2015 – 2018

11. AUTHOR OF PAPER/REPORT:

Name:	***Designation:***
Jonathan Procter	**IM&T Director / eHealth Lead**

Approved by:

Name:	***Designation:***
Fiona Ramsay	**Director of Finance**

Draft
Procurement Strategy
2015 to 2018

Executive Director	Fiona Ramsay, Director of Finance
Responsible Director:	Jonathan Procter, IM&T Director/ eHealth Lead
Approved By:	Forth Valley NHS Board
Date Approved:	
Date for Review:	April 2017

Replaces Previous Version:	April 2012

Index

1. INTRODUCTION AND SCOPE

The proper management of procurement is an important factor contributing towards the efficient operation of NHS Forth Valley and the attainment of corporate objectives. In order to support steps already underway to deliver better healthcare, it is vital to staff and patients that products and services are delivered at the highest quality and optimum value, within systems tested as fit for purpose at point of delivery, whilst managing risk and due diligence.

NHS Forth Valley currently expends over £125 million p.a. on non-pay expenditure, this includes PPP expenditure of c£58m and Utilities and Estates (e.g. day work , maintenance and property) Expenditure of £6.5M. This leaves approximately £60.5m of annual revenue expenditure that is procured across the organisation including pharmacy expenditure of c£23m.

In relation to Estates (e.g. day work , property projects etc) , this is procured through the Strategic Properties and Projects Directorate with input and support from the procurement team on specific projects. Routine purchasing is handled through the estates departments and will follow the procurement principles to ensure consistency with the Board's Standing Financial Instructions (SFI).

This Procurement Strategy positions procurement activity visibly within the organisation establishing Board level commitment to and involvement in the management of the Board's procurement deliverables. It additionally sets out clear, measurable objectives and priorities for improvement which will be closely monitored. Progress against strategic objectives will be reported to the NHS Forth Valley Board through the Corporate Management Team.

The strategy addresses key procurement issues including compliance with CEL 05 (2012) i.e. Dealing with Key Procurement Principles, the Procurement Reform (Scotland) Act 2014 along with New Public Contracts Regulations 2015.

The strategy will be supported in line with management accountability structures and savings targets will in turn be reflected within the savings plans of Departments.

The strategy will additionally shape the Board's procurement procedures which set out the detailed operational controls governing procurement activity in a manner which meets the requirements of the Board's Standing Financial Instructions, Financial Operating Procedures and relevant procurement legislation.

Like many corporate support areas across the NHS in Scotland, the Procurement function is part of the National Shared Service Review Programme. The Programme will determine the future shape of Logistics and Procurement functions across Scotland to meet the improving health objectives as well as driving efficiency and best practice. As these plans develop our Strategy will be reviewed and updated.

The emerging picture of Health and Social Care Integration across Forth Valley will be kept under review and the Strategy will be updated accordingly.

The principles of this strategy encompass all relevant procurement activity undertaken by the Board.

2. ROLES AND RESPONSIBILITIES

The Director of Finance is accountable to the Board for the achievement of the objectives associated with the procurement strategy. Specific responsibility for the delivery of the strategic objectives is vested in managers who are professionally accountable in relation to procurement activity. Through the Lead Director for Procurement and The Head of Procurement, they are expected to review spend that is able to be influenced and develop formal plans to ensure spend is appropriately managed through a single procurement gateway, in line with public procurement reform best practice, for the delivery of the strategic objectives.

Pharmacy work In line with pharmacy professional standards, medicines procurement is managed by pharmacy. Quality assured medicines are procured through robust and appropriate processes, with NHS National Procurement the main source of procurement support for pharmacy medicines procurement in NHS Forth Valley. As described in this Procurement Strategy the NHS Forth Valley Procurement Department will continue to work collaboratively with the Pharmacy and other departments to ensure that assistance, guidance, consistency of standards and best practice is captured, shared and maintained.

Progress with the Procurement Strategy will be reported through the Corporate Management Team (CMT) on a quarterly basis. An overview of the Governance and Reporting Lines is presented in **Appendix 1.**

3. STRATEGIC ALIGNMENT

To ensure effective alignment through organisational strategies the following national and local strategies are referenced and have been taken into consideration in formulating this strategy.

3.1 NHS Forth Valley Strategy, Vision and Values

Strategic Aims

- Contribute to closing the health inequalities gap within a generation
- Improve health life expectancy by supporting people to look after themselves
- Ensure that services meet agreed quality standards, especially patient experience
- Be cost effective in all decisions, actions and services

Vision

- Safe, effective and person-centred care which supports people to live as long as possible at home or in a homely setting, the 20/20 Vision.

Values

- Committed Team Member
- Ambitious
- Supportive

- Person Centred
- Respectful
- Integrity

Effective and efficient procurement makes a key contribution by optimising the resources available for local health priorities.

1. Improving experience of Care

1 *Build a greater understanding of the service needs to support the improvement in patient care.*

Evidence to support this aim can be demonstrated in a number of ways:-

- Customer Survey
- Technical User Groups

2 *Work through structures to test interventions to enhance organisational capacity to improve quality of patient care. And*

3 *Ensure we buy the "right thing" for the patient rather than buy in the "right way".*

Evidence to support these aims is through the development of the role of a Clinical Procurement Specialist who has engaged a wide range of stakeholders to learn, train and consult on product use and requirements.

2. Ensuring the best use of money

The Main Aims of the Strategy are to deliver: -

- *Lower Prices.*
- *Cost avoidance/Preventable Spend.*
- *Reduced waste and variation.*
- *Process efficiencies.*
- *Lower operating costs.*
- *Improved affordability/VfM.*
- *Value of RTC (Releasing Time to Care) efficiency.*

Strategic Objective 1:

Consistent Review of Best Use of Nationally Agreed Contracts –

All organisational National Contract up take will be reported, monitored and assessed.

3.2 Review of Public Sector Procurement in Scotland

John F. McClelland's "Review of Public Procurement in Scotland" in 2006, commonly referred to as the McClelland Report, outlined the path to "Best Value" in Public Sector Procurement and contained attributes and performance assessment metrics for organisations to aspire to and map their way to superior performance. NHS Scotland has

used the McClelland Report as a basis for its Reform Programme and to develop its reform agenda aligned with Scottish Government and its Public Procurement Reform Programme.

There is an accepted principle all of an organisation's non-pay expenditure should be subject to professional procurement influence and that is a measurable aspiration. This has been further developed and expanded by the recent Procurement Reform (Scotland) Act 2014 which is due to come into Law in April 2016 the main additional focus that the Act are transparency of procurement (e.g. annual report) , supporting opportunities for Small , Medium sized Enterprises (SMEs) and the requirement to publish more widely previous agreed contracts and plans of work for the following 2 years.

Within NHS Forth Valley there are c200 contracts which are managed and operated through the Procurement department including nationally agreed contracts.

A focus of NHS Scotland's drive to attain "Best Value" is the use of a Procurement & Commercial Improvement Programme (PCIP). This was formerly known as the Procurement Capability Assessment (PCA) and is conducted annually assessing performance in terms of the attributes outlined in the McClelland report.
These attributes accumulate to provide an overall Procurement Status for each organisation evaluated in 4 key categories of "Non Conformance", "Conformance", "Improved Performance" or "Superior Performance".

The 2012/13 cycle was the seventh annual assessment of procurement activity in Health within Scotland. NHS Forth Valley retained an overall Procurement Status of Superior Performance, demonstrating continuous improvement, evidenced by increasing total score from 75% to 83%. As a result of achieving a "Superior" assessment NHS Forth Valley were not subjected to a further review in 13/14. During 2014/15 the new PCIP arrangements were being formulated and therefore no assessments were carried out in Health during this period.

Recognition of NHS Forth Valley's positioning in such an assessment is merely the foundation to support the wider organisation meet its objectives in what will be a challenging financial future, but it is presented to reinforce confidence that the Procurement Team are in a strong position to do so.

Improvement action plans and associated work sessions on specific areas will continue to ensure continuous improvement and innovation as we move onto the new pan Public Sector PCIP.

Strategic Objective 2:

Continuous improvement and innovation - We will baseline NHS Forth Valley's performance rating within the PCIP process during the initial assessment of the new National Accreditation system.

In order to ensure top level support for Procurement activity and improvement in the organisation regular reports and reviews will be presented.

Strategic Objective 3:
NHS Forth Valley Board informed of progress and positioning - The Lead Director for Procurement will submit a Quarterly Report to the Corporate Management Team (CMT) and an Annual Report to the Procurement Steering Group prior to the approval and sign off at the Corporate Management Team.

3.3 CEL 05(2012) Key Procurement Principles

The Accelerated Procurement Initiative was established by the NHS Chief Executive Officers' Group in August 2010. The group recognised the essential nature of the engagement between procurement professionals and the wider Health Board teams to maximise the delivery of benefits for NHS Scotland and to ensure that appropriate professional input from across the service is provided to assist Best Value outcomes for procurement activity.

This work was developed further and is now controlled within the NHS Scotland Procurement Steering Group. The CEL 05 (2012) sets out the key principles of this engagement to be adopted by all Health Boards and Special Boards in Scotland with regards to Procurement activity.

In particular:-

- National, Regional and Local Contracts will be used as part of the strategy
- Where a contract exists then it must be used within the health board or exceptions noted and justified.
- Procurement, Clinical and Technical leads will work with National Procurement, Regional Procurement and Local Procurement to support these contracts and ensure best value decisions are made for the board on their use.
- Commodity Advisory Panels (CAPs) and Technical Users Groups (TUGs) will continue to function and progress reported through Procurement Steering Group.
- Wide coverage on all the various National, Regional and Local contracts will be maintained through the engagement of the TUGs and CAPs.

3.4 Supplier Development and Contract Management

A key element of the Procurement Reform Bill is that of supplier engagement and involvement and monitoring of key contracts. Through this strategy NHS Forth Valley have set out the following key aims:-

- **Health and Safety** -Contractors and sub-contractors will be required to comply with the Health and Safety at work Act 1974 (c37) and any provision made under the Act.
- **Contract Management** - Major Suppliers' performance will be reviewed quarterly with all aspects of performance assessed and improvements agreed.
- **Payment of Invoices** – NHS Forth Valley Payment terms will support the aims of Section 15 of the Procurement Reform (Scotland) Act 2014 with an aim to settle all invoices within 30 days. This is monitored through the financial KPIs and reported as part of the Health Boards Annual Report and Accounts and Procurement Annual Report.

3.5 National NHSS Procurement and Logistics Strategy

The National Procurement (NP) organisation is tasked with procuring and delivering a wide range of products and services to support Health Board in providing the highest levels of patient care and with promoting procurement reform within the sector, all underpinned with effective e-enabled technology solutions to allow Health Boards visibility and control of expenditure.

Forth Valley will collaborate with NP and take an active and lead role in the Health Procurement Delivery Group

In line with the national logistics strategy, NHS Forth Valley has adopted the National Distribution Centre (NDC) service. The model has been implemented which provides incentives to increase NDC activity in order to optimise NDC operating cost values and subsequent charge to Health Boards.

Strategic Objective 4:

NDC value optimised - Joint working of National Procurement (NP) and NHS Forth Valley officers will be evident. Progress is measured through quarterly analysis of the NP Management information.

NHS Forth Valley will continue to support and react to changes in organisational structure and systems in customer functions. An enhanced Customer Services Strategy will be developed which will utilise current call-handling technology, surveys as well as regular Directorate and Stakeholder meetings and engagement.

Strategic Objective 5:

Optimal customer service - Evidence of strong stakeholder and peer support will be apparent and an enhance Customer Service engagement plan will be in place.

4. STRATEGIC COMMODITY MANAGEMENT

Strategic Commodity Management is the concept and principles of a cross functional team approach to managing contracts. By leveraging skills and expertise as well as economies of scale, greater saving opportunities and value benefits can be achieved.

At a strategic level, comprehensive sourcing group strategies convert NHS Forth Valley's objectives into tangible plans that outline the current and future business changes required. Developing and documenting individual category or sourcing group plans enables all sourcing strategies to be considered together, allowing NHS Forth Valley to prioritise those that yield the greatest benefit across the organisation where a number of clinical areas may be impacted.

The approach followed identifies and quantifies opportunities and then develops a strategy to realise the benefits. Benefits are recorded in monetary terms and time-phased. In parallel, the team will consider the costs and investment associated with realising the benefits. This is evidenced through the local "Savings Benefits Tracker" and the "National Single Tracker" which is reported regularly through the Procurement Steering Group.

At an operational level, a documented sourcing group strategy underpins successful implementation. It converts robust analysis into actionable plans. The category group lead will include the high-level plan in the strategy, which identifies the main activities, timescales and cross-functional team member responsibilities, for both part and full-time members. In this instance, a documented sourcing group strategy acts as a consistent frame of reference on the approach being taken.

Technical user engagement is a key success factor and sourcing will be supported by user groups at appropriate local, regional and national levels. Whilst procurement must respond to user demand, the sourcing group teams also need to review how the supply market will change over the same period. The strategy defines what actions they need to take, in terms of relationship strategies and supplier development to ensure they are working with those suppliers that will support achievement of long term business plans.

The team will gain a clear understanding of how product/service specifications meet customer and both clinical and business needs. The potential rationalisation and standardisation of specifications may generate savings locally, regionally and nationally.

The foundation for this is an understanding of the cost drivers for both the supplier and NHS Forth Valley. One feature of the sourcing group strategy will be the improvement and integration of processes between NHS Forth Valley and its suppliers. This will be realised through the implementation of supplier capability and improvement initiatives.

Clear, consistent, categorised spend profiles that identify non compliant spend, including existing wholesaler pricing agreements will be developed.

Strategic Objective 6:

Consistent and professional management of expenditure – By implementing the Procurement Journey Toolkit, The Strategy will ensure that , across the three best value supply chain dimensions (*Purchase Demand Management; Supply Base Management and Total Cost Management,)* there will be a consistent approach in supporting Directorates to manage expenditure.

5. EXPENDITURE MANAGEMENT AND MANAGEMENT INFORMATION

Using enhanced information systems to inform users on expenditure and volume data will allow attention to be drawn to variation, waste and cost on a systematic basis.

The NHS Forth Valley Procurement team will provide managers with relevant and timely information to service performance. A key tool in delivering this key information will be the deployment of the National Procurement Activity and Cost Module.

An important part of cost and contract control is the implementation of Catalogue Management processes to support efficiency and best value.

Strategic Objective 7:

Support customers and budget holders – with the deployment of the National Information Module, the Procurement Team will provide Managers with information on :-

- Comparative product consumption and price trends
- Contract Compliance
- Opportunities for further efficiency through improved contract compliance

Strategic Objective 8:

Catalogue Management – In conjunction with the Clinical Procurement Lead and key service leads, the Procurement Team will put in place a plan to rationalise key product catalogues.

Although in 2012 NHS Forth Valley retained an overall Procurement Status of Superior Performance and demonstrated year on year improvement through the forerunner to the PCIP being the Procurement Capability Assessment, future performance will based upon the new PCIP which will take place in 2015/16.

The systematic use of improvement action plans and associated work sessions on specific areas will continue to ensure continuous improvement and innovation. NHS Forth Valley will be transparent by lodging all evidence on the Knowledge Hub website and assist other Boards in achieving improvement.

In addition a set of local Key Performance Indicators will be developed to augment those used to assess the level of service provided to NHS Forth Valley from the National Distribution Centre (NDC)

7. INTEGRATION, COLLABORATION AND SHARED SERVICES

Health and Social Care Integration is in progress with the 2 local Partnerships (Stirling/ Clackmannanshire and Falkirk), moving forward there will be more opportunities for joint procurement of services and the strategy will be developed to support these developments

The East of Scotland Procurement Consortium (ESPC) has been created to support regional working and collaboration in pursuit of procurement savings and sharing of best practice this will continue at least until the national review of Shared Services is concluded.

Focusing on the medium to longer term, the National Shared Services Review will be looking at options and models for logistics and procurement delivery for the whole of the health sector. The impact of this review will be reflected in an updated local strategy. In the meantime engaging in a voluntary collaborative approach will continue to harness opportunities either in physical cash savings or in shared approaches to local procurement.

8. QUALITY, RISK AND SYSTEMS OF ASSURANCE

The Procurement Steering Group, which is multi-disciplinary governs assurance and records NHS Forth Valley's position within the national Procurement & Commercial Improvement Programme (PCIP), The PCIP Programme has been adopted as the Quality Management System which is scrutinised independently and audited by Audit Scotland.

Risk registers are maintained in line with the Procurement Journey and the organisational risk assessment system is supported.

On an annual cycle Internal Audit review procurement positioning, performance and controls and advises the Audit Committee appropriately.

9. HAI AND INFECTION CONTROL

Procurement staff have a clear commitment in working with Clinical Directorates and Community Health Partnerships in supporting the Organisation's drive for on-going improvement on HAI and Infection Control. This commitment will include management responsibilities, personal objectives, action plans and regular review.

Procurement will work with the Infection Control Department on the selection of suppliers and products to meet the needs of preventing HAI within the health board.

This objective will be supported by National Procurement with any tactical and local minor capital purchases (e.g. dispensers') supported by the local Procurement team.

Strategic Objective 9:

Clinical stakeholders fully supported - In the achievement of the corporate HAI objective the Procurement Team will prioritise procurement support in this area.

10. MANAGEMENT OF CAPITAL EQUIPMENT EXPENDITURE

The Head of Procurement is a member of the Medical Devices group and will support the Director of Strategic Property Projects with the procurement of capital equipment advising on the best route to market and appropriate procurement legislation.

11. CORPORATE SOCIAL RESPONSIBILITY AND SUSTAINABILITY

Corporate Social Responsibility (CSR) defines a range of initiatives aimed at improving our ability to make positive impacts on society whilst reducing impact on the environment by improving and changing Procurement policy and practice.

Corporate and Social Responsibility (CSR) is summarised by the Chartered Institute of Purchasing and Supply as:
"the commitment to systematic consideration of the environmental, social and cultural aspects of an organisation's operations. This includes the key issues of sustainability, human rights, labour and community relations, as well as supplier and customer relations beyond legal obligations; the objective being to create long-term business value and contribute to improving the social conditions of people affected by an organisation's operations."

CSR activities include:

- Impact of Society and Community Involvement
- Equality, Diversity and Human Rights
- Green Policies and Sustainability
- Improve the health, wellbeing and education of our community by working with our Partners, Forth Health, in the provision of food supplied in our hospitals
- Supporting our colleagues in Health Promotions encouraging local businesses to sign up for a Health Check.
- Support Workplaces registered with NHS Healthy Working lives to reinforce and strengthen community health, safety and wellbeing and develop their own capacity for corporate social responsibility.
- Work to address health an employability partnerships in each of the community planning partnership.
- Support Local Employability Partnerships through providing Modern Apprenticeship opportunities.

- All new private contractors agree that they are willing to engage with NHD Healthy Working Lives.
- Ethics and Ethical Trading

NHS Forth Valley's Environmental Action Plan commits the organisation to account for sustainable procurement practices and processes and is measured by the Scottish Government's Flexible Framework for Sustainable Procurement.

Strategic Objective 10:

Ethical trading credentials will be improved – Via the National Invitation to Tender (ITT) process, we will develop and implement Ethical Procurement Policy.

12. WORKFORCE TRAINING AND DEVELOPMENT

All Procurement staff will have PDP/eKSF reviews on a planned basis. A Training Competency Matrix will be maintained in parallel with that of the main Procurement Team to ensure training is focused on core competencies for the appointed role. Succession plans and mentoring are included in personal objectives.

There is a commitment to improving the level of professionally qualified staff in-line with the recommendations of the McClelland Report. Staff undertaking the CIPS professional qualification will be given full support.

Strategic Objective 11:

Well trained and skilled staff – The procurement team ensure activity is compliant with the most current regulation and governance; formal and informal training and development will be encouraged and supported via the Health Board's EKSF and PDP review process.

13. KEY PERFORMANCE INDICATORS AND BALANCED SCORECARD

To ensure the department's performance is visible to Procurement Management and Stakeholders, a comprehensive set of Key Performance Indicators (KPIs) will be maintained. Progress will be reviewed at the Procurement Steering Group.

Strategic Objective 12:

Performance measurement – To match the needs of the Organisation, Regional and National Stakeholders. KPIs and Balanced Scorecard will be subject to quarterly review.

14. POLICY MANAGEMENT & MONITORING

Review

This strategy will be subject to ongoing review and formal regular review by Finance Director, the Lead Director and Head of Procurement. This will take account of any changes to organisational objectives and in NHS and Scottish Government policies and

strategies. This review will also take account of the key targets and National Framework objectives under development by the Procurement Steering Group.

Communication and Implementation Plan

This strategy will be published on the NHS Forth Valley Internet and Intranet Sites.

Monitoring

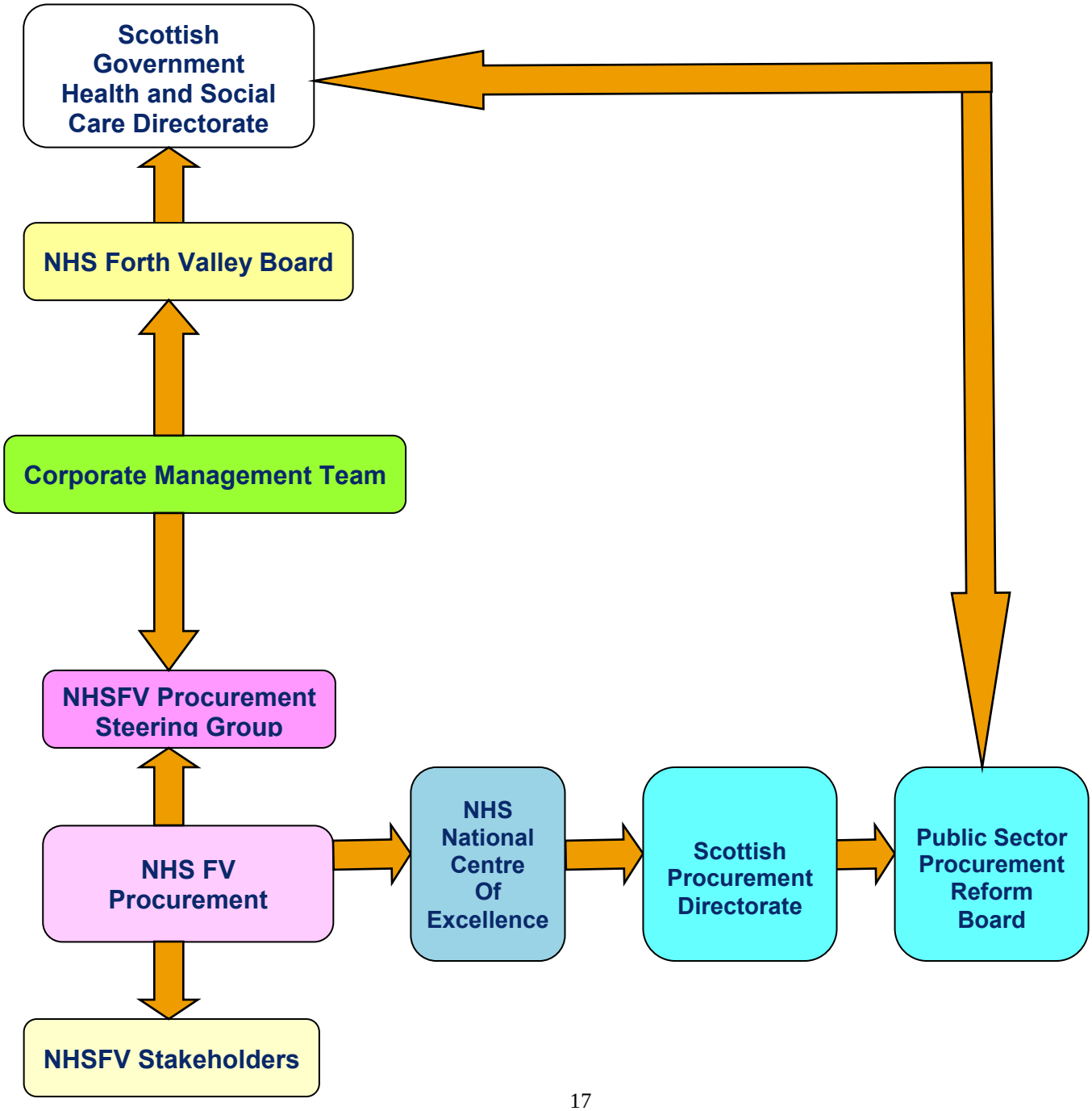
The objectives and targets contained in this strategy will be reviewed at Procurement Steering Group and reported to the Corporate Management Team.

APPENDIX 1

Appendix 1 shows the reporting lines to the various governance groups.

Reporting Lines

The diagram below (Diagram 1.0) illustrates the reporting lines for the Procurement Steering Group and associated governance relationships.



FORTH VALLEY NHS BOARD

26 January 2016

This report relates to
Item 9.2 on the agenda

Records Management Plan

(Paper presented by Miss Tracey Gillies, Medical Director)

For Approval

NHS
Forth Valley

RECORDS MANAGEMENT

1.0 Purpose of paper

The purpose of this paper is to present to the Forth Valley NHS Board the draft Records Management Plan (RMP) for NHS Forth Valley, as per the Public Records (Scotland) Act 2011. This considers work undertaken to assess our current position, the requirements of the RMP, including key decision points, and summarising next steps.

2.0 Importance of Good Records Management

The importance of good records management has been acknowledged as a corporate governance standard but was brought into sharp focus by the 2007 "*Historical Abuse Systematic Review of Residential Schools and Children's Homes in Scotland*" by Tom Shaw ('the Shaw Report'). A significant part of the Shaw Report focused on shortcomings of the legislative or regulatory framework, best exemplified by ageing public records legislation. Shaw revealed poor record keeping within the looked after children sector. It also identified problems for abuse survivors when attempting to trace records for purposes of identity, family or medical issues. It expressed a wider concern over record keeping problems throughout the sector. Shaw stated that his review "*pointed to an urgent need to take action to preserve historical records, ensure that residents can get access to records and information about their location".*

The recommendations of the Shaw Report and the subsequent 2009 review by the Keeper of the Records of Scotland led to the "Public Records (Scotland) Act 2011" in March 2011.

2.1 The Public Records (Scotland) Act 2011

The Public Records (Scotland) Act 2011 (the Act) came into force on 1 January 2013. Under the Act, all Scottish public authorities are required to manage their corporate records efficiently. Each authority must submit a formal records management plan (RMP) to the Keeper of the Records of Scotland (the Keeper) for assessment and agreement. All NHS Boards are being invited by the Keeper to submit their RMPs, giving a reasonable period of notice after this initial contact.

2.2 Legislation

The Act puts far greater emphasis on the importance of records management carrying the weight of legislation. Authorities who fail to submit a RMP when requested by the Keeper, or who fail to modify their plan for resubmission when returned, may be deemed to have failed in their obligations under the Act. The Keeper is obliged to report any such failure to Scottish Ministers.

2.3 Definition

In the Act, "public records", in relation to an authority, means:-

- Records created by or on behalf of the authority in carrying out its functions
- Records created by or on behalf of a contractor in carrying out the authority's functions
- Records created by any other person that have come into the possession of the authority or a contractor in carrying out the authority's functions

The Act defines a record as “Anything in which information is recorded in any form”. A record can be recorded in computerised or manual form or in a mixture of both. Data can be held on a range of media, including text, sound, image and/or paper. Increasingly records are being kept on electronic and document management systems. Records may include such things as hand-written notes; emails and correspondence; radiographs and other imaging records, printouts from monitoring equipment, photographs; videos and tape-recordings of telephone conversations.

Some documents need to be kept as evidence of business transactions, routine activities or as a result of legal obligations, such as policy documents. These should be placed into an official filing system and at this point, they become official records.

Under the legislation defined in the Act, it makes it clear that senior managerial responsibility for records is compulsory and covers both clinical and non clinical records and information.

2.4 Principles

The guiding principles of records management are to ensure that information is available when and where it is needed, in an organised and efficient manner, and in a well maintained environment. Records management offers tangible benefits to organisations, from economic good practice in reducing storage costs of documents, to enabling legislative requirements to be met.

2.5 Key Requirements

The RMP must set out proper arrangements for the management of the organisation’s records and be submitted to the Keeper for his agreement.

The RMP considers all 14 elements, six of which are compulsory, as advised in the Keeper’s Model RMP and supporting guidance material.

2.6 National Records of Scotland Assessment process

On receipt of the RMP the National Records of Scotland (NRS) Implementation team will begin the assessment process, considering each element of the RMP against all accompanying evidence. The Keeper regards the assessment as an opportunity to highlight good practice as well as identifying areas of current provision that may benefit from improvement.

On completion of the assessment, a report will be produced and submitted to the Chief Executive. This will indicate whether the Keeper has agreed the RMP or not. A copy of this report will be published on the NRS website. Although not compulsory, it is deemed good practice for the NHS Board to publish the RMP on their website.

2.7 Review

The Keeper urges all authorities to comply with the spirit of the Act by regularly reviewing and updating their plan. NHS Forth Valley understands that the Keeper may undertake a review of any authority to determine compliance with its records management plan. If an authority is deemed not to be compliant with its plan, the Keeper may serve an action notice on the authority setting out details of the alleged failure and requiring the authority to take specific action by a specified date.

3.0 Invitation from the Keeper of the Records of Scotland (the Keeper)

On 6 October 2015, the Chief Executive of NHS Forth Valley received an invitation from the Keeper requesting submission of the NHS Forth Valley RMP by **29 February 2016**. The Keeper also requested that the contact details for the person designated as having records management responsibility for NHS Forth Valley be provided as soon as possible.

3.1 Insight into practices

A pilot survey to provide insight into current records management practices, covering all types of media (e.g. paper/electronic) and all records type (e.g. health records, corporate records, departmental records) was undertaken in September 2015. The survey identified significant variation of practice across departments, e.g. differing filing methods, retention and destruction arrangements, audit arrangements and business continuity plans.

NHS FORTH VALLEY 'RECORDS MANAGEMENT PLAN'

4.0 NHS Forth Valley Records Management Plan (RMP) Requirements

The draft NHS Forth Valley's RMP *(Appendix 1)* sets out the overarching framework for ensuring that NHS Forth Valley records are managed and controlled effectively, and commensurate with the legal, operational and information needs of the organisation. The format is based on national guidance. The draft RMP incorporates a programme that will assist NHS Forth Valley in attaining records management compliance.

Every aspect of the NHS Forth Valley RMP must be approved. Sign-off is used as evidence that the submitted RMP accurately reflects the policies and practices implemented in the organisation. Initial focus has been given to compulsory elements. The need for ongoing improvement of quality, availability and effective use of records in NHS Forth Valley for all records management activities is vital to ensure that information is available when and where it is needed, in an organised and efficient manner, and in a well maintained environment.

Regular assessment and review of records management systems is required to ensure that practices are developed and conform to the Records Management Plan. Further work is also required to ensure that appropriate policies, e.g. Corporate Records Management Policy, are visible to staff and are adhered to. This should be supported by a specific records management communication plan.

4.1 Action Required

The key areas for consideration by the NHS Board include: -

- **Element 1 (compulsory) Senior Management Responsibility**,
- **Element 2 (compulsory) Records Manager Responsibility** and
- **Element 3 (compulsory) Policy Statement**, which is detailed in *Appendix 3.*

A review has been undertaken of what has been executed in other NHS Boards as they prepare their RMPs. It is proposed that the Senior Manager responsibility is undertaken by the ***Tracey Gillies, Medical Director***, and that the Records Manager responsibility undertaken by the ***Elaine Vanhegan, Head of Performance and Governance*** to lead on the development and roll-out of the plan, with appropriate

operational support. Technical expertise will be provided by ***Deirdre Coyle, Head of Information Governance***. This approach will also require all Directorates and Corporate Departments to nominate a key lead of sufficient seniority to ensure implementation of the RMP.

Element 4 – Business Classification Scheme – Note that a Business Classification Scheme for NHS Forth Valley requires to be developed.

Element 5 Retention Schedules, **Element 6 (compulsory) Destruction Arrangements** and **Element 7 (compulsory) Archiving and Transfer Arrangements**. Note that the Scottish Government Records Management Code of Practice is currently followed with regard to these elements, however adherence to this Code locally is variable. Note that no central register is held and that detailed local procedures require to be developed.

Element 8 (compulsory) Information Security Since publication of the Act, DL 2015 (17) has been circulated requiring review of information security. This will be taken forward in conjunction with implementation of the RMP.

Elements 9 – 14 These elements are either in development or under review and any action will form part of the RMP Implementation Plan.

9. **Data protection:** Policy in place, review of compliance ongoing.
10. **Business continuity and vital records:** For review with Civil Contingencies Team.
11. **Audit trail:** Core to good practice for implementation of the RMP – approach in development.
12. **Competency framework for records management staff:** Core to good practice for implementation of the RMP.
13. **Assessment and review:** Some assessment undertaken through the Information Governance Group, requires further review.
14. **Shared information:** Scottish Accord on the Sharing of Personal Information (SASPI) agreements in place.

A robust Implementation Plan will require to be developed against each of the elements. The CMT and the NHS Board will be kept updated of progress. All policies required for submission to the Keeper as evidence are being updated accordingly.

5.0 Recommendations

The Forth Valley NHS Board is asked to:

- Consider and agree the proposed individuals who will assume **Senior Manager** responsibility and **Records Manager** responsibility as detailed above, noting the operational support that will be required, and that this will also require all Directorates and Corporate Departments to nominate a key lead of sufficient seniority to ensure implementation of the RMP.
- Consider and agree the **Policy Statement** as detailed in Appendix 2.
- Note and support the work required to achieve compliance with all 14 elements of the RMP paying particular attention to those that are compulsory in the first instance.
- Approve the **Record Management Plan**, for submission to the Keeper by 29 February 2016

Appendix 1

DRAFT

NHS Forth Valley Records Management Plan

CONTENTS

Page No.

Introduction

Records management is the systematic control of an organisation's records , throughout their life cycle, in order to meet operational business needs, statutory and fiscal requirements, and community expectations. Effective management of information allows fast, accurate and reliable access to records, ensuring the timely destruction of redundant information and the identification and protection of vital and historically important records.

Effective records management involves efficient and systematic control of creation, storage, retrieval, maintenance, use and disposal of records, including processes for capturing and maintaining evidence.

Systematic management or records allows organisations to:

- know what records they have, and locate them easily
- increase efficiency and make effectiveness
- make savings in administration costs, both in staff time and storage
- support decision making
- be accountable
- achieve business objectives and targets
- provide continuity in the event of a disaster
- meet legislative and regulatory requirements
- protect the interests of employees, clients and stakeholders

The guiding principle of records management is to ensure that information is available when and where it is needed, in an organised an efficient manner, and in a well maintained environment.

The importance of good records management has been brought into sharp focus by the "2007 Historical Abuse Systemic Review of Residential Schools and Children's Homes in Scotland" by Tom Shaw ("the Shaw Report"). The recommendations of the Shaw Report and the subsequent 2009 review by the Keeper of the Records of Scotland led to the "Public Records (Scotland) Act 2011" ("PRSA") in March 2011.

The Act makes provision about the management of public records by named public authorities. Provisions include the preparation of a Records Management Plan ("RMP") setting out and evidencing proper arrangements for the management of the authority's public records, and its submission for agreement by the Keeper. Each Board's Health Records and Corporate Records Management Policies should provide further detail concerning standards for the management of records.

The PRSA defines a record as "Anything in which information is recorded in any form." A record can be recorded in computerised or manual form or in a mixture of both. Data can be held on a range of media, including text, sound, image, and/or paper. Increasingly records are being kept on electronic and document management systems. Records may include such things as hand-written notes; emails and correspondence; radiographs and other imaging records; printouts from monitoring equipment; photographs; videos; and tape-recordings of telephone conversations.

Public Records (Scotland) Act 2011 – Records Management Plan

Under the Public Records (Scotland) Act 2011, Scottish public authorities must produce and submit a records management plan setting out proper arrangements for the management of the organisations

records to the Keeper of the Records of Scotland for his agreements under Section 1 of the Public Records (Scotland) Act 2011.

NHS Forth Valley Records Management Plan (RMP) sets out the overarching framework for ensuring that NHS Forth Valley records are managed and controlled effectively, and commensurate with the legal, operational and information needs of the organisation. The RMP considers all 14 elements as advised in the Keeper's Model RMP and supporting guidance material. The 14 elements are:

1. Senior management responsibility
2. Records manager responsibility
3. Records management policy statement
4. Business classification
5. Retention schedules
6. Destruction arrangements
7. Archiving and transfer arrangements
8. Information security
9. Data Protection
10. Business continuity and vital records
11. Audit trail
12. Competency framework for records management staff
13. Assessment and review
14. Shared information

Each element details:-

- Introduction – Key requirement
- Statement of Compliance – Current Position
- Evidence of Compliance – Varying forms of evidence required, e.g. policies, guidance, minutes, etc
- Future Developments – Next steps to improve compliance
- Assessment and Review – NHS Forth Valley assessment of our compliance
- Responsible Officer(s) - Varied

The RMP defines NHS Forth Valley's Action Plan for improving the quality, availability and effective use of records in NHS Forth Valley and provides a strategic framework for all records management activities. Any outstanding actions will be incorporated into the relevant action plans to progress the work with overall progress monitored by the Corporate Management Team.

NHS Forth Valley Records Management Plan is effective from .....

Agreed by ..... Date.....

Jane Grant, Chief Executive, NHS Forth Valley

Element 1: Senior Management Responsibility

Introduction	A **compulsory element** of the Public Records (Scotland) Act 2011, Element 1: Senior management responsibility is the single, most important piece of evidence to be submitted as part of NHSFV's Records Management Plan. This element must identify the person at senior level who has overall strategic responsibility for records management within the organisation.
Statement of Compliance	The Senior Responsible Officer for Records Management within NHS Forth Valley is ***Tracey Gillies, Medical Director***.
Evidence of Compliance	Evidence in support of Element 1 includes: 1.1 Policy Statement from Chief Executive. 1.2 Minute of Forth Valley NHS Board meeting, 26.01.16, when agreement took place
Future Developments	There are no planned future developments in respect of Element 1. However, if the Senior Responsible Officer for records management were to change, policies and procedure would need to be updated in light of these changes.
Assessment and Review	This element will be reviewed as soon as there are any changes in personnel.
Responsible Officer(s)	***Tracey Gillies, Medical Director***

Element 2: Records Manager Responsibility

Introduction	A **compulsory element** of the Public Records (Scotland) Act 2011, Element 2: Records manager responsibility must identify the individual(s) within the organisation, answerable to senior management, to have operational responsibility for records management within the organisation.
Statement of Compliance	The officer with operational responsibility for records management within NHS Forth Valley is ***Elaine Vanhegan, Head of Performance and Governance***, with technical experience/support provide by ***Deirdre Coyle, Head of Information Governance.*** Supported operationally by an identified individual for each Directorate area of responsibility as listed in the Corporate Records Management Policy.
Evidence of Compliance	Evidence in support of Element 2 includes: 2.1 Records Management Job Statement/ Addendum to Job Descriptions 2.2 Minute of Forth Valley NHS Board meeting, 26.01.16, when agreement took place
Future Developments	Job statements to be prepared for the nominated individuals in each area. The Corporate Records Management Policy requires to be amended to reflect change of responsibility.
Assessment and Review	This element will be reviewed as soon as there are any changes in personnel.
Responsible Officer(s)	***Elaine Vanhegan, Head of Performance and Governance*** ***Deirdre Coyle, Head of Information Governance***

Element 3: Records Management Policy Statement

Introduction	A **compulsory element** of the Public Records (Scotland) Act 2011, Element 3: Records management policy statement must demonstrate the importance of managing records within the organisation and serve as a mandate for the activities of the allocated records managers. It is necessary in order to provide an overarching statement of the organisation's priorities and intentions in relation to recordkeeping, and deliver a supporting framework and mandate for the development and implementation of a record management culture.
Statement of Compliance	NHS Forth Valley is committed to a systematic and planned approach to the management of records within the organisation, from their creation to their ultimate disposal. This will ensure that NHS Forth Valley can: • Control the quality, quantity and security of the information that it generates; • Maintain that information in an effective manner whilst ensuring compliance with the recommendations of the appropriate authorities. NHS Forth Valley has an approved and current Records Management Policy that reflects the agreed structure for records management.
Evidence of Compliance	Evidence in support of Element 3 includes: 3.1 NHS Forth Valley Policy Statement, signed by Chief Executive 3.2 NHS Forth Valley Corporate Records Management Policy 3.3 The Health Records Management Policy 3.4 Minute of Forth Valley NHS Board meeting, 26.01.16, when agreement took place.
Future Developments	Establish a list of all record types for each Directorate.
Assessment and Review	This element will be informally reviewed by *Elaine Vanhegan*, *Head of Performance and Governance* on a regular basis. It will be formally reviewed by the responsible person and Corporate Management Team on an annual basis.
Responsible Officer(s)	***Tracey Gillies, Medical Director***

Element 4: Business Classification

Introduction	The Keeper expects an organisation to carry out a comprehensive assessment of its core business functions and activities, and represent these within a business classification scheme (BCS). It is expected that Element 4 should confirm that the organisation has developed or is in the process of developing a BCS.
Statement of Compliance	NHS Forth Valley recognises that the Business Classification Scheme (BCS) will become the keystone of the records management function within NHS Forth Valley. This will be developed and maintained in partnership with each unit and function to ensure that it meets specific operational requirements. The Business Classification Scheme will be based on the NHS Scotland template.
Evidence of Compliance	Evidence in support of Element 4 includes: 4.1 Business Classification Scheme – to be developed
Future Developments	Business Classification Scheme requires to be developed for the organisation by responsible officers although not a compulsory element this is critical for the organisation to ensure consistency Set up an information asset register.
Assessment and Review	This will be reviewed annually
Responsible Officer(s)	***Elaine Vanhegan, Head of Performance and Governance*** ***Deirdre Coyle, Head of Information Governance*** ***Record Management Officers in Directorates/departments***

Element 5: Retention Schedules

Introduction	Element 5: Retention schedules must demonstrate the existence of and adherence to corporate records retention procedures. These procedures must show that the organisation routinely disposes of information, whether this is destruction or transfer to an archive for permanent preservation. A retention and disposal schedule, which sets out recommended retention periods for records created and held by an organisation, is essential for ensuring that the organisation's records are not retained longer than necessary (in line with legal, statutory and regulatory obligations), storage costs are minimised (through the timely destruction of business information), and records deemed worth of permanent preservation are identified and transferred to an archive at the earliest opportunity.
Statement of Compliance	NHS Forth Valley adheres to the Scottish Government Records Management: NHS Code of Practice (Scotland) Version 2.1 January 2012 and other relevant guidance and standards. The NHS Forth Valley Corporate Records Management Policy, NHS Forth Valley Health Records Management Policy and NHS Forth Valley Financial Operating Procedures FOP 13 – Records Management draws on the guidelines specified in the Scottish Government Records Management: NHS Code of Practice (Scotland)
Evidence of Compliance	Evidence in support of Element 5 includes: 5.1 The Scottish Government Records Management: NHS Code of Practice (Scotland) Version 2.1 January 2012 5.2 NHS Forth Valley Corporate Records Management Policy 5.3 NHS Forth Valley Health Records Management Policy 5.4 NHS Forth Valley Financial Operating Procedures FOP 13 – Records Management
Future Developments	This element will be kept up to date in line with the national code of practice.Consistent detailed procedures should be developed for each Directorate/department. Set up and maintain retention schedules for each Directorate/department Identify and retain documents for permanent preservation in each Directorate/department. Establish procedures for managing documents that require to be permanently preserved.
Assessment and Review	Deirdre Coyle, Head of Information Governance and the identified Directorate support will be responsible for monitoring and reviewing the schedule every three months, ensuring that it continues to reflect recordkeeping best practice as well as legal and statutory obligations. A formal review of the schedule, will take place annually.
Responsible Officer(s)	***Elaine Vanhegan, Head of Performance and Governance*** ***Deirdre Coyle, Head of Information Governance***

Element 6: Destruction Arrangements

Introduction	A **compulsory element** of the Public Records (Scotland) Act 2011, Element 6: Destruction arrangements should evidence the arrangements that are in place for the secure destruction of confidential information. Clear destruction arrangements detailing the correct procedures to follow when destroying business information are necessary in order to minimise the risk of an information security incident and ensure that the organisation meets its obligations in relation to the effective management of its records, throughout their lifecycle.
Statement of Compliance	NHS Forth Valley adheres to the Scottish Government Records Management: NHS Code of Practice (Scotland) Version 2.1 January 2012 and other relevant guidance and standards. NHS Forth Valley has procedures for managing the confidential destruction of expired records in all formats, in a way that is auditable and irreversible. NHS Forth Valley is currently reviewing the retention arrangements for emails to ensure compliance with relevant Acts and policies. NHS Forth Valley currently has contracts with confidential waste contracts for the destruction of bagged confidential waste, e.g. paper, etc.
Evidence of Compliance	Evidence in support of Element 6 includes: 6.0The Scottish Government Records Management: NHS Code of Practice (Scotland) Version 2.1 January 2012 6.1 NHS Forth Valley Waste Disposal Operational Policy 6.2 Sample Certificate of Destruction 6.3 ICT Destruction of Equipment Policy
Future Developments	Detailed procedures for each area require to be developed. Section on destruction of confidential waste needs to be expanded in the Waste Disposal Operational Policy. Development of clear destruction protocols and registers in Directorate/department. Identification of records for permanent preservation in each Directorate/department. Set up and maintain disposal schedule for each Directorate/department
Assessment and Review	This will be reviewed annually
Responsible Officer(s)	***Elaine Vanhegan, Head of Performance and Governance*** ***Deirdre Coyle, Head of Information Governance***

Element 7: Archiving and Transfer Arrangements

Introduction	A **compulsory element** of the Public Records (Scotland) Act 2011, Element 7: Archiving and transfer arrangements should detail the processes in place within an organisation to ensure that records of long term historical value are identified and deposited with an appropriate archive repository. Arrangements for the transfer of material of enduring value to an archive should be clearly defined and made available to all staff in order to ensure that the records are transferred at their earliest opportunity and the corporate memory of the organisation is fully and accurately preserved.
Statement of Compliance	NHS Forth Valley adheres to the Scottish Government Records Management: NHS Code of Practice (Scotland) Version 2.1 January 2012. Records identified as having enduring value or are of historic interest are transferred to the University of Stirling.
Evidence of Compliance	Evidence in support of Element 7 includes: 7.1 Archiving arrangements with University of Stirling 7.2 Receipt from Archivist 7.3 Example from archive register
Future Developments	Set up and maintain a procedure for archiving and transfer of records for each area
Assessment and Review	This will be reviewed annually
Responsible Officer(s)	***Elaine Vanhegan, Head of Performance and Governance*** ***Deirdre Coyle, Head of Information Governance***

Element 8: Information Security

Introduction	A **compulsory element** of the Public Records (Scotland) Act 2011, Element 8: Information security must make provisions for the proper level of security of its records. There must be evidence of robust information security procedures that are well understood by all members of staff. Information security policies and procedures are essential in order to protect an organisation's information and information systems from unauthorised access, use, disclosure, disruption, modification, or destruction.
Statement of Compliance	NHS Forth Valley has a number of information security policies and procedures in place which staff are required to comply with. NHS Forth Valley provides systems which maintain appropriate confidentiality security and integrity for all data including storage and use in line with NHS Scotland Information Assurance Strategy. NHS Forth Valley is responsible for ensuring that adequate physical controls are put in place to ensure the security and confidentiality of all health and business sensitive data, whether held manually or electronically. NHS Forth Valley IT policies comply with NHS Scotland minimum requirements. These are subject to regular review.
Evidence of Compliance	Evidence in support of Element 8 includes: 8.1 Information Security Policy 8.2 E-Mail Acceptable Use Policy 8.3 Internet Acceptable Use Policy 8.4 Moveable Media Acceptable Use Policy 8.5 Information Governance Remote Working Guidance 8.6 ICT/IG Security Management Incident Procedure 8.7 ICT Infrastructure Security Policy 8.8 Learn-pro mandatory training 8.9 Face to face training
Future Developments	All Information security policies require review under DL 2015 (17) Governance procedures required for the use of Apps in clinical care
Assessment and Review	Policies are reviewed in line with policy guidance.
Responsible Officer(s)	***Fiona Ramsay, Director of Finance, SIRO*** ***Elaine Vanhegan, Head of Performance and Governance*** ***Scott Jaffray, Head of ICT***

Element 9: Data Protection

Introduction	The Keeper expects an organisation to provide evidence of compliance with data protection responsibilities for the management of all personal data.
Statement of Compliance	NHS Forth Valley has a legal obligation to comply with the requirements of the Data Protection Act 1998, in relation to the management, processing and protection of personal data. The NHS Forth Valley Data Protection and Confidentiality Policy is a statement of public responsibility and demonstrates the organisations commitment to compliance with the Act and the safeguarding and fair processing of personal data held. All NHS Scotland staff are bound by the NHS Code of Confidentiality NHS Forth Valley staff receive mandatory training on Data Protection at induction and are required to complete the Learn-pro Data Protection Module. NHS Forth Valley also has bespoke Information Governance training available. Patients receive information on what their information will be used for. Leaflets are available within outpatients and ward areas regarding confidentiality and Freedom of Information. This information is also published on the NHS Forth Valley website.
Evidence of Compliance	Evidence in support of Element 9 includes: 9.1 NHS FV Data Protection and Confidentiality Policy 9.2 NHS Forth Valley Data Protection Registration Details 9.3 Privacy Notice of NHS Forth Valley 9.4 Data Protection Subject Access Procedure 9.5 Job Description for Data Protection Lead 9.6 Learn-pro mandatory training 9.7 Face to face training
Future Developments	Changes on the horizon for EU Data Protection regulations.
Assessment and Review	This will be reviewed in line with any changes made in Data Protection legislation and regulation
Responsible Officer(s)	***Deirdre Coyle, Head of Information Governance***

Element 10: Business Continuity and Vital Records

Introduction	It is recommended that a Business Continuity and Vital Records Plan is in place in order to ensure that key records and systems are protected and made available as soon as possible in the event of, and following, an emergency. The plan should identify the measures in place to prepare for, respond to and recover from such an emergency.
Statement of Compliance	NHS Forth Valley has corporate, departmental and site Business Recovery/Continuity Plans. These plans include arrangements for the recovery of both physical and digital records and data. All records and data held on NHS Forth Valley networks are subject to regular back-up and associated recovery procedures.
Evidence of Compliance	Evidence in support of Element 10 includes: 10.1 Extract from NHS Forth Valley Business Continuity Management Plan 10.2 Civil Contingencies Delivery Plan
Future Developments	Set up and maintain business continuity plan for records in each Directorate/department.
Assessment and Review	This will be reviewed annually
Responsible Officer(s)	***Elaine Vanhegan, Head of Performance and Governance*** (Robert Stevenson, Head of Civil Contingencies)

Element 11: Audit Trail

Introduction	An audit trail is a sequence of steps documenting the movement and/or editing of a record resulting from activities by individuals, systems or other entities. The Keeper will expect an authority's records management system to provide evidence that the authority maintains a complete and accurate representation of all changes that occur in relation to a particular record.
Statement of Compliance	The tracking of movement and changes to records is undertaken as appropriate based on assessment of risk and commensurate with the sensitivity of information which they contain, and its value as evidence.
Evidence of Compliance	Evidence in support of Element 11 includes: 11.1 Principles of Audit Trails 11.2 TOPAS case note tracking 11.3 Staff Brief – evidence of audit and checking
Future Developments	Set up and maintain audit and monitoring for records in each Directorate/department.
Assessment and Review	This will be reviewed annually
Responsible Officer(s)	***Elaine Vanhegan, Head of Performance and Governance*** ***Deirdre Coyle, Head of Information Governance***

Element 12: Competency Framework for Records Management Staff

Introduction	Core competencies and key knowledge and skills required by staff with responsibilities for records management should be clearly defined and made available within organisations so as to ensure that staff understand their roles and responsibilities, can offer expert advice and guidance, and can remain proactive in their management of recordkeeping issues and procedures. With core competencies defined, the organisation can identify training needs, assess and monitor performance, and use them as a basis from which to build future job descriptions.
Statement of Compliance	NHS Forth Valley will provide appropriate training and development support to ensure all staff are aware of their records management responsibilities. All new staff undertake mandatory training on their NHS induction. This training includes modules on Information Governance and Information security. NHS Forth Valley recognises the important role of Administration and Clerical staff in the management of records and will include this in their learning and development plan.
Evidence of Compliance	Evidence in support of Element 12 includes: 12.1 NHS Scotland Information Governance Competency Framework 12.2 NHS Information Governance e-Learning Module 12.3 Training certificate 12.4 Training certificate 12.5 NHSFV Records Management Competencies Framework
Future Developments	Development of a Learn-pro training module for records management underway Define core competencies required for records management in each Directorate/department. Provision of training in records management in each Directorate/department.
Assessment and Review	This will be reviewed annually
Responsible Officer(s)	***Elaine Vanhegan, Head of Performance and Governance*** ***Deirdre Coyle, Head of Information Governance***

Element 13: Review and Assessment

Introduction	Records Management practices in place within an organisation must remain fit for purpose. Procedures should be closely monitored, assessed and reviewed with a view to ensuring ongoing compliance and commitment to best practice recordkeeping. The Keeper expects the Records Management Plan to have in place mechanisms for regularly reviewing the contents of the Plan to ensure processes are operating successfully and identifying processes which require modification.
Statement of Compliance	The Head of Performance and Governance along with the Head of Information Governance will regularly review NHS Forth Valley's Records Management Plan and an annual report is required by the Corporate Management Team. The Public Records (Scotland) Act is a standing item on the NHS Forth Valley Information Governance Group agenda. This Group reports to the Clinical Governance Committee, which in turn reports to the Forth Valley NHS Board.
Evidence of Compliance	Evidence in support of Element 13 includes: 13.1 Information Governance Group Agenda 13.2 Information Governance Group Minutes 13.3 Health Records Committee Minutes 13.4 Information Governance Annual Report
Future Developments	Provide a regular review of all practices in relation to records management in each Directorate/department.
Assessment and Review	This will be reviewed annually
Responsible Officer(s)	***Elaine Vanhegan, Head of Performance and Governance*** ***Deirdre Coyle, Head of Information Governance***

Element 14: Shared Information

Introduction	Procedures for the efficient sharing of information both within an organisation and with external partners are essential for ensuring information security and recordkeeping compliance. Protocols should include guidance as to what information can be shared, who should retain the data, what levels of security are to be applied, who should have access, and what the disposal arrangements are.
Statement of Compliance	Sharing of information is a core NHS Scotland activity and takes place in line with the Data Protection Act 1998 and other relevant privacy regulation. All sharing of information is subject to the appropriate level of risk assessment NHS Forth Valley patients can be sent to other NHS hospitals for healthcare. NHS Forth Valley is satisfied these hospitals take records governance seriously and to the same standard as NHS Forth Valley. They are scheduled public authorities and are therefore bound by the requirements of the Public Records (Scotland) Act 2011. NHS Forth Valley adheres to the requirements of the Freedom of Information (Scotland) Act 2002. Details of how to make a request under FOI are included via the NHS Forth Valley website.
Evidence of Compliance	Evidence to be submitted in support of Element 14 includes: 14.1 Scottish Accord on the Sharing of Personal Information (SASPI) Guidance 14.2 SASPI Template 14.3 SASPI Agreement 14.4 Data Sharing Group role and remit 14.5 Agenda for Data Sharing Group 14.6 Freedom of Information Policy
Future Developments	Set up and maintain procedures for sharing information across partners.
Assessment and Review	This will be reviewed annually
Responsible Officer(s)	***Deirdre Coyle, Head of Information Governance***

Annex A: Evidence to be submitted

Please find a list of evidence to be submitted in support of each of the elements of the Records Management Plan below. This evidence will be submitted separate to this Records Management Plan, in electronic and paper format.

Evidence Item Reference No	Details	In support of Element (s)
1.1	Policy Statement from Chief Executive	1, 2, 3
1.2/2.2/3.4	Minute of NHS Board Meeting	1, 2, 3
2.1	Records Management Job Statement/Addendum to Job Descriptions	2
3.1	NHS Forth Valley Policy Statement, signed by Chief Executive	
3.2/5.2	NHS Forth Valley Corporate Records Management Policy	3, 5
3.3/5.3	Health Records Management Policy *under review*	3, 5
4.1	Business Classification Scheme	4
5.1/6.0	The Scottish Government Records Management: NHS Code of Practice (Scotland) Version 2.1 January 2012	5, 6
5.4	NHS Forth Valley Financial Operating Procedures FOP 13 – Records Management	5
6.1	NHS Forth Valley Waste Disposal Operational Policy	6
6.2	Sample Certificate of Destruction	6
6.3	ICT Destruction of Equipment Policy	6
7.1	Archiving arrangements with University of Stirling	7
7.2	Receipt from Archivist	7
7.3	Example from archive register	7
8.1	Information Security Policy	8
8.2	E-mail Acceptable Use Policy	8
8.3	Internet Acceptable Use Policy	8
8.4	Moveable Media Acceptable Use Policy	8
8.5	Information Governance Remote Working Guidance	8
8.6	ICT/IG Security Management Incident Procedure	8
8.7	ICT Infrastructure Security Policy	8
9.1	NHS Forth Valley Data Protection and Confidentiality Policy	9
9.2	NHS Forth Valley Data Protection Registration Details	9
9.3	Privacy Notice of NHS Forth Valley	9
9.4	Data protection Subject Access Procedure	9
9.5	Job Description for Data Protection Lead	9
10.1	Extract from NHS Forth Valley Business Continuity Management Plan	10
10.2	Civil Contingencies Delivery Plan	10
11.1	Principles of Audit Trails	11
11.2	TOPAS case note tracking	11
11.3	Staff Brief – evidence of audit and checking	11
12.1	NHS Scotland Information Governance Competency Framework	12
12.2	NHS Information Governance e-Learning Module	12
12.3	Training Certificate	12
12.4	Training Certificate	12
12.5	NHS Forth Valley Records Management Competencies Framework	12
13.1	Information Governance Group Agenda	13
13.2	Information Governance Group Minutes	13
13.3	Health Records Committee Minutes	13
13.4	Information Governance Annual Report	13
14.1	Scottish Accord on the Sharing of Personal Information (SASPI) Guidance	14

Appendix 2

DRAFT **NHS FORTH VALLEY POLICY STATEMENT (Element 3)**

The Public Records (Scotland) Act 2011

The Public Records (Scotland) Act 2011 requires that NHS Forth Valley creates and maintains a robust Records Management Plan (RMP) to ensure the efficient management of all corporate and health records.

This Policy statement covers both Administrative and Health Records. It is a requirement of the Scottish Government for NHS Forth Valley to look after its records appropriately and is based on current legal requirements and professional best practice and aims to:

- establish, as part of the wider information governance framework, records management best practice in relation to the creation, use, storage, management and disposal of NHS records;
- provide information on the general legal obligations that apply to NHS records;
- set out recommendations for best practice to assist in fulfilling these obligations;
- explain the requirement to select records for permanent preservation;
- set out recommended minimum periods for retention of NHS personal health and administrative records regardless of the media on which they are held, and indicate where further information on records management may be found.

I write to advise that as the Chief Executive of NHS Forth Valley, I have overall accountability for ensuring that the management of records is undertaken legally within this Board. NHS Forth Valley will ensure that it fully complies with its responsibilities under the Act. I am entirely supportive of the RMP developed within NHS Forth Valley, which is submitted for your consideration and agreement. It is understood that failure to abide by the specific Health Records Policy and Administrative Records Policy could lead to breach of the Data Protection Act, Freedom of Information Act and Caldicott recommendations.

In respect of *Element 1* of the plan, *Miss Tracey Gillies, Medical Director*, will undertake responsibility of 'Senior Manager' for records management.

In respect of *Element 2* of the plan, *Ms Elaine Vanhegan, Head of Performance and Governance* will undertake the role of 'Records Manager', to lead on the development and roll-out of the plan, with appropriate operational support. Technical expertise/support will be provided by *Ms Deirdre Coyle, Head of Information Governance.*

As part of the plan I endorse the Records Management Policies for corporate and health records as required in *Element 3*. These Policies are circulated throughout the organisation and senior management teams are responsible for their dissemination and implementation locally.

Jane Grant
Chief Executive

Forth Valley NHS Board

26 January 2016

This report relates to
9.3.1 on the agenda

Governance Committee Minutes

Clinical Governance: 22 May 2015 & 13 November 2015

For Noting

Minute of the **Forth Valley NHS Board Clinical Governance Committee** meeting held on **Friday 22 May 2015 at 9.00am** in the **Boardroom, Carseview House**

Present:
Ms Julia Swan, Non Executive Board Member *(Chair)*
Dr Allan Bridges, Chair of Area Clinical Forum
Dr Stuart Cumming, Chair of Community Health Partnership Professional Committee
Mr Jim King, Non Executive Board Member
Mr Alex Linkston, NHS Forth Valley Chairman
Mrs Helen McGuire, Patient Public Panel Representative

In Attendance:
Ms Christine Christie, Senior Dietician
Miss Tracey Gillies, Medical Director
Mrs Irene Graham Notetaker
Mrs Jane Grant, NHS Forth Valley Chief Executive
Mr Jonathan Horwood, Infection Control Manager
Mrs Monica Inglis, Head of Clinical Governance
Mrs Rosemary Millar - shadowing Medical Director
Ms Helen Paterson, Associate Director of Nursing
Professor Angela Wallace, Director of Nursing

1/ APOLOGIES FOR ABSENCE

Apologies for absence were intimated on behalf of Mrs Gail Caldwell, Ms Fiona Gavine, Dr Graham Foster, Mrs Alison Richmond-Ferns and Ms Elaine Vanhegan.

2/ DECLARATIONS OF INTEREST

There were no declarations of interest.

3/ MINUTE OF NHS FORTH VALLEY CLINICAL GOVERNANCE COMMITTEE MEETING HELD ON 27 MARCH 2015

The minute of the Clinical Governance Committee meeting held on 27 March 2015 was approved as an accurate record.

4/ REVIEW OF ACTIONS

27 March 2014

Item 6.1 - NHS Forth Valley Clinical Governance Draft Annual Report

- Annual Report was amended and circulated to the member of the Group and then signed off by the Chair.

5/ FOOD, FLUID & NUTRITION ANNUAL REPORT

The Committee received a presentation from Ms Christine Christie, Senior Dietician.

Ms Christie advised that she was Nutrition Champion for NHS Forth Valley which covered the provision of appropriate nutrition and hydration for patients in hospital and in the community. The main topics of her presentation were:

- Malnutrition: the over 75s group were most vulnerable with the majority of this group living in the community.
- Costs of malnutrition: people were more likely to visit their GP resulting in a higher risk of admission to hospital due to impaired immune system which results in poor wound healing, reduced muscle strength, longer stays in hospital
- Financial Costs of malnutrition: annual cost in the UK was estimated to be at least £13 billion
- Highlights & Challenges:
    - Scrutiny - Older People in Acute Hospital (OPAH) inspections, catering monitoring surveys, food in the hospital was 99% compliant against the standards.
    - Nutritional risk screening - The Malnutrition Universal Screening Tool (MUST) was used throughout the hospital. An appropriate screening tool will be implemented in Paediatrics in the future. It was also used in the community by District Nurses but work needed to be done to include Health Visitors and School Nurses.
    - Training - MUST was also available on Learnpro
    - Hydration campaign - new resources, staff training, baseline audit, fluid monitoring policy

Ms Christie advised that the revised national standard now extended to the community and work was required to scope the implications.

In response to a question from Mr Linkston on how to provide support to voluntary services such as lunch clubs in the community, Ms Christie stated that a bid for funding to provide training for this group had been unsuccessful but further funding may be available at a later date. Professor Wallace stated that we would address this as a partnership and Joint Integrated Health and Social Care Boards would be included. Mr Linkston thought a presentation on this at the Integrated Joint Boards would be welcomed.

In response to a question from Mr King regarding the 93% of people living in the community with malnutrition, what were the emerging issues? Ms Christie said that District Nurses used the MUST screening tool to assess patients in the community.

There was discussion on what is meant by malnutrition and the importance of hydration, in response to a question from Ms Swan.

Mrs McGuire asked how we dealt with dementia patients and Ms Christie said that monitoring fluid intake helped to increase hydration rates. Discussion with the patient and family on preferences for eating and drinking also helped.

The Committee thanked Ms Christie for her presentation.

6/ CLINICAL GOVERNANCE: STRATEGY AND OBJECTIVES

6.1 Organ Donation Committee Annual Report

The Committee considered a paper presented by Miss Tracey Gillies, Medical Director.
Miss Gillies reported that the Committee met twice a year and she highlighted the figures for organ donation in NHS Forth Valley. Although figures were relatively low this was reflected in the fact that NHS Forth Valley does not have a neuro Intensive Care Unit. She also advised that Scottish Government's private members bill to consider an 'opt out' policy had been put on hold meantime. Spain had recently introduced this policy and Scottish Government was waiting to see the impact this made before taking forward the private members bill.

She also highlighted that the Committee were presently investigating options to install an art project to commemorate donors and also raise awareness of the Organ Donation Register.

The Committee noted the response.

6.2 NHS Forth Valley Healthcare Associated Infection (HAI) Annual Report

The Committee considered a paper presented by Mr Jonathan Horwood, Infection Control Manager in the absence of Dr Graham Foster, Director of Public Health.

Mr Horwood summarised the report as follows:

- 92 cases of Staphylococcus aureus Bacteraemias (SABs) which was an increase since the previous year. There had been an increase in hospital acquired SABs, a lot of work was being taken forward with clinicians to help to reduce hospital device associated SABs.
- 53 cases of Clostridium difficile infection (CDI) associated with antimicrobial use. Reviewing cases with pharmacy, infection control doctor and clinicians to look at rationale for using antibiotics.
- 70 cases of Device Associated Bacteraemia (DABs, mostly catheter associated. Ongoing work to introduce a urinary catheter maintenance bundle across the acute sector and a urinary catheter passport in the community. Forth Valley is the only Health Board in Scotland looking at all device associated bacteraemias.
- SAB related deaths - 9
- CDI related deaths - 6
- Norovirus - there had been 6 outbreaks which resulted in 5 ward closures.
- Unannounced visit by Healthcare Environment Inspectors had resulted in 2 requirements and 1 recommendation. HEI agreed to use Forth Valley Royal Hospital to trial patient experience questionnaires.

In response to a question from Mr King regarding trends in other Health Board that could help us to improve our HEAT targets, Mr Horwood said that discussions had taken place with NHS Fife regarding ways of reducing SABs and peripheral venous catheter (PVC) use.

The Committee recognised the importance of prioritising work in this area and it was agreed that a presentation would be given at the meeting in September.

The Committee noted the report.

6.3 NHS Forth Valley Clinical Governance Forward Planner 2015-2016

The Committee considered a paper presented by Miss Tracey Gillies, Medical Director.

Miss Gillies stated that this paper set out items which the Committee would consider over the coming year. More items would be added to the forward planner over the course of the year.

Mr Linkston suggested adding a presentation on End of Life Care, however following discussion it was agreed this would be better presented at a Board Seminar.

The Committee noted the report.

7 ASSURANCE AND IMPROVEMENT

7.1 Clinical Governance Balanced Scorecard and Quality Report

The Committee received a paper presented by Professor Angela Wallace, Director of Nursing and Mrs Monica Inglis, Head of Clinical Governance.

Stroke
Miss Gillies reported that there were sufficient beds in the stroke unit but due to capacity issues in the remainder of the hospital, this impacted on the discharge from the stroke unit. Daily prioritising of patients in/out of the stroke unit in order to accelerate discharge from this unit to community hospitals for rehabilitation was being undertaken. The aim is to progress patients getting a bed in the stroke unit within 24 hours. The Committee noted that the Clinical Services Review would be looking at patient flow and bed usage.

HSMR
Miss Gillies reported on NHS Forth Valley's figures for Hospital Standardised Mortality Ratio (HSMR). There are three main areas of focus:

- Data capture and data quality
- Quality of care - for example responding to deteriorating patients
- System to avoid hospital admission if alternatives are available

Miss Gillies and Mrs Inglis had attended a learning session on Developing the Scottish HSMR and it had been recognised that it was not yet clearly understood why there are variations in HSMR across Scotland and variations over the course of a year. The HSMR model is currently under review.

Cardiac Arrest
Miss Gillies reported that there were no concerns regarding the cardiac arrest data. The review of 41 deaths from December recorded 39 expected deaths and 2 explicable, both of whom had a Do Not Resuscitate (DNR) in place.

Falls
Mrs Inglis reported that there was an ongoing reduction in falls with the following figures recorded:

- January 2015 - total number of falls with harm 11
- February 2015 - total number of falls with harm 9
- March 2015 - total number of falls with harm 10

Work was being carried out around bone health and how to prevent falls at large.

In response to a question from Mr Linkston on whether bone health related to nutrition, Mrs Inglis stated that it was mostly due to osteoporosis.

Pressure Area Care
Professor Wallace stated that NHS Forth Valley had been asked to share data and progress at an upcoming national meeting. It was agreed to add pressure injury to the forward planner for a more detailed update.

Person Centred Care
Professor Wallace reported that ongoing feedback from patients included:

- I had privacy when my care was being delivered
- I was welcomed on arrival to the ward
- I feel staff listen to what I had to say

Areas identified for improvement included:

- Before going home I was told how long I would need to wait
- I was happy with the food and drink I received
- I was given advice on how to improve my health and wellbeing

Work was ongoing with data being added to the ward action plan for each month.

The Committee noted the report.

8/ PERSON CENTRED CARE

8.1 NHS Forth Valley Complaints Performance Report

The Committee received a paper presented by Professor Angela Wallace, Director of Nursing.

Professor Wallace reported that the total performance in meeting timescales against the 20 day target for response to March 2015 had been 84.9%, the total number of complaints for the period 1 April 2014 to 31 March 2015 was 977.

Next steps to take forward included:

- A new target for dealing with complaints set at 80% for this year
- Continued roll out of the Safeguard Customer Care module
- Further development of a person centred approach to the management of complaints
- Installation of call recording within the Patient Relations Team
- Working with colleagues to gain learning from complaints and inform service improvements
- Further develop feedback mechanisms within the organisation
- Develop learning tools to enable staff to manage feedback, comments, concerns and complaints
- Complaints Reduction Plan
- Completion of the Annual Report and Participation Standard

In response to a question from Mr King regarding whether the nature of complaints had changed over the years, Professor Wallace stated that complaints regarding waiting times and cancellation of appointments/surgery had reduced.

With regard to the resolution of complaints informally, Ms Swan said it would be useful to see how many complaints were resolved in this manner before they became formal.

The Committee noted the report.

9/ SAFE CARE

9.1 Significant Adverse Events Report

The Committee received a paper presented by Mrs Monica Inglis, Head of Clinical Governance.

Mrs Inglis reported that following work to look at how to improve the timeliness of reviews, a formal proposal would be presented to the Clinical Governance Working Group in June. Healthcare Improvement Scotland (HIS) had also recently published an updated National Framework 'Learning from adverse events through reporting and review'.

Mrs Inglis, Professor Wallace and Miss Gillies would work on driving improvement in this area.

The Committee note the report.

9.2 Significant Case Reviews Report

The Committee received a paper presented by Professor Angela Wallace, Director of Nursing.

Professor Wallace stated that this report had been developed in conjunction with Clackmannanshire and Stirling Councils and Police Scotland. Due to the need to maintain confidentiality it was agreed that the report would not be made public. The multi-agency action plan produced will continue to be progressed.

The Committee noted the report.

10/ EFFECTIVE CARE

10.1 Standards and Reviews Report

The Committee received a paper from Mrs Monica Inglis, Head of Clinical Governance.

Mrs Inglis highlighted the following new guidance:

- SIGN 144: Glaucoma referral and safe discharge
- SIGN 142: Management of osteoporosis and the prevention of fragility fractures
- Penrose Inquiry 25 March 2015
- Healthcare Improvement Scotland (HIS) Bowel Screening Standard
- Healthcare Improvement Scotland (HIS) Local Delivery Plan April 2015
- Strathcarron Hospice Independent Healthcare Inspection Report April 2015
- Learning from adverse events through reporting and review: A national framework for Scotland
- Nuffield Hospital Glasgow - Independent Healthcare Inspection Report: April 2015
- Forth Valley Royal Hospital - Safety and cleanliness inspection report: April 2015

In response to a question from Ms Swan regarding the Joint Inspection for Older People in Falkirk, Mrs Grant stated that there had been a long delay in receiving the draft report from the Care Commission however it had now been received and was being considered for factual accuracy.
The Committee noted the report.

11/ REPORTS FROM ASSOCIATED CLINICAL GOVERNANCE GROUPS

11.1 Draft Minute of Area Prevention and Control of Infection Committee held on 29 April 2015

The Committee noted the draft minute as presented by Mr Jonathan Horwood, Infection Control Manager in the absence of Dr Graham Foster, Director of Public Health.

11.2 Child Protection Action Group Quarterly Report

The Committee noted the Child Protection Action Group Quarterly Report presented by Professor Angela Wallace, Director of Nursing.

11.3 Draft Minute of the Clinical Governance Working Group held on 16 April 2015

The Committee noted the draft minute of the meeting as presented by Mrs Monica Inglis, Head of Clinical Governance.

Miss Gillies stated that the Group discussed how they could deal with the large volume of minutes more effectively in order that nothing of importance was missed. She would bring an update on actions agreed back to this Committee
Action: Tracey Gillies

11.4 Draft Minute of the Organ Donation Committee held on 19 March 2015

The Committee noted the draft minute of the meeting as presented by Miss Tracey Gillies, Medical Director.

12/ ANY OTHER COMPETENT BUSINESS

Penrose Inquiry
Miss Gillies highlighted a Scottish Government letter received following the publication of the Penrose inquiry report which had produced the following recommendation:

'That the Scottish Government takes all reasonable steps to offer an HCV test to everyone in Scotland who had a blood transfusion before September 1991 and who has not been tested for HCV'

Miss Gillies assured the Committee that NHS Forth Valley has processes in place to manage the use of blood appropriately.

Fatal Accident Inquiries
Miss Gillies reported on two recent FAIs. We awaited recommendations from the Sheriff on the first one which was likely to highlight training of staff in suicide risk; the second one involved Scotland's longest serving prisoner. No recommendations were expected for this case but there may be media attention regarding this prisoner.

Medical Certification of Cause of Death (MCCD)
Miss Gillies stated that the Commencement of the Certificate of Death (Scotland) Act 2011 had been launched on 13 May 2015 whereby a number of deaths would be randomised for review before a death certificate was issued. In these cases this meant that there could be a delay for families arranging the funeral, however funeral directors, registrars and all doctors were fully aware of the detail of this new process.

In response to a question from Mrs McGuire regarding communication to the public about this Act, Miss Gillies stated that responsibility for communication with the public rested with the Scottish Government and they had taken the view that only communication materials on a broad basis would be circulated as people would not take in the detail until it affected them personally. It was noted that hospitals provide information to bereaved families.

13/ DATE AND TIME OF FUTURE MEETINGS

The next meeting of the NHS Forth Valley Clinical Governance Committee would be held on **Friday, 17 July 2015 at 9.00am** in the Boardroom, Carseview House, Stirling.

There being no further business, the Chair closed the meeting at 11.10am.

DRAFT Minute of the **Forth Valley NHS Board Clinical Governance Committee** meeting held on **Friday 13 November 2015 at 9.00am** in the **Boardroom, Carseview House**

Present:
Ms Julia Swan, Non Executive Board Member *(Chair)*
Mr Jim King, Non Executive Board Member
Mr Alex Linkston, NHS Forth Valley Chairman
Mrs Helen McGuire, Patient Public Panel Representative

In Attendance:
Dr Hugh Edwards, Consultant Haematologist
Dr Graham Foster, Director of Public Health & Strategic Planning
Miss Tracey Gillies, Medical Director
Mrs Irene Graham, Notetaker
Mrs Jane Grant, NHS Forth Valley Chief Executive
Mr Jonathan Horwood, Infection Control Manager
Mrs Monica Inglis, Head of Clinical Governance
Mrs Kathy O'Neill, Community Health Partnership General Manager
Mrs Alison Richmond-Ferns, Associate HR Director
Professor Angela Wallace, Nurse Director

1/ APOLOGIES FOR ABSENCE

Apologies for absence were intimated on behalf of Dr Allan Bridges, Mrs Gail Caldwell and Dr Stuart Cumming.

2/ DECLARATIONS OF INTEREST

There were no declarations of interest.

3/ MINUTE OF NHS FORTH VALLEY CLINICAL GOVERNANCE COMMITTEE MEETING HELD ON 11 SEPTEMBER 2015

The minute of the Clinical Governance Committee meeting held on 11 September 2015 was approved as an accurate record.

4/ REVIEW OF ACTIONS

Item 10.1 Standards and Reviews Report

- Mrs Inglis stated that a local review of Clackmannan cases had been carried out and no common themes or concerns had been identified.

5/ HAEMATOLOGY PRESENTATION

(Presentation by Dr Hugh Edwards, Consultant Haematologist)

Miss Gillies introduced Dr Edwards who had been invited to give a presentation regarding the governance aspects around the use of blood and the regulatory pathways to ensure that blood is used as safely as possible. Dr Edwards presentation covered:

Better blood transfusion: The governance infrastructure which promote the safe use of blood and which is overseen by the Hospital Transfusion Committee. There are there principles – safety, effectiveness and efficient use of blood. In relation to safety Dr Edwards described the local and national reporting requirement and staff education and training. The effective use of blood includes a rolling programme of national and local audits, review of key performance indicators and guidelines to support practice. The efficient use of blood includes review of wastage, usage of blood products and cell salvage. Dr Edwards advised that the Hospital Transfusion Committee was well attended. In response to a question from Ms Swan on how we ensure that practices are carried out by an appropriately trained person, Dr Edwards stated that the LearnPro module was not specific to any one part of the procedure but covered all people who were involved at any one stage. At present the training module not undertaken in GP Practices. Miss Gillies stated that she had taken this matter to the GP Sub-committee for consideration.

In response to a question from Mr King on whether any trends had been identified in the reporting of incidents, Dr Edwards stated the Serious Hazards of Transfusion (SHOT) haemovigilance had highlighted blood overload which led to guidance on 'don't give 2 without review' which is included in foundation year doctor education.

In response to a question from Mr Linkston on the low training statistics for midwives, Dr Edwards highlighted some challenges on how national figures were produced. He highlighted that we focus on training staff who will be involved in the transfusion process.

Mr Linkston also raised the question of whether we had a safe pathway to ensure the wrong blood was not given to patients and Dr Edwards assured the Committee that details were checked from the patient and not the notes to minimise this happening. Dr Edwards highlighted risks of 'wrong blood in tube' events and provided information on proposals to introduce a second sample to reduce risk.

Professor Wallace agreed to reinforce good practice around sampling with nursing staff. Miss Gilles stated that training of consultant staff could be reiterated through their appraisal system.

Ms Swan thanked Dr Edwards for his presentation and should any members wish to view the Hospital Transfusion Committee Annual Report, this could be made available to them.

6. CLINICAL GOVERNANCE: STRATEGY AND OBJECTIVES

6.1 NHS Forth Valley Healthcare Associated Infection (HAI) Quarterly Report

The Committee considered a paper presented by Dr Graham Foster, Director of Public Health & Planning who introduced Jonathan Horwood who gave a detailed report.

Mr Horwood reported the figures for the period July – September 2015

- Staphylococcus Aureus Bacteraemias (SABs) – total number of cases had been 24, 5 of which had been hospital acquired. This was a decrease from last quarter. It was reported that there had been a decrease in device associated SAB's.
- Clostridium Difficile Infections (CDIs) – total number of cases had been 10, 2 of which had been community required.
- Device Associated Bacteraemias (DABs) – total number of cases had been 22, half of these are attributed to long lines and an improvement plan is in place which includes the implementation of insertion and maintenance bundles.
- Health Related Deaths - 3 SAB related deaths reported (part 1of the death certificate) and 1 CDI related death (part 2 of the death certificate).
- Outbreak and Incident Management - No incidences of ward closures reported this quarter.
- Surgical Site Infection Surveillance - following the mandatory surveillance for hip arthroplasty and caesarean section procedures, there was now a more robust system of reporting.
- HAI Annual Workplan - we were still awaiting the Scottish Government workplan but Forth Valley already developed a workplan to March 2016.

In response to a question from Ms Swan regarding the number of surgical site infections recorded following a caesarean section, Mr Horwood explained that this had been reviewed by the directorate who were reviewing wound dressings.

In response to a question from Mr Linkston on whether there was more work to be done regarding norovirus; Dr Foster stated that an intensive plan is in place which includes posters across the hospital. Mrs McGuire enquired whether the Integration Joint Boards and the local authorities were involved and Mrs Grant stated that this was part of the Winter Plan and all partners were aware.

The Committee noted the report.

7/ ASSURANCE AND IMPROVEMENT

7.1 Clinical Governance Balanced Scorecard and Quality Report

The Committee received a paper presented by Mrs Monica Inglis, Head of Clinical Governance.

Stroke
Admissions were reviewed on a daily basis. There had been a dip in performance for admission to the stroke unit but of the data on compliance with elements of the stroke bundle provided assurance that patients were getting reliable care even if they were not in the stroke unit.

HSMR
Miss Gillies stated that for the last reported quarter the Forth Valley position mirrored the position across Scotland. Monthly HSMR data has been obtained from Public Health and Intelligence to inform the ongoing HSMR Improvement Plan.

Care of Deteriorating Patients
There is an improvement plan in place and focused work commenced in the Acute Assessment Unit.

Falls
There is a sustained a reduction in falls in wards B21 and B22. Professor Wallace, Mrs Inglis and Miss Gillies have met to discuss further actions to reduce falls and falls with significant harm. .

Food, Fluid and Nutrition
Professor Wallace advised that a review of data had highlighted 3 wards who were impacting on the overall performance and issues had been identified in relation to documentation of the assessments that had been undertaken. The Practice Development Unit are supporting improvement in these wards.

Person Centred Care
Professor Wallace highlighted the use of the 'red post boxes' to obtain feedback from patients and visitors. In response to a question from Ms Swan on how this is feedback, Professor Wallace advised that mechanisms to feedback were being reviewed. A thematic analysis of patient feedback is being undertaken and feedback at a future meeting was proposed.

In response to a question from Mrs McGuire on where whether electronic check in could be introduced in out-patient areas, Professor Wallace stated that this was a technology issue which would be looked at.

There was discussion regarding the 21% of comments received regarding poor care. Professor Wallace advised that the feedback cards did not always provide specific information on issues of concern. Miss Gillies stated that we need to keep this in context as the denominator was unknown.

The Committee noted the report

7.2 Services for Children & Young People in Clackmannanshire & Stirling - Progress Reviews following Joint Inspections

The Committee received a paper presented by Mrs Kathy O'Neill, Community Health Partnership General Manager.

Mrs O'Neill reported on the progress reviews for Stirling and Clackmannanshire. She highlighted that this was a progress review rather than a re-inspection and it reviewed the five areas for improvement from the 2014 review.

Mrs O'Neill stated that we provided feedback to the review on the significant amount of work which had been undertaken since the inspection in early 2014; however it was too early to measure any outcomes. The conclusion of the report stated that the inspectors were assured by the improvements put in place and they did not plan a further inspection.

In response to a question from Mr King regarding evaluation of progress, Mrs O'Neill stated we would continue to carry out multi-agency and healthcare audits.

In response to a question from Mrs McGuire on how the proposed changes to arrangements in Stirling and Clackmannan would affect progress, Mrs O'Neill stated that it was too early to know how this would impact but she highlighted that the multi-agency planning group would remain in place.

The Committee noted the report.

8 PERSON CENTRED CARE

8.1 NHS Forth Valley Complaints Performance Report

The Committee received a paper presented by Professor Angela Wallace, Nurse Director

Professor Wallace reported the total performance in meeting timescales against the 20 day target for responses to September 2015 had been 82.4%.

Additional steps to support directorates had been put in place with weekly operational meetings and a focus on complaints at directorate performance reviews. Work continues with directorates to encourage local resolution in order to reduce the number of formal complaints. First impressions were hugely important and would go a long way in helping to reduce complaints regarding attitude and behaviour. Preparatory work towards the 20% reduction target has been undertaken but to date no improvement has been demonstrated. Work is focusing on 'hot spots' and themes. Professor Wallace advised that the Quality Improvement Strategic Leadership Group had agreed on improvement methodology approach to reduce complaints.

The Committee noted the report.

9/ SAFE CARE

9.1 Significant Adverse Events Report

The Committee received a paper presented by Mrs Monica Inglis, Head of Clinical Governance.

Mrs Inglis reported there was ongoing discussion nationally regarding significant adverse events. Locally there was a focus on timelines following concerns about the length of time significant adverse events took to be investigated. A plan is in place to improve the timelines of reviews. This includes training for staff involved in the process which is planned to commence in December, There will be a specific focus on establishing terms of reference when the review is being commissioned. The Clinical Governance Working Group has agreed a template for directorates to feedback themes, actions and learning to ensure a systemic and consistent approach. The format of the significant adverse events report will be changed to support more detailed reporting of both adverse events and significant adverse events going forward.

The Committee noted the report.

9.2 Scottish Independent Review of the Use, Safety and Efficacy of Transvaginal Mesh Implants - Interim Report

The Committee received a paper presented by Miss Tracey Gillies, Medical Director.

Miss Gillies advised that following an announcement from the previous Cabinet Secretary last year the use of mesh implants had been suspended until an independent review had been concluded. The recommendations in the interim report did not give conclusive advice in order to reinstate the use of mesh implants and therefore the position remains the same and this type of surgery is not being undertaken unless it exceptional circumstances where the patient understand the risk involved and with the approval of the Medical Director in Forth Valley. Advice from the Chief Medical Officer regarding the use of these implants is awaited and where the patient understands the risks involved.

In response to a question from Mrs McGuire regarding the numbers of patients in Forth Valley that this affects, Miss Gillies stated that it was between 20-30 patients and to date we had no requests for this type of surgery from any of these patients. This patient group received support in managing their symptoms from Obstetrics & Gynaecology, physiotherapy and their GPs.

The Committee noted the report.

10/ EFFECTIVE CARE

10.1 Standards and Reviews Report

The Committee received a paper from Mrs Monica Inglis, Head of Clinical Governance.

Mrs Inglis highlighted the new guidance:

- HM Inspection of Prisons for Scotland: Report on HMP Glenochil Full Inspection
- Healthcare Improvement Scotland: Introduction of the Regulation of Independent Clinic
- Healthcare Improvement Scotland: Unannounced Inspection to Spire Murrayfield Hospital
- West of Scotland Gynaecological Managed Clinical Network: Report of the ovarian cancer QPI Clinical Audit Data
- Burial and Cremation (Scotland) Bill

The Committee noted the report

11/ REPORTS FROM ASSOCIATED CLINICAL GOVERNANCE GROUPS

11.1 Draft Minute of Area Prevention and Control of Infection Committee

No meeting had taken place.

11.2 Child Protection Action Group Quarterly Report

The Committee noted the report of the meeting as presented by Professor Angela Wallace, Nurse Director.

Professor Wallace emphasised that this was the draft minute of the Child Protection Action Group held on 21 September 2015 and not the quarterly report. The quarterly report would be presented to the Committee at the next meeting.

11.3 Draft Minute of the Clinical Governance Working Group held on 8 October 2015

The Committee noted the draft minute of the meeting as presented by Mrs Monica Inglis, Head of Clinical Governance.

11.4 Minute of the Organ Donation Committee

No meeting had taken place.

12/ ANY OTHER COMPETENT BUSINESS

12.1 Miss Gillies informed members of a recent Freedom of Information request from a national newspaper which asked for various data regarding incidents that involved faulty medical devices. Part of the response to this FOI indicated that there had been one death in 2012 which involved an implantable defibrillator. This incident was investigated locally at the time and reported to Medicines and Healthcare products Regulatory Agency (MHRA). Miss Gillies wished to bring this to the Committee's attention should there be any press coverage.

12.2 Mrs Grant advised that the Joint Inspection of Falkirk Children's Services was currently underway. There will be a further visit later in November and a proportionate visit in December.

13/ DATE AND TIME OF FUTURE MEETINGS

The next meeting of the NHS Forth Valley Clinical Governance Committee would be held on **Friday, 15 January 2016 at 9.00am** in the Boardroom, Carseview House, Stirling.

There being no further business, the Chair closed the meeting at 11.10am

Forth Valley NHS Board

26 January 2016

This report relates to
Item 9.3.2 on the agenda

Governance Committee Minutes

Performance and Resources Committee: 22 December 2015

For Noting

NHS FORTH VALLEY PERFORMANCE & RESOURCES COMMITTEE
DRAFT Minute of the Performance & Resources Committee meeting held on Tuesday 22 December 2015 at 9.00am in the Boardroom, NHS Forth Valley, Carseview House, Castle Business Park, Stirling, FK9 4SW

Present:
Mr James King (Chair)
Mr Alex Linkston, Chairman
Mrs Jane Grant, Chief Executive
Miss Tracey Gillies, Medical Director
Dr Graham Foster, Director of Public Health and Planning
Prof. Angela Wallace, Director of Nursing
Mrs Fiona Ramsay, Director of Finance
Mrs Helen Kelly, Director of HR
Dr Stuart Cumming, Non Executive Director

In Attendance
Ms Elaine Vanhegan, Head of Performance and Governance
Mrs Elsbeth Campbell, Head of Communications
Ms Morag Farquhar, Programme Director
Miss Jo McLaren, Performance Management Officer (Minute)

1. APOLOGIES FOR ABSENCE

Apologies for absence were intimated on behalf of; Ms Fiona Gavine, Mr John Ford, Ms Julia Swan, Mr David McPherson and Mr Tom Steele

2. DECLARATIONS OF INTEREST

There were no declarations of interest.

3. MINUTE OF PERFORMANCE & RESOURCES COMMITTEE MEETING HELD ON 27 OCTOBER 2015

The Performance and Resources Committee approved the minute of the meeting held on 27 October 2015 as an accurate record. .

4. ROLLING ACTION LOG

The Performance and Resources Committee considered a paper 'Rolling Action Log' presented by Mr Jim King, Chair.

It was highlighted that actions had been addressed under the specific agenda items.

5. MATTERS ARISING

6. URGENT BUSINESS

Dr Foster advised that an announced HAI visit would take place at Clackmannanshire Community Healthcare Centre on the 27 and 28 January 2016.

Mrs Ramsay reported that there were two potential pharmacy applications to be reviewed. These were currently going through the consultation process and it was anticipated that there would be a need to hold the Pharmacy Practices Committee prior to the end of March 2016. Mr King agreed to chair this Committee.

Action: Jim King

7. Scottish Government Spending Review 2015

The Performance and Resources Committee received a presentation on the 'Scottish Government Spending Review 2015' by Mrs Fiona Ramsay, Director of Finance, based on slides provided by SGHSCD (Scottish Health and Social care Directorate).

It was noted that this was a draft budget which would be finalised in February 2016, it was anticipated that for Health there would be no further change. The budget highlighted a 5.3% increase for Health, however this was inclusive of the £250m investment for Health and Social Care Integration therefore, there was a health uplift of 1.7%.

An overview of the strategic priorities was provided for 2016/17 and it was highlighted that additional detail around this was still to be provided. Mrs Ramsay gave a brief background on how each was funded and advised further discussion would be required around the Alcohol and Drug partnership when sole responsibility transferred to health.

This was a considerable change from previous years and would be extremely challenging. Based on current information on funding and estimated cost increases, a cash savings requirement of 6% was indicated.

It was stressed that communication was key to ensure workforce understanding of the implications of this budget. It was highlighted that every budget manager across the organisation would be required to influence and contribute to the savings initiative. Regular update to the NHS Board would be provided. It was noted that a NHS Board Seminar would be held early next year to discuss this in further detail.

The Performance and Resources Committee noted the update provided.

8. FINANCIAL AND PERFORMANCE ISSUES

8.1 Core Performance

The Performance and Resources Committee considered a paper 'Core Performance Report' presented by Ms Elaine Vanhegan, Head of Performance and Governance.

It was highlighted that following the Performance and Resources Committee in October 2015, a number of additional child dental health performance indicators had been included within the report. Work was ongoing around the Hospital scorecard with regards to Readmissions and this would be addressed under the specific agenda item.

A brief overview of the key areas per section were provided as follows:

Safe

- The number of SABs in November 2015 was 7; 1 hospital acquired, 3 healthcare acquired, 2 community acquired and 1 nursing home acquired. The in month rate per 1000 acute occupied bed days for November was 0.3, with a provisional 12 month rolling average of 0.34, against an agreed trajectory of 0.24. It was highlighted that the healthcare acquired SABs for November had not been related to previous hospital stays.

Person Centred

- In respect of CQI's the position was highlighted as; Falls 97.5%, Pressured Area Care 96.8% and Food, Fluid and Nutrition 95.9%.
- The absence rate for October 2015 was 5.07% against the 4% target. It was highlighted that NHS Forth Valley had been below the Scottish average consistently for 8 months, with the figures for July, August, September and October being the lowest for these months in 5 years.
- The position in relation to eKSF was 79% against an 80% target. Further improvement work was to take place to ensure the target is met and sustained.
- In October 2015 there were 81.8% of patients with an initial diagnosis of stroke who received the appropriate bundle of care.
- In respect of the 20 day response rate for complaints the October position was highlighted as 90.5% against a local 80% target.
- Work was continuing in relation to the 20% reduction in complaints, overall, excluding prisons there had been a 9.5% decrease in the number of complaints, however, there is variability within individual directorates. The prison complaints has seen a 20.2% increase in numbers.

Discussion took place in relation to the food, fluid and nutrition CQI performance. It was noted that this was an improved position from October 2015. Work was ongoing to look at additional metrics around nutrition using the Malnutrition Universal Screening Tool (MUST). It was agreed that additional key indicators would be included within the scorecard for the next meeting of the Performance and Resources Committee.

Action: Elaine Vanhegan

Equitable

- There were 73 successful smoking quits at 12 weeks post quit in the 40% most deprived areas at quarter ending June 2015, against a target of 59.
- Following agreement at the October Performance and Resources Committee, Fluoride Varnish Applications, General Anaesthetics for Extraction and National Dental Inspection Programme information had been included within the report. It was agreed that these additions were useful for continued reporting around child dental health.

Timely

- The ED position for November 2015 was highlighted as 94.8%. There had been 2 eight hour breaches and zero twelve hour breaches in November 2015.
- With regards to the 62 day cancer target it was highlighted that 95.2% of patients with a suspicion of cancer were treated within 62 days for the quarter ending September 2015 against the 95% standard. For Quarter ending September 2015 98.7% of patients were treated within 31 days against the 95% standard.

With regards to unscheduled care, work was ongoing to address variability in performance within these services. The 4 hour ED target continued to be monitored on a weekly basis through the CEO Operational Group. Following an update from Miss Gillies at the October meeting around the Emergency Department, it had been requested that a breach analysis be included within future Performance Reports to the Committee. It was agreed that the content included within the paper which highlighted the breaches and reasons for

breaching between September and November 2015 was beneficial and should be included within future reports.

Action: Elaine Vanhegan

Effective and Efficient

- The position for delayed discharges over 14 days at the November 2015 census was 30 against the standard of zero. There were 3 delays noted for local authorities outside Forth Valley.
- The total bed days lost due to delayed discharge in November 2015 had increased to 1284 from 1094 at the October 2015 census.

Further discussion took place around the delayed discharge position which continued to be a challenge for Forth Valley. Weekly monitoring of the position was in place through the CEO Operational Group with greater focus on those patients who are delayed in their discharge with Code 9 exemptions, including Guardianship.

It was agreed that there was a need to review the pathways around discharge and identify how the additional beds are currently being used. Further discussion was required around this with Kathy O'Neill. Dr Cumming advised that from a primary care perspective there had been difficulty around access to care packages, in particular crisis care.

Action: Jane Grant

The Performance and Resources Committee noted the update provided.

8.2 Annual Review 2014/15 Letter

The Performance and Resources Committee considered a paper 'Annual review 2014/15 Letter' presented by Ms Elaine Vanhegan, Head of Performance and Governance.

The paper highlighted the key points covered within the follow up letter from the Cabinet Secretary following the Annual Review in September 2015.

It was highlighted that any issues raised within the letter, the Board had previously been sighted on. It was agreed that this was a positive position for NHS Forth Valley. The letter would be put onto the public website following the meeting.

Action: Elsbeth Campbell

The Performance and Resources Committee noted the update provided.

8.3 Waiting Times Report

The Performance and Resources Committee considered a paper 'Waiting Times Report' presented by Ms Elaine Vanhegan, Head of Performance and Governance.

The following key areas were highlighted within the report;

- In October 2015 the 18 week RTT was 93.2% against the 90% target. It was noted that this compared well with the national position.
- At November 2015 the number of outpatients with ongoing waits over 12 weeks increased to 1572 from 1450 in October 2015. The number of patients exceeding 16 weeks was 636.

- There had been 5 breaches of the TTG during the financial year to November 2015. There were no patients with ongoing waits over 12 weeks at the end of November 2015.
- Radiology has remained compliant with the 42 day waiting time standard.
- With regards to Endoscopy there were 58 patients waiting over 42 days at November 2015. Work was underway around the Endoscopy sustainability plan in order to help address the issues within the service around waiting times.
- At November 2015, NHS Forth Valley had 345 (13.5%) inpatients / daycases unavailable for treatment, an increase on the previous month (10%).
- The data for both the 31 and 62 day cancer targets for quarter ending September 2015 highlight NHS Forth Valley has achieved the 95% standard.
- The Drug and alcohol Service has remained compliant with the 21 day waiting time standard.
- In November 2015 Psychological therapies treated 82.5% of their patients with 18 weeks of referral
- CAMHS treated 28.4% of patients within 18 weeks of referral at October 2015.

The paper highlighted an improving position in terms of AHP waits. Further discussion took place around the need to significantly improve the position in order to move towards the 4 week musculoskeletal target which would come into effect on 1 April 2016. It was highlighted that the data available around AHP Waits had improved considerably and improvements within previous areas of challenge had already been seen.

It was agreed that a sustainability plan was required for musculoskeletal services.

Action: David McPherson

The Performance and Resources Committee noted the update provided.

8.4. Finance Report

The Performance and Resources Committee considered a paper 'Finance Report' presented by Mrs Fiona Ramsay, Director of Finance.

A balanced financial position was reported to the end of November 2015 for both revenue and capital. It was highlighted that a projected surplus of £0.200m for revenue was expected at year end. There were a number of key issues and risks around the financial position which were discussed in further detail as follows:

It was highlighted that the winter period from January to March would be challenging due to remaining capacity pressures within the system which would intensify over this period. In terms of waiting times, a clear message had been given around use of waiting list initiatives and the suspension of private sector use, it was likely that this would impact waiting times performance going forward.

With regards to those directorates with a sizable overspend, regular meetings had been taking place to support progress around the overspend and these meetings would continue until in month financial balance was achieved. It was stressed that in terms of efficiency any improvements which could be made this year would help next year's financial outlook.

It was noted that property sales for Bonnybridge and Bannockburn would fall into the next financial year; however the NHS Forth Valley Capital Resource Limit would be increased for this year in order to manage between financial years.

The Performance and Resources Committee noted the update provided.

Temporary Workforce Spend

The Performance and Resources Committee received a presentation on Bank and Agency Spend by Mrs Fiona Ramsay, Director of Finance.

With regards to medical agency spend, an overview of the long and short term protocol which had been implemented was provided. Details of the process and governance arrangements which were in place regarding use of medical agency were also provided.

The process for requesting staff through the nurse bank / agency was detailed highlighting the responsible person for approving requests which had since been implemented within all relevant areas.

An overview of the agreed process for use of in house Waiting Times Initiatives and Private Sector use was provided, outlining responsible person for approving requests as the Director of Finance or the Chief Executive.

Discussion took place following the presentation and it was highlighted that the challenge was currently around re designing the current system and reviewing whole system pathways, linking in with primary care in order to manage services and ensure maximum efficiency.

The Performance and Resources Committee noted the update provided.

8.5 Hospital scorecard – Readmissions

The Performance and Resources Committee considered a paper 'Hospital Scorecard Readmissions' presented by Miss Tracey Gillies, Medical Director.

It was highlighted that this piece of work had been taken forward to try and address the reasons for differences in the rate of readmissions between ISD and Forth Valley data. The paper was the first part of a detailed analysis to understand the readmission rate in greater detail.

The analysis would help identify any aspects of care which could be improved, through changing the way things are done or additional actions which could be put in place at particular stages of care.

The key issues with regards to medical and surgical readmissions were provided within the paper and further detail around specific metrics such as age profile, GP practice and areas of deprivation had been provided. Of those patients readmitted work had been undertaken to identify whether an Anticipatory Care Plan was in place. Further work was to take place with the Anticipatory Care Team going forward to agree how they can target their resources towards patients and GP practices.

Mr King advised that had been a positive piece of work and requested that further updates be provided to the Performance and Resources Committee

Action: Tracey Gillies

Discussion took place around the coding issue which had impacted the data previously, it was highlighted that this had been resolved but would not be seen until the next edition of the hospital scorecard was published.

Following a specific question regarding the GP contract which would come into effect in 2017, discussion took place around the content. It was noted that there was currently no clear framework around this.

The Performance and Resources Committee noted the update provided.

8.6 Annual Plan Mid Year Performance Update

The Performance and Resources Committee considered a paper 'Annual Plan Mid Year Review 2015/16' presented by Ms Elaine Vanhegan, Head of Performance and Governance.

The paper provided a midyear position against the key actions and indicators within the NHS Forth Valley Annual Plan. An overview of the layout was provided which considered both the LDP and Annual Plan indicators / actions as well as a number of additional local priorities.

It was highlighted that indicators were monitored frequently through the Performance and Resources Committee and further detail on each presented at the relevant Governance Committee.

It was noted that the paper would come back to the Committee at a later date highlighting the year end position.

Action: Elaine Vanhegan

The Performance and Resources Committee noted the update provided.

8.7 Capital Projects, Property Transactions and Medical Equipment Update

The Performance and Resources Committee considered a paper 'Capital Projects, Property Transactions and Medical Equipment Update' presented by Ms Morag Farquhar, Programme Director, Estates and Facilities.

A brief overview of the key issues were provided, as follows:

With regards to Stirling Care Village, project resolution around the inability to input capital was yet to be agreed. With regards to Health the contribution process was now clear but where other areas had planned to provide capital contributions the position was yet to be resolved. Mrs Grant advised that she would take forward the outstanding issues as necessary.

Action: Jane Grant

The Draft Outline Business Case for Doune Health Centre had been supported at the Corporate Management Team on the 17 December 2015 and would be considered later on the agenda where the Performance and Resources Committee would be asked to approve it.

With regards to the corporate accommodation moves it was noted that all moves were now complete and the decommissioning phase had begun to ensure the Eurohouse was clear prior to handover to the landlord in early January 2016.

The Performance and Resources Committee noted the update provided.

9.1 Budget Setting for Integrated Joint Boards – Health Funds

The Performance and Resources Committee considered a paper 'Budget Setting for Integrated Joint Boards – Health Funds' presented by Mrs Fiona Ramsay, Director of Finance.

The paper outlined the process to be followed to for the 2015/16 budget baseline for preparation of budget setting for Integrated Joint Boards.

It was highlighted that the document had been seen previously by Board members and had gone through appropriate stages of approval. There required to be further discussions between the Chief Executives to agree on a final budget and it was anticipated that this would be clearer in January 2016 following these planned discussions.

The Performance and Resources Committee approved the following:

- The 2015/16 Budget information presented within the paper was to be used as the starting budget for drafting the 2016/17 budgets.
- The 2015/16 budget information could be formally shared with the Integrated Joint Boards.

9.2 GP Practice Boundary Change

The Performance and Resources Committee considered a paper 'GP Practice Boundary Change' presented by Mrs Fiona Ramsay, Director of Finance.

NHS Forth Valley had received an application from Kinglass Medical Practice to redefine its area of practice as described in the GMS Contract.

It was noted that this application had been through the appropriate consultation process and no issues around this had been raised.

The Performance and Resources Committee, on the basis of recommendations of both professional committees and the West Lothian Health and Social Care Partnership approved the application.

9.3 Doune Health Centre Draft Outline Business Case

The Performance and Resources Committee considered a paper 'Doune Health Centre, Draft Outline Business Case' presented by Ms Morag Farquhar, Programme Director, Estates and Facilities.

An overview of the key issues were provided and following discussion the Performance and Resources Committee approved the Draft Outline Business Case for onward submission to the NHS Board.

9.4 Community Planning Partnership

The Performance and Resources Committee considered a paper 'Community Planning Partnership Update' presented by Dr Graham Foster, Director of Public Health and Planning.

The paper provided an overview of the ongoing work around community planning and aimed to increase the visibility of the work ongoing around this.

Discussion took place and it was agreed that this would be a standing item on future Performance and Resources Committee agendas. Dr Foster advised that the intention was to have more input around Health Inequalities going forward.

Action: Graham Foster

The Performance and Resources Committee noted the update provided.

9.5 Corporate Risk Register

The Performance and Resources Committee considered a paper 'Corporate Risk Register' presented by Ms Gail Caldwell, Pharmacy Director.

The paper provided an updated position to the Committee on the Corporate Risk Register which was reviewed quarterly. A brief overview of those risks classed as very high was provided, this included:

- Sustainability of GMS Services
- Balance of elective and emergency flow
- CAMHS and Psychological Therapy waiting times

Following discussion at this meeting it was agreed additional risk around the 2016/17 financial outlook would be included.

The Performance and Resources Committee noted the update provided.

8 AOCB

Dr Foster advised that the Forth Road Bridge would re open on the 23 December 2015.

9 Date of Next Meeting

Tuesday 23 February 2016 at 9am in the Boardroom Carseview.

Forth Valley NHS Board

26 January 2016

This report relates to
9.3.3 on the agenda

Governance Committee Minutes

Endowment Committee: 16 October 2015

For Noting

ENDOWMENT COMMITTEE

Minute of the Forth Valley NHS Board Endowment Committee meeting held on Friday 16th October 2015 in the Forth Valley NHS Board Headquarters, Carseview House, Castle Business Park, Stirling.

Present: Ms Fiona Gavine, Non Executive Member, Forth Valley NHS Board (Chair)
Mrs. Fiona Ramsay, Director of Finance, NHS Forth Valley
Mr. Jim King, Non Executive Member, Forth Valley NHS Board

In attendance: Mr. Jonathan Procter, IM&T Director/E-health Lead, NHS Forth Valley (Lead Director)
Mr. Garry Wells, Treasury Services Manager
Mr. Craig Holden, Fundraising Manager

1/ APOLOGIES FOR ABSENCE

Apologies for absence were intimated on behalf of: Mr. Alex Linkston, Chair of NHS Forth Valley NHS Board (Trustee), Cllr. Les Sharp, Non Executive Member, Forth Valley NHS Board, Mrs. Jane Grant, Chief Executive, Forth Valley NHS Board and Mr. Tom Hart, Employee Director, Forth Valley NHS Board.

2/ DECLARATIONS OF INTEREST

There were no declarations of interest.

3/ MINUTE OF THE FORTH VALLEY NHS BOARD ENDOWMENT COMMITTEE MEETING HELD ON 5th JUNE 2015

The Committee approved the minute of the Forth Valley NHS Board Endowment Committee held on 5th June 2015 as a correct record.

4/ MATTERS ARISING

i) Small Grant Application - Mental Health Young Persons Group.
In accordance with the request made by the Committee at the previous meeting, Mr. Wells provided further details relating to the purpose and costs of this application. Having considered this further information the Committee approved the grant application in full.

ii) Prostate Cancer –contribution to robotic assisted treatment.
Mrs. Ramsay advised the Committee that NHS Forth Valley, having considered the West of Scotland Regional Planning Group's initial proposal that funding for this service be provided by Health Board Endowment Funds, considered that local Endowment Funding was not sufficient to support such a sizeable commitment and had agreed to support the project via revenue/capital funding as appropriate.

iii) Utilisation of Gordon Melrose Fund
Mr. Wells advised the Committee that Mr. Hart and Mrs. Angela Wallace, Director of Nursing having considered the under-utilisation of the Gordon Melrose Fund, recommended that the Fund be amalgamated with the Staff Bursaries Fund to maximise

the training opportunities available to staff. The Committee agreed to consider this recommendation during the annual budget setting exercise for 2016/17.

iv) Gifting of Funds from RVS
Mr. Procter advised the Committee that the Endowment Fund had received £19,998 from the RVS in September 2015 and that in accordance with the Letter of Intent agreed between the Committee and the RVS in January 2015, these funds will be utilised to extend the Service Level Agreement currently in place for the provision of on-ward services at Falkirk Community Hospital.

5/ FINANCIAL REPORT FOR THE 6 MONTHS ENDED 30TH SEPTEMBER 2015

The Committee considered a paper "Financial Report for the 6 months ended 30th September 2015" presented by Mr. Wells.

i) Mr Wells reported that for the first six months of the financial year the cost of activities funded from the Accumulated Unrestricted Reserves were in accordance with budgeted levels. Mr. Wells also reported that there was a net receipt of £48,294 of Restricted Funds during this same period. Mr. Wells provided further details on factors contributing to any variations from budgeted income and spend for the reported period. Mr Wells also presented a paper illustrating the movement in the market value of the investment portfolio since 2004 and asked the Committee to note that despite the gains made since the stock market crash in October 2008, the current value of the portfolio was equivalent to March 2010 levels. Mr. Wells also advised that the attached quarterly investment and performance report received from the Fund's Investment Managers contained further analysis and commentary on the factors contributing to the fall in the market value of the portfolio together with an analysis of the performance of the portfolio during the last quarter. Mr. Wells asked the Committee to note that the benchmark performance data contained in the quarterly report showed that despite the relatively low return on the portfolio over the last 12 months, the returns over the last five years had exceeded all other relevant benchmarks.

After discussion the Committee approved the "Financial Report for the 6 months ended 30th September 2015".

6/ ARTLINK CENTRAL – SERVICE LEVEL AGREEMENT

The Committee considered a paper "Artlink Central – Service Level Agreement" presented by Mr. Procter

Mr. Procter advised the Committee that the current three year Service Level Agreement between the Endowment Fund and Artlink Central was due to expire on 31st March 2016 and asked the Committee to consider the level of participatory arts services required post March 2016. In the discussion that followed it was noted that the services provided by Artlink Central had been well supported operationally and had received strong positive feedback from service users. It was agreed therefore that Babs McCool, Arts & Wellbeing Co-ordinator be asked to commence discussions with Artlink Central and service users in order to prepare a draft Service Level Agreement, up to a value of £50,719 per annum, for the provision of services post March 2016. It was agreed that Ms. McCool be asked to submit the draft Service Level Agreement to the next Committee meeting for consideration.

Following this discussion the Committee approved "Artlink Central – Service Level Agreement".

7/ FUNDRAISING MANAGERS REPORT

The Committee considered a paper "Fundraising Manager's Report" presented by Mr. Holden.

Mr. Holden reported the progress to date on the goals included in the Fundraising Plan for 2015/16. Mr. Holden provided a brief update on each of the activities together with additional comments on other relevant matters arising from the report.
Mr. Holden indicated that he had contacted several local companies and grant distributing charities in order to secure prizes for the Endowment Fund's Annual Prize Draw due to take place on the 23rd December 2015. Mr. Holden also advised that the beneficiary of the proceeds of the prize Draw had yet to be identified. Mr. Holden was asked to submit a list of potential beneficiaries to the next Committee meeting for consideration.

After discussion the Committee noted the Fundraising Manager's Report.

8/ INVESTING IN HEALTH – SMALL GRANTS APPLICATIONS

The Committee considered a paper "Investing in Health - Small Grants Applications" presented by Mr. Procter.

Mr. Procter advised the Committee that since the last Committee meeting the following urgent bids had been received and were approved in accordance with the delegated authority contained in the Investing in Health Policy.
i) Radio Royal - implementation of Broadband service (£1,483)
ii) Radio Royal - extension of service to FVRH restaurant (£967)

Mr. Procter also advised that in accordance with the terms of the Investing in Health Policy the Committee are now required to review these grant applications and consider ratifying the award of funding.

After discussion the Committee ratified the award of funding.

9/ REVIEW OF OBSOLETE AND SLOW-MOVING FUNDS

The Committee considered a paper "Review of Obsolete and Slow-Moving Funds" presented by Mr. Wells.

Mr. Wells reported that in accordance with Financial Operating Procedure a review had been carried out of all fund balances in order to identify any obsolete or slow-moving funds. Mr. Wells advised the committee that the review had identified 2 obsolete funds with balances totalling £2,612.33 and 34 slow-moving funds with balances totalling £58,490.52, It was agreed that the Obsolete fund balances be transferred to the Accumulated General Reserves and instructed Mr. Wells to obtain proposed expenditure plans from the fund holders of the

Slow-Moving funds and submit a report of these plans to the next meeting for further consideration.

After discussion the Committee approved "Review of Obsolete and Slow-Moving Funds".

10/ REVIEW OF NON-CHARITABLE ACTIVITIES

The Committee considered a paper - "Review of non-charitable activities" presented by Mr. Wells.

Mr. Wells advised that recent amendments to Scottish Charities legislation and subsequent guidance issued by the Office of the Scottish Charities Regulator recommended that fees and other income that use Board's facilities and/or resources in its generation is non-charitable in nature and should be excluded from the charity's income. Mr. Wells also advised that a recent review of all endowment funds' income had identified a number of funds whose income was wholly from these "non-charitable" sources. It was agreed that the non-charitable income arising from clinical related activities would remain a part of the Endowment Fund until 31st March 2016, whereupon the balances and all subsequent activity would be transferred to the Health Board whilst the non-charitable income from staff related activities would be subject to further review.

After discussion the Committee agreed the "Review of non-charitable activities".

11/ APPOINTMENT OF AUDITORS

The Committee considered a paper "Appointment of Auditors" presented by Mr. Procter.

Mr. Procter advised that the current three year contract with the Endowment Funds external auditors is due to conclude following the completion of the 2015/16 accounts. Mr. Proctor also advised that a review of the contract awarding process for Endowment Fund and Patient Funds Auditors is being considered that will take into account the outcome of the imminent national tendering process for the appointment of the Board's External Auditors for the next five year term commencing in financial year 2016/17

After discussion the Committee noted the "Appointment of Auditors"

11/ ANY OTHER COMPETENT BUSINESS

There being no further business the Chair closed the meeting at 12:45 p.m.

Forth Valley NHS Board

26 January 2016

This report relates to

9.3.4 on the agenda

Governance Committee Minutes

Staff Governance: 11 December 2015

For Noting

DRAFT Minute Staff Governance Committee meeting held on Friday 11 December 2015 in the Board Room, Carseview House, Castle Business Park, Stirling.

Present:- Mr John Ford, Non Executive Director (Chair)
Mr Alex Linkston, Chairman, NHS Forth Valley
Mr Tom Hart, Employee Director
Ms Janette Sneddon, Co-Chair, Acute Services Partnership Forum

In Attendance:- Mrs Jane Grant, Chief Executive
Mrs Helen Kelly, Director of Human Resources
Professor Angela Wallace, Director of Nursing
Mrs Alison Richmond-Ferns, Associate Director of Human Resources
Ms Linda Donaldson, Associate Director of Human Resources
Mrs Morag McLaren, Associate Director of Human Resources
Mr Peter Mackie, Head of Health and Safety
Ms Marjolein Don, Strategic Planning Officer (Observer)
Ms Marian Smith, PA to Director of Human Resources (minute)

1/ Welcome and Introduction

Mr Ford welcomed everyone to the meeting.

2/ Apologies for Absence

Apologies for absence were intimated on behalf of Mr George Kerr and Mr Tom Steele

3/ Declarations of Interest

There were no declarations of interest to note.

4/ Minute of Meetings

4.1 Minute of Staff Governance Committee meeting held on 15 September 2015

The minute of the Staff Governance Committee meeting held on 15 September 2015 was approved as a correct record.

4.2 Draft Minute of Staff Governance Remuneration Sub Committee meeting held on 15 September 2015

The Staff Governance Committee noted the Draft minute of the Remuneration Sub Committee meeting held on 15 September 2015

5/ Rolling Action Log

The Staff Governance Committee noted the items on the action log which had been completed and those that were on the agenda.

6/ Matters Arising

There were no matters arising.
The following item was brought forward on the agenda.

13/ Health and Safety Quarterly Report

Consideration was given to a paper 'Health and Safety Quarterly Report – April – June 2015,' presented by Mr Peter Mackie, Head of Health and Safety.

Mr Mackie highlighted the following key points as detailed in the paper:-

- Adverse Events
- Management of Violence and Aggression
- Lone Working
- Fire Safety
- Manual Handling
- Needlestick and Sharp incidents
- Holding Bay
- Health and Safety Executive
- European Health and Safety Week

Mr Mackie advised that the report on Lone Working had been completed and was being considered by relevant managers.

The Staff Governance Committee discussed in detail the increase in needlestick/sharps incidents, the ongoing discussion with the replacement system for Safeguard, and self harm reporting. Mr Mackie gave an assurance to the committee that appropriate training, education and reporting for needlestick/sharp incidents was in place across the organisation. In response to a question from Mr Ford. He gave a further assurance that environmental risk assessments were in place for equipment and the hospital environment to minimise self harm incidents. Mr Mackie advised that each department would receive a self review questionnaire before the end of the year. These reviews would be followed up by visits from the Health and Safety Advisers by the end of March 2016. A report on the findings will be submitted to a future Staff Governance Committee. Action PM

In response to a question from Mr Ford regarding the increase in violence and aggression incidents being reported and whether this was related to increased awareness Mr Mackie indicated that it was a combination of this and better staff awareness of unacceptable behaviours. Mr Hart asked if the increase had any correlation with prisons. Mr Mackie advised that there was no correlation with the increase in incidents and advised that regular discussions took place with Prison staff.

Following discussion the Staff Governance Committee noted the paper.

Mr Mackie left the meeting at this point.

7/ Youth Employment and Modern Apprenticeships

Consideration was given to a paper 'Youth Employment and Modern Apprenticeships,' presented by Mrs Alison Richmond-Ferns, Associate Director of Human Resources.

Modern Apprentices
Mrs Richmond-Ferns advised that following a successful recruitment campaign for NHS Forth Valley's Business and Administration Modern Apprenticeship scheme, 14 Modern Apprentices had taken up posts in a variety of departments across NHS Forth Valley. They will be supported and trained to carry out the duties and responsibilities as outlined in the job descriptions and have an agreed training plan. On completion of their training they will receive an SVQ qualification awarded through Forth Valley College. The Staff Governance Team is also providing support to the Modern Apprentices and Managers.

Investors in Young People
Mrs Richmond-Ferns reported that following on from NHS Forth Valley's Silver Investor's in People Award, NHS Forth Valley had held discussions with Investors in Young People (IiYP). IiYP is an accreditation framework which offers recommendations, guidance to support the recruitment, retention and development of young people. Work was ongoing with the Organisation Development Team to 'map' out the current activities for young people in NHS Forth Valley and the activities in the IiYP Framework.

Princes Trust
During 2016/17 work would commence around a potential programme of placements for young people within NHS Forth Valley. NHS Ayrshire and Arran and NHS Lothian had already showcased their work with the Princes Trust.

Mrs Kelly advised that a meeting had been arranged for early January, with Mr Steele and Professor Wallace to explore opportunities for placements in Estates and Facilities Directorate and Nursing.

Mrs Richmond-Ferns further highlighted that discussions were ongoing with the three Local Authorities regarding their Employability schemes and placements within NHS Forth Valley.

Mr Linkston acknowledged the range of work ongoing to support young people into employment. He was encouraged to see the Modern Apprentices at the recent Long Service Award Ceremony.

In response to a question from Mr Linkston regarding the government's 0.5% was mentioned if so its 0.5% Levy, effective from April 2017, on employers who offered apprenticeships and if there were any implications for NHS Forth Valley. Mrs Kelly agreed to look into this and feedback to Mr Linkston. **Action – HK**

The Staff Governance Committee noted the paper.

8/ Staff Governance

8.1 Attendance Management

Consideration was given to a paper 'Attendance Management,' presented by Mrs Alison Richmond-Ferns, Associate Director of Human Resources.

Mrs Richmond-Ferns reported on the October 2015 figures. The October report showed an absence rate of 5.07% which was an increase of 0.30 % from September 2015. This compared favourably to the rate of 5.51 % at October 2014 and was the lowest October rate for five years and below the Scottish average which was 5.13%. She further reported on that significant efforts continued to be made to achieve the national standard of 4%.

Mrs Richmond-Ferns highlighted the absence figures by Directorate, the areas achieving 4% or under, monthly comparators, sickness absence monitoring trajectory, national comparators, and the management of long term absence as detailed in the paper.

Mr Linkston highlighted that October traditionally saw a higher absence rate and enquired as to the possible reasons for this. Mrs Kelly advised that as winter approached there was traditionally a higher number of upper respiratory tract infections amongst staff. Mrs Richmond-Ferns advised that work was ongoing to look at the reasons for the increase.

She further reported that the absence audit was now complete. The current NHS Forth Valley Attendance Training course now incorporated the findings of the audit so that best practice was shared and policy compliance issues resolved. Plans to carry out a further audit during 2016 will be agreed in January.

The Staff Governance Committee discussed new actions and initiatives to assist with achieving the national standard, the use of the return to work interview and assisting staff to return to their substantive or an alternative position, the case conference reviews and the early involvement of Occupational Health.

Mrs McLaren highlighted the Healthy Working Lives Award and the preventative actions that can be taken to keep staff well and at work.

Professor Wallace highlighted the need to manage temporary spend and ensuring using staff appropriately to avoid extra pressures on services.
The Staff Governance Committee noted the:-

- current update on absence for September – October 2015
- current priorities of work on Attendance Management

8.2 Staff Governance Update

Consideration was given to a paper 'Staff Governance Update,' presented by Mrs Alison Richmond-Ferns, Associate Director of Human Resources.

Long Service Awards
The Chairman and Chief Executive hosted a Long Service Award Ceremony on 4 December 2015 and a number of staff had received awards for 20, 30 or 40 years service.

Video clips from three long servicing staff members had been shown and photographs taken. The recently appointed Modern Apprentices had joined the ceremony showcasing how the organisation values long by staff members.

Staff Survey
The Staff Survey had run from 10 August to 21 September 2015 and the results had been published on 11 December 2015.

Mrs Richmond-Ferns advised that NHS Forth Valley had a 42 % response rate; this was 4% higher than the national response rate of 38%. Feedback from the Survey would inform action plans at Directorate and Board level.

NHS Forth Valley had received a letter from the Scottish Government which confirmed the current position with the national survey. There would be no national survey in 2016 with iMatter becoming the lead vehicle for staff experience in 2016 as a transitional year.

Policy Development

Mrs Richmond-Ferns advised that the HR Policy Steering Group (HRPSG) would review the NHS Forth Valley policies against the Working Life Balance PiN. This had been issued nationally in June 2015 and included policies on flexible working, special leave and retirement.

The HRPSG were currently reviewing the following local policies:-

- Alcohol and Drugs
- Tobacco – staff section in the revised organisational policy

Mr Hart highlighted the recent discussions on iMatter at the Employee Directors meeting. The Employee Directors group welcomed the news that the there would be no national staff survey in 2016.

There was a discussion on the information available through iMatter, the role of Partnership Fora around staff engagement and experience and the employer/employee responsibilities in the Governance Standard.

The Staff Governance Committee noted the paper.

10/ Health and Social Care Integration

Consideration was given to a paper, 'Health and Social Care Integration,' presented by Mrs Helen Kelly, Director of Human Resources.

Mrs Kelly advised that the Joint Staff Forum had held a development session in September 2015. It was a well attended session including both Chief Officers. There was a discussion on Staff Forum priorities, behaviours and ways of working. A report had been prepared and had been discussed at the Joint Staff Forum held on 9 December 2015.

At its meeting on 9 December 2015, the Joint Staff Forum had agreed the constitution; a report would be submitted to the Integration Joint Boards in January. They also held a discussion on Unisons Ethical Charter. The Joint Staff Forum acknowledged the principles of the charter in relation to zero hour's contracts and the living wage and agreed that this should be included in future procurement discussions.

She further advised that work was progressing on Workforce Planning and that Health and Social Care Integration was discussed at NHS Forth Valley Partnership Fora meetings. Mrs Kathy O'Neill had attended the October Area Partnership Forum meeting and presented an update on a wide range of activity.

Chief Officer Recruitment

Following a successful and robust selection and recruitment process the recruitment of both Chief Officers had been successfully concluded. Ms Patricia Cassidy had recently been appointed, on a permanent basis, as Chief Officer for the Falkirk Partnership and would commence work on 14 December 2015. Ms Tracey McKigen's secondment would end on 31 December 2015.

The Staff Governance Committee noted the update.

11/ Everyone Matters 2020 Workforce Vision Implementation Framework

Consideration was given to a paper 'Everyone Matters 2020 Workforce Vision Implementation Framework,' presented by Mrs Morag McLaren, Associate Director of Human Resources.

Mrs McLaren advised on progress of the actions against the five Everyone Matters priorities and activity underway in Forth Valley to ensure the framework was implemented effectively. The following were highlighted as detailed in the paper:-

- Everyone Matters 2020 Workforce Vision Review of Progress 2014 -15
- The 2016 -17 Implementation Plan

She further advised that the 2016 –17 Implementation Plan had a range of activities to tackle health inequalities and the delivery of integrated health and social care services across the NHS, Local Authorities and third party providers. A further update on the Implementation Plan would be provided at the next Staff Governance Committee. **Action - MMcL**

The Staff Governance Committee Noted:-

- the current local progress made on the implementation of the Everyone Matters Implementation Framework and Plan 2015 -16
- that the 2016/17 Implementation Plan had been received
- the content of the Director Letter 25 (2015)
- Requested further updates on the range of work as detailed in the paper

12/ Update on Organisational Development Priorities including Learning, Education and Training

Consideration was given to a paper 'Update on Organisational Development Priorities including Learning, Education and Training', presented by Mrs Morag McLaren, Associate Director of Human Resources.

Mrs McLaren highlighted the following priority actions as detailed in the paper:-

- KSF Reviews and Personal Development Planning
- iMatter Roll out Plan
- Mandatory Training
- Shaping the Future Programme
- Integration of Health and Social Care Integration

Mrs McLaren reported on the progress towards achieving the KSF Personal Development Review Standard of 80%. The overall achievement rate at October 2015 was 79% with improvement plans in place to support all areas to achieve 80% by the end of September 2015. A range of training and resources were available to support Mangers to have high quality and meaningful reviews.

She further reported that NHS Forth Valley had achieved a 52% roll out of iMatter with an overall response rate of 67%. The results from the iMatter Survey would be included in the Corporate Performance Report and Directorate Scorecards during 2016. Themes from the reports would be used to inform Team level, Directorate Level and the overall Organisational Action Plan and would link to the Staff Survey Action Plan.

Mr Linkston advised that the Integration Joint Boards development sessions had been well received.

The Staff Governance Committee noted the paper.

13/ Reshaping the Workforce

The Staff Governance Committee received a paper and presentation, 'Reshaping the Workforce,' presented by Ms Linda Donaldson, Associate Director of Human Resources.

Ms Donaldson highlighted the key issues as detailed in the paper:-

- eESS Implementation
- Recruitment Activity
    - Psychology Recruitment
    - Winter Recruitment
    - Medical Workforce

Ms Donaldson advised that work was progressing with the roll out of the Manager and Employee Self Service modules of eESS. It was anticipated that all substantive post holders would have active accounts by the end of March 2016.

NHS Forth Valley was currently testing the ePayroll and eESS interfaces. Payroll and the HR Workforce Team had completed preparatory work and initial testing had taken place with a successful outcome. It is anticipated that work would be completed by the end of February 2016 with any highlighted teething problems resolved.

The Staff Governance Committee was advised that the Chief Executives Group had commissioned an external review of the eESS system to ensure it was fit for purpose. Senior HR colleagues from NHS Forth Valley had met with the reviewer to feedback on experience to date. The report will be shared with the Chief Executives Group in January 2016.

Mrs Richmond-Ferns reported on the number of vacancies, by Directorate, that were currently being managed by the HR Recruitment Team. Each of the vacancies were at varies stages within the Recruitment Process.

She further reported the recruitment for winter was nearing completion. This programme of recruitment had been run concurrently with the ongoing recruitment programme.

Ms Donaldson highlighted that Junior Doctor monitoring had taken place, during November and those rotas which had been changed, following receipt of the Paul Gray Letter in June 2014, had monitored compliant, with European Working Time Directive and New Deal, and within approved banding.

Mrs Grant acknowledged the hard work of the Medical Workforce and HR Recruitment Teams on eESS and winter recruitment. Mrs Grant advised that work NHS Forth Valley had completed in relation to 7 day working and monitoring had received positive feedback. There was a discussion around NHS FV success in recruiting to vacant posts as it was seen as a forward thinking employer with supportive Training and Development and a good culture. Ms Donaldson also reported on the positive feedback from the Junior Doctors survey. The Staff Governance Committee acknowledged the hard work of the Human Resources Directorate and other staff in delivering this position.

Mrs Kelly gave an assurance to Staff Side members that NHS Forth Valley was successfully recruiting to and retaining posts and investing in its workforce.

The Staff Governance Committee noted the paper.

14/ Reports from Sub Committees

Draft Area Partnership Forum: 30 October 2015

Mr Hart highlighted the Development Session held on 30 October 2015 and the changes to the agenda and way of working that had been agreed for future meetings.

The Staff Governance Committee noted the draft minute of the Area Partnership Forums held on 30 October 2015.

Draft Health and Safety Committee – 28 October 2015

The Staff Governance Committee noted the draft minute of the Health and Safety Committee meeting held on 28 October 2015.

Minutes of the eESS Project Board - 11 September 5 and 28 October 2015

The Staff Governance Committee noted the minutes of the eESS Project Board - 11 September 5 and 28 October 2015

15/ Staff Governance Committee Proposed Meeting dates 2016 – 17

The Staff Governance Committee noted the proposed meeting dates 2016 – 17.

16 ANY OTHER COMPETENT BUSINESS

Professional Careers Placement Scheme

Mrs McLaren advised that NHS Scotland had committed to take part in a Professional Careers Placement Scheme, supporting a Graduate with a self-identified Disability to be placed in each Board in Scotland, supporting them to undertake a 2-year work placement designed to secure their return to employment.

NHS Forth Valley has now been allocated a Trainee who has an interest in a general Human Resources Placement. Linda Penn commenced her placement in the OD Team on the 30 November 2015.

She will then move around the wider HR Team steadily widening her experience of the fuller HR function over her 2 year placement. Our ultimate goal is to support Linda into permanent employment.

There being no other competent business the Chair closed the meeting at. 3.10 pm

18/ DATE OF NEXT MEETING

The Staff Governance Committee will meet again as scheduled on 15 March 2016 at 9.30 am in the Board Room, Carseview House, Castle Business Park, Stirling.

M Smith
15 December 2015

Forth Valley NHS Board

26 January 2016

This report relates to

9.4.1 on the agenda

Advisory Committee Minute

Area Clinical Forum: 19 November 2015

For Noting

Draft Minute of the **Area Clinical Forum** meeting held on **Thursday 19 November 2015** at **6.15pm** in the **Boardroom, NHS Headquarters, Carseview House, Castle Business Park, Stirling, FK9 4SW**.

Present:	Dr Allan Bridges, Associate Medical Director *(Chair)* Ms Kathleen Cowle, Area Pharmaceutical Committee Ms Bette Locke, Allied Health Professional Committee Mr Tendai Ndoro, Area Optical Committee Dr Leslie Cruickshank Dr Stuart Cumming Mr Iain Watt
In Attendance:	Ms Kirsten McIntosh Mrs Sarah Smith, Corporate Services Assistant/PA *(Minute Taker)*

1. WELCOME AND APOLOGIES

The Chair welcomed everyone to the meeting.

Apologies for absence were intimated on behalf of May Fallon; Miss Tracey Gillies; Mrs Jane Grant; Dr James King; Ms Allison Ramsay.

2. MINUTE OF AREA CLINICAL FORUM HELD ON 17 SEPTEMBER 2015

The minute of the Area Clinical Forum meeting held on 17 September 2015 was approved as an accurate record..

3. SUSTAINABILITY

The Area Clinical Forum received a presentation and briefing paper on "Sustainability of General Practice in Forth Valley – Update" by Dr Stuart Cumming.

Detail was provided around some of the issues being experienced within General Practice around recruitment and implementation of the new contract in 2017.

The work being done to support practices in difficulty was outlined with detail being provided around List Extension Growth Uplift, locality meetings and amendments made to the QOF.

It was noted that there was a need to build an infrastructure to support General Practitioners due to independent contractor status. There was also a requirement to ensure retention of additional staff to provide resources when other practices experienced difficulty.

There was discussion around multi-agency working with the examples of Kersiebank and Bannockburn being highlighted. It was noted that the full benefit would not be seen until additional

support had been fully embedded. Vigilance would be required to ensure this did not create gaps in other professions.

Limited information was available around the new GP contract, however it was anticipated that this would provide guidance around working in localities and linkage with Health and Social Care.

The need for improvement in Primary Care premises was also recognised.

The Area Clinical Forum noted the update and surrounding discussion.

4. CLOSER TO HOME SERVICE

The Area Clinical Forum received a presentation and briefing paper on "Closer to Home Service" by Ms Bette Locke.

A brief background was provided to the Closer to Home Service highlighting demographic changes in the population and increased requirements for social and health care needs.

Ms Locke provided detail around the model, its aims and anticipated outcomes.

Detail was provided around the three main components of the Enhanced Community Team, workforce and three categories of patients that would be the target of the model. It was noted that the third category of patients "Rapid Acute Assessment" would not be undertaken within the first phase of implementation. Ms Locke advised the Forum of the support offered by Dr Leslie Cruickshank.

Referral routes were outlined and it was confirmed that the model would commence on 14 December 2015.

Ms Locke also outlined the ALFY (Advice Line for You) which was a 24/7 telephone support line for the public and health and social care professionals. The service would be rolled out on 1 December 2015 after a successful pilot in Bo'ness.

Dr Bridges then opened the floor for discussion.

It was noted that the models provided an opportunity to substantially reduce the number of hospital admissions and it was agreed that there was a need to evidence hospital admissions and ED attendances subsequent to implementation of these models.

The model outlined that the aim was that patients would be under the care of the Enhanced Community Team for a period of 7 days. It was confirmed that subsequent to this, the patient would either be discharged or moved into mainstream service. It was agreed that linkage between the services had to be smooth to provide consistency of care.

The Area Optical Committee and Pharmacy offered their support. Ms Locke confirmed that she would be happy to discuss outwith the meeting to enhance multi-disciplinary responses to patients.

The Area Clinical Forum noted the discussion.

5. CROSS PROFESSION PATIENT REFERRAL FORM

The Area Clinical Forum received a "Community Pharmacy Referral Form" presented by Ms Kathleen Cowle and Ms Kirsten McIntosh Community Pharmacy Practitioner Champions.

Ms McIntosh noted the challenges within the GP workforce and a greater reliance on Community Pharmacies. It was also confirmed that there was currently no non-urgent pathway into GP/Dentist or Optician.

It was anticipated that this could be undertaken by use of a form that would be provided to a patient after presentation at a pharmacy. The form layout was detailed.

As an initial step, the Forum were advised that two PDDs had also been created for

- Uncomplicated UTIs in women 16-65 years
- Impetigo

The need for clarity of information within the form was detailed.

During discussion it was agreed that it would be beneficial to have a process of routine communication. Increased clarity and avoidance of misinterpretation was also noted.

Ms McIntosh confirmed that a pilot would commence in December, with additional training being provided in January 2016.

Governance was discussed and it was proposed that the form could be presented to the Primary Care Quality Group for information.

It was noted that the form could be extended to cover other areas, such as referral from GP to Optician. Mr Ndoro advised that he would discuss the topic with the Area Optical Committee and provide detail around the information format that would be required.

6. AHP NATIONAL DELIVERY PLAN FEEDBACK ON ENGAGEMENT EVENT – 8 OCTOBER 2015

The Area Clinical Forum received an update from Ms Bette Locke on the recent engagement event that took place on 8 October 2015.

Detail was provided around the purpose of the event and the AHP National Delivery Plan that ran from 2012-2015.

Ms Locke advised that feedback had been received from the Scottish Government that acknowledged some of the problems that had been experienced with the Plan. There were in line with those of AHP members.

The next steps were detailed prior to the implementation of the new delivery plan “Active & Independent Living Improvement Programme (AILIP) 2016-2020. This document would be expected in April 2016.

The Area Clinical Forum noted the update.

7. ANY OTHER COMPETENT BUSINESS

There was no other competent business.

8. ITEMS FOR FUTURE AGENDA

- ANMAC Presentation
  - **minute taker agreed to action**
- Initial progress around ‘Closer to Home’

- Sustainability
- Nursing Revalidation
- Development of cross boundary templates (TBC)

9. ELECTION TO CHAIR OF AREA CLINICAL FORUM

The nomination of Dr James King, for the post of ACF Chair had been received.

After consideration, the ACF unanimously agreed to appoint Dr King to the role of Chair form 1 April 2016. It was noted that Dr Bridges' appointment would end on 31 March 2016.

10. DATE OF NEXT MEETING

The next meeting of the Area Clinical Forum would take place on Thursday 21 January 2016 at 6.16 p.m. within the Boardroom, NHS Forth Valley, Carseview House, Castle Business Park, Stirling.

There being no other competent business, the Chair closed the meeting at 7.40 p.m.

Forth Valley NHS Board

26 January 2016

This report relates to
Item 9.5 on the agenda

2016 Schedule of Meetings

(Presented by Mrs Jane Grant, Chief Executive)

For Noting

2016 Schedule for Performance & Resources Committee meetings, Board Meetings and Board Seminars.

NHS Forth Valley Performance & Resources Committee

1. Tuesday 23 February 2016
2. Friday 26 April 2016
3. Tuesday 28 June 2016
4. Tuesday 30 August 2016
5. Tuesday 25 October 2016
6. Tuesday 20 December 2016

Forth Valley NHS Board

1. Tuesday 26 January 2016
2. Tuesday 29 March 2016
3. Tuesday 31 May 2016
4. Tuesday 07 June 2016 (Special Board meeting to approve annual accounts – will follow on from the NHS Board Seminar)
5. Tuesday 2 August 2016
6. Tuesday 27 September 2016
7. Tuesday 29 November 2016

Forth Valley NHS Board Seminars

1. Tuesday 16 February 2016
2. Tuesday 19 April 2016
3. Tuesday 07 June 2016
4. Tuesday 06 September 2016
5. Tuesday 18 October 2016
6. Tuesday 13 December 2016

All meetings will commence at 9.00am and will be held in the NHS Forth Valley Headquarters, Carseview House, Castle Business Park, Stirling, FK9 4SW, unless advised otherwise.