Finance, Performance and Resources Committee

Tue 10 May 2022, 09:00 - 12:00

via MS Teams

Agenda

09:00 - 09:00
0 min

1. Apologies for Absence

Rona Laing

09:00 - 09:00
0 min

2. Declaration of Members' Interests

Rona Laing

09:00 - 09:00
0 min

3. Minutes of Previous Meeting held on Tuesday 15 March 2022

Rona Laing

- Item 3 - Unconfirmed FPR Minutes March 2022 V2 mm.pdf (7 pages)

09:00 - 09:00
0 min

4. Matters Arising / Action List

Rona Laing

- Item 4 Action List - FPR.pdf (3 pages)

09:00 - 09:00
0 min

5. GOVERNANCE MATTERS

5.1. Finance, Performance & Resources Committee Annual Statement of Assurance 2021/2022

Gillian MacIntosh

- Item 5.1 SBAR FPR Annual Report.pdf (3 pages)
- Item 5.1 - FPR Annual Statement of Assurance 2021-22.pdf (23 pages)

5.2. Board Assurance Framework – Financial Sustainability

Margo Mcgurk

- Item 5.2 BAF Financial Sustainability - SBAR FPR April 2022 MMi mm.pdf (4 pages)
- Item 5.2 1. NHS Fife Board Assurance Framework (BAF) V36.0 080422 - Financial sustainability.pdf (1 pages)
- Item 5.2 1. BAF Risks - Financial Sustainability - Linked operational risks as at 080422.pdf (1 pages)

5.3. Board Assurance Framework – Strategic Planning

Margo Mcgurk

- Item 5.3 SBAR FPRC BAF 5 3 5 22 v2.pdf (3 pages)
- Item 5.3 5. NHS Fife Board Assurance Framework (BAF) V36.0 300322 - Strategic Planning.pdf (1 pages)

5.4. Board Assurance Framework – Environmental Sustainability

Neil McCormick

- Item 5.4 - SBAR (BAF) Environmental Sustainability FP&R May 2022 (1).pdf (3 pages)
- Item 5.4 - 2. NHS Fife Board Assurance Framework (BAF) V33.0 160322 - Environmental Sustainability.pdf (1 pages)
- Item 5.4 - 2. BAF Risks - Environmental Sustainability - Linked operational risks as at 160322.pdf (1 pages)

5.5. Risk Management Improvement Programme Progress Report

Gemma Couser

- Item 5.5 SBAR Risk Management Improvement Programme Update for FPRC on 100522 V1.0 (1).pdf (12 pages)

5.6. Review of General Policies & Procedures

Gillian MacIntosh

- Item 5.6 - SBAR - General Policies and Procedures Update.pdf (11 pages)

5.7. Review of Annual Workplan

Gillian MacIntosh

- Item 5.7 SBAR Review of Annual Workplan.pdf (5 pages)

5.8. Committee Development Sessions Programme 2022/23

Rona Laing/ Margo McGurk

- Item 5.8 Committee Development Session Programme 2022 2023mm (1).pdf (3 pages)

09:00 - 09:00
0 min

6. STRATEGY / PLANNING

6.1. Corporate Objectives 2022/2023

Margo Mcgurk

- Item 6.1 SBAR Proposal on Corporate Objectives FP&R.pdf (4 pages)

6.2. Fife Capital Investment Group Report 2022/2023

Maxine Michie

- Item 6.2 Fife Capital Investment Group Report 2022-2023.pdf (6 pages)

6.3. Orthopaedic Elective Project

Janette Owens

- Item 6.3 - SBAR FEOC.pdf (7 pages)

6.4. Kincardine & Lochgelly Health Centres Business Case

Ben Johnstone

- Item 6.4 - 20220420 L-K HC OBC - FPR SBAR.pdf (7 pages)
- Item 6.4 KHC OBC - 20.04.22 Rev. 5.pdf (92 pages)
- Item 6.4 LHC OBC - 20.04.22 Rev. 5.pdf (101 pages)

09:00 - 09:00
0 min

7. QUALITY / PERFORMANCE

7.1. Integrated Performance & Quality Report

Maxine, Claire & Nicky

- Item 7.1 - SBAR FPR Committee (1).pdf (3 pages)
- Item 7.1 - IPQR Apr 2022.pdf (44 pages)

7.2. Progress of Annual Delivery Plan (RMP4) 2021/2022

Susan Fraser

- Item 7.2 - SBAR FPRC Annual Delivery Plan RMP4 Update 29 4 22.pdf (9 pages)
- Item 7.2 - Appendix 2 Review of national response to Winter 2021 v1.0 (1).pdf (21 pages)
- Item 7.2 - Appendix 3 Winter Planning Performance Summary Mar 2022 v1.0 EDG (1).pdf (5 pages)

09:00 - 09:00
0 min

8. LINKED COMMITTEE MINUTES

Rona Laing

8.1. Minutes of the Capital Investment Group held on 9 March 2022

- Item 8.1 - FCIG Notes March 2022 v2.pdf (4 pages)

8.2. Minutes of the Pharmacy Practice Committee held on 18 March 2022 (unconfirmed)

- Item 8.2 - PPC 18 March 2022 Report and Appendices.pdf (48 pages)

09:00 - 09:00
0 min

9. ESCALATION OF ISSUES TO NHS FIFE BOARD

Rona Laing

9.1. To the Board in the IPQR Summary

9.2. Chair’s comments on the Minutes / Any other matters for escalation to NHS Fife Board

09:00 - 09:00
0 min

10. Any Other Business

Rona Laing

MINUTE OF THE FINANCE, PERFORMANCE & RESOURCES COMMITTEE MEETING HELD ON TUESDAY 15 MARCH 2022 AT 09:30AM VIA MS TEAMS

RONA LAING
Chair

Present:

R Laing, Non-Executive Director (Chair)
C Potter, Chief Executive
M McGurk, Director of Finance & Strategy
W Brown, Employee Director
A Morris, Non-Executive Director
Dr J Tomlinson, Director of Public Health
J Owens, Director of Nursing

In Attendance:

N Connor, Director of Health & Social Care
N McCormick, Director of Property & Asset Management
Dr G MacIntosh, Head of Corporate Governance & Board Secretary
M Michie, Deputy Director of Finance
K Booth, Head of Financial Services & Procurement
A Graham, Associate Director of Digital and Information
L Stewart, PA to Director of Finance (Minutes)

1. Welcome / Apologies for Absence

The Chair welcomed everyone to meeting. Acknowledgement was made of staff efforts and all their continued hard work during a challenging time of continuing high pressure.

The Chair also highlighted the exceptional work of the Finance Department within this financial year, recognising the significant additional resource both in capital and revenue that has been achieved.

Apologies for the meeting had been received from members Alastair Grant, Non-Executive Director, Aileen Lawrie, Stakeholder member, Dr Chris McKenna, Medical Director, and Mansoor Mahmood, Non-Executive Director, and attendees Claire Dobson, Director of Acute Services, and Ben Hannan, Director of Pharmacy & Medicines.

Kevin Booth and Alistair Graham were both welcomed to the meeting to present papers.

2. Declaration of Members' Interests

No interests were declared.

3. Minute of the last Meeting held on 11 January 2022

The Committee formally **approved** the minute of the last meeting.

4. Action List / Matters Arising

The Committee **noted** the updates provided and the closed items on the Action List.

5. GOVERNANCE / ASSURANCE

5.1 Annual Review of Committee's Terms of Reference

The Head of Corporate Governance & Board Secretary introduced the paper noting that proposed amendments are identified as tracked changes in the document. One area of change includes adding a new clause to ensure the role of the Committee is clearly defined in the development of the new strategy.

Alistair Morris, Non-Executive Member, suggested that within section 1.2, the Committee should have a more strategic role than 'monitor' and asked the wording was reconsidered. After discussion, the Committee agreed that the wording should be amended in the version to be forwarded to the Board, to read 'consider, review and take assurance'.

Action: Head of Corporate Governance & Board Secretary

The Committee **approved** the refreshed Terms of Reference and **endorsed** the paper for Board approval subject to the agreed change of wording detailed above.

5.2 Committee Effectiveness Self–Assessment Report

The Head of Corporate Governance & Board Secretary presented the report to the Committee, thanking members for the time and effort put into providing valuable feedback on the Committee's operation. It was advised that the main themes from the return are common across all the Board committees. Most items highlighted are already being addressed through separate ongoing workstreams, such as review of data within the IPQR and the presentation of risks through the risk management improvement programme.

It was noted there is an ongoing requirement to review the agenda and papers being presented, to ensure that the committee make best use of time within the meeting. Alistair Morris, Non-Executive Member, highlighted that there is a need to ensure that papers presented to the Committee hold the right amount of detail, to ensure that Non–Executive Directors can review from a strategic perspective rather than getting into operational detail. The Chief Executive noted that balance is required, to ensure there is the right level of detail for individuals, as some members may prefer to see more than others. It could be part of our Active Governance actions if Non-Executives could provide feedback to authors following the meeting, to reflect on the level detail provided. It was agreed that time will be dedicated at each next agenda setting meeting to reflect on this point at each meeting and agree any improvements on a continuous basis.

The Committee agreed to the scheduling of Committee Development Sessions on a bi-annual basis and members were encouraged to contribute topics for discussion and 'deep-dives' at these sessions.

The Committee **took assurance** from this year's self-assessment exercise.

5.3 Annual Finance, Performance and Resources Committee Workplan

The Director of Finance & Strategy presented the revised workplan for the Committee 2022/23. It was highlighted that most items on the workplan are standing items. However, following discussions at the Board, the workplan may require amendments to incorporate specific activity relating to the Strategy Development as they are brought forward.

The Committee **approved** the current draft of the Workplan.

5.4 Board Assurance Framework – Financial Sustainability

The Director of Finance & Strategy presented the BAF on Financial Sustainability. It was highlighted that this iteration remains unchanged from the last presentation.

It was noted that, moving forward, there may require to be two risks reported on the Financial Sustainability BAF. One should relate to in-year financial performance and the other would be a risk on financial improvement and sustainability for the medium-term. This will be discussed and reviewed appropriately.

The Committee **considered** and **approved** the BAF and the moderate risk position reported.

5.5 Board Assurance Framework – Strategic Planning

The Director of Finance & Strategy presented the BAF on Strategic Planning noting no significant change to report and the risk remains moderate.

The Committee **considered** and **approved** the BAF and the moderate risk position reported.

5.6 Board Assurance Framework – Environmental Sustainability

The Director of Property and Asset Management presented the BAF on Environmental Sustainability. It was reported that the risk remains high in terms of statutory compliance. It was noted that the risk is being managed and mitigated and it is expected that this risk will be closed by the end of 2022.

The Committee **considered** and **approved** the BAF and the risk position reported.

5.7 Digital and Information – Business Case Process

Alastair Graham, Associate Director of Digital and Information, presented the paper which outlines a new process to the governance arrangements for digital and information activities.

The Committee took **assurance** from the report presented.

5.8 Annual Procurement Report 2020/21

Kevin Booth, Head of Financial Services and Procurement, presented the Annual Procurement Report 2020/21

The report details the 56 contracts that exceeded the £50,000 regulatory thresholds during the year, and it details future contracts which are due for renewal. It highlights the adoption of the Anchor Institution Programme, which works towards the community benefit aspirations. The report was presented to the Procurement Governance Board in January.

The Committee **agreed** to **recommend** the report for Board approval and took **assurance** that the 2021/22 report will be presented earlier in line with correct timescales.

5.9 Orthopaedic Elective Centre Financial Update

Maxine Michie, Deputy Director of Finance, introduced the paper to the Committee. It was highlighted that the Business Case for the Orthopaedic Centre was approved in late 2020 and work commenced in March 2021. The Workforce Workplan Group was then established to review the workplan in the Full Business Case. The initial workforce plans were reviewed and found to be insufficient for the expected demand. The new levels of staffing identified have now been agreed and approved by Scottish Government and reflect a significant increase in workforce.

There has been a £2m increase in staffing costs, which has increased from 30 WTE to 78 WTE members of staff.

The Director of Nursing noted that 14 applications were received for the Orthopaedic Consultant positions that were recently advertised and four Consultants have been successfully appointed.

The Committee took **assurance** from the report.

6. STRATEGY / PLANNING

6.1 Fife Capital Investment Group Report 2021/22

Maxine Michie, Deputy Director of Finance, introduced the report, noting that during 2021/22 , further opportunities were made available to NHS Fife to secure additional funding from Scottish Government. An additional £10.5m has been secured. In addition, a significant grant was received by NHS Fife to support greater energy efficiency across the estate. Introducing energy efficiency schemes will help to generate savings in later years.

The Chair recognised the significant amount of work undertaken to secure the additional funding. It was recognised that the spend achieved in 2021/22 is one of the largest capital programmes in NHS Fife for a number of years.

The Committee **noted** the position and took **assurance** from the report**.**

6.2 Hospital Electronic Prescribing and Medicines Administration (HEPMA)

Alastair Graham, Associate Director of Digital and Information, presented the paper which details significant issues with the HEPMA contract award and the eventual ceasing of negotiation with the preferred supplier in January 2022.

It is likely that a full re-procurement exercise will now be required, the Committee will be regularly updated on progress.

The Committee noted their disappointment that the procurement could not be concluded but were assured that this was a late decision on a major contractual term by the preferred supplier. The Committee took **assurance** from the report and specifically the lessons learned through this work.

7. QUALITY / PERFORMANCE

7.1 Integrated Performance & Quality Report (Inc. Q3 Review of Financial Position)

The Chair introduced the Integrated Performance & Quality Report (IPQR). It was noted that this iteration reflects the December 2021 position.

The Chief Executive provided an update on the Acute element of the IPQR report, as follows:

- A programme will be launched for urgent and unscheduled care to discuss the government position on the 4-hour access target. A milestone plan may be developed for 2022/23 to ensure interim targets are achieved.
- The A&E performance on the 4-hour target was improving and was above the Scottish average but under the 95% target.
- The OPEL framework is in place to support and manage situations on site, providing clarity to managers on what actions to take.
- On 15 March 2022, the OPEL position is purple. There have been a number of 12-hour breaches over the last two days. There has been an increase in Covid patients, with 50 Covid-positive patients currently onsite at VHK. There are long waits and increased volumes of patients in A&E.
- HSCP have been managing discharges well to support the flow.
- There is ongoing pressure on the nursing workforce.
- TTG performance from week ending 6 March 2022 saw approximately 80% of pre-Covid elective activity achieved.

The Director of Health & Social Care provided an update on the Health & Social Care element of the IPQR report:

- As of 15 March 2022, the delayed discharge position is improving in terms of trajectory. Standard delay is currently sitting at 46, including mental health, and 96 in overall delay. Total bed days lost are 486 compared to November's 1082. This has improved significantly.
- A weekly verification process is in place to examine patients on delayed discharge and the HSCP continue to utilise redirection of patients through flow and the hub.

The Deputy Director of Finance provided an update on the Capital and Revenue position.

- The December 2021 position reported an overspend of £14m due mainly to external commissioning costs and Acute services spend.
- The HSCP was reporting £600k underspend, following a cash transfer to Fife Council for £3.7m. A final transfer will be undertaken at the end of the financial year to reflect the forecast underspend within the Partnership.
- The forecast outturn of £13.7m should be achieved.
- The Board was committed to deliver £8m savings, £9.6m has been delivered due to additional in-year non-recurring savings.

The Committee **discussed** and **considered** NHS Fife performance and took **assurance** on the report.

7.2 Integrated Performance & Quality Report Review Process

The Director of Finance & Strategy presented the paper on progress with the IPQR Review Process.

The range of proposed improvements were discussed and supported by the Committee. The Director of Finance & Strategy suggested that a Non-Executive Member may wish to be involved in the development of the IPQR, this was agreed and contact will be made in due course to facilitate that engagement on this work.

The Committee took **assurance** from the report and the proposed changes as part of the IPQR Review.

7.3 Joint Remobilisation Plan 2021/22 – Winter Plan Actions

The Director of Nursing presented the report.

The Chair questioned the impact on the 'Moving On Policy' and it was noted that actions are ongoing to mitigate the risks in this area.

The Committee **discussed** the progress of deliverables within the Joint Remobilisation Plan 4 and took **assurance** from the report.

7.4 Operational Pressures Escalation Levels (OPEL)

The Chair presented the paper to the Committee. It was noted that there were significant and in-depth discussions on this at the last Board Development Session and the paper is therefore presented to the Committee for assurance.

The Committee **considered** the paper and **confirmed** that progress presented in the paper provides **assurance**.

8. LINKED COMMITTEE MINUTES

8.1 Minute of IJB Finance & Performance Committee, dated 10 November 2021

The Committee **noted** the Minutes of the Integration Joint Board Finance & Performance Committee, dated 10 November 2021.

8.2 Minute of Procurement Governance Board, dated 28 January 2022

The Committee **noted** the Minutes of the Procurement Governance Board, dated 28 January 2022.

8.3 Minute of Fife Capital Investment Group, dated 1 February 2022

The Committee **noted** the Minutes of the Fife Capital Investment Group, dated 1 February 2022.

8.4 Minute of Primary Medical Services Committee, dated 1 March 2022

The Committee **noted** the Minutes of the Primary Medical Services Committee, dated 1 March 2022.

9. ITEMS TO BE ESCALATED TO THE BOARD

The Committee reviewed and supported the key assumptions with the financial plan for 2022/23 and recommend the plan for Board approval. The Committee noted specifically the important work of the Financial Improvement and Sustainability Programme as we move into 2022/23.
The Committee also commended the work done by the finance team to attract and deliver an additional capital allocation of over £10m in 2021/22.

10. ANY OTHER BUSINESS

There were no other items of business considered.

Date of Next Meeting: Tuesday 10 May 2022 at 9.30am via MS Teams.

KEY:	Deadline passed / urgent
	In progress / on hold
	Closed

FINANCE, PERFORMANCE & RESOURCES COMMITTEE – ACTION LIST

Meeting Date: Tuesday 11 January 2022

NO.	DATE OF MEETING	AGENDA ITEM / TOPIC	ACTION	LEAD	TIMESCALE	COMMENTS / PROGRESS	RAG
1.	10/09/19	**Kincardine & Lochgelly Health & Wellbeing Centres Initial Agreements**	Include in the Outline Business Cases information on how technology and digitisation would be utilised.	**JT**	TBC – see comments	The OBC will incorporate information on IT and digital elements of the project. The project team are progressing discussions with IT and are seeking clarification on funding steams as well as preparing a full technical brief for the project. The digital initiatives under consideration at this stage are listed below: •A patient appointment system •A consultant room with near me facilities •A GP text messaging system • A self check-in facility •Subject to security considerations, public access to IT equipment to combat digital poverty	In progress
2.	07/09/21	**Integrated Performance & Quality Report**	A paper on the remits and responsibilities of the new senior management team roles within the Health & Social Care Partnership, for information to be provided to the Chair.	**NC**	September 2021	November 2021 - Closed	Closed
3.	07/09/21		The Director of Finance & Strategy agreed to report back to the Chair out with the meeting on the point raised in relation to the health delegated budget of £0.332m.	**MM**	September 2021	November 2021 - Closed	Closed

NO.	DATE OF MEETING	AGENDA ITEM / TOPIC	ACTION	LEAD	TIMESCALE	COMMENTS / PROGRESS	RAG
4.	08/09/20	**Mental Health Strategy**	Present a paper to the Committee at appropriate time around the implementation of the Mental Health Strategy.	**NC**	November 2021	November 2021 - Closed	Closed
5.	10/11/20	**CAMHS**	Provide an update to the Committee on which recommendations made by the Scottish Government can be actioned, once agreed by HSCP Senior Leadership.	**NC**	November 2021	November 2021 - Closed	Closed
6.	07/09/21	**NHS Fife Population Health and Wellbeing Strategy Development Progress**	A group had been involved in exploring the best approach to engagement with the public and an update will be shared with the Chair once feedback has been received.	**MM**	Once feedback has been received	RL to check if this should move to H&WB Committee	Closed
7.	07/09/21	**Review of Health & Social Care Integration Scheme**	It was agreed a further discussion on the Health & Social Care Integration guidance on the use of Directions be brought back to a future meeting, for members' information	**NC**	A future meeting – still to be agreed	Further directions will come forward to the FPR Committee when available.	Closed
8.	07/09/21	**Items to be Escalated to NHS Board**	The Chair and Director of Finance & Strategy agreed to discuss items to be escalated to the Board out with this meeting.	**MM / Chair**	September 2021	20/09/21 – Closed. Items agreed.	Closed
9.	09/11/21	**SPRA – Financial Information**	The Director of Finance should provide a detailed paper on the financial support received to date and the full financial plan. Alongside the SPRA process.	**MM**	March 2022		Closed
10.	09/11/21	**BAF Environmental Sustainability**	It was agreed that the Director of Property and Asset Management will review the typo included in the risk review date for the BAF.	**NM**	March 2022		Closed
11.	09/11/21	**Action Plan for 4 hour access target**	The Director of Acute services will provide a paper detailing the actions in place regarding the 4 hour access target following meetings with the unscheduled care team.	**CD**	March 2022	21/02/22 – Closed. Issue reported routinely through IPQR.	Closed
12.	11/01/22	**Community Asset Transfer Request for Land at Stratheden - Lucky Ewe**	The Director of Estates and Facilities will provide a paper highlighting key details in the proposal made by Lucky Ewe for consideration by the Committee.	**NM**	March 2022 and May 2022		

NO.	DATE OF MEETING	AGENDA ITEM / TOPIC	ACTION	LEAD	TIMESCALE	COMMENTS / PROGRESS	RAG
13.	15/03/22	**Committee TORs**	The Head of Corporate Governance & Board Secretary will update section 1.2 of the TORs to detail that the Committee will '…consider, review and take assurance…' rather than 'monitor'.	**GM**	March 2022		
14.	15/03/22	**Committee Annual Workplan**	The Director of Finance and Strategy will present a second iteration of the workplan in May 2022 following additions for Strategy Development.	**MM**	May 2022		

NHS Fife

Meeting:	**Finance, Performance & Resources Committee**
Meeting date:	**10 May 2022**
Title:	**Draft Finance, Performance & Resources Committee Annual Statement of Assurance 2021-22**
Responsible Executive:	**Margo McGurk, Director of Finance & Strategy**
Report Author:	**Gillian MacIntosh, Board Secretary**

1 Purpose

This is presented to the Committee for:

- Assurance

This report relates to a:

- Legal requirement
- Local policy

This aligns to the following NHSScotland quality ambition(s):

- Effective

2 Report summary

2.1 Situation

All formal Committees of the NHS Board are required to provide an Annual Statement of Assurance for the NHS Board, which is consider initially by the Audit & Risk Committee. The requirement for these statements is set out in the Code of Corporate Governance. The Finance, Performance & Resources Committee is invited to review the draft of this year's report and comment on its content, with a view to approving a final paper for onward submission.

2.2 Background

Each Committee must consider its proposed Annual Statement at the first Committee meeting of the new financial year, as per the Committee's workplan. The current draft takes account of initial comments received from the Committee Chair and Director of Finance & Strategy.

2.3 Assessment

In addition to recording practical details such as membership and rates of attendance, the format of the report includes a more reflective and detailed section (Section 4) on agenda business covered in the course of 2021-22, with a view to improving the level of assurance given to the NHS Board.

2.3.1 Quality/ Patient Care

Delivering robust governance across the organisation is supportive of enhanced patient care and quality standards.

2.3.2 Workforce

N/A.

2.3.3 Financial

The production and review of year-end assurance statements are a key part of the financial year-end process.

2.3.4 Risk Assessment/Management

The identification and management of risk is an important factor in providing appropriate assurance to the NHS Board.

2.3.5 Equality and Diversity, including health inequalities

This paper does not relate to the planning and development of specific health services, nor any decisions that would significantly affect groups of people. Consequently, an EQIA is not required.

2.3.6 Other impact

N/A.

2.3.7 Communication, involvement, engagement and consultation

N/A.

2.3.8 Route to the Meeting

This paper has been considered in draft by the Committee Chair and Executive Lead and has been reviewed by EDG at its meeting on 22 April.

2.4 Recommendation

The paper is provided for:

- **Approval** – subject to members' comments regarding any amendments necessary, for final sign-off by the Chair and submission to the Audit & Risk Committee.

Report Contact
Dr Gillian MacIntosh
Head of Corporate Governance & Board Secretary
gillian.macintosh@nhs.scot

ANNUAL STATEMENT OF ASSURANCE FOR THE FINANCE, PERFORMANCE & RESOURCES COMMITTEE 2021/22

1. Purpose of Committee

1.1 The purpose of the Committee is to keep under review the financial position and performance against key non-financial targets of the Board, and to ensure that suitable arrangements are in place to secure economy, efficiency and effectiveness in the use of all resources, and that these arrangements are working effectively.

2. Membership of Committee

2.1 During the financial year to 31 March 2022, membership of the Finance, Performance & Resources Committee comprised:

Rona Laing	Chair / Non-Executive Member
Wilma Brown	Non-Executive Stakeholder Member
Eugene Clarke	Non-Executive Member (to July 2021)
Alastair Grant	Non-Executive Member (from September 2021)
Aileen Lawrie	Area Clinical Forum Representative
Mansoor Mahmood	Non-Executive Member (from September 2021)
Margo McGurk	Director of Finance & Strategy
Dona Milne	Director of Public Health (to May 2021)
Alistair Morris	Non-Executive Member
Dr Chris McKenna	Medical Director
Janette Owens	Director of Nursing
Carol Potter	Chief Executive
Joy Tomlinson	Director of Public Health (from May 2021)

2.2 The Committee may invite individuals to attend the Committee meetings for particular agenda items, but the Director of Acute Services, Director of Health & Social Care, Director of Property & Asset Management, Director of Pharmacy & Medicines and Board Secretary will normally be in attendance at Committee meetings. Other attendees, deputies and guests are recorded in the individual minutes of each Committee meeting.

3. Meetings

3.1 The Committee met on six occasions during the financial year to 31 March 2022, on the undernoted dates:

- 11 May 2021
- 13 July 2021

- 7 September 2021
- 9 November 2021
- 11 January 2022
- 15 March 2022

3.2 The attendance schedule is attached at Appendix 1.

4. Business

4.1 The business of the Committee during the year continues to have been impacted greatly by the need for NHS Fife as a whole to address the ongoing challenges of the global Covid pandemic. The Committee Chair has liaised closely with the Director of Finance & Strategy, as lead Executive Officer, to identify what business must be considered by the Committee and what must be prioritised in agenda planning. In the period covered by this report, some routine business has been suspended or deferred, with the occasional meeting running with a prioritised agenda. This has maximised the time available for management and operational staff to deal with the significant challenges of addressing Covid-surge-related demand within clinical services, and, at the same time, allowed the Board to appropriately discharge its governance responsibilities. The Committee workplan has been regularly reviewed to ensure that new items related to Covid have been covered appropriately and that the required assurances could be provided to the Board throughout the year and as part of the year-end process.

4.2 In October 2021, the Board established a new Public Health & Wellbeing Committee, which has taken under its remit some areas previously covered by the Finance, Performance & Resources Committee (chiefly scrutiny over mental health performance delivery in Child & Adolescent Mental Health Services (CAMHS) and Psychological Therapies (PT)). A review of workplans and terms of reference has attempted to limit any duplication in reporting and enhance clarity on roles and responsibilities. This remains, however, a work-in-progress, as the new Committee develops, and gives the Finance, Performance & Resources Committee an opportunity for more focused agendas and enhanced scrutiny on the key aspects of business aligned to its specific remit.

4.3 At each meeting the Finance, Performance & Resources Committee considers the most up-to-date financial position for the year for both revenue and capital expenditure. This function is of central importance, as the Committee provides detailed scrutiny of the ongoing financial position and on aspects of operational performance across NHS Fife activities, including those delegated to the Integration Joint Board. Considerable time was spent in meetings discussing and reviewing the financial pressures facing the Board, the delivery of in-year savings and consideration of the financial consequences, particularly of Covid. Updates on the predicted year-end position were presented and discussed by members.

4.4 The Finance, Performance & Resources Committee's first meeting of the 2021/22 reporting year took place in May 2021. An update on the budget setting process for 2021/22 was given, including its relationship with the Strategic Planning & Resource Allocation process (SPRA), then in its initial phase of operation.

4.5 In January 2022, the Committee gained assurance from a detailed report proposing the creation of a dedicated Financial Improvement & Sustainability Programme, building on the solid foundation provided by the first two years of the SPRA. Members noted that NHS Fife are committed to delivering a cost improvement programme that has capacity to deliver substantial cost reduction benefits. It was noted that, moving forward, there may require to be two risks reported on the Financial Sustainability Board Assurance Framework. One would relate to in-year financial performance and the other would be a risk on financial improvement and sustainability for the medium-term. This will be discussed and reviewed appropriately by the Committee in the year ahead.

4.6 The Committee has received updates on financial planning in light of the Covid response, with further iterations of the Board's Remobilisation Plan prepared and submitted to members, prior to seeking Scottish Government agreement on its content. In May 2021, the Committee considered in Private Session comments received from the Scottish Government on the Board's Remobilisation Plan 3, noting the requirement for further discussion on the management of legacy savings from 2020/21. In September 2021, an update on the next iteration of the Remobilisation Plan (RMP4) was given, which also encompassed the annual Winter Plan actions. An action tracker, outlining key actions and progress on deliverables, has helped support the delivery of the Plan and scrutiny of its achievements against target dates.

4.7 Updates have been given to the Committee on the Strategic Planning & Resource Allocation process for 2022-23, now in its second year of operation, which has generated key content to support the Remobilisation Plan for 2022/23, financial and workforce plans and the Corporate Objectives for the year. It is considered that this focus will improve the overall lines of reporting and assurance to the Committee over the forthcoming year. Ongoing reports have been provided on the Strategy Development work, including details on the proposed engagement approach and the development of the Population Health Needs Assessment, which will create the baseline for the new strategy. Development of the individual workstreams are being taken forward through a Portfolio approach involving all members of the Executive Directors' Group. Overall, the workstreams will be linked to the five national care programmes that have been initiated by the Scottish Government. Early engagement has taken place with key stakeholders and members of the public, and updates have been given to the Committee thereon. The Public Health & Wellbeing Committee is the lead Committee for the development of the new Strategy, though the Finance, Performance & Resources Committee will continue to have a specific role in the scrutiny and assurance of the financial plan.

4.8 The draft Corporate Objectives 2021/22 were presented to the Committee in July 2021. The report described what NHS Fife aims to achieve in-year, in tandem with a looking-back review of Directors' Objectives for 2020/21. Each objective has been carefully refined, with details on what Directors are leading on or supporting more generally. The objectives are framed under the four key strategic priorities of the Board and reference the ongoing Strategy Development work being undertaken in this reporting year. The Committee were pleased to endorse the Corporative Objectives for onward submission to the Board for formal approval.

4.9 The Committee scrutinised operational performance at each meeting through review of the Integrated Performance & Quality Report (IPQR), specifically those measures that fall within its own remit (performance updates related to CAMHS and Psychological Therapies have transitioned to come under the responsibility of the new Public Health & Wellbeing Committee over the year). The impact of coronavirus on traditional key performance measures monitored by the Committee was significant, particularly in relation to Treatment Times Guarantee measures, numbers of new referrals and diagnostic performance. In general, the plans to tackle the resultant backlog from the pause of services during the height of the pandemic remains a significant focus of the Committee going forward. Demand for services has continued to exceed expectation for much of the year, leading to significant pressures particularly at the front-door of the Emergency Department. Spikes in Covid-related infection have continued to negatively impact upon the delay position and discharge / flow, with the Committee receiving a specific paper on this issue at its September 2021 meeting. Scrutiny of the actions underway to improve the situation was undertaken, with members noting the negative impact on whole-system care, quality and workforce in consequence of the delay position.

4.10 The Committee discussed planning for the Winter Period (as part of the Board's Remobilisation Plan) and reflected on Winter performance via a report on the 2020/21 period. It was recognised that, particularly with Covid activity ongoing, planning for pressures and surges was, in essence, a year-round activity, which goes beyond the actual Winter season. Services have been recovering as well as remobilising, and close working relationships (particularly with colleagues in the Health & Social Care Partnership) have helped to manage delay and flow, with varying results across the

year. It has been important for the Board continuously review proposals to mitigate capacity issues, to ensure that pressures 365 days per year are accounted for in overall planning. Activity levels have at some periods been unrelenting, and the Committee were fully apprised of the impact this had on the variability of performance overall, particularly around key targets such as A&E attendances. Clinical prioritisation, however, ensures that the most urgent cases continue to receive timely treatment. In March 2022, members were pleased to note the introduction of a new Operational Pressures Escalation Levels (OPEL) process, which is helping manage day-to-day pressures, with clear triggers for action and escalation.

4.11 At the Committee's July 2021 meeting, members received an update on the Smoke-Free Environmental Strategy, which closed an action on the Committee rolling action list in reference originally to work to support smoking cessation at the Stratheden Intensive Psychiatric Care Unit (IPCU).

4.12 The Committee has considered updates around the status of General Policies & Procedures, noting that the introduction of a new post-holder in the Corporate Governance support team has led to considerable work being undertaken to improve the follow-up processes and guidance available to staff. The format and content of the report to the Committee has also been enhanced to provide clearer detail and assurance around areas that require further follow-up work. Members have previously been supportive of efforts to move to a more streamlined review process, utilising electronic software solutions where appropriate, and this remains under review with an option appraisal process underway by Clinical Governance colleagues. Dedicated staff resource secured to assist with the general administration and review of General Policies is expected to improve the situation in the long term with the backlog of overdue reviews and the Committee will receive ongoing updates on this, for assurance.

4.13 The Committee considered progress in relation to the following capital schemes:

- Fife Orthopaedic National Treatment Centre
- Hospital Electronic Prescribing & Medicines Administration (HEPMA)
- Kincardine & Lochgelly Health Centres
- Robotic Assisted Surgery

4.14 Ongoing quarterly updates were provided to members on the progress with the Elective Orthopaedic Centre construction project. A report from NHS Scotland Assure was considered in May 2021, which reviewed the delivery, quality and sustainability of the build and assessed the capability and capacity of the Board to deliver the project on time and on budget. Two risks identified in the report were discussed and assurance provided that both had the required mitigation in place. The NHS Scotland Assure review process is intended to support local work by providing a central bank of knowledge and intelligence to support boards deliver large-scale capital projects. Members were pleased to note its findings and took assurance from the proposed governance routes set out to close the residual actions arising from the report. In July 2021, an update on build progress was given, outlining a number of developing issues on construction material availability and associated price increases, which were being actively managed by the Project Board. Further information was given on work ongoing with Fife Health Charity to enhance the patient and staff areas and deliver supplementary audio visual capability within theatres. The Committee also took assurance from the dedicated workforce strategy within the programme to ensure availability of appropriately-trained staff by its opening. In November 2021, further detail was given on workforce planning and also the service model being designed for the new centre, and in March 2022 members received information on recruitment of posts and the financial implications and additional Scottish Government funding required to support an increase in planned workforce for the Centre.

4.15 At the Committee's March 2022 meeting, members received a report detailing significant contractual issues with the HEPMA contract award and the eventual ceasing of negotiation with the preferred supplier in January 2022. It was noted that a full re-procurement exercise will now be required. The Committee noted their disappointment that the original procurement process could not be concluded successfully, but recognised that this was a late decision on a major contractual

term by the preferred supplier. The Committee took assurance that lessons learned throughout the original negotiations will help assist the revised procurement stage for a replacement supplier.

4.16 Updates on the Outline Business Case for the new Kincardine & Lochgelly Health & Wellbeing Centres were delivered to the Committee at its 2021/22 meetings. Consultation with local stakeholders and design of the replacement Health Centres progressed throughout the year and, in July 2021, the Committee received a detailed update on progress in creating the Outline Business Case. Communication with local communities was noted as being critical, with the creation of a number of 'personas' to help support delivery of the project aims.

4.17 In March 2021, the Committee supported the initial Business Case for the purchase of a surgical robot. The Business Case was updated and reviewed by the Committee in May 2021, with a final Business Case following in July 2021. Members recognised the significant capital funding received to support the procurement of a surgical robot was an important development in enhancing surgery in Fife and driving forward innovation. Detail was provided on how Acute Services would manage the revenue costs of this programme within the directorate. The launch of this service will deliver clinical benefits to patients and be an important driver in attracting highly skilled staff to work in Fife, and these benefits were warmly welcomed by members.

4.18 The Committee also considered and endorsed the Capital Formula Allocation for 2021/22, which provided budget distributions from the core capital allocation of £7.2m. Detail was provided on the individual projects and business cases being supported. In September 2021, a specific report on the work of the Fife Capital Investment Group (FCIG) was considered, with discussion on the risk mitigation processes in place to help lessen supply chain-related shortages. At the same meeting, a detailed report on the Quarter 1 Financial Review 2021/22 was discussed with members, with focus on the risk of unachieved (and legacy) savings, the pressures in respect of Service Level Agreements and the longer term-impact of Covid on the Board financial position. Committee members recognised that delivery of savings in-year, when the workforce remains under significant pressure, is very challenging and were assured that the review process outlined viable medium-term cash reduction plans, to help the Board achieve recurring financial balance in the next three years. In November 2021, the Annual Report of FCIG was reviewed and an update received on the targeted spend of the full capital allocation by the end of March 2022. It was recognised that the spend achieved in 2021/22 supported the largest capital programme in NHS Fife for a number of years, and Finance and Property and Assets colleagues were congratulated on their efforts.

4.19 The annual Public Private Partnership (PPP) Monitoring Report for 2020/21, covering the sites of St Andrews Community Hospital and Phase 3 of the Victoria Hospital in Kirkcaldy, was considered by the Committee in November 2021, with members gaining assurance from the positive audit opinion detailed therein. Members reviewed the interim Property & Asset Management Strategy (PAMS) update for 2020 at its March 2021 meeting, with a further update on the preparation of the full strategy given in July, prior to the final document coming forward to the November 2021 meeting. It was recognised that the PAMS document is an important supporting framework to the development of the organisation strategy, describing how the NHS Fife estate will help deliver and support its ambitions. The current iteration, considered by the Committee in November 2021, gave a local focus to the work underway in NHS Fife related to Anchor Institution ambitions, plus further detail on our plans to improve Environmental Sustainability though our work on zero carbon initiatives, enhancing green spaces and embracing bio-diversity. Members noted that NHS Fife has a large estate footprint and diverse asset base, with considerable potential for this to be better exploited in the future. Another learning point to be captured further in future planning is the impact of remote working, which has increased greatly in the pandemic, and has consequences for how we best use our estate and existing buildings going forward. Members greatly welcomed the report's enhancements, noting its strategic focus across the wider organisation has direct relevance to the work underway in developing a new organisational strategy to help serve our local communities.

4.20 In July 2021, the Committee considered a report on the Transfer of Third-Party Leases from GP practices, to help support GP sustainability. The Committee took assurance on the interim arrangements being put in place for the first two premises and the discussions ongoing to help support the policy changes overall. In September 2021, members reviewed a paper outlining the ongoing Primary Care Premises Review, which will help support the delivery of the new General Medical Services Memorandum of Agreement (GMS MoU2). This workstream is also of critical importance to the development of the organisational strategy, to help alleviate pressures within GP practices and to ensure that local services appropriately address local needs. Members supported this approach, which is an important cornerstone of the work being undertaken to review the NHS Fife property and asset needs and requirements over the longer term.

4.21 The Committee has received a briefing on the Board's participation in the Non-Domestic Energy Efficiency Framework (NDEE), which aims to support public sector bodies to decarbonise and use less energy. Members noted the Board had been successful in its bid for funding to support low energy initiatives, which will have a positive impact on financial savings and help improve carbon off-setting performance. In March 2022, a further update was given, with members welcoming the significant grant received by NHS Fife to support greater energy efficiency across the estate.

4.22 The Committee received initial updates on a Community Asset Transfer (CAT) request, submitted under the Community Empowerment Act 2015, by a charity body seeking a long-term lease of mainly agricultural land adjacent to the Stratheden Hospital site. Members agreed to a short-life working group being established to formally evaluate the request and its supporting business case against the defined criteria described in the legislation, with a recommendation on the proposal expected in May 2022. A scoring matrix was developed to enable the proposal to be appraised against key indicators.

4.23 In November 2020, the Committee originally considered the South East Payroll Consortium Business Case, which has also been considered by the Staff Governance Committee. The proposal outlines the ambition to build a single employer, with multiple bases, to ensure the resilience of payroll on a regional basis in the future, given long-standing capacity challenges across boards. Members supported the proposal in principle, noting the criticality of the service to the Health Board, but recommended discussions take place about a more phased approach than the draft timeline suggested. A further update was given in January 2022, where an addendum to the original Business Case was given to address previously submitted feedback, particularly around the staff TUPE process and phasing of the implementation. Given that staffing levels in the local payroll team continue to represent a significant risk to the organisation, and also recognising the criticality of the function, members welcomed the resilience the consortium approach would provide. The Committee supported the implementation of the regional solution as soon as practically possible.

4.24 In March 2022, the Committee considered and endorsed the Annual Procurement Report, which sets out compliance with national standards in relation to procurement.

4.25 The Committee considered the revised Fife Integration Scheme. The Committee took assurance from and endorsed the revisions particularly within the finance section. The formal sign-off by Scottish Government was achieved in March 2022. The Committee has also considered further guidance on the IJB's increasing use of Directions at its meeting in November 2021, which indicates how Directions to NHS Fife will be issued, responded to and monitored on a performance-related basis. Members noted the helpful clarity that Directions provide and agreed that the Committee will receive such instructions from the IJB as required.

4.26 The Committee considered internal audit reports relevant to its remit and the actions required thereunder, which are monitored for completion by the Audit & Risk Committee. Also considered in July 2021 was an internal audit report on Financial Process Compliance, with the auditors' findings discussed and noted. Members noted that there had been no requirements to revise any internal control mechanism across the Board during Covid, and that commendation had been given

to work undertaken to redistribute staff to ensure procurement-related work and securing PPE were prioritised at key stages of the pandemic. The Annual Internal Audit report was considered in November 2021, with members noting the positive comments from the auditors on the SPRA and strategy development process. In addition, in July 2021, the Committee received the annual report on the Laboratories Managed Service Contract, focused on the performance against contract.

4.27 An updated draft of the Board's Model Publication Scheme, required under Freedom of Information legislation, was also considered and approved at the Committee's meeting in July, noting its relevance to ensuring improved FOI performance more generally.

4.28 Minutes of Committee meetings have been approved by the Committee and presented to Fife NHS Board. The Board also receives a verbal update at each meeting from the Chair, highlighting any key issues discussed by the Committee at its preceding meeting. The Committee maintains a rolling action log to record and manage actions agreed from each meeting, and reviews progress against deadline dates at subsequent meetings. The format of the action log has been enhanced, to provide greater clarity on priority actions and their due dates.

5. Outcomes

5.1 The Committee has, through its scrutiny and monitoring of regular finance reports and other one-off reports, been able to assure the Board that NHS Fife:

- complied with statutory financial requirements and achieved its financial targets for the financial year 2021/22;
- met specific reporting timetables to both the Board and the Scottish Government Health & Social Care Directorates;
- exceeded the in-year efficiency saving target, though this required Scottish Government support for the historical underlying target associated with a recurring overspend in Acute services; and
- has taken account of planned future policies and known or foreseeable future developments in the financial planning process.

6 Best Value

6.1 The introduction of both the SPRA process in 2020/21 and the Financial Improvement & Sustainability Programme in 2021/22 build on the aims of the previous organisational Best Value Framework (2018). Their combined impact facilitates a more effective triangulation of workforce, operational and financial planning, which supports the promotion and delivery of best value across all of our resource allocation. The Committee supported both these initiatives and throughout 2021/22 received progress reports and plans for consideration. The Committee were able to take ongoing assurance that the organisation had the plans and processes in place to promote and deliver best value.

6.2 Appendix 2 provides evidence of where and when the Committee considered the relevant best value characteristics during 2021/22.

7 Risk Management

7.1 In line with the Board's agreed risk management arrangements, the Committee considered risk through a range of reports and scrutiny, including oversight on the detail of the Board Assurance Frameworks (BAF) covering Financial Sustainability, Strategic Planning and Environmental Sustainability. Progress and appropriate actions were noted. The Committee monitored and took assurance from the BAF reporting on Financial Sustainability throughout the year and particularly the additional costs and funding associated with the Covid response and the delivery of in-year and historical efficiency savings.

7.2 In the current year, the complexity of financial reporting remained high, as a result of maintaining the core and Covid financial monitoring and reporting arrangements. The Committee has maintained an appropriate focus on these risks in its discussions, in addition to its regular scrutiny of the Financial Sustainability BAF and the tracking of the high risks identified therein.

7.3 The Committee closely monitored the position in relation to Financial Sustainability, noting in May 2021 that, due to achieving full funding for the Covid position and a break-even position for Year End 2020/21, the risk for this BAF would be amended to moderate (down from the previous high rating). In the longer term, members noted that receiving the required level of Covid-related funding and delivering the required level of previously unachieved savings on a recurring basis was an important driver for maintenance of the risk at this lower level. Discussions with Scottish Government in relation to the lack of NRAC parity have been carried out, in the context of achieving financial balance for this reporting year. The Board has received non-repayable financial support from Scottish Government to enable a break-even position to be achieved at this year's financial Year End. This has reduced financial sustainability risk levels, though the Committee recognise the pressure of reducing the recurrent financial gap and the requirement to deliver on cost improvements in the medium to longer term. Moving forward, the Board will need to deliver on transformation, as we move beyond the current pandemic landscape.

7.4 In relation to the Strategic Planning BAF, the Committee took assurance from and endorsed the core risk description change to clearly reference the development and the delivery of the Population Health & Wellbeing Strategy and to focus this at a more strategic level. New wording was agreed for this particular risk, which highlights the key role of the Board's governance committees in shaping and influencing strategy development, and thus scrutinising progress delivery once a new strategy has been agreed. The Committee welcomed the investment made in enhancing the Board's Programme Management Office (PMO), which will provide valuable resource to drive forward individual strategy workstreams and help support efficiencies in services going forward.

7.5 The Committee took assurance from and closely monitored progress in mitigating a range of environmental and estate sustainability risks, noting that two of the three residual operational risks in this area require the completion of the Elective Orthopaedic Centre to be achieved before these can be closed (both relate to activity currently being undertaken in the Phase 2 Tower Block at VHK and require the move of all non-ambulatory patients from this location). Enhancing fire safety training has reduced and mitigated this risk until the new orthopaedic wards are opened. The remaining risk, in relation to the replacement of flexible hoses by the PFI contractor, is being addressed by an ongoing programme of work covered by a lifecycle contract.

8 Self-Assessment

8.1 The Committee has undertaken a self-assessment of its own effectiveness, utilising a revised questionnaire considered and approved by the Committee Chair. Attendees were also invited to participate in this exercise, which was carried out via an easily-accessible online portal. A report summarising the findings of the survey was considered and approved by the Committee at its March 2022 meeting, and action points are being taken forward at both Committee and Board level.

9. Conclusion

9.1 As Chair of the Finance, Performance and Resources Committee at 31 March 2022, I am satisfied that the integrated approach, the frequency of meetings, the breadth of the business undertaken and the range of attendees at meetings of the Committee has allowed us to fulfil our remit as detailed in the Code of Corporate Governance. As a result of the work undertaken during the year, I can confirm that adequate financial planning and monitoring and governance arrangements were in place throughout NHS Fife during the year, including scrutiny of all aspects of non-financial performance metrics, noting the particular impact of Covid upon the indicators generally.

9.2 I would pay tribute to the dedication and commitment of fellow members of the Committee and to all attendees. I would thank all those members of staff who have prepared reports and attended meetings of the Committee, particularly in this most challenging of years, set against the backdrop of the Coronavirus pandemic.

Signed:  Date: 10 May 2022

Rona Laing, Chair
On behalf of the Finance, Performance and Resources Committee

Appendix 1 – Attendance Schedule
Appendix 2 – Best Value

APPENDIX 1

FINANCE, PERFORMANCE AND RESOURCES COMMITTEE
ATTENDANCE SCHEDULE 2021/22

Members	11/05/21	13/07/21	07/09/21	09/11/21	11/01/22	15/03/22
R Laing, Non-Executive Member **(Chair)**	✓	✓	✓	✓	✓	✓
W Brown, Non-Executive Member	x	x	✓	✓	✓	✓
E Clarke, Non-Executive Member	✓	✓				
A Grant, Non-Executive Member				✓	✓	x
A Lawrie, Area Clinical Forum Representative	✓	✓	✓	✓	x	x
M Mahmood, Non-Executive Director				✓	✓	x
A Morris, Non-Executive Member	✓	✓	✓	✓	✓	✓
J Owens, Stakeholder Member	✓	✓	✓	✓	✓	✓
C Potter, Chief Executive	✓	✓	x	✓	✓	✓
M McGurk, Director of Finance & Strategy **(Exec Lead)**	✓	✓	✓	x	✓	✓
C McKenna, Medical Director	x	✓	x	✓	✓	x
D Milne, Director of Public Health	✓					
J Tomlinson, Director of Public Health		✓	✓	✓	✓	✓
In attendance						
K Booth, Head of Financial Services & Procurement					✓	✓
N Connor, Director of H&SC	✓	✓	✓	✓	✓	✓
C Dobson, Director of Acute Services	✓	x	✓	✓	✓	x
S Fraser, Associate Director of Planning & Performance				✓		
S Garden, Director of Pharmacy & Medicines (to March 2022)	✓	✓	✓	✓	✓	
B Hannan, Director of Pharmacy & Medicines (from March 2022)						x
G MacIntosh, Head of Corporate Services & Board Secretary	✓	✓	✓	✓	✓	✓
A MacKay, Deputy Chief Operating Officer		✓				
N McCormick, Director of Property & Asset Management	✓	✓		✓	✓	✓
M Michie, Deputy Director of Finance		✓ observing	✓	✓	✓	✓
R Robertson, Deputy Director of Finance	✓	✓				
A Graham, Associate Director of Digital & Information						✓

BEST VALUE FRAMEWORK

Vision and Leadership

A Best Value organisation will have in place a clear vision and strategic direction for what it will do to contribute to the delivery of improved outcomes for Scotland's people, making Scotland a better place to live and a more prosperous and successful country. The strategy will display a clear sense of purpose and place and be effectively communicated to all staff and stakeholders. The strategy will show a clear direction of travel and will be led by Senior Staff in an open and inclusive leadership approach, underpinned by clear plans and strategies (aligned to resources) which reflect a commitment to continuous improvement.

REQUIREMENT	MEASURE / EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME / EVIDENCE
Resources required to achieve the strategic plan and operational plans e.g. finance, staff, asset base are identified and additional / changed resource requirements identified.	Financial Plan Workforce Plan Property & Asset Management Strategy	**FINANCE, PERFORMANCE & RESOURCES COMMITTEE** **STAFF GOVERNANCE COMMITTEE** **BOARD**	Annual Annual Annual Bi-annual Bi-monthly	Annual Operational / Remobilisation Plan Financial Plan Workforce Plan Property & Asset Management Strategy Integrated Performance & Quality Report
The strategic plan is translated into annual operational plans with meaningful, achievable actions and outcomes and clear responsibility for action.	Winter Plan Capacity Plan	**FINANCE, PERFORMANCE & RESOURCES COMMITTEE** **CLINICAL GOVERNANCE COMMITTEE** **BOARD**	Annual Bi-monthly Bi-monthly	Winter Plan Minutes of Committees Integrated Performance & Quality Report

GOVERNANCE AND ACCOUNTABILITY

The "Governance and Accountability" theme focuses on how a Best Value organisation achieves effective governance arrangements, which help support Executive and Non-Executive leadership decision-making, provide suitable assurances to stakeholders on how all available resources are being used in delivering outcomes and give accessible explanation of the activities of the organisation and the outcomes delivered.

OVERVIEW

A Best Value organisation will be able to demonstrate structures, policies and leadership behaviours which support the application of good standards of governance and accountability in how the organisation is improving efficiency, focusing on priorities and achieving value for money in delivering its outcomes. These good standards will be reflected in clear roles, responsibilities and relationships within the organisation. Good governance arrangements will provide the supporting framework for the overall delivery of Best Value and will ensure open-ness and transparency. Public reporting should show the impact of the organisation's activities, with clear links between the activities and what outcomes are being delivered to customers and stakeholders. Good governance provides an assurance that the organisation has a suitable focus on continuous improvement and quality. Outwith the organisation, good governance will show itself through an organisational commitment to public performance reporting about the quality of activities being delivered and commitments for future delivery.

REQUIREMENT	**MEASURE / EXPECTED OUTCOME**	**RESPONSIBILITY**	**TIMESCALE**	**OUTCOME / EVIDENCE**
Board and Committee decision-making processes are open and transparent.	Board meetings are held in open session and minutes are publicly available. Committee papers and minutes are publicly available	**BOARD** **COMMITTEES**	On going	NHS Fife website

APPENDIX 2

REQUIREMENT	MEASURE / EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME / EVIDENCE
Board and Committee decision-making processes are based on evidence that can show clear links between activities and outcomes	Reports for decision to be considered by Board and Committees should clearly describe the evidence underpinning the proposed decision.	**BOARD** **COMMITTEES**	Ongoing	SBAR reports EQIA section on all reports
NHS Fife conducts rigorous review and option appraisal processes of any developments.	Business cases	**BOARD** **FINANCE, PERFORMANCE & RESOURCES COMMITTEE**	Ongoing	Business Cases

USE OF RESOURCES

The "Use of Resources" theme focuses on how a Best Value organisation ensures that it makes effective, risk-aware and evidence-based decisions on the use of all of its resources.

OVERVIEW

A Best Value organisation will show that it is conscious of being publicly funded in everything it does. The organisation will be able to show how its effective management of all resources (including staff, assets, information and communications technology (ICT), procurement and knowledge) is contributing to delivery of specific outcomes.

REQUIREMENT	**MEASURE / EXPECTED OUTCOME**	**RESPONSIBILITY**	**TIMESCALE**	**OUTCOME / EVIDENCE**
NHS Fife understands and measures and reports on the relationship between cost, quality and outcomes.	Reporting on financial position in parallel with operational performance and other key targets	**BOARD** **FINANCE, PERFORMANCE & RESOURCES COMMITTEE**	Bi-monthly	Integrated Performance & Quality Report
The organisation has a comprehensive programme to evaluate and assess opportunities for efficiency savings and service improvements including comparison with similar organisations.	National Benchmarking undertaken through Corporate Finance Network. Local benchmarking with similar sized organisation undertaken where information available. Participation in National Shared Services Programme Systematic review of activity / performance data through use of Discovery tool	**FINANCE, PERFORMANCE & RESOURCES COMMITTEE** **BOARD**	Annual Bi-monthly Ongoing	Financial Plan Integrated Performance & Quality Report Financial overview presentations

APPENDIX 2

REQUIREMENT	MEASURE / EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME / EVIDENCE
Organisational budgets and other resources are allocated and regularly monitored.	Annual Operational / Remobilisation Plan Integrated Performance & Quality Report	**FINANCE, PERFORMANCE & RESOURCES COMMITTEE**	Bi-monthly	Integrated Performance & Quality Report SPRA Process
NHS Fife has a strategy for procurement and the management of contracts (and contractors) which complies with the SPFM and demonstrates appropriate competitive practice.	Code of Corporate Governance Financial Operating Procedures	**FINANCE, PERFORMANCE & RESOURCES COMMITTEE**	Reviewed annually	Code of Corporate Governance Financial Operating Procedures Procurement Annual Report
NHS Fife understands and exploits the value of the data and information it holds.	Annual Operational / Remobilisation Plan Integrated Performance & Quality Report	**BOARD** **COMMITTEES**	Annual Bi-monthly	Annual Operational / Remobilisation Plan Integrated Performance & Quality Report

APPENDIX 2

REQUIREMENT	MEASURE / EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME / EVIDENCE
Fixed assets including land, property, ICT, equipment and vehicles are managed efficiently and effectively and are aligned appropriately to organisational strategies.	Property and Asset Management Strategy	**FINANCE, PERFORMANCE & RESOURCES COMMITTEE**	Bi-annual Ongoing Bi-monthly Monthly	Property and Asset Management Strategy Report on asset disposals Integrated Performance & Quality Report Minutes of NHS Fife Capital Investment Group

PERFORMANCE MANAGEMENT

The "Performance Management" theme focuses on how a Best Value organisation embeds a culture and supporting processes which ensures that it has a clear and accurate understanding of how all parts of the organisation are performing and that, based on this knowledge, it takes action that leads to demonstrable continuous improvement in performance and outcomes.

OVERVIEW

A Best Value organisation will ensure that robust arrangements are in place to monitor the achievement of outcomes (possibly delivered across multiple partnerships) as well as reporting on specific activities and projects. It will use intelligence to make open and transparent decisions within a culture which is action and improvement oriented and manages risk. The organisation will provide a clear line of sight from individual actions through to the National Outcomes and the National Performance Framework. The measures used to manage and report on performance will also enable the organisation to provide assurances on quality and link this to continuous improvement and the delivery of efficient and effective outcomes.

REQUIREMENT	**MEASURE / EXPECTED OUTCOME**	**RESPONSIBILITY**	**TIMESCALE**	**OUTCOME / EVIDENCE**
Performance is systematically measured across all key areas of activity and associated reporting provides an understanding of whether the organisation is on track to achieve its short and long-term strategic, operational and quality objectives	Integrated Performance & Quality Report encompassing all aspects of operational performance, AOP targets / measures, and financial, clinical and staff governance metrics. The Board delegates to Committees the scrutiny of performance Board receives full Integrated Performance & Quality Report and notification of any issues for escalation from Committees.	**COMMITTEES** **BOARD**	Every meeting	Integrated Performance & Quality Report Code of Corporate Governance Minutes of Committees

APPENDIX 2

REQUIREMENT	MEASURE / EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME / EVIDENCE
The Board and its Committees approve the format and content of the performance reports they receive	The Board / Committees review the Integrated Performance & Quality Report and agree the measures.	**COMMITTEES** **BOARD**	Annual	Integrated Performance & Quality Report
Reports are honest and balanced and subject to proportionate and appropriate scrutiny and challenge from the Board and its Committees.	Committee Minutes show scrutiny and challenge when performance is poor as well as good; with escalation of issues to the Board as required	**COMMITTEES** **BOARD**	Every meeting	Integrated Performance & Quality Report Minutes of Committees
The Board has received assurance on the accuracy of data used for performance monitoring.	Performance reporting information uses validated data.	**COMMITTEES** **BOARD**	Every meeting Annual	Integrated Performance & Quality Report Annual Accounts including External Audit report

APPENDIX 2

REQUIREMENT	MEASURE / EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME / EVIDENCE
NHS Fife's performance management system is effective in addressing areas of underperformance, identifying the scope for improvement, agreeing remedial action, sharing good practice and monitoring implementation.	Encompassed within the Integrated Performance & Quality Report	**COMMITTEES** **BOARD**	Every meeting	Integrated Performance & Quality Report Minutes of Committees

CROSS-CUTTING THEME – SUSTAINABILITY

The "Sustainability" theme is one of the two cross-cutting themes and focuses on how a Best Value organisation has embedded a sustainable development focus in its work.

OVERVIEW

The goal of Sustainable Development is to enable all people throughout the world to satisfy their basic needs and enjoy a better quality of life without compromising the quality of life of future generations. Sustainability is integral to an overall Best Value approach and an obligation to act in a way which it considers is most sustainable is one of the three public bodies' duties set out in section 44 of the Climate Change (Scotland) Act 2009. The duty to act sustainably placed upon Public Bodies by the Climate Change Act will require Public Bodies to routinely balance their decisions and consider the wide range of impacts of their actions, beyond reduction of greenhouse gas emissions and over both the short and the long term.

The concept of sustainability is one which is still evolving. However, five broad principles of sustainability have been identified as:

- promoting good governance;
- living within environmental limits;
- achieving a sustainable economy;
- ensuring a stronger healthier society; and
- using sound science responsibly.

Individual Public Bodies may wish to consider comparisons within the wider public sector, rather than within their usual public sector "family". This will assist them in getting an accurate gauge of their true scale and level of influence, as well as a more accurate assessment of the potential impact of any decisions they choose to make.

A Best Value organisation will demonstrate an effective use of resources in the short-term and an informed prioritisation of the use of resources in the longer-term in order to bring about sustainable development. Public bodies should also prepare for future changes as a result of emissions that have already taken place. Public Bodies will need to ensure that they are resilient enough to continue to deliver the public services on which we all rely.

REQUIREMENT	**MEASURE / EXPECTED OUTCOME**	**RESPONSIBILITY**	**TIMESCALE**	**OUTCOME / EVIDENCE**
NHS Fife can demonstrate that it respects the limits of the planet's environment, resources and biodiversity in order to improve the environment and ensure that the natural resources	Sustainability and Environmental report incorporated in the Annual Accounts process.	**FINANCE, PERFORMANCE & RESOURCES COMMITTEE** **BOARD**	Annual	Annual Accounts

REQUIREMENT	MEASURE / EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME / EVIDENCE
needed for life are unimpaired and remain so for future generations.				Climate Change Template

APPENDIX 2

CROSS-CUTTING THEME – EQUALITY

The “Equality” theme is one of the two cross-cutting themes and focuses on how a Best Value organisation has embedded an equalities focus which will secure continuous improvement in delivering equality.

OVERVIEW

Equality is integral to all our work as demonstrated by its positioning as a cross-cutting theme. Public Bodies have a range of legal duties and responsibilities with regard to equality. A Best Value organisation will demonstrate that consideration of equality issues is embedded in its vision and strategic direction and throughout all of its work.

The equality impact of policies and practices delivered through partnerships should always be considered. A focus on setting equality outcomes at the individual Public Body level will also encourage equality to be considered at the partnership level.

REQUIREMENT	**MEASURE / EXPECTED OUTCOME**	**RESPONSIBILITY**	**TIMESCALE**	**OUTCOME / EVIDENCE:**
NHS Fife meets the requirements of equality legislation.		**BOARD** **COMMITTEES**	Ongoing	EQIA section on all reports
The Board and senior managers understand the diversity of their customers and stakeholders.	Equality Impact Assessments are reported to the Board and Committees as required and identify the diverse range of stakeholders.	**BOARD** **COMMITTEES**	Ongoing	EQIA section on all reports

APPENDIX 2

REQUIREMENT	MEASURE / EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME / EVIDENCE:
NHS Fife's policies, functions and service planning overtly consider the different current and future needs and access requirements of groups within the community.	In accordance with the Equality and Impact Assessment Policy, Impact Assessments consider the current and future needs and access requirements of the groups within the community.	**BOARD** **COMMITTEES**	Ongoing	Development of new Strategy EQIA section on reports
Wherever relevant, NHS Fife collects information and data on the impact of policies, services and functions on different equality groups to help inform future decisions.	In accordance with the Equality and Impact Assessment Policy, Impact Assessments will collect this information to inform future decisions.	**BOARD** **COMMITTEES**	Ongoing	EQIA section on reports

NHS Fife

Meeting:	**Finance, Performance & Resources Committee**
Meeting date:	**10 May 2022**
Title:	**BAF – Financial Sustainability**
Responsible Executive:	**Margo McGurk, Director of Finance & Strategy**
Report Author:	**Maxine Michie, Deputy Director of Finance**

1 Purpose

This is presented to the Committee for:

- Assurance

This report relates to a:

- Annual Operational Plan
- Emerging Issue
- Government policy/directive

This aligns to the following NHS Scotland quality ambition(s):

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

The purpose of this paper is to update the Committee on the BAF for Financial Sustainability and the associated risks.

The Committee has a vital role in scrutinising the risk and where indicated, the Committee will seek further information from risk owners. This report provides the Committee with an update on NHS Fife BAF specifically in relation to Financial Sustainability as at 31 March 2022.

2.2 Background

As previously reported, the BAF brings together pertinent information on the above risk integrating objectives, risks, controls, assurances and additional mitigating actions.

- Identifies and describes the key controls and actions in place to reduce or manage the risk
- Provides assurances based on relevant, reliable and sufficient evidence that controls are in place and are having the desired effect
- Links to performance reporting to the Board and associated risks, legislation & standing orders or opportunities

The Committee is invited to consider the following:

- Does the risk score feel right?
- Do the current controls match the stated risk?
- Will the mitigating actions bring the risk down to its target level?
- If the mitigating actions are fully implemented would the outcome be achieved?
- Does the assurance provided describe how the controls are performing?
- Do the assurances come from more than one source including independent sources?
- Are limited resources being allocated appropriately i.e. on uncontrolled high risks or in otherwise well controlled areas of risk?

2.3 Assessment

The Committee can be assured that systems and processes are in place to monitor the financial performance and sustainability of NHS Fife, including the potential impact of the financial position of the Integration Joint Board.

The high-level risks are set out in the BAF, together with the current risk assessment given the mitigating actions already taken. These are detailed in the attached papers. In addition, further detail is provided on the linked operational risks on the corporate risk register. Each risk has an owner who is responsible for the regular review and update of the mitigations in place to manage the risk to financial sustainability and strategic planning.

Through the Code of Corporate Governance, the Board has delegated executive responsibility to the Chief Executive and Director of Finance to ensure the appropriate systems and processes operate effectively to manage and mitigate financial risk on behalf of NHS Fife. The Finance, Performance & Resources Committee is tasked on behalf of the Board to provide appropriate oversight and scrutiny of the associated financial performance. The accountability and governance framework associated with the financial performance of the organisation are key aspects of both internal and external audit review. Individual Directors and managers, through the formal delegation of budgets, are accountable for financial management in their respective areas of responsibility, including the management of financial risks.

The attached schedule reflects the position at 31 March 2022. Since the last update (at 14 February 2022) the BAF current score has been reviewed and remains at moderate for 2021/22.

This reflects the current position where, following our Quarter 3 reporting submission, and follow up meeting with Scottish Government, non-repayable funding support to allow the Board to break even this financial year has been received. In addition, full funding of Covid-

19 costs have also been received for this financial year. Although Scottish Government support for our financial gap is confirmed our BAF risk remains at a Moderate risk rating level reflecting the underlying financial gap the board has going into the new financial year 2022/23.

In relation to financial sustainability, the organisation has launched a Financial Improvement/Sustainability (FIS) Programme. This programme will report through the Portfolio Board and aligns firmly with one the strategic priorities to "Drive Value and Sustainability". This is a key enabling programme to support the delivery of our 2022/23 corporate objectives and longer-term strategy development.

Further detail on the financial position is set out in the Integrated Performance & Quality Report.

2.3.1 Quality/ Patient Care

Effective financial planning, allocation of resources and in-year management of costs supports the delivery of high-quality care to patients.

2.3.2 Workforce

Effective financial planning, allocation of resources and in-year management of costs supports staff health and wellbeing and is integral to delivering against the aims of the workforce plan.

2.3.3 Financial

Please refer to the full report at Annex 1.

2.3.4 Risk Assessment/Management

Please refer to the full report at Annex 1.

2.3.5 Equality and Diversity, including health inequalities

Effective financial planning, allocation of resources and in-year management of costs includes the appropriate equality and diversity impact assessment process.

2.3.6 Other impact

N/A.

2.3.7 Communication, involvement, engagement and consultation

Appropriate communication, involvement, engagement and consultation within the organisation and with key external stakeholders is integral to the NHS Fife financial planning, allocation of resources and in-year management of costs processes.

2.3.8 Route to the Meeting

This paper was presented to EDG on 21 April 2022 in advance of discussion at other groups.

2.4 Recommendation

The Committee is invited to:

- **Consider** the questions set out above; and
- **Approve** the updated financial sustainability element of the Board Assurance Framework

3 List of appendices

The following appendices are included with this report:

- BAF – Financial Sustainability
- BAF Risks – Financial Sustainability Linked Operational Risks

Report Contact

Margo McGurk
Director of Finance
Email margo.mcgurk@nhs.scot

NHS Fife Board Assurance Framework (BAF)

Risk ID	Strategic Framework Objective	Date last reviewed	Date of next review	Description of Risk	Initial Score: Likelihood (Initial)	Initial Score: Consequence (Initial)	Initial Score: Rating (Initial)	Initial Score: Level (Initial)	Current Score: Likelihood (Current)	Current Score: Consequence (Current)	Current Score: Rating (Current)	Current Score: Level (Current)	Rationale for Current Score	Owner (Executive Director)	Assurance Group Standing Committee and Chairperson	Current Controls (What are we currently doing about the risk?)	Gaps in Control	Mitigating actions - what more should we do?	Assurances (How do we know controls are in place and functioning as expected?)	Sources of Positive Assurance on the Effectiveness of Controls	Gaps in Assurance (What additional assurances should we seek?)	Current Performance	Target Score: Likelihood (Target)	Target Score: Consequence (Target)	Target Score: Rating (Target)	Target Score: Level (Target)	Rationale for Target Score
Board Assurance Framework (BAF) - Financial Sustainability																											
1671	Sustainable	30/03/2022	30 April 2022	There is a risk that the funding required to deliver the current and anticipated future service models, particularly in the context of the COVID 19 pandemic, will not match costs incurred. There is a risk that the organisation may not fully identify the level of savings required to achieve recurring financial balance. Thereafter there is a risk that failure to implement, monitor and review an effective financial planning, management and performance framework would result in the Board being unable to deliver on its required financial targets.	4 – Likely – Strong possibility this could occur	4 – Major	16	High Risk	3 – Possible – May occur occasionally – reasonable chance	3 – Moderate	9	Moderate Risk	SG have confirmed they will provide funding support to Breakeven in 2021/22 however a number of actions must be completed by the board including minimising the requirement for support as much as possible. Funding has been received from SG to enable to board to Breakeven at 31.03.2022 and the actions requested by SG have been completed. However underlying financial gap remains going into 2022/23	Margo McGurk Director of Finance and Strategy	Finance, Performance & Resources (F,P&R) Rona Laing	*Ongoing actions designed to mitigate the risk including:* 30 March 2022 Funding has been received from Scottish government to support Covid expenditure in 2021/2022 and to support the board deliver a break even position at the financial year end. Savings in excess of the original level of savings planned for 2021/22 have been achieved albeit a number on a non recurring basis. The actions requested by Scottish Government in November to support the provision of funding support are complete. The level of savings plans required to achieve recurring financial balance is reflected in the risk level remaining at moderate. 14 Feb 2022 We have submitted our Quarter 3 reporting to SG indicating our 21/22 Covid-19 funding requirements across HB retained and HSCP; and have signposted the level of financial support to deliver a break even RRL position for 21/22. Whilst formal funding notification has yet to be received, indications at our Q3 review meeting with SG suggest funding support, following our significant efforts reported each month, will be forthcoming. Hence the risk level is updated to moderate risk. 14 Jan 2022 Monthly reporting returns to SG indicate improvement in delivery of in year savings targets indicating the target will be achieved. Draft financial gap for 2022/23 and savings plans for 50% of the gap have been identified as per the instructions received from SG. Recruitment to PMO continues to enhance capacity within the team and the Portfolio board has been established including the Financial improvement and sustainability programme	Nil	1. Continue a relentless pursuit of all opportunities identified through the transformation programme in the context of sustainability & value. Responsible Person: Director of Finance / Director of Acute Services / Director of Health & Social Care Timescale: Ongoing 2. Continue to maintain an active overview of national funding streams to ensure all NHS Fife receives a share of all possible allocations. 3. Continue to scrutinise and review any potential financial flexibility. 4. Engage with H&SC / Council colleagues on the risk share methodology and in particular ensure that EDG, FP&R and the Board are appropriately advised on the options available to manage any overspend within the IJB prior to the application of the risk share arrangement Responsible Person: Director of Finance Timescale: Ongoing	1. Produce monthly reports capturing and monitoring progress against financial targets and efficiency savings for scrutiny by all responsible managers and those charged with governance and delivery. 2. Undertake regular monitoring of expenditure levels through managers, Executive Directors' Group (EDG), Finance, Performance & Resources (F,P&R) Committee and Board. As this will be done in parallel with the wider Integrated Performance Reporting approach, this will take cognisance of activity and operational performance against the financial performance.	1. Internal audit reviews on controls and process; including Departmental reviews. 2. External audit review of year end accounts and governance framework.	1. Enhanced reporting on various metrics in relation to supplementary staffing. 2. Confirmation via the Director of Health & Social Care on the social care forecasts and the likely outturn at year end.	SG has provided COVID 19 non recurring funding for finance year 2021/22 which includes funding required to support the board achieve a balanced position at 31.03.2022. SG has confirmed COVID-19 funding will be received in line with the LMP submissions. Current performance indicates the board is in line with the submission provided to SG at time of Quarter 2. This will be reviewed for Q3 before onward submission to SG Covid funding has been received following each of our quarterly returns in 2021/22; and we anticipate a further allocation following our Q3 return. Full funding is anticipated, although not yet confirmed. Whilst full Covid-19 funding was received for 2020/21 and we delivered a small underspend £0.340m subject to external audit review; funding for 2021/22 will be determined post formal quarter 1 review of Boards' financial performance.	3 – Possible – May occur occasionally – reasonable chance	3 – Moderate	9	Moderate Risk	Financial risks will always be prevalent within the NHS / public sector however it would be reasonable to aim for a position where these risks can be mitigated to an extent.

Linked Operational Risk(s)

Risk ID	Risk Title	Risk Status	Current Level	Current Rating	Risk Owner
522	Prescribing and Medicines Management - Prescribing Budget	Active Risk	High Risk	15	McKenna, Christopher

Previously Linked Operational Risk(s)

Risk ID	Risk Title	Risk Status	Current Level	Current Rating	Risk Owner
1357	Financial Planning, Management and Performance	Active Risk	Moderate	12	McGurk, Margo
1363	Health and Social Care Integration	Active Risk	Moderate	9	McGurk, Margo
1513	Financial and Economic impact of Brexit	Active Risk	Low Risk	6	McCormick, Neil
1846	Test and Protect/Covid Vaccination	Active Risk	Moderate	12	Connor, Nicky
1364	Efficiency Savings	Closed Risk	High Risk	16	McGurk, Margo
1784	Finance (Short Term/Immediate)	Closed Risk	Moderate	8	Connor, Nicky

ID	
Position of Risk (Risk Register)	CORPORATE RISK REGISTER, NHSFBD - Finance Directorate Risk Register, NHSFBD - Prescribing & Medicines Management Risk Register
Opened	30/03/2006
Title	Prescribing and Medicines Management - Prescribing Budget
Description	Prescribing and Medicines Management - Prescribing Budget: There is a risk that NHS Fife will be unable to control the prescribing budget.
Likelihood (initial)	3 - Possible - May occur occasionally - reasonable chance
Consequence (initial)	3 - Moderate
Risk level (initial)	Moderate Risk
Rating (initial)	9
Current Management Actions	27/4/22 - GP Prescribing is £68k underspent at February, on an annual budget of £74.7m; forecast year-end position is breakeven. £400k to the end of Q2 has been recharged to COVID funding in line with national guidance. Hospital prescribing is £1.7m overspent at February, on an annual budget of £38.27m. Current year efficiency savings in Acute is £136k with a recurring benefit of £77k at February. Current year efficiency savings in Acute is £736k.
Likelihood (current)	5 - Almost Certain - Expected to occur frequently - more likely than not
Consequence (current)	3 - Moderate
Risk level (current)	High Risk
Rating (current)	15
Likelihood (Target)	3 - Possible - May occur occasionally - reasonable chance
Consequence (Target)	3 - Moderate
Risk level (Target)	Moderate Risk
Rating (Target)	9
Risk Owner	McKenna, Christopher
Handler	Reid, Euan
Previous Review Date	26/11/2021
Next Review	30/04/2022

NHS Fife

Meeting:	**Finance, Performance and Resource Committee**
Meeting date:	**10 May 2022**
Title:	**NHS Fife Board Assurance Framework (BAF) Strategic Planning**
Responsible Executive:	**Margo McGurk, Director of Finance & Strategy**
Report Author:	**Susan Fraser, Associate Director of Planning and Performance**

1 Purpose

This is presented to the Committee for:

- Assurance

This report relates to a:

This aligns to the following NHS Scotland quality ambition(s):

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

The Board Assurance Framework (BAF) is intended to provide accurate and timely assurances to the Committee and ultimately to the Board that the organisation is delivering on its strategic objectives in line with the following:

- NHS Fife Strategic Framework
- NHS Fife Clinical Strategy
- Fife Health & Social Care Integration Strategic Plan

The Committee has a vital role in scrutinising the risk and where indicated, the Committee will seek further information from risk owners.

This report provides the Committee with the next version of the NHS Fife BAF 5 on 10.5 22.

2.2 Background

This BAF brings together pertinent information on the above risk, integrating objectives, risks, controls, assurances and additional mitigating actions.

- Identifies and describes the key controls and actions in place to reduce or manage the risk
- Provides assurances based on relevant, reliable and sufficient evidence that controls are in place and are having the desired effect
- Links to performance reporting to the Board and associated risks, legislation & standing orders or opportunities

The Committee is invited to consider the following:

- Does the risk score feel right?
- Do the current controls match the stated risk?
- Will the mitigating actions bring the risk down to its target level?
- If the mitigating actions are fully implemented would the outcome be achieved?
- Does the assurance provided describe how the controls are performing?
- Do the assurances come from more than one source including independent sources?
- Are limited resources being allocated appropriately i.e., on uncontrolled high risks or in otherwise well controlled areas of risk?

2.3 Assessment

This BAF reflects the changes that have happened over the COVID period and included the strategic planning for the new Population Health and Wellbeing Strategy for NHS Fife. The current risk level is assessed as Moderate, the expectation is that as we progress through the milestone plan activity in terms of the new strategy development and, as the recently recruited additional PMO capacity embeds, that this risk level should reduce.

Following discussion at previous committees, previous risks have remained on the BAF until the new Strategy is produced. The risks have been reviewed and updated. The BAF and risk also describes how:

- the Strategic Priorities form the focus of strategic planning direction going forward for NHS Fife.
- Work is progressing in the development of the Population Health and Wellbeing Strategy with revised timescales. The analysis from the public and staff survey will inform the production of a broader engagement proposal for consideration at the Portfolio Board and the Public Health and Wellbeing Committee in May 2022. Engagement planning is ongoing and will continue over the next few months. Milestone plan to December 2022 has been produced.
- The process for SPRA for 2022/23 has concluded with the production of a transitional organisational 1-year plan and financial plan. Corporate objectives are due to be signed off by the Board in May 2022. The actions from SPRA will form the basis of the Annual Delivery Plan 2022/23.
- An update on RMP4 has been submitted at the end of April for the year 2021/22. Any undelivered actioned will be carried over to the Annual Delivery Plan 22/23. This will be reported separately.

The committee are asked to note the current risk level against progress made in the development of the Population Health and Wellbeing Strategy and the robust planning through SPRA.

2.3.1 Quality/ Patient Care

Quality of Patient Care underpins the work undertaken by Strategic Planning and the development of the Population Health and Wellbeing Strategy.

2.3.2 Workforce

Workforce planning is aligned to the work undertaken by Strategic Planning through SPRA and the development of the Population Health and Wellbeing Strategy.

2.3.3 Financial

Financial planning is aligned to the work undertaken by Strategic Planning.

2.3.4 Risk Assessment/Management

Risk Assessment and Management is an integral part of the work undertaken by Strategic Planning.

2.3.5 Equality and Diversity, including health inequalities

Equality and Diversity is part of the work undertaken by Strategic Planning.

2.3.6 Other impact

n/a

2.3.7 Route to the Meeting

This paper was presented to EDG on 21 April 2022 in advance of discussion at other committees.

2.4 Recommendation

The Committee is invited to:

- **Approve** the current position in relation to the Strategic Planning risk of Moderate.

Report Contact
Susan Fraser
Associate Director of Planning and Performance
Email: susan.fraser3@nhs.scot

NHS Fife Board Assurance Framework (BAF)

Risk ID	Strategic Framework Objective	Date last reviewed	Date of next review	Description of Risk	Initial Score: Likelihood (Initial)	Initial Score: Consequence (Initial)	Initial Score: Rating (Initial)	Initial Score: Level (Initial)	Current Score: Likelihood (Current)	Current Score: Consequence (Current)	Current Score: Rating (Current)	Current Score: Level (Current)	Rationale for Current Score	Owner (Executive Director)	Assurance Group Standing Committee and Chairperson	Current Controls (What are we currently doing about the risk?)	Gaps in Control	Mitigating actions - what more should we do?	Assurances (How do we know controls are in place and functioning as expected?)	Sources of Positive Assurance on the Effectiveness of Controls	Gaps in Assurance (What additional assurances should we seek?)	Current Performance	Target Score: Likelihood (Target)	Target Score: Consequence (Target)	Target Score: Rating (Target)	Target Score: Level (Target)	Rationale for Target Score
Board Assurance Framework (BAF) - Strategic Planning																											
1675	Clinically Excellent, Exemplar Employer, Person Centred, Sustainable	30/03/2022	25 May 2022	There is a risk that the development and the delivery of the new NHS Fife Population Health and Wellbeing strategy is not adequately supported by the required planning and programme management capacity, capability and governance arrangements. Key Risks from previous BAFs will remain until committees are content they are covered in renewed PHW Strategy. 1. Community/Mental Health redesign is the responsibility of the H&SCP/IJB 2. Governance remains between IJB and NHS Fife. 3. Regional Planning - risks around alignment with regional plans 4. Clinical Strategy does not reflect that the strategic direction of the organisation following the COVID-19 pandemic.	4 – Likely – Strong possibility this could occur	4 – Major	16	High Risk	3 – Possible – May occur occasionally – reasonable chance	4 – Major	12	3 – Moderate	Following period of COVID-19, portfolio management is being put in place. Programme management approach being refreshed through Strategic Planning Resource Allocation (SPRA) process.	Director of Finance and Strategy Margo McGurk	Clinical Governance. Christina Cooper.	*Ongoing actions designed to mitigate the risk including:* 30/03/22 1. PHW Portfolio Board meeting regularly and working well 2. Plan for delivery of PHW strategy to be agreed including analysis of Public and Staff Survey that will be used to inform strategy and public engagement work going forward. 3. SPRA 22/23 almost complete with draft Corporate Objectives for 22/23 still to be finalised	EDG Portfolio Board will provide the required leadership and executive support to enable strategy development - now in place.	PHW Portfolio Board is now meeting monthly. TOR signed off. Governance route will be Public Health and Wellbeing Committee Time period for Strategy has been amended to start from 23/24 rather than 22/23. Annual Delivery Plan for 22/23 providing interim strategic direction. Work will continue during 2022 to ensure delivery of Strategy for 23/24. Responsible Person: Director of Finance Timescale: 31/03/2022	1. Minutes of meetings record attendance, agenda and outcomes. 2. Reporting of key priorities to governance groups from the SPRA process. .	1. Internal Audit Report on Strategic Planning (no. B10/17) 2. Governance committee scrutiny and reporting. .	Governance of new arrangements will be agreed to deliver the required assurance. This gap have now been closed..	Corporate Objectives in draft for 22/23. SPRA 2022/23 will inform the Annual Delivery Plan due in July 22 and corporate objectives for 22/23. RMP4 Q3 update on deliverables was submitted in February 22 with Q4 update due in April 22.	2 – Unlikely – Not expected to happen – potential exists	4 – Major	8	3 – Moderate	Position is improving as Portfolio Board and Public Health and Wellbeing Committee is in place.

Linked Operational Risk(s)

Risk ID	Risk Title	Risk Status	Current Level	Current Rating	Risk Owner
	Nil currently identified				

Previously Linked Operational Risk(s)

Risk ID	Risk Title	Risk Status	Current Level	Current Rating	Risk Owner
	Nil applicable				

NHS Fife

Meeting:	**Finance, Performance and Resources Committee**
Meeting date:	**15 May 2022**
Title:	**Board Assurance Framework – Environmental Sustainability**
Responsible Executive:	**Neil McCormick, Director of Property & Asset Management**
Report Author:	**Jimmy Ramsay, Estates Manager - Compliance**

1 Purpose

This is presented to FP&R for:

- Awareness
- Discussion

This report relates to a:

- Board Governance & Strategic Objectives

This aligns to the following NHSScotland quality ambition(s):

- Safe
- Effective

2 Report Summary

2.1 Situation

The Board Assurance Framework (BAF) is intended to provide assurances to this Committee and to the Board, that the organisation is delivering on its strategic objectives as they relate to environmental sustainability.

This report provides the committee with an update in relation to BAF risks.

The Internal Audit Internal Control Evaluation (ICE B08/22) Recommended that the risks around delivery of the PAMs and capital programme would benefit from having a BAF or operational risk which would aid and support the delivery of the future Health and Wellbeing Strategy.

2.2 Background

Property & Asset Management receive capital funding from Scottish Government via NHS Fife's Capital Investment Group to address high risk statutory compliance or backlog maintenance issues. Prioritisation of this limited resource is carried out using a risk assessment methodology.

2.3 Assessment

The Environmental sustainability BAF remains as a **high** risk. Property & Asset Management continue to mitigate the identified risks.

Both PFI providers at St Andrews and the VHK have started the replacement programme for flexible hoses and these risks will be removed once these projects have been completed.

The Fire Evacuation Phase 2 linked risk remains at 15 following a review of the extensive mitigations undertaken last month.

The Theatre Phase 2 Remedial Works have been carried out as far as possible and this risk and the Fire Evacuation Phase 2 linked risk will remain as a residual risk until the commissioning of the new Fife Orthopaedic Elective Centre towards the end of 2022. Good progress is being made on site with respect to the new build.

The Director of Property & Asset Management has discussed the internal audit recommendation with the NHS Fife Risk Manager, and they have agreed to develop an appropriate corporate risk which would aid and support the delivery of the future Health and Wellbeing Strategy as part of the corporate risk register which is intended to replace the BAF as part of the overall review of risk management within NHS Fife

2.3.1 Quality/ Patient Care

There is no negative impact to patient care as the risks are being managed.

2.3.2 Workforce

N/A.

2.3.3 Financial

Projects are managed as and when funding becomes available through the capital planning process.

2.3.4 Risk Assessment/Management

Please see attached risks and BAF.

2.3.5 Equality and Diversity, including health inequalities

N/A.

2.3.6 Other impact

N/A.

2.3.7 Communication, involvement, engagement and consultation

External stakeholders are consulted where appropriate.

2.3.8 Route to the Meeting

This paper has been previously considered by the following groups as part of its development. The groups have either supported the content, or their feedback has informed the development of the content presented in this report.

- EDG 21 April 2022

2.4 Recommendation

The Committee is invited to:

- **Consider** the position set out above
- **Approve** the updated environmental sustainability element of the Board Assurance Framework

3 List of Appendices

The following appendices are included with this report:

- BAF Environmental Sustainability
- BAF Environmental Sustainability linked operational risks

Report Contact
Neil McCormick
Director of Property & Asset Management
neil.mccormick@nhs.scot

NHS Fife Board Assurance Framework (BAF)

Risk ID	Strategic Framework Objective	Date last reviewed	Date of next review	Description of Risk	Initial Score: Likelihood (Initial)	Initial Score: Consequence (Initial)	Initial Score: Rating (Initial)	Initial Score: Level (Initial)	Current Score: Likelihood (Current)	Current Score: Consequence (Current)	Current Score: Rating (Current)	Current Score: Level (Current)	Rationale for Current Score	Owner (Executive Director)	Assurance Group Standing Committee and Chairperson	Current Controls (What are we currently doing about the risk?)	Gaps in Control	Mitigating actions - what more should we do?	Assurances (How do we know controls are in place and functioning as expected?)	Sources of Positive Assurance on the Effectiveness of Controls	Gaps in Assurance (What additional assurances should we seek?)	Current Performance	Target Score: Likelihood (Target)	Target Score: Consequence (Target)	Target Score: Rating (Target)	Target Score: Level (Target)	Rationale for Target Score
Board Assurance Framework (BAF) - Environmental Sustainability																											
1672	Clinically Excellent, Sustainable	09/03/2022	31 March 2022	There is a risk that Environmental & Sustainability legislation is breached which impacts negatively on the safety and health of patients, staff and the public and the organisation's reputation.	4 – Likely – Strong possibility this could occur	5 - Extreme	20	1_HIGH	4 – Likely – Strong possibility this could occur	5 - Extreme	20	1_HIGH	Estates currently have significant high risks on the E&F risk register; until these have been eradicated this risk will remain. Action plans have been prepared and assuming capital is available these will be reduced in the near future.	Neil McCormick Director of Property & Asset Management	Finance, Performance & Resources (F,P&R). Rona Laing.	*Ongoing actions designed to mitigate the risk including:* 1. Operational Planned Preventative Maintenance (PPM) systems in place 2. Systems in place to comply with NHS Estates 3. Action plans have been prepared for the risks on the estates & facilities risk register. These are reviewed and updated at the monthly risk management meetings. The highest risks are prioritised and allocated the appropriate capital funding. 4. The SCART (Statutory Compliance Audit & Risk Tool) and EAMS (Estates Asset Management System) systems record and track estates & facilities compliance. 5. Sustainability Group manages environmental issues and Carbon Reduction Commitment(CRC) process is audited annually. 6. Externally appointed Authorising Engineers carry out audits for all of the major services i.e. water safety, electrical systems, pressure systems, decontamination and so on.	Nil	1. Capital funding is allocated depending on the E&F risks rating Responsible person: Director of Estates, Facilities & Capital Services Timescale: Ongoing as limited funding available 2. Increase number of site audits Responsible person: Estates Compliance Manager Timescale: Ongoing	1. Capital Investment delivered in line with budgets 2. Sustainability Group minutes. 3. Estates & Facilities risk registers. 4. SCART & EAMS. 5. Adverse Event reports..	1. Internal audits 2. External audits by Authorising Engineers 3. Peer reviews.	None.	High risks still exist until remedial works have been undertaken, but action plans and processes are in place to mitigate these risks.	1 – Remote – Can't believe this event would happen	5 - Extreme	5	3_LOW/	All estates & facilities risk can be eradicated with the appropriate resources but there will always be a potential for failure i.e. component failure or human error hence the target figure of 5..

Linked Operational Risk(s)

Risk ID	Risk Title	Risk Status	Current Level	Current Rating	Risk Owner
1007	Theatre Phase 2 Remedial work	Active Risk	High Risk	15	Cross, Murray
1252	Flexible PEX hoses in PHASE 3 VHK	Active Risk	High Risk	15	McCormick, Neil
1296	Emergency Evacuation, VHK Phase 2 Tower Block	Active Risk	High Risk	15	McCormick, Neil

Previously Linked Operational Risk(s)

Risk ID	Risk Title	Risk Status	Current Level	Current Rating	Risk Owner
1207	Water system Contamination STACH	Active Risk	Moderate Risk	10	McCormick, Neil
1275	South Labs Plantroom	Active Risk	Moderate Risk	8	Lowe, David
1306	Risk of pigeon guano on VHK Ph2 Tower Windows	Active Risk	Moderate Risk	12	Lowe, David
1316	Inadequate Compartmentation VHK Phase 1, Phase 2 floors B-1st	Active Risk	Moderate Risk	8	McCormick, Neil
1341	Oil Storage - Fuel Tanks - Central/NEF	Active Risk	Moderate Risk	10	Keatings, Gordon
1342	Oil Storage - Fuel Tanks - QMH/DWF	Active Risk	Moderate Risk	10	Wishart, James
735	Medical Equipment Register	Closed Risk	Moderate Risk	10	Lowe, David
749	836 - VHK Ph.2 Main Foul Drainage Tower Block	Closed Risk	High Risk	15	Lowe, David
1083	VHK CLO2 Generator (Legionella Control)	Closed Risk	High Risk	15	GRB
1312	Vertical Evacuation - VHK Phase 2 Tower Block	Closed Risk	Moderate Risk	10	Fairgrieve, Andrew
1314	Inadequate Compartmentation of Escape Stairs and Lift Enclosures	Closed Risk	Low Risk	6	Fairgrieve, Andrew
1315	Vertical Evacuation - VHK Phases 1 and 2 (excluding Tower Block)	Closed Risk	Moderate Risk	8	BAN
1335	FCON Fire alarm potential faiure	Closed Risk	High Risk	15	GRB
1352	Pinpoint malfunction	Closed Risk	High Risk	16	Pirie, Margaret
1384	Microbiologist Vacancy	Closed Risk	High Risk	20	JGARDN
1473	Stratheden Hospital Fire Alarm System	Closed Risk	High Risk	20	Keatings, Gordon

ID	1007	1252	1296
Position of Risk (Risk Register)	Acute Services - Planned Care - Theatres/Anaesthetics Risk Register	Corporate Directorate - Estates Risk Register	CORPORATE RISK REGISTER, Corporate Directorate - Estates Risk Register
Opened	11/02/2015	02/06/2016	22/08/2016
Title	Theatre Phase 2 Remedial work	Flexible PEX hoses in PHASE 3 VHK	Emergency Evacuation, VHK Phase 2 Tower Block
Description	Risk of increased loss of service due to deteriorating fabric of building resulting in reduced ability to reach TTG targets.	AF 2/8/16 There is a risk to patient safety due to a legionella risk in phase 3 building. EFA DH (2010)03 stated that flexible hoses when used for the supply of potable water may have an enhanced risk of harboring Legionella bacteria and other harmful microorganisms.	There is a risk that a second stage fire evacuation, or complete emergency evacuation, of the upper floors of Phase 2 VHK, may cause further injury to frail and elderly patients, and/or to staff members from both clinical and non-clinical floors.
Likelihood (initial)	3 - Possible - May occur occasionally - reasonable chance	3 - Possible - May occur occasionally - reasonable chance	4 - Likely - Strong possibility this could occur
Consequence (initial)	5 - Extreme	5 - Extreme	5 - Extreme
Risk level (initial)	High Risk	High Risk	High Risk
Rating (initial)	15	15	20
Current Management Actions	DL 01/02/2022 - Significant works carried out in 2020 to redecorate & address infection control HAI risks within Theatre areas. Package of Fire compartmentation remedials, fire door upgrades and fire safety improvements completed end of 2020. Reactive repairs, routine planned maintenance activities and re-validation of Theatre ventilation plant is continuing to be managed through the Estates Department. New Fife Elective Orthopaedic Theatre (National Treatment Centre) project began construction in early 2021, and is progressing on programme. Planned completion late 2022, with handover for operational use by end of 2022.	JR - 21/02/2022 - Info from George Campbell. Delays in getting governance approvals therefore programme is not yet complete. Liaising with contractor to establish a firm commencement date.	09/03/2022 - All the doors in ward 10 fire compartment boundary have been inspected and are planned for a repair and replacement programme in March 2022, completion by end of March to be achieved
Likelihood (current)	3 - Possible - May occur occasionally - reasonable chance	3 - Possible - May occur occasionally - reasonable chance	3 - Possible - May occur occasionally - reasonable chance
Consequence (current)	5 - Extreme	5 - Extreme	5 - Extreme
Risk level (current)	High Risk	High Risk	High Risk
Rating (current)	15	15	15
Likelihood (Target)	1 - Remote - Can't believe this event would happen	2 - Unlikely - Not expected to happen - potential exists	1 - Remote - Can't believe this event would happen
Consequence (Target)	5 - Extreme	5 - Extreme	5 - Extreme
Risk level (Target)	Low Risk	Moderate Risk	Low Risk
Rating (Target)	5	10	5
Risk Owner	Cross, Murray	McCormick, Neil	McCormick, Neil
Handler	Lowe, David	Bishop, Paul	Ramsay, Jimmy
Previous Review Date	09/04/2021	21/02/2022	09/03/2022
Next Review	02/05/2022	17/05/2022	31/05/2022

NHS Fife

Meeting:	**Finance, Performance and Resources Committee**
Meeting date:	**10 May 2022**
Title:	**Risk Management Improvement Programme Update**
Responsible Executive:	**Margo McGurk, Director of Finance & Strategy**
Report Author:	**Gemma Couser, Associate Director of Quality and Clinical Governance and Pauline Cumming, Risk Manager**

1 Purpose

This is presented to the Committee for:

- Assurance

This report relates to a:

- Annual Operational Plan
- Government policy/directive
- Local policy

This aligns to the following NHSScotland quality ambition(s):

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

This paper sets out a record of the progress made since the risk management improvement programme was approved by the NHS Fife Board in March 2022.

2.2 Background

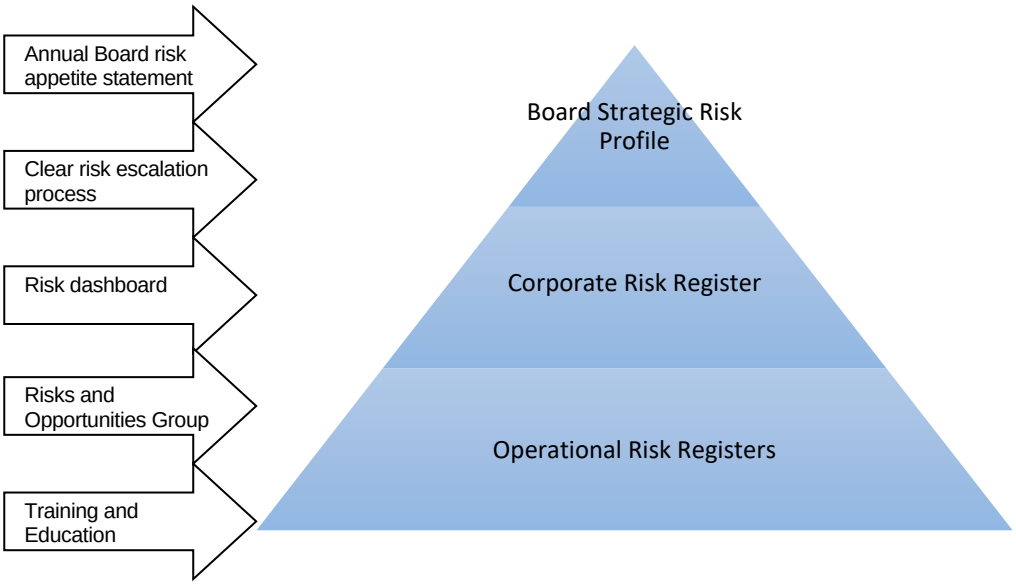
NHS Fife is committed to delivering this agreed improvement programme in relation to risk management.

2.3 Assessment

Strategic and operational risks are an inherent part of healthcare delivery. An effective risk management structure and approach is paramount in supporting the organisation to achieve strategic priorities. The objective is to deliver:

- A structured approach where risks are reviewed, addressed and controlled through governance structures of the Board
- Alignment of the organisational risk profile to the strategic planning agenda
- Promotion of a just culture to encourage the proactive identification and mitigation of risks from ward to Board
- Development of an annual Board risk appetite statement; stating the nature/ level of risks to be accepted/tolerated and the balance of risk versus reward

The current Risk Management Framework will be replaced with the following structure:



A summary of the Risk Management Improvement plan is summarised below:

	Workstream	Description/ Actions	Status update	By when
1	Board Strategic Risk Profile	Development of a risk profile against our strategic priorities: 1. To improve health and wellbeing 2. To improve the quality of health and care services 3. To improve staff experience and wellbeing 4. To deliver value and sustainability	Initial feedback has indicated the requirement to include environmental sustainability and inequality risks. Work is underway to develop these risks.	Draft complete (see Appendix 1)
2	Corporate Risk Register to replace Board Assurance Framework	A Corporate Risk Register (CRR) - contains the highest scoring risks from across the organisation that have the potential to affect the whole organisation, or operational risks which have been escalated e.g. can no longer be managed by a service or require senior ownership and support to mitigate*. The register will be routinely reviewed and monitored by Executive Directors. The CRR will be comprised of the following components: 1. Clinical Quality and Safety 2. Property and Infrastructure (including Digital and Information) 3. Workforce 4. Finance There will be a containment of number of risks on the CRR to ensure focus and impact Engagement sessions will be held in April and May with Senior Leadership Teams (SLT) for Acute Services, Health & Social Care Partnership, Workforce, Finance, Pharmacy, Medical Director's Directorate (including Digital and Information and Research & Development), Property	Risks for inclusion in CRR are being identified through discussions with SLTs; review of existing risks; and identification of new risks which meet criteria*. Engagement sessions planned. Meetings are underway.	June 2022

		and Asset Management , Public Health and the Nursing Directorate. Sessions will include the review of risks to clarify strategic risks v corporate risks v operational risks. A FORMS questionnaire to be issued to EDG members to complete on behalf of their SLTs. Questions cover the focus of team discussions about risk, their use of risk information e.g.to inform decision making or plan services, and the support that teams need to effectively manage risk including education and training. Feedback will be used to develop an effective and visible framework that connects with and is used by staff from ward to board.	FORMS questionnaire issued March 2022.	
3	Risk Dashboard	This will support a proactive risk management culture that is integral to performance and quality management. The dashboard will align to the refreshed Integrated Performance & Quality Report (IPQR) and will include metrics related to corporate risks. Purpose: • Enable oversight of risk level of corporate risks • Provide assurance that adequate controls are in place to proactively manage risks • Align to improvement actions contained within the IPQR • Integrate with Key Performance Indicators (KPIs) & Quality Performance Indicators (QPIs) • Risk is linked to an assurance committee Principles: • Provide simple, visual high level overview for	An outline of proposed risk content for the IPQR is in development and will be submitted to EDG as part of an update paper on the IPQR review.	May 2022

		assurance • Weave risk management into business as usual (BAU) • Corporate risks will be contained and regularly scrutinised The dashboard will capture current and target risk levels, related improvement or deterioration, and consider risk mitigation and anticipated timescales to achieve risk reduction. For risks which are deteriorating, it is proposed a 'deep dive' summary profile will be provided. It is proposed that risk content is integrated as follows: • The dashboard features at the start of the IPQR before the Indicator Summary • Narrative related to the risks is woven into respective components of IPQR		
4	Escalation Process	All staff throughout the organisation have a responsibility for identifying risk. To ensure that risks are managed effectively, they must be escalated to the appropriate levels in the organisation and to external stakeholders where necessary. Directors will have overall responsibility for establishing effective risk escalation procedures supported by: • Risk reviews • Governance group risk reviews; and Risk Leads who chair the Management Groups and provide advice on risk under the following broad categories :Clinical Quality and Safety, Property and Infrastructure (including Digital and Information), Workforce and Finance	Being developed for submission to EDG in May 2022	June 2022

		• EDG review risks and escalate to the Board any strategic risks **ESCALATION PROCESS** This will include consideration of the following: EDG • Discuss risk at EDG or proposed Risk & Opportunities Group • Develop action plan • Manage through risk register and Directorate or equivalent Management Group Executive Risk Owner • Can this risk be managed with directorate? • Does the risk impact on the wider organisation? • Share with EDG Line Manager, Risk Owners, Portfolio, Project and Programme leads • Can this risk be managed locally? • Is the risk on the register? • Who is the risk owner? Other directorate? Escalate to appropriate Directorate senior manager • Escalate to Executive risk owner All Staff • Can the risk be managed as part of Business As Usual (BAU)? • What is the impact and likelihood of the risk? • Escalate to line manager		

5	Risks and Opportunities Group	A Risks and Opportunities Group will be established. This will be chaired by the Associate Director of Quality and Clinical Governance, with membership likely to include the Risk Manager and Associate and Deputy Directors. Governance lines are to be confirmed but the group is likely to report into EDG. The Group's broad remit is expected to: • Provide leadership to ensure the organisation gives risk management the appropriate priority; and facilitates and delivers effective risk management arrangements • Promote effective risk management and seek opportunity for the organisation • Link risks and opportunities to the strategic objectives of the organisation • Review aggregation of risk across the organisation to determine the most appropriate response on behalf of the whole organisation • Based on changing risk levels, provide beneficial direction / focus to the assurance functions • Horizon scan for future opportunities, threats and risks aligned to the strategic priorities • Ensure continuous improvement of the internal control environment	Terms of Reference are being drafted and will be presented to EDG in May 2022	August 2022

2.3.1 Quality/ Patient Care

Elevating the risk management framework in NHS Fife will support the further development of the quality and patient safety agenda through improved operational governance and strategic planning.

2.3.2 Workforce

There is a requirement to ensure that the appropriate workforce is in place to support the changes to the framework including updates to the Datix system. Arrangements for this are currently being explored.

The refresh of the Risk Management Framework will also include a training needs analysis to design an effective training and education strategy to support this change.

2.3.3 Financial

Once the workforce arrangements to support this change are confirmed an update to summarise the financial impact will be provided.

2.3.4 Risk Assessment/Management

This paper summarises actions to enable NHS Fife to progress an effective risk management framework and culture to support the achievement of the strategic priorities.

2.3.5 Equality and Diversity, including health inequalities

An impact assessment has not been conducted.

2.3.6 Other impact

None

2.3.7 Communication, involvement, engagement and consultation

This paper has been developed in discussion with key stakeholders.

2.3.8 Route to the Meeting

An earlier version of this paper was considered and supported by:

- EDG, 17 February 2022
- Audit & Risk Committee, 17 March 2022
- Fife NHS Board, 29 March 2022

2.4 Recommendation

The Committee is asked to take **assurance** from this update on the plan to refresh and improve the Risk Management Framework.

Report Contact
Gemma Couser
Associate Director of Quality and Clinical Governance
Email gemma.couser2@nhs.scot

Appendix 1

DRAFT STRATEGIC PRIORITIES AND RISKS

STRATEGIC PRIORITY	Comments
To Improve Health and Wellbeing	
RISKS	
1.There is a risk that after more than 2 years of reduced levels of healthcare service as a consequence of the COVID -19 pandemic, and foreseeable continuation into the future compounded by the challenges of emerging variants and other respiratory pathogens, population health and wellbeing will be adversely affected which could result in: • increased population morbidity and mortality • increased pressure on healthcare and support services affecting service delivery • reduced capacity for non urgent services • high levels of employee absence due to personal illness and caring responsibilities • limited capacity to develop, transform and sustain services • non delivery on key quality performance measures	
2. There is a risk that the development and the delivery of the NHS Fife Population Health and Wellbeing Strategy is not adequately supported by the required planning and programme management capacity, capability and governance arrangements, resulting in delays to progression and implementation of this critical component of Fife's strategic approach to delivering the 4 national Care Programmes: Integrated Unscheduled Care; Integrated Planned Care; Place and Wellbeing; and Preventative and Proactive Care.	
3. There is a risk that if the Population Health & Wellbeing Strategy does not incorporate learning from the COVID-19 pandemic and align with the motivations, aspirations and expectations of the people of Fife, the Board's vision, corporate objectives and key priorities will not be achieved, resulting in services that are neither transformational nor sustainable in the long term.	
STRATEGIC PRIORITY	
To Improve the Quality of Health and Care Services	
RISKS	
1. There is a risk that due to failure of clinical governance, performance and management systems (including information governance & information	

security), NHS Fife may be unable to provide safe, effective, person centred care. Additionally, there is a risk that the effects of the COVID - 19 pandemic, including restricted capacity, reduced elective & non urgent services, and workforce pressures, will impact on the quality & safety of patient care and service delivery.	
2. There is a risk that sustained whole system pressures due to factors including COVID -19, and demand outstripping capacity within acute, primary and social care services will result in: • inability to timeously discharge medically fit patients, thus increasing their length of stay resulting in: o increased clinical risk including healthcare associated infection and deconditioning o reduced number of downstream beds o delayed patient pathways and negative impacts on safe capacity and patient flow o financial and workforce impacts due to the need to open and staff additional beds o increased Emergency Department (ED) attendances o unmet performance targets including those relating to: • 4 hour ED access • patients in delay • waiting times • treatment times • Remobilisation Plan • sub optimal patient experience and outcomes • reputational harm	
3.There is a risk that if we do not implement effective strategic workforce planning (including aligning funding requirements), we will not have the right size of workforce, with the right skills and competencies, organised appropriately within an affordable budget, to deliver business as usual services, respond to the ongoing challenges of COVID-19, and implement necessary transformation, resulting in sub optimal delivery, reputational harm, and further impacts on staff wellbeing and recruitment / retention rates.	
4. There is a risk that failure to invest appropriately in D&I resilience including the D&I Strategy and current operational lifecycle commitment, may result in an inablity to make essential transformation across Health and Social care to deliver sustainable and integrated services that are safe, secure and compliant with governance frameworks and associated legislation including Cyber Essentials	

and Network & Informations Systems Regulations, and future proofed as far as reasonable and practicable.	
STRATEGIC PRIORITY **To Improve Staff Experience and Wellbeing**	
RISKS	
1. There is a risk that because of current pressures and capacity challenges, staff may be unable to fully engage with the development of the Population Health and Wellbeing Strategy which underpins our aspiration to be an Anchor Institution i.e. one that positively influences the health and wellbeing of our communities. This may result in a strategy which does not: • recognise staff opinions and experiences • reflect staff values and motivations • reinforce the vital contribution of staff to creating a listening and learning organisation • relate to staff understanding of how we will achieve our ambition to develop and deliver a person-centred health and care system that reduces health inequalities and improves health and wellbeing for all citizens across Fife	
2. There is a risk that operating under restrictions including social distancing and working from home through subsequent waves of the pandemic whilst trying to recover / maintain services and manage increased public need, expectations and tensions, may result in result in: • sub optimal working relationships • staff feeling isolated • reduced staff resilience • increased staff absence • impact on safety and quality of patient care and services	
3. There is a risk that at a time of significant pace and scale of change, we are unable to meet our obligations in relation to required staff training and development, resulting in: • staff feeling unsupported and vulnerable due to not having the correct competencies • reduced staff resilience • reduced job satisfaction • negative impacts on role performance and the safety and quality of patient care and services • reputational damage	

• impacts on retention and recruitment rates	
STRATEGIC PRIORITY **To Deliver Value and Sustainability**	
RISKS	
1.There is a risk that the funding required to deliver the current and anticipated future service models, particularly in the context of the EU exit and the COVID - 19 pandemic, and associated supply chain issues and increased prices, will not match costs incurred, which may result in an inability to maintain and develop services and meet legislative requirements.	
2.There is a risk that failure to implement, monitor and review an effective financial planning, management and performance framework, including fully identifying the level of savings required to achieve recurring financial balance, may result in the Board being unable to deliver on its required financial targets.	
3.There is a risk that failure to assess our property and assets, and secure resources to support improvements to the condition, capacity and resilience of the estate and infrastructure may: • affect compliance with statutory obligations in relation to environmental & sustainability legislation • limit our ability to redesign and accommodate reconfigured services and different models of care to meet clinical demand • impede delivery of the Population Health and Wellbeing Strategy	

NHS Fife

Meeting:	**Finance, Performance & Resources Committee**
Meeting date:	**10 May 2022**
Title:	**General Policies & Procedures Update**
Responsible Executive:	**Margo McGurk, Director of Finance & Strategy**
Report Author:	**Hazel Thomson, Board Committee Support Officer**

1 Purpose

This is presented to the Finance, Performance & Resources Committee for:

- Assurance

This report relates to a:

- Local policy

This aligns to the following NHSScotland quality ambition(s):

- Safe
- Effective

2 Report summary

2.1 Situation

In March 2013, an internal audit report - B12/13, Policies and Procedures - identified that 108 (81%) out of 133 policies then listed on the NHS Fife intranet were beyond their review date. Members of the Audit & Risk Committee questioned the level of risk to the Board from any delay in reviewing such policies in line with target dates. Management agreed that a more robust approach to enforcing reviews was required and that a new risk should be added to the Corporate Risk Register until such time as the new processes were fully implemented. FP&R therefore receives a bi-annual update on the status of 'general' (i.e., non-clinical or HR related) policies, for assurance purposes.

2.2 Background

All policies and procedures are currently classified as either General, Human Resources or Clinical. The responsibility for managing the three separate policy groupings within the Corporate Risk Register has been aligned to the relevant standing Committees of the Board as follows:

- General Policies – Finance, Performance & Resources Committee
- Clinical Policies – Clinical Governance Committee
- Human Resources – Staff Governance Committee

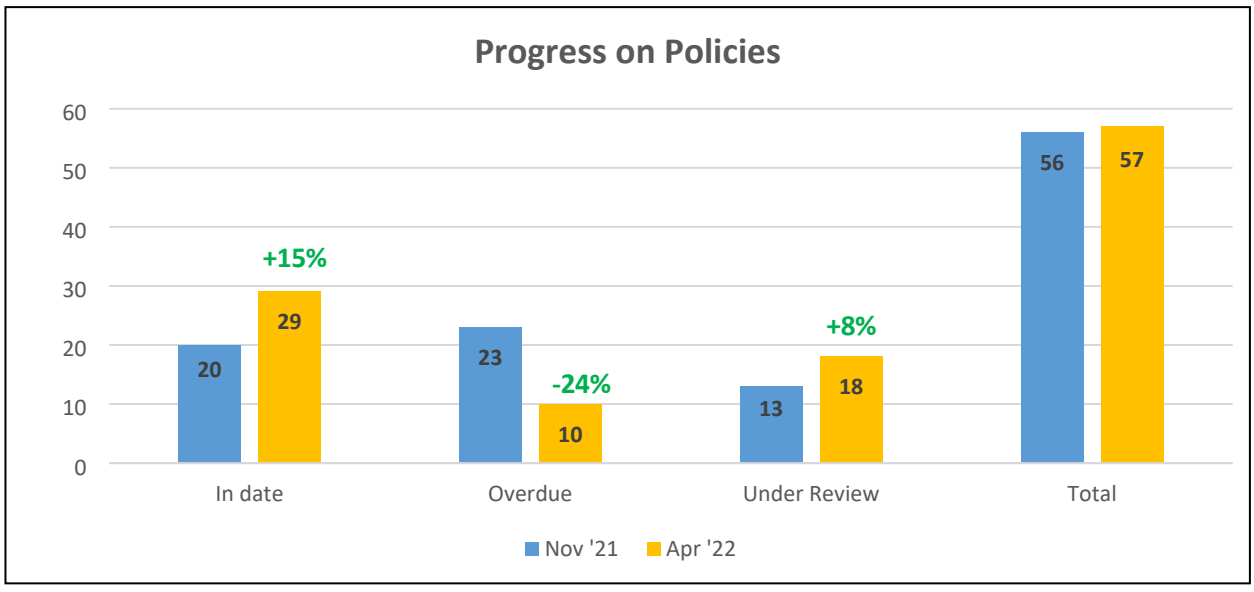
2.3 Assessment

An update on General Policies was last provided to the Committee in November 2021, where it was noted that the Board Committee Support Officer, who commenced in post on 31 May 2021, now manages the administrative processes for NHS Fife General Policies & Procedures. Good progress has been made since November 2021, as further detailed below. Work is ongoing in tackling the historic backlog of General Policies & Procedures that are overdue, and the Board Committee Support Officer is in close contact with respective colleagues across the relevant departments to get these documents reviewed and taken through the approval process.

A General Policies and Procedures Guidelines Pack has now been developed, providing advice, templates and details on submission routes to the General Policies Group, which will better support colleagues during the review period. In addition, a workplan has also been developed. The workplan is attached as an appendix and lists General Policies & Procedures that are overdue, under review and in date. The workplan will support the relevant departments to meet deadlines for reviews going forward and ensure a more proactive approach in ensuring policies are identified, followed up and reviewed before their due date.

General Policies

In April 2022, of the 57 General Policies, 10 (17%) remain beyond their due date, and are presently being followed up. Work is underway for 18 (32%) of General Policies, which are either being reviewed by the relevant authors or are presently out for consultation to the General Policies Group. 29 (51%) of General Policies are up to date. This is an improved position since last reported to the Committee.

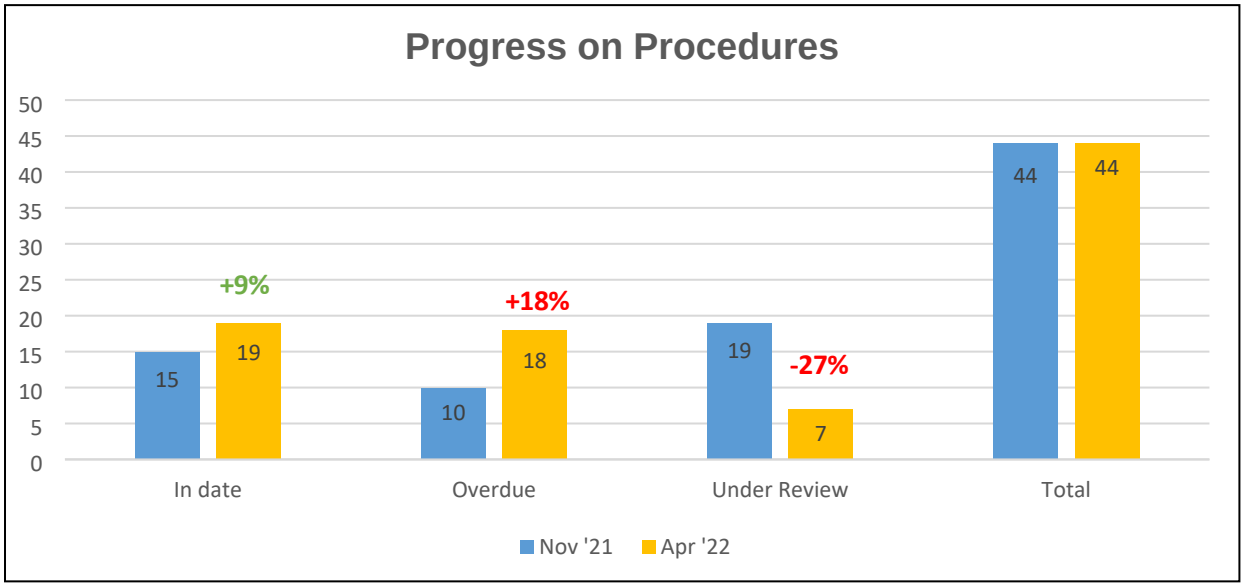


**New policy created: GP/I5 Information Security Policy*

General Procedures

In April 2022, of the 44 General Procedures available on Stafflink, 18 (41%) remain beyond their due date, and are presently being followed up. Work is underway for 7 (16%) of General Procedures, which are either out for review by the relevant authors or out for consultation to the General Policies Group. 19 (43%) of General Procedures are up to date. This is a slightly improved position since last reported to the Committee, with overdue and under review combined at 25, compared to 29 in November 2021.

Further work is required to be carried out to identify General Procedures which are not currently available on Stafflink, to ensure these are uploaded and fully accessible to staff.



Due to changes in responsibility and staff changes, a number of procedures have moved from under review to overdue and are being followed up on a regular basis with those now responsible for their completion.

Exploratory discussions continue to be ongoing on the benefits of introducing an electronic solution for policy management. Further detail will be provided when available.

2.3.1 Quality / Patient Care

N/A

2.3.2 Workforce

N/A

2.3.3 Financial

As previously reported, the estimated financial costs of introducing potential policy management software have proved to be significant and likely beyond the budget of an individual service to meet. An organisational solution is therefore required.

2.3.4 Risk Assessment/Management

Ensuring policies and procedures are reviewed and revised as necessary, on a regular cycle, is an important mitigation of risk.

2.3.5 Equality and Diversity, including health inequalities

This paper does not relate to the planning and development of specific health services, nor any decisions that would significantly affect groups of people. Consequently, an EQIA is not required.

2.3.6 Other impact

N/A

2.3.7 Communication, involvement, engagement and consultation

N/A

2.3.8 Route to the Meeting

N/A

2.4 Recommendation

This paper is provided for:

- **Assurance** – For Members' information only.

3 List of appendices

The following appendices are included with this report:

- Appendix A, General Policies & Procedures Workplan

Report Author
Hazel Thomson
Board Committee Support Officer
hazel.thomson4@nhs.scot

Report Presenter
Gillian MacIntosh
Board Secretary & Head of Corporate Governance
gillian.macintosh@nhs.scot

Appendix A **General Policies & Procedures Workplan**

In Progress/Outstanding

GENERAL POLICIES						
No.	**Department**	**Policy / Procedure No.**	**Policy or Procedure**	**Policy / Procedure Title**	**Review Date**	**Progress Notes**
1	Digital & Information	GP/E7	Policy	Non NHS Equipment Policy	01 May 2019	Followed up.
2	Digital & Information	GP/I4	Policy	e-Health Procurement Policy	01 May 2019	Followed up.
3	Digital & Information	GP/I6	Policy	IT Change Management Policy	01 June 2021	Followed up.
4	Digital & Information	GP/V2	Policy	IT Virus Protection Policy	01 January 2022	Followed up.
5	Estates & Facilities	GP/E4	Policy	Medical Equipment Management	01 November 2020	Followed up 25/03/22. Not started review yet due to other priorities.
6	Health & Safety	GP/M1	Policy	Manual Handling	01 February 2022	Followed up.
7	Medical Director	GP/R3	Policy	Research Fraud & Misconduct	12 September 2021	Followed up.
8	Medical Director	GP/P3	Policy	Picture Archiving and Communication System	01 March 2020	Followed up.
9	Nurse Director	GP/A2	Policy	Use of Independent Advocacy	22 December 2021	Followed up.
10	Nurse Director	GP/R7	Policy	Risk Register and Risk Assessment	01 December 2018	Followed up.
11	Corporate Services	GP/O2	Policy	Online Communications	15 May 2017	In progress.
12	Digital & Information	GP/D3	Policy	Data Protection and Confidentiality Policy	01 June 2021	In progress - almost complete.
13	Digital & Information	GP/S8	Policy	e-Health Incident Management Policy	01 November 2020	In progress.
14	Digital & Information	GP/M5	Policy	Mobile Device Management Policy	01 May 2019	In progress.
15	Estates & Facilities	GP/A1	Policy	Asbestos Policy	01 November 2020	In progress - almost complete
16	Estates & Facilities	GP/P9	Policy	Pressure Systems - NHS Fife	24 July 2021	In progress - almost complete.
17	Estates & Facilities	GP/W1	Policy	Waste Management	22 March 2021	In progress - Awaiting National Policy being updated. Followed up 25/03/22.
18	Estates & Facilities	GP/H4	Policy	Hospitality Policy	01 April 2019	In progress and followed up.
19	Estates & Facilities	GP/L1	Policy	Water Systems Management	26 March 2020	In progress and followed up.
20	Estates & Facilities	GP/P7	Policy	Care of Patients' Personal Laundry	01 September 2020	In progress and followed up.

No.	Department	Policy / Procedure No.	Policy or Procedure	Policy / Procedure Title	Review Date	Progress Notes
21	Estates & Facilities	GP/V1	Policy	Ventilation Systems	09 August 2021	In progress and followed up.
22	Estates & Facilities	GP/W4	Policy	Window Management	09 July 2021	In progress and followed up.
23	Estates & Facilities	GP/M2	Policy	Control of Mercury	09 July 2021	In progress - to be transferred to H&S once new Manager in post.
24	Estates & Facilities	GP/F2	Policy	Fire Safety Policy	01 May 2021	In progress & under review.
25	Medical Director	GP/I9	Policy	Adverse Events	22 March 2021	In progress - review is underway with the policy. Due for update in July/Aug, further to completion of improvement work.
26	Medical Director	GP/S6	Policy	Screening of NHS Fife Staff during the outbreak of an infectious disease	01 December 2020	In progress and going through the approval process.
27	Nurse Director	GP/I8	Policy	Infection Control	01 January 2019	In progress - followed up 25/03/22
28	TBC	GP/S2	Policy	Smoking	01 March 2016	In progress - followed up 25/03/22 - still in progress.

GENERAL PROCEDURES						
No.	**Department**	**Policy / Procedure No.**	**Policy or Procedure**	**Policy / Procedure Title**	**Review Date**	**Progress Notes**
1	Digital & Information	GP/D3-7	Procedure	Good Practice Guide - Using Office Equipment & Machinery	01 December 2015	Followed up.
2	Digital & Information	GP/D3-1	Procedure	Data Protection - Annex 1 - Compliance Aims	01 December 2015	Followed up.
3	Digital & Information	GP/D3-11	Procedure	Supplier Relationships	01 September 2020	Followed up.
4	Digital & Information	GP/D3-10	Procedure	Lost & Stolen Health Records Procedure (Operational Division)	01 December 2015	Followed up. Not started yet.
5	Digital & Information	GP/D3-14	Procedure	Guidance for Staff on Information Sharing with Police	01 August 2016	Followed up. Not started yet.
6	Digital & Information	GP/D3-2	Procedure	Access Controls for Information Systems	01 September 2019	Followed up. Not started yet.
7	Digital & Information	GP/D3-8	Procedure	Lost & Stolen Health Records Procedure	01 December 2015	Followed up. Not started yet.

No.	Department	Policy / Procedure No.	Policy or Procedure	Policy / Procedure Title	Review Date	Progress Notes
8	Digital & Information	GP/D3-9	Procedure	Lost & Stolen Health Records Procedure (Community Health Partnership Division)	01 December 2015	Followed up. Not started yet.
9	Estates & Facilities	GP/E8-1	Procedure	Food Safety	22 February 2016	Followed up.
10	Estates & Facilities	GP/E8-2	Procedure	Catering Services - Contingency Plan Kitchen Failure	22 April 2015	Followed up.
11	Estates & Facilities	GP/E8-4	Procedure	Catering: Hazard Analysis & Critical Control Point (HACCP)	23 April 2016	Followed up.
12	Estates & Facilities	GP/E8-5	Procedure	Safe Handling of Laundry	23 April 2016	Followed up.
13	Estates & Facilities	GP/F2-1	Procedure	Fire Safety Procedure Guidance	01 May 2021	Followed up.
14	Estates & Facilities	GP/E4-01	Procedure	Medical Physics Operational Procedure	01 July 2019	Followed up. Not started review yet due to other priorities.
15	Health & Safety	GP/E8-8	Procedure	Dangerous Substance and Explosive Atmosphere (DSEAR)	01 May 2020	Followed up.
16	Health & Safety	GP/L6	Procedure	Lone Working	01 November 2021	Followed up.
17	Health & Safety	GP/M1	Procedure	The Safer Handling of the Heavier/Plus Size Patient	01 February 2022	Followed up.
18	Corporate Services	FOI/1	Procedure	Freedom of Information Statement and Review	31 March 2014	Followed up.
19	Digital & Information	GP/D3-4	Procedure	Safe Haven Procedure for Fax Machines - Position and Access Controls	01 December 2015	In progress - almost complete.
20	Digital & Information	GP/D3-5	Procedure	Access Controls for Information Systems	01 December 2015	In progress - almost complete.
21	Digital & Information	GP/D3-6	Procedure	Safe Haven Procedure - Actions to be taken in event of fax sent or received in error	01 December 2015	In progress - almost complete.
22	Digital & Information	GP/D3-12	Procedure	Subject Access to Health Records	01 December 2016	In progress.
23	Estates & Facilities	GP/P9-1	Procedure	Pressure Systems (Various procedures included in the one document)	24 July 2021	In progress - almost complete.
24	Estates & Facilities	GP/L2	Procedure	Dealing with Lead at Work	01 February 2021	In progress - to be transferred to H&S once new Manager in post.
25	Health & Safety	GP/E8.9	Procedure	Work Environment	01 January 2017	To be deleted - awaiting completed form to progress.

In Date (Review 2022/23)

Department	Policy / Procedure No.	Policy or Procedure	Policy / Procedure Title	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Corporate Services	GP/E5	Policy	Processing External Hazard and Safety Notices and Alerts			✓									
Digital & Information	GP/A4	Policy	Acceptable Use Policy				✓								
Digital & Information	GP/B2	Policy	e-Health Remove Access								✓				
Estates & Facilities	GP/C1	Policy	Confined Spaces		✓										
Estates & Facilities	GP/C8	Policy	Car Parking Policy										✓		
Estates & Facilities	GP/M3	Policy	Management of Medical Gases								✓				
Estates & Facilities	GP/S3	Policy	Safe And Effective Use Of Unwrapped Instrument And Utensil Sterilizers			✓									
Health & Safety	GP/P4	Policy	Personal Protective Equipment							✓					
Medical Director	GP/I1	Policy	Management of Intellectual Properties							✓					
Corporate Services	GP/O2-3	Procedure	All Staff Email								✓				
Estates & Facilities	GP/E8-6	Procedure	Grounds and Gardens							✓					
Estates & Facilities	GP/M3-1	Procedure	Medical Glass Cylinders								✓				
Estates & Facilities	GP/M3-2	Procedure	Medical Gas Pipeline Systems								✓				
Estates & Facilities	GP/M3-3	Procedure	Procedure for the Safe Storage, Use of Transport of Liquid Nitrogen								✓				
Health & Safety	GP/G1-1	Procedure	Glove Selection Procedure									✓			
Health & Safety	GP/N1	Procedure	Noise at Work								✓				
Health & Safety	GP/V1	Procedure	Control of Vibration at Work										✓		
Health & Safety	GP/W2	Procedure	Work at Height										✓		
Research & Development	GP/I1-1	Procedure	Procedure for the management of intellectual property							✓					

In Date (Review 2023/24)

Department	Policy / Procedure No.	Policy or Procedure	Policy / Procedure Title	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Digital & Information	GP/I3	Policy	Internet Policy											✓		
Digital & Information	GP/R8	Policy	Health Records and Destruction				✓									
Digital & Information	GP/R9	Policy	Health Records							✓						
Estates & Facilities	GP/C4	Policy	Control of Contractors								✓					
Estates & Facilities	GP/E3	Policy	Electrical Safety							✓						
Health & Safety	GP/V4	Policy	Reduction of Violence and Aggression at Work										✓			
Nurse Director	GP/V3	Policy	Volunteering Policy													
Estates & Facilities	GP/E3-1	Procedure	Electrical Safety & Operation							✓						
Estates & Facilities	GP/E8-3	Procedure	Emergency/Restoration Cleaning													
Health & Safety	GP/C3	Procedure	Control of Substances Hazardous to Health								✓					
Health & Safety	GP/D1-1	Procedure	Display Screen Equipment				✓									
Health & Safety	GP/E8-8	Procedure	Dangerous Substances and Explosive Atmosphere				✓									
Health & Safety	GP/V1	Procedure	Control of Vibration at Work								✓					

In Date (Review 2024/25)

Department	Policy / Procedure No.	Policy or Procedure	Policy / Procedure Title	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Corporate Services	GP/R4	Policy	Management, Retention, Storage and Destruction of all Business and Administrative Information and Records					✓								
Digital & Information	GP/C10	Policy	Clear Desk Policy											✓		
Digital & Information	GP/D6	Policy	Data Encryption Policy											✓		
Digital & Information	GP/E6	Policy	Email Policy											✓		
Digital & Information	GP/I5	Policy	Information Security Policy											✓		
Digital & Information	GP/M4	Policy	Media Handling Policy										✓			
Digital & Information	GP/P2	Policy	Secure Use of Passwords											✓		
Digital & Information	GP/P8	Policy	Patient Access Policy				✓									
Digital & Information	GP/P8	Policy	Standard Operating Procedures				✓									
Estates & Facilities	GP/D1	Policy	Fife Wide Decommissioning of Premises Policy							✓						
Health & Safety	GP/H1	Policy	Health & Safety Policy												✓	
Health & Safety	GP/H5	Policy	Health Assessment & Surveillance						✓							
Nurse Director	GP/V3	Policy	Volunteering Policy		✓											
Estates & Facilities	GP/E3-7	Procedure	Room Bookings							✓						
Estates & Facilities	GP/E8-10	Procedure	Driver Operating Procedures (& Handbook)						✓							
Estates & Facilities	GP/E8-3	Procedure	Emergency/Restoration Cleaning		✓											
Estates & Facilities	GP/S1	Procedure	Reallocation of Spaces							✓						

In Date (Review 2025/26)

Department	Policy / Procedure No.	Policy or Procedure	Policy / Procedure Title	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Digital & Information	GP/H6	Policy	e-Health Equipment Home Working Policy										✓			

NHS Fife

Meeting:	**Finance, Performance & Resources Committee**
Meeting date:	**10 May 2022**
Title:	**Review of Annual Workplan**
Responsible Executive:	**Margo McGurk, Director of Finance & Strategy**
Report Author:	**Hazel Thomson, Board Committee Support Officer**

1 Purpose

This is presented to the Finance, Performance & Resources Committee for:

- Approval

This report relates to a:

- Local policy

This aligns to the following NHSScotland quality ambition(s):

- Effective

2 Report summary

2.1 Situation

The Finance, Performance & Resources Committee approved the Annual Workplan at the March 2022 meeting. For assurance, the Annual Workplan, presented as a tracked version, will go to each future Committee meeting to enable the Committee to clearly monitor items that have been covered, carried forward to a future meeting, or removed.

2.2 Background

The Finance, Performance & Resources Committee sets out the planned work for the financial year in its annual workplan, which is used to inform the content of individual meeting agendas.

2.3 Assessment

The Workplan attached sets out the key plans, reports, business cases and proposals which the Committee will receive and be asked to consider, endorse or take assurance from during 2022/23.

2.3.1 Quality/ Patient Care

Delivering robust governance across the organisation supports sustaining and improving patient care and quality standards.

2.3.2 Workforce

Workforce considerations as included as appropriate in proposals considered by the Committee.

2.3.3 Financial

Ensuring appropriate scrutiny of the NHS Fife financial planning and financial performance is a core part of the Committee's remit.

2.3.4 Risk Assessment/Management

The identification and management of risk is an important factor in the Committee providing appropriate assurance to the NHS Board.

2.3.5 Equality and Diversity, including health inequalities

This paper does not relate to the planning and development of specific health services, nor any decisions that would significantly affect groups of people. Consequently, an EQIA is not required.

2.3.6 Other impact

N/A

2.3.7 Communication, involvement, engagement and consultation

N/A

2.3.8 Route to the Meeting

N/A

2.4 Recommendation

The paper is provided for:

- **Approval**

3 List of appendices

- Finance, Performance & Resources Annual Workplan 2022/23

Report Author
Hazel Thomson
Board Committee Support Officer
hazel.thomson4@nhs.scot

Appendix 1

FINANCE, PERFORMANCE AND RESOURCES COMMITTEE

ANNUAL WORKPLAN 2022/23

Governance - General							
	Lead	**10/05/22**	**12/07/22**	**13/09/22**	**15/11/22**	**17/01/23**	**14/03/23**
Minutes of Previous Meeting	**Chair**	✓	✓	✓	✓	✓	✓
Action List	**Chair**	✓	✓	✓	✓	✓	✓
Escalation of Issues to NHS Board	**Chair**	✓	✓	✓	✓	✓	✓
Governance Matters							
	Lead	**10/05/22**	**12/07/22**	**13/09/22**	**15/11/22**	**17/01/23**	**14/03/23**
Committee Self-Assessment	**Board Secretary**						✓
Corporate Calendar / Committee Dates	**Board Secretary**			✓			
Review of Annual Workplan	**Board Secretary**	✓	✓	✓	✓	✓	✓ Approval
Review of Terms of Reference	**Board Secretary**						✓ Approval
Annual Assurance Statement 2021/22	**Board Secretary**	✓					
Internal Audit Annual Report 2021/22	**Director of Finance & Strategy**		✓				
Board Assurance Framework (BAF)	**Director of Finance & Strategy**	✓	✓	✓	✓	✓	✓
Review of General Policies & Procedures	**Board Secretary**	✓			✓		
PPP Performance Monitoring Report	**Director of Property & Asset Management**				Private Session		
Internal Audit Review of Property Transaction Report 2021/22	**Internal Audit**	**As required**					
Strategy / Planning							
	Lead	**10/05/22**	**12/07/22**	**13/09/22**	**15/11/22**	**17/01/23**	**14/03/23**
Strategic Planning Resource Allocation 2022/23	**Director of Finance & Strategy**	**Postponed (awaiting national guidance)**	✓ **TBC**	✓			

Strategy / Planning (cont.)							
	Lead	**10/05/22**	**12/07/22**	**13/09/22**	**15/11/22**	**17/01/23**	**14/03/23**
Corporate Objectives	**Director of Finance & Strategy / Associate Director of Planning & Performance**	✓			✓		
Annual Budget Setting Process 2022/23	**Director of Finance & Strategy**	Private Session					
Property & Asset Management Strategy (PAMS)	**Director of Property & Asset Management**		✓				
Fife Capital Investment Group Reports 2022/23	**Director of Finance & Strategy / Director of Property & Asset Management**	✓	✓	✓	✓	✓	✓
Orthopaedic Elective Project	**Director of Nursing**	✓		✓		✓	✓
Quality / Performance							
	Lead	**10/05/22**	**12/07/22**	**13/09/22**	**15/11/22**	**17/01/23**	**14/03/23**
Integrated Performance & Quality Report	**Exec. Leads**	✓	✓	✓	✓	✓	✓
RMP4 / Winter Performance Report	**Director of Finance**	✓		✓ **Review**	✓ **Plan 2022-23**	✓	✓
Labs Managed Service Contract (MSC) Performance Report	**Director of Acute Services**		✓				
Linked Committee Minutes							
	Lead	**10/05/22**	**12/07/22**	**13/09/22**	**15/11/22**	**17/01/23**	**14/03/23**
Fife Capital Investment Group	**Chair**	✓ 09/03	✓ 20/04	✓ 09/06 & 27/07	✓ 14/09	✓ 28/10 & 07/12	TBC
Procurement Governance Board	**Chair**	TBC	TBC	TBC	TBC	TBC	TBC
IJB Finance & Performance Committee	**Chair**	**11/03 – deferred to next mtg**	✓ 11/03 & 29/04	✓ 08/07	✓ 16/09	✓ 11/11	TBC

Linked Committee Minutes (cont.)							
	Lead	**10/05/22**	**12/07/22**	**13/09/22**	**15/11/22**	**17/01/23**	**14/03/23**
Primary Medical Services Committee	**Chair**			✓ 07/06	✓ 06/09		✓ 06/12
Pharmacy Practice Committee	**Chair**	✓ 18/03	TBC	TBC	TBC	TBC	TBC
Other / Adhoc							
	Lead	**10/05/22**	**12/07/22**	**13/09/22**	**15/11/22**	**17/01/23**	**14/03/23**
Receipt of Business Cases	**As required**						
Consideration of awards of tenders	**As required**						
Asset Disposals							
Additional Agenda Items (Not on the Workplan e.g. Actions from Committee)							
	Lead	**10/05/22**	**12/07/22**	**13/09/22**	**15/11/22**	**17/01/23**	**14/03/23**
CAT – Lucky Ewe Proposal	**Director of Property & Asset Management**	✓					
Kincardine & Lochgelly Health Centres Business Case	**Head of Capital Planning**	✓					

NHS Fife

Meeting:	**Finance, Performance and Resources Committee**
Meeting date:	**10 May 2022**
Title:	**Committee Development Session Programme 2022/23**
Responsible Executive:	**Rona Laing, Non-Executive Board Member and Alistair Morris, Non-Executive Board Member**
Report Author:	**Margo McGurk, Director of Finance and Strategy**

1 Purpose

This is presented to the Board for:

- Approval

This report relates to a:

- Annual Operational Plan
- Emerging issue
- Government policy/directive
- Legal requirement
- Local policy

This aligns to the following NHSScotland quality ambition(s):

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

The committee holds a number of development sessions to consider specific issues relevant to their remit. This paper sets out an initial plan for these sessions in 2022/23.

2.2 Background

The committee development sessions allow more time for detailed discussions on a range of issues and developments which enable members to receive information and briefings to support their consideration of proposals which will come through the committee in public session during the year.

2.3 Assessment

Members have been consulted and offered a number of suggestions on the areas of focus for 2022/23.

Development Session Topics	Lead Exec
Presentation on the SCIM (Scottish Capital Investment Manual) Business Case Process. Focussing on Non-Executive scrutiny role in this area.	MM/NM
Presentation on the development of the Medium-Term financial Strategy including assessment of Scottish Government Funding Arrangements.	MM
Presentation on the Corporate PMO and how that will support the NHS Fife Portfolio Board and Strategy Development. Specific reflection on the FIS Programme.	MM
A presentation on the Primary Care Premises Strategy and the findings of this review.	NM

2.3.1 Quality/ Patient Care

The development session topics cover areas which will have a direct impact on the quality of patient care.

2.3.2 Workforce

Workforce issues will be reflected where appropriate in development session briefings.

2.3.3 Financial

The financial frameworks associated with issues discussed in development session will be presented as appropriate.

2.3.4 Risk Assessment/Management

The risk and opportunity profiles associated with issues discussed in development session will be presented as appropriate.

2.3.5 Equality and Diversity, including health inequalities

Impact assessments will always be completed as part of any proposals arising from development session discussion.

2.3.6 Other impact

n/a

2.3.7 Communication, involvement, engagement and consultation

This is the first presentation of the issues to be considered at the development sessions of the committee.

2.3.8 Route to the Meeting

This is the first presentation of the issues to be considered at the development sessions of the committee.

2.4 Recommendation

The committee is asked to review and **Approve** the proposed development session topics for 2022/23.

3 List of appendices

The following appendices are included with this report:

- N/A

Report Contact
Margo McGurk
Director of Finance and Strategy
Email Margo.McGurk@nhs.scot

NHS Fife

Meeting:	**Finance, Performance and Resources Committee**
Meeting date:	**10 May 2022**
Title:	**Corporate Objectives**
Responsible Executive:	**Carol Potter, Chief Executive**
Report Authors:	**Margo McGurk, Director of Finance & Strategy, Linda Douglas, Director of Workforce**

1 Purpose

This paper sets out the proposed corporate objectives for 2022/23.

This is presented to the committee for:

- Endorsement and Assurance

This report relates to:

- Annual Operational Plan
- Government policy/directive
- National Health & Well-Being Outcomes

This aligns to the following NHSScotland quality ambition(s):

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

The committee requires to consider the corporate objectives annually, these objectives have been derived from the SPRA process and will inform the Annual Operational Plan or RMP for 2022/23.

2.2 Background

This is the second year of the SPRA process and the joint consideration of corporate objectives across the organisation and directorate functional areas.

2.3 Assessment

The corporate objectives of any organisation normally reflect the in-year, highest level actions which will inform the objectives of the Chief Executive. In that context, this paper proposes a refinement of the SPRA generated objectives to reflect those at that corporate level. This is our second year of generating our corporate objectives in this way and we continue to develop and embed this process.

The corporate objectives are linked to one of the 4 NHS Fife agreed strategic priorities, there may be a number which span more than one however they have been initially linked to what is considered to be the "primary" strategic priority.

In setting corporate objectives it is important to ensure individual director role clarity within the executive team. The lead roles have been confirmed through EDG discussion. Directors will determine the allocation of the other roles and confirm this by the end of April. The table below sets out the categories of involvement proposed (LSCI).

Lead - Executive Lead, accountable for delivery of objective
Critical - critical role in supporting the delivery of objective
Supporter - actively engaged in supporting those with executive lead and others with critical roles
Informed - not actively involved in delivery of objective but informed and supportive.

Annex 1 presents 25 corporate objectives for Committee consideration.

2.3.1 Quality/ Patient Care

NHS Fife corporate objectives link directly to the strategic priorities to either "Improve Health and Wellbeing" or "Improve the Quality of Health and Care Services".

2.3.2 Workforce

NHS Fife corporate objectives link directly to the strategic priority to "Improve Staff Experience and Wellbeing".

2.3.3 Financial

NHS Fife corporate objectives link directly to the strategic priority to "Deliver Value and Sustainability".

2.3.4 Risk Assessment/Management

Each corporate objective has an appropriate risk and opportunities assessment as detailed through the SPRA process.

2.3.5 Equality and Diversity, including health inequalities

Each corporate objective either has a completed Impact Assessment or is in the process of completing one.

2.3.6 Other impact

Each corporate objective has a range of impacts which are documented through the SPRA process.

2.3.7 Communication, involvement, engagement and consultation

Directors have been involved in the SPRA process which has generated this initial proposal.

2.3.8 Route to the Meeting

EDG reviewed and approved the corporate objectives on 21 April 2022.

2.4 Recommendation

The committee is asked to **consider** and **endorse** the corporate objectives.

3 List of appendices

The following appendices are included with this report:

- Annex 1, Draft Corporate Objectives.

Report Contacts

Margo McGurk Director of Finance & Strategy Email margo.mcgurk@nhs.scot	Linda Douglas Director of Workforce

Annex 1 : Proposed Corporate Objectives

	NHS FIFE STRATEGIC PRIORITIES - *(Objectives are linked to a primary strategic priority but will contribute directly and indirectly to others)*									
	To Improve Health and Wellbeing	**Medical Director**	**Director of Nursing**	**Director of Public Health**	**Director of Finance & Strategy**	**Director of Workforce**	**Director of Pharmacy & Medicines**	**Director of Property & Asset Mgt**	**Director of Acute Services**	**Director of Health and Social Care**
1	Develop the Population Health and Wellbeing Strategy				L					
2	Develop the strategic plan to secure teaching Health Board Status with the University of St Andrews	L								
3	Develop and deliver the Fife COVID Recovery and Rehabilitation Framework		L							
4	Deliver the OBC for the Mental Health Services Programme	L								
5	Refreshed mental health strategic plan informed through collaborative working with people with lived experience and trauma informed practice									L
6	Deliver the OBC and progress to FBC for both the Kincardine and Lochgelly Health Centres			L						
	Improve the Quality of Health and Care Services	**Medical Director**	**Director of Nursing**	**Director of Public Health**	**Director of Finance & Strategy**	**Director of Workforce**	**Director of Pharmacy & Medicines**	**Director of Property & Asset Mgt**	**Director of Acute Services**	**Director of Health and Social Care**
7	Deliver the National Treatment Centre Fife and ensure operational readiness for opening		L							
8	Develop and implement a system wide medicines safety programme with initial focus on high-risk pain medicines						L			
9	Develop and deliver an enhanced model of care in the Emergency Department								L	
10	Develop and deliver an augmented ambulatory, interface care model (RUC) supporting early and appropriate discharge Integrated Unscheduled Care Programme								L	
11	Develop and implement an integrated planned care programme to address waiting list backlog, including the optimisation of day surgery at QMH								L	
12	Oversight of NHS Fife Anchor Institution delivery plan for 2022/23			L						
13	Deliver Home First to enabling Prevention of admission, person centred transfers of care and a responsive integrated system									L
14	Deliver an approved Integrated Primary and Preventative Care Strategy to set the strategic direction supporting early intervention									L
15	Increase the pace of delivery in the localities of Fife in line with in line with the Plan for Fife.									L
16	Develop and implement an NMAHP Care Assurance Framework		L							
	Improve Staff Experience and Wellbeing	**Medical Director**	**Director of Nursing**	**Director of Public Health**	**Director of Finance & Strategy**	**Director of Workforce**	**Director of Pharmacy & Medicines**	**Director of Property & Asset Mgt**	**Director of Acute Services**	**Director of Health and Social Care**
17	Deliver high quality systems to support staff health and wellbeing					L				
18	Deliver corporate and system leadership that contributes to system wide activities including Plan 4 Fife					L				
19	Develop and deliver the Faculty for Excellence in NMAHP education, training and professional development		L							
20	Develop and deliver strategic and career frameworks for NMAHP Bands 2 - 4		L							
	Deliver Value & Sustainability	**Medical Director**	**Director of Nursing**	**Director of Public Health**	**Director of Finance & Strategy**	**Director of Workforce**	**Director of Pharmacy & Medicines**	**Director of Property & Asset Mgt**	**Director of Acute Services**	**Director of Health and Social Care**
21	Develop and deliver the medium-term financial plan including the implementation of the Financial Improvement and Sustainability Programme				L					
22	Develop the Workforce Strategy to support Population Health & Wellbeing Strategy					L				
23	Implement the Climate Emergency and Sustainable Development Policy including agreed Net Zero commitments							L		
24	Develop the business case and commence implementation of Paper lite systems across NHS Fife	L								
25	Develop the Initial agreement (IA) and Outline Business Case (OBC) for Robotics in Pharmacy						L			

NHS Fife

Meeting:	**Finance, Performance and Resources Committee**
Meeting date:	**10 May 2022**
Title:	**Fife Capital Investment Group Report April 2022**
Responsible Executive:	**Margo McGurk, Director of Finance & Strategy**
Report Author:	**Maxine Michie, Deputy Director of Finance**

1 Purpose

This is presented for:

- Assurance

This report relates to:

- Capital Expenditure 2021/22 Outturn
- Capital Funding Prioritisation 2022/23

This aligns to the following NHS Scotland quality ambition(s):

- Safe
- Effective
- Person Centred

2 Report Summary

2.1 Situation

Capital Expenditure 2021/22 Outturn

Subject to external audit, NHs Fife has delivered on its Capital Resource Limit (CRL) financial target for 2021/22. Appendix 1 shows total capital expenditure of £33.038m incurred against a CRL target of £33.006m. The small overspend of £0.032m is in relation to an asset write off which is permitted in achieving the CRL target. Included in the total capital expenditure is ring fenced funding of £16.484m for specific projects, all of which will continue into finance year 2022/23 with the National Treatment Centre – Fife Orthopaedics expected to be handed over to NHS Fife mid-October. The remaining capital expenditure reflects the core capital allocation the board received which was increased through significant additional capital funding secured from Scottish Government in 2021/22.

Capital Funding Prioritisation 2022/23

A Core Funding allocation of £7.764m is anticipated for 2022/23 and in future years along with additional anticipated allocations for specific projects either already approved by Scottish Government or for which approval is being sought.

The key spend areas for the core capital expenditure plans are:

- Digital and Information: support key digital priorities for the NHS Board, software and hardware replacement and upgrades and digital developments.
- Equipment: Through the FCIG and the Capital Equipment Management Group who oversee the prioritisation of new and replacement equipment.
- Statutory Compliance: which includes maintenance and development of the non PFI estates to ensure compliance with statutory standards.
- Clinical Prioritisation Group: through FCIG and the Clinical Prioritisation Group who oversee the prioritisation of changes to the NHS estate to support service improvement and service redesign.

Other projects anticipating funding for 2022/23 include completion of the National Treatment Centre, progressing Kincardine & Lochgelly replacement Health centres, mental health review and refurbishment of the theatres reception area at Queen Margaret hospital. NHS boards were required to submit their financial plans to Scottish Government in the middle of March which included a 5-year plan as detailed at Appendix 2. The Fife Capital investment Group agreed the prioritisation of the core capital allocation at its meeting on April 20 2022.

2.2 Assessment

Significant additional funding was received in 2021/2022 enabling purchase and delivery of several capital expenditure schemes previously planned for 2022/23.

Following detailed financial planning and prioritisation, it has been agreed that £2m of the capital formula allocation for 2022/23 will be transferred to revenue in the form of a Capital to Revenue transfer.

On actioning the approved Capital to revenue transfer, a balance of £5.764m remains of the core capital allocation to be prioritised amongst the groups responsible for capital expenditure. However, due to the timing of funding received for a project at QMH, other commitments planned for 2022/23 were brought forward into 2021/22 to ensure optimum use was made of available funds. Approximately £0.734m is required to be ring fenced from the 2022/23 formula allocation to deliver the QMH project which will be completed in 2022/23. Table 1 below provides detail on the available funding and the agreed capital allocations to the various groups to take forward capital expenditure plans in 2022/23.

In arriving at the allocations for each expenditure area cognisance was taken account of prior year's allocations and the additional capital allocations received in 2021/22. The Strategic Planning and Resource Allocation returns submitted in Autumn 2021 were also reviewed to assist with the prioritisation of the allocations.

At the end of March 2022 an allocation of £1.022m was provided by Scottish Government to Fife IJB for Mental Health Facilities Improvement and carried forward into 2022/23 in an ear-marked reserve. Funding was allocated on a 'revenue' basis but IJBs have been

asked to work with Health Boards to maximise the potential for positive impact of the funding.

Table 1

Prioritisation of Core capital Funding

	2022/23
Source of Funding	£m
Scottish Government Allocation	7.764
Revenue to capital Transfer	(2.000)
Total Core Funding	**5.764**
Planned capital Expenditure	
QMH Theatres	0.734
Digital & information	0.877
Capital Equipment	1.507
Statutory Compliance	2.185
Clinical Prioritisation	0.461
Total Capital Expenditure	**5.764**
Balance	**0**
Project Specific Planned Expenditure	
Fife National Elective Centre	13.39
Kincardine Health Centre	0.856
Lochgelly Health Centre	1.228
Mental Health Review	0.100
Pharmacy Robot	0.100
QMH Theatre	1.500
Net App SAN	0.605
Main Servers	0.352
Project Total Planned Expenditure	**18.130**
Total Planned Capital expenditure	**23.894**
Less Payback to SG	(0.200)
Total Capital Resource limit	**23.694**

The National Infrastructure and Equipping Board have requested boards submit their equipping requirements for years 22/23 and 23/24. The purpose of this request is to enable boards to take a co-ordinated approach nationally with procurement to gain best value. A national procurement approach may secure greater purchasing power for existing capital allocations.

2.2.1 Quality/ Patient Care

There is a potential risk to patient care if there are delays in upgrading buildings and replacement of equipment due to insufficient available funds.

2.2.2 Workforce

The prioritisation of capital to secure safe and effective working environments for our staff and patients supports health and wellbeing.

2.2.3 Financial

The appropriate prioritisation of capital to meet our corporate objectives is a key aim of the SPRA process.

2.2.4 Equality and Diversity, including health inequalities

All capital schemes follow the appropriate equality and diversity impact assessment process.

2.2.5 Other impact

n/a

2.3.6 Communication, involvement, engagement and consultation

All capital schemes require appropriate communication and engagement through the FCIG subgroups and specific project groups for particular schemes.

2.3.7 Route to the Meeting

Fife Capital investment group 20 April 2022

2.3 Recommendation

This paper is presented to the Committee for:

- **Assurance**

3 List of appendices

Appendix 1 Capital Programme outturn 2021/22
Appendix 2 5-year Capital Investment Plan

Report Contact

Maxine Michie
Deputy Director of Finance
maxine.michie @nhs

Appendix 1

NHS FIFE - CAPITAL BUDGET 2021/22

CAPITAL PROGRAMME EXPENDITURE REPORT - March 2022

	CRL New Funding	Total Expenditure to Date	Projected Expenditure 2021/22	0 Projected Variance
Project	**£'000**	**£'000**	**£'000**	**£'000**
Statutory Compliance/Backlog Maintenance	**3,403,357**	**3,506,240**	**3,506,239**	**(102,882)**
Clincial Prioritisation	**981,032**	**897,892**	**897,893**	**83,139**
Capital Equipment	**7,774,550**	**7,843,643**	**7,843,644**	**(69,095)**
Digital & Information	**1,730,249**	**1,643,165**	**1,643,164**	**87,085**
QMH Theatre Upgrades	**708,301**	**753,893**	**753,894**	**(45,593)**
Total Covid Capital	**897,742**	**46,016**	**46,016**	**851,726**
Elective Orthopaedic Centre	**15,907,000**	16,740,019	**16,740,019**	(833,019)
Lochgelly Health Centre	**348,000**	347,999	**347,999**	1
Kincardine Health Centre	**207,000**	207,000	**207,000**	0
SG & Louisa Jordan Equipment	**49,754**	49,753	**49,753**	1
Energy Funding	**627,096**	627,096	**627,096**	0
Mental Health Review	**22,000**	25,774	**25,774**	(3,774)
Decontamination Unit	**350,000**	350,000	**350,000**	0
TOTAL ALLOCATION FOR 2021/22	**33,006,081**	**33,038,490**	**33,038,492**	**(32,412)**

Appendix 2

NHS Fife
FINANCIAL PLAN 2022-23
Capital Investment

		2022-23	2023-24	2024-25	2025-26	2026-27
		£000s	£000s	£000s	£000s	£000s
Gross Capital Resource Planned Expenditure		23,694	31,788	16,838	26,414	14,264
Less: Capital Receipts Retained Locally		0	0	0	0	0
Net Capital Resource Expenditure		**23,694**	**31,788**	**16,838**	**26,414**	**14,264**
SGHSCD Capital Formula Allocation		7,764	7,764	7,764	7,764	7,764
Project Specific Funding		17,930	24,024	9,074	18,650	6,500
Covid Specific Funding		0	0	0	0	0
Radiotherapy Funding						
Other Centrally Provided Capital Funding						
Revenue to Capital Transfers		(2,000)				
Total Capital Resource Limit		**23,694**	**31,788**	**16,838**	**26,414**	**14,264**
Variance against CRL *(overspend)/surplus*		**0**	**0**	**0**	**0**	**0**

Project & Covid Specific Funding:	**Category (Please select from Dropdown list)**	2022-23	2023-24	2024-25	2025-26	2026-27
Fife National Elective Centre	Project - Approved	13,389				
Kincardine Health Centre	Project - In Governance	856	5,749	967		
Lochgelly Health Centre	Project - In Governance	1,228	9,735	1,660		
Mental Health Review	Project - Proposed	100	3,000	3,000	4,400	4,500
Pharmacy Robot	Project - Proposed	100	400	500	9,000	
HEPMA	Project - In Governance	0	925	747		
QMH Theatre	Project - Proposed	1,500				
SG Payback	Project - Proposed	(200)	(200)	(200)	(200)	
QMH Theatre Phase 2	Project - Proposed		150	200	3,150	
North Labs	Project - Proposed			200	800	500
VHK Phase 2 Tower Block	Project - Proposed			2,000	1,500	1,500
Net App SAN	Project - Proposed	605				
Main Servers	Project - Proposed	352				
CUCM Platform Replacement	Project - Proposed		860			
Deskphones and Portable Phones	Project - Proposed		1,155			
GP Server Hardware	Project - Proposed		330			
LIMS	Project - Proposed		1,920			
Total Project & Covid Specific Funding		**17,930**	**24,024**	**9,074**	**18,650**	**6,500**

Capital Receipts - Asset Sale Proceeds (NBV)	2022-23	2023-24	2024-25	2025-26	2026-27
Total Asset Sale Proceeds	**0**	**0**	**0**	**0**	**0**

NHS Fife

Meeting:	**Finance, Performance and Resources Committee**
Meeting date:	**10 May 2022**
Title:	**NTC – Fife Orthopaedics: Status Update**
Responsible Executive:	**Janette Owens, Director of Nursing**
Report Author:	**Ben Johnston, Head of Capital Planning & Project Director**

1 Purpose

This is presented to the group for:

- Awareness

This report relates to a:

- Project update

This aligns to the following NHS Scotland quality ambition(s):

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

The purpose of this paper is to provide an update on the current position regarding the National Treatment Centre.

2.2 Background

The project involves providing a new National Treatment Centre for orthopaedics at the Victoria Hospital in Kirkcaldy, Fife. The accommodation generally comprises of 3 theatres together with in-patient and outpatient accommodation. The Gross Internal Floor Area is currently 6,142m2 and the forecast project cost is currently £33.2m.

The Full Business Case was approved by the Board in November 2020 and then by the Scottish Capital Investment Group on 11 March 2021, allowing the construction phase of the project to commence. Following the completion of car par enabling works, the project

started on site on 1 March 2021 and is currently due for completion in October 2022. Following a client transfer and commissioning period it is anticipated that the facility will be operational in January 2023.

The project has been procured through Health Facilities Scotland, Frameworks Scotland 2 and is being delivered by Graham Construction.

2.3 Assessment

The project continues to make good progress despite ongoing turbulence in the global market, national changes in law and changes in health guidance/policy.

The project is still targeting an October 2022 completion date, but this under strain given these external pressures. Progress will continue to be monitored and reported regularly to the Project Board.

2.3.1 Quality/Patient Care

<u>Construction</u>

Quality and patient care has been managed through the pre-construction stage of the project in the following ways:

- Compliance with all appropriate healthcare guidance expect where a derogation is agreed
- Staff and patient involvement in the design development process
- A technical audit by NHS Scotland Design Assessment Process
- A technical audit by NSS Design Assure

Quality continues to managed through the construction stage via the following methods:

- Delivering the facilities in accordance with the agreed Quality and Commissioning Strategies
- Appointment of an NEC Supervisor to monitor and manage quality
- Authorising Engineer involvement on key elements (medical gases, water and ventilation)
- Completion and close-out of the NSS Design Assure Action Tracker
- Participation in the NSS Design Assure Key Stage Reviews (construction)
- Planning for a Soft-Landing post-handover (equipment, staffing, training, patient awareness)

Service

A sub-group is in place to design and agree a service model. This workstream is being led by Pauline Hope, Clinical Nurse Manager.

The subgroup will:

- Oversee development of service plans for inpatient areas; theatres; OPD
- Develop procedures and protocols for pre-admission area; wards, including increase in single room accommodation; theatres
- Review and reconfigure Consultant Clinic allocations in agreement with Consultant body
- Review and reconfigure theatre allocations in agreement with Consultant body and theatre teams
- Identify strategic opportunities arising at national and regional level which will support service delivery
- Consider implications from NHS Scotland Recovery Plan and impact this will have on service requirements

Patient & Staff Experience

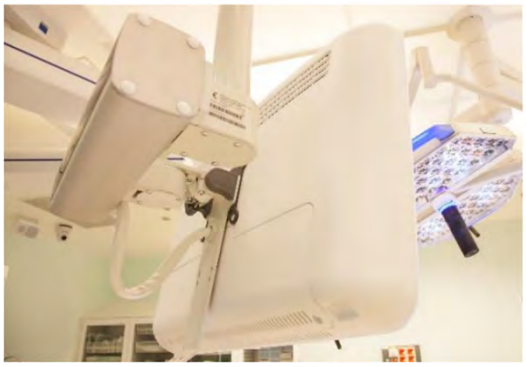
It is also important to note that the project has engaged with the Fife Health Charity to identify and agree funding to support a number of patient and staff enhancements. These include:

- Art Enhancements
  - Landscaping upgrades
  - Children's wall
  - Diorama (mini worlds) installation for children's waiting area
  - Staff balcony enhancements
  - Full wall artistic vinyl's (images of Fife by staff)
  - LED ceiling tiles for anaesthetic and recovery areas

Indicative images below:

- Theatre AV solution – benefits
  - Enhanced surgical experience and surgical ergonomics
  - Teaching and training - enhancing ability to visualise the surgery
  - Patient safety – by minimising theatre footfall and reducing infection risks
  - Future proof the building to adopt new technologies (robotic)
  - Maximises the flexibility in how the theatres are used

  Indicative images below



2.3.2 Workforce

The workforce establishment has been revised and agreed with the National NTC Programme together with the requested funding allocation.

Recruitment is underway – three consultants have successfully been appointed and work to appoint a fourth plus a consultant anaesthetist is progressing well.

A Gantt chart demonstrating the timeline from recruitment through to education and training to commissioning is being updated and should be in place by the end of April.

2.3.3 Financial

The financial allocation approved by the Scottish Government is £33.2m. In addition to this funding has been granted by Fife Health Charity for art enhancements and an AV theatre solution.

The project continues to operate with a healthy contingency, although the effects of War, BREXIT, COVID and changes in law need to be carefully administered and managed to completion of the project.

2.3.4 Risk Assessment/Management

The current key risks and issues to note are outlined in the table below.

Risk / Issue	Mitigation Action
COVID-19: impact on material costs and availability	Secure materials/orders early where possible. Agree deviations to specifications where there is no reduction in quality but improved availability.
BREXIT: impact on material cost and availability	As above.
War: impact on material cost and availability	As above.
Rebated Fuel Change in Legislation: Change in law that no longer permits rebated (known as red diesel) fuel being used for construction purposes. There is a significant cost difference from rebated fuel which was previously used to run generators, plant etc., to diesel or biofuel which will now have to used.	A change in law is a compensation event under the contract, so requires to be assessed and settled.
Availability of workforce	Prepare plan and aim to recruit in accordance with plan. Funding has been agreed with the NTC National Programme regarding the requested posts.

2.3.5 Equality and Diversity, including health inequalities

An Equality Impact Assessment is in place for the project.

2.3.6 Other impact

Not applicable.

2.3.7 Communication, involvement, engagement and consultation

A communication engagement plan has been prepared for the project. With the project in construction the strategy is currently focusing on staff and patient awareness through a monthly newsletter and updates to the project's webpage. As the project moves towards completion in 2022, communications will move towards making patients aware of changes to the elective orthopaedic service and how they may access the new facilities.

As part of the Fife Health Charity art enhancement allocation, one of the initiatives is to provide large vinyl wall images in selected areas throughout the building. The Project Team have extended an invitation to staff to submit images of Fife for consideration. So far, the request has been well received with some excellent images supplied by staff.

In respect to community benefits the Contractor (Graham Construction) is delivering against a wide range of targets – some key highlights to date include:

- 70% of the construction workforce has been sourced from the local supply chain
- 7 new apprenticeships, 9 graduate starts, work experience and educational visits offered through the project

2.3.8 Route to the Meeting

Information contained in SBAR, discussed at Project Board meeting and EDG on 21 April 2022.

2.4 Recommendation

This paper seeks to provide a project update and general awareness. FPR is asked to **note** the status of the project and take **reassurance** from the current position. The project is being delivered in a challenging environment and notwithstanding some ongoing pressures in respect to cost and time, continues to generally perform well. Ongoing risks and issues will be managed at Project Board level but escalated where necessary.

3 List of appendices

None

Report Contact
Ben Johnston
Head of Capital Planning & Project Director

Email: ben.johnston2@nhs.scot

Meeting:	**Finance Performance & Resources**
Meeting date:	**10 May 2022**
Title:	**Kincardine and Lochgelly Health and Wellbeing Centre – Outline Business Cases**
Responsible Executive:	**Joy Tomlinson, Director of Public Health**
Report Author:	**Ben Johnston, Head of Capital Planning**

1 Purpose

This is presented to the group for:

- Approval

This report relates to a:

- Business Case

This aligns to the following NHSScotland quality ambition(s):

- Safe
- Effective
- Person Centred
- Sustainability

2 Report summary

2.1 Situation

The purpose of this paper is to present the Outline Business Cases for the Kincardine and Lochgelly Health and Wellbeing Centres.

2.2 Background

The Initial Agreements for these projects were approved by the Scottish Government in January 2020. The project development process was then paused due to the global pandemic and the Outline Business Case stage commenced in earnest with associated project governance around March 2021.

The projects were initiated to tackle the following key needs for change:

- Restricted access to local clinical services
- Constrained ability to provide integrated care models
- Inability to increase accommodation to offer capacity to meet demand
- Current accommodation does not meet modern standards
- Safety and operational issues resulting from ongoing maintenance requirements

These needs for change are recognised by the Scottish Government's Place Based Needs Planning tool which places Kincardine and Lochgelly within the "top 3" primary care facilities requiring investment and improvement within Fife's portfolio.

The vision for primary care and community services in NHS Fife and Fife Health and Social Care Partnership is to enable the people of Fife to live independent and healthier lives. We will deliver this by working with people to transform services to ensure these are safe, timely, effective and high quality, focused on achieving personal outcomes. This requires access to the right professional at the right time in the right place; where services can be provided within a community setting, closer to where service users live. Care should be provided in an environment that supports staff to provide an excellent experience and has modern facilities that meet the needs and expectations of service users, carers and staff well into the late 21st century.

2.3 Assessment

Within the Outline Business Case stage the following key activities have taken place.

- Development of the services and requirements taking account of General Medical Services (GMS) contract obligations
- Initial work around tests of change and service re-design based on the patient's perspective (ongoing)
- Development of the schedule of accommodation to align with the updated service requirements
- Public engagement to capture end-user views and expectations on what the facilities might deliver
- Development of the outline design proposals
- Development of the associated costs

2.3.1 Quality/Patient Care

Quality and patient care are at the forefront of this important work as we are fundamentally seeking to deliver an appropriate compliment of integrated services locally within modern facilities. This has and will continue to progressively be delivered though two key workstreams.

Service

The service will concentrate on maximising the benefits of new accommodation through exploring service re-designs, integration opportunities and new ways of working to support the patient's needs. The Project Team will work with stakeholders including the public, local community and services to define operating models for the new facilities. These operating models will create a blueprint of how the facilities should function and form a basis for the change, improvement, integration and test of change work. This process will make use of a variety of strategic change and improvement methodologies (e.g. Systems Thinking principles, Service design, Process Improvement/Lean) as we as use the Patient Personas & Pathways work already undertaken. This will ensure service business perspectives, as well as patient/service user perceptions and journeys, both inform the service redesign process. This workstream has commenced but will continue through the Full Business Case and construction stages of the projects.

Design & Construction

The facilities to date have been designed around briefing from the services in respect to their needs and around the design statement which was generated at the initiation of the project.

Furthermore, the facilities will be designed in accordance with all statutory regulations and relevant healthcare guidance. Critical friend key stage reviews will take place by NHS Scotland Design Assessment Process (NDAP) and NHS Assure ensuring that the facilities are compliant and fit for operational use.

2.3.2 Workforce

The expected staff environment was briefed as part of the design statement process. Taking account of these requirements and embedding them into the design, it can be said that the facilities will offer excellent places to work, develop and rest.

There is likely to be changes to the working culture with a more agile environment being offered for office spaces. This will allow space within the asset to maximised and used flexibly by multiple services. This cultural change will be worked through as part to the re-design work.

Operational (FM) workforce requirements and costs have been estimated within the Outline Business Case.

The clinical/business support workforce and costs have been established and set out within the Outline Business Case. These will be further refined and tuned during the Full Business Case stage as the detailed service re-design work progresses and operating

models are agreed upon. This element will be responsibility of the HSCP via the Project Team.

2.3.3 Financial

Capital

The project costs have increased significantly since the Initial Agreement where initial budget costs were established. The key reasons for this are:

- More maturity around GMS requirements leading to an increase in building area.
- Volatile market conditions with an excessive inflationary impact
- More stringent sustainability/energy requirements.
- Site survey/investigation information being incorporated into the design

The capital cost position for each project is summarised in the table below (inclusive of VAT):

	IA Budget	**Current (OBC) Budget**	**Difference**
Kincardine	£4,656,975	£7,817,528	£3,160,553
Lochgelly	£8,155,615	£13,031,178	£4,875,563

Despite the increases in capital cost, given the mitigating circumstances the projects are considered to represent value for money in the current market place and this view has been upheld by our independent Lead Advisors who have helped us to interrogate and understand the cost movements.

Revenue

The estimated revenue costs are noted in the table below for each project.

Kincardine			
Description	**Baseline**	**Preferred Option**	**Difference**
Property pays (NHSF)	£12,605	£33,474	£20,869
Property non-pays (NHSF)	£16,612	£76,550	£59,938
Property non-pays – GP offset (NHSF)	-£16,584	-£27,142	-£10,558
Net Increase (NHSF)	**£12,633**	**£82,882**	**£70,249**
Service model		£31,500	-

(FHSCP)			

Lochgelly			
Description	**Baseline**	**Preferred Option**	**Difference**
Property pays (NHSF)	£24,467	£75,566	£51,099
Property non-pays (NHSF)	£61,920	£178,330	£116,409
Property non-pays – GP offset (NHSF)	-£37,718	-£83,165	-£45,448
Net Increase (NHSF)	**£48,670**	**£170,731**	**£122,061**
Service model (FHSCP)		£724,500	-

- NHS Fife's revenue costs have increased from the baseline primarily due to the increase in the size of the facilities.
- The revenue costs relating to the service model continues to be developed in consultation with the Scottish Government around MOU1/2 for urgent care and what Multi-Disciplinary Teams (MDT) means for Fife. The service model costs will have a nil impact on the revenue outturn position as funding sources have been identified.

2.3.4 Risk Assessment/Management

A risk register has been prepared for the projects and is appended to the Initial Agreement itself.

For each project, to cover risk from a financial position at this stage, Hubco have retained 5% to cover further inflation and some design development. At the end of the Full Business Case stage their risk provision is capped at 1%.

From NHS Fife's perspective, for each project, 13% has been retained at this stage in the process. An optimism bias matrix has been completed to substantiate the maturity of the projects and this resulting allocation.

Two key risks arising should be highlighted and noted – these are:

1. NHS Key Stage Review: the key stage review has been undertaken however the draft report from NHS Assure is delayed. The comments may have an impact on cost/programme depending on the findings.
2. Sustainability: the project briefing in respect to sustainability was established using the Building Research Establishment Evaluation Assessment Method (BREEAM) 2018 tool (current at the time of project implementation), however Scottish Government and Health Facilities Scotland have recently stated that the projects must be assessed during Full Business Case against SHTN 02-01 Sustainable Design and Construction Guide (SDaC). This guidance incorporates a new sustainability tool that is untested so the possible effects on the projects are difficult to quantify. That's said, Scottish Government are mandating the use of the tool so will need to be aware and accept any associated cost escalation through it's use.

2.3.5 Equality and Diversity, including health inequalities

Stage 1 of the Equality Impact Assessment (EQIA) has been completed. Stage 2 will be developed during the Full Business Case stage.

2.3.6 Other impact

Not applicable.

2.3.7 Communication, involvement, engagement and consultation

A communication engagement plan has been prepared for the projects – this is a live document and will be updated progressively as the projects develop.

During the Outline Business Case stage the following key pieces of engagement have taken place.

- Public engagement survey
- GP's integrated into design process
- Public representation during design process
- Public representation groups established
- Service communication and engagement meeting established
- Attendance at Councillor ward meetings
- Staff and public attendance at Achieving Excellence Design Evaluation Toolkit (AEDET) workshops

2.3.8 Route to the Meeting

The governance route for the IJB has been affected by the political process and Purdah. The H&SCP and IJB governance routes are outlined below. Discussions about the Lochgelly and Kincardine developments have taken place with the IJB members at IJB

meetings. An event being planned for June 2022 will form part of on-going engagement around the model as it is refined.

Governance milestones noted below:

Project Board – complete
H&SCP Transformation Board updates January and March 2022 – complete
NHS Fife, FCIG: 27 January 2022 – complete
H&SCP SLT Business 21st February 2022 – complete
NHS Fife, Portfolio Board: 17 March 2022 – complete
NHS Fife, FP&R: 10 May 2022
NHS Fife Public Health & Wellbeing Committee – 16 May 2022
NHS Fife, Board: 31 May 2022
SCIG Submission: 18 May 2022
SCIG Meeting: 29 June 2022
IJB Briefing Session to be held in June 2022

2.4 Recommendation

This case for change remains. The health centres are required to offer a full range of integrated health services locally within an appropriate environment.

In addition, these two initial health centres will act as exemplar facilities on which to establish a wider primary care premises strategy in Fife. Work regarding this strategy is also underway separately.

The capital costs for the health centres have increased since the Initial Agreement stage. There are key reasons for these increases, but importantly, in today's marketplace, the facilities represent value for money.

For these reasons we recommend that the Outline Business Cases are supported to allow swift development of the Full Business Cases in advance of construction delivery.

3 List of appendices

- Kincardine Outline Business Case
- Lochgelly Outline Business Case

Report Contact
Ben Johnston
Head of Capital Planning & Project Director
Email: ben.johnston2@nhs.scot

Kincardine Health and Wellbeing Centre

Outline Business Case

20 April 2022, Rev. 5

VERSION CONTROL

Draft R.0	29.09.21	First OBC Draft
Draft R.1	03.12.21	Updated Draft
Draft R.2	11.01.22	Updated Draft – Ben Johnston
Draft R.3	16.02.22	Updated Draft to incorporate FCIG comments – Ben Johnston
Draft R.4	28.03.22	Updated Section 4.4.14 – Ben Johnston
Draft R.5	20.04.22	Updated risks Section 1.4 and 4.5.2 – Ben Johnston

Contents

Glossary of Terms

ADAPT	Alcohol and Drug Abuse Prevention & Treatment
ADB	Activity Data Base
AEDET	Achieving Excellence Design Evaluation Toolkit
A&DS	Architecture & Design Scotland
BEP	Building Information Modelling Execution Plan
BIM	Building Information Modelling
BPC	Benefit Point Cost
BREEAM	Building Research Establishment Environmental Assessment Method
BRUKL	Building Regulations UK Part L
BSL	British Sign Language
CAB	Change Advisory Board
CDM	Construction (Design and Management)
CHaWS	Community Health and Wellbeing Sub-group
CHD	Coronary Heart Disease
CLD	Community Learning & Development
COPD	Chronic Obstructive Pulmonary Disease
CTAC	Community Treatment & Care
DBDA	Design and Build Development Agreement
DSM	Dynamic Simulation Model
DVLA	Driver and Vehicle Licensing Agency
EIR	Employers Information Requirements
FASS	Fife Alcohol Support Service
FBC	Full Business Case
FHSCP	Fife Health & Social Care Partnership
FVA	Fife Voluntary Action
GIFA	Gross Internal Floor Area
GMS	General Medical Services
GP	General Practitioner
HAI	Healthcare Associated Infection
HAI SCRIBE	HAI System for Controlling Risk in the Built Environment
HFS	Health Facilities Scotland
HHG	High Health Gain

HIS	Healthcare Improvement Scotland
HV	Health Visiting
IA(D)	Initial Agreement (Document)
IJB	Integration Joint Board
ISD	Information Services Division
LAC	Local and Community
L&D	Learning & Development
M&E	Mechanical and Electrical
MDT	Multi Disciplinary Team
MOU	Memorandum of Understanding
NCM	National Calculation Methodology
NDAP	NHSScotland Design Assessment Process
NPC	Net Present Cost
NSS	National Services Scotland
OBC	Outline Business Case
PA	Per Annum
PBA	Project Bank Account
PPD	Practice & Professional Development
PPE	Post Project Evaluation
PSCP	Principal Supply Chain Partners
QOF	Quality Outcome Framework
RAG	Red Amber Green
RIBA	Royal Institute of British Architects
SA	Strategic Assessment
SCIM	Scottish Capital Investment Manual
SFT	Scottish Futures Trust
SIMD	Scottish Index of Multiple Deprivation
SoA	Schedule of Accommodation
SPARRA	Scottish Patients at Risk of Readmission and Admission
SRO	Senior Responsible Officer
STAND	Dementia Friendly Fife
STAR	Stop Think Assess Respond/Report/Refer Method
TUPE	Transfer of Undertakings (Protection of Employment) Regulations 1981
VfM	Value for Money

WBP	Weighted Benefit Points
WLC	Whole Life Cost
WFVF	West Fife Villages Forum
WTE	Whole Time Equivalent

1 Executive Summary

1.1 Introduction

Fife Health and Social Care Partnership is working with local communities, teams and stakeholders to support the delivery of a fully integrated 24/7 community health and social care model that ensures sustainable, safe, individual partnerships of care. The purpose of this outline business case (OBC) is to seek approval to develop the full business case (FBC) to re-provide Kincardine Health Centre in purpose designed facilities whilst making provision for a holistic offer of local health and wellbeing services to fulfil the General Medical Services (GMS) contract[1] requirements.

The OBC establishes the need for investment, building on the NHS Fife and Fife Health and Social Care Partnership (FHSCP) strategic goals to deliver a model of local care, focused on individual outcomes, supported by health and social care delivered by the right person in the right place at the right time. It describes the appraisal of a long list of options, identifies the short list, and recommends a preferred way forward to enable the delivery of Fife's Community Health and Wellbeing Hub model within the Kincardine community. The OBC's commercial, financial and management cases have been developed further to identify how the project can be practically delivered.

The vision for primary care and community services in NHS Fife and Fife Health and Social Care Partnership is to enable the people of Fife to live independent and healthier lives. We will deliver this by working with people to transform services to ensure these are safe, timely, effective and high quality, focused on achieving personal outcomes. This requires access to the right professional at the right time in the right place; where services can be provided within a community setting, closer to where service users live. Care should be provided in an environment that supports staff to provide an excellent experience and has modern facilities that meet the needs and expectations of service users, carers and staff well into the late 21st century.

1.2 Strategic Case

1.2.1 Current Arrangements

Kincardine Health Centre, located on the edge of the village, provides General Medical Services through Clackmannan and Kincardine Medical Practice who are contracted by NHS Forth Valley, as part of a two centre practice arrangement. Community services are provided by both NHS Fife (including District Nursing, Health Visiting and Podiatry) and NHS Forth Valley (the majority) for Kincardine residents. Services are working to deliver high quality person-centred health and social care services in a way which promotes and enhances the health and wellbeing of the people of Fife.

The Kincardine Health Centre Practice population is circa 3,200, the locality population is predicted to grow by 9% in the 25 years. However, the population in the older age group is projected to increase by 52%, this will see the proportion of the practice population who are frail, whom our local care model has demonstrated benefit from integrated holistic care management, grow from 4% to 5%.

[1] GMS contract: 2018 - gov.scot (www.gov.scot)

The current facility is a 1930's construction, originally built as a police station. Models of care have changed over time with the building considerably modified and extended throughout its lifetime. Our new model of working requires accommodation that is fit for purpose, which enables multi-disciplinary and group working, which supports the community and partners to deliver collaboratively. The current building and configuration is not fit for purpose, the building does not work for modern health and social care delivery, with corridors and treatment rooms which do not meet minimum standards, areas which do not enable disabled access and no storage.

The development of the health and wellbeing model and delivery of the new GMS contract is constrained by structural and layout constraints. All possible reasonable changes have been made to the existing building. Kincardine Health Centre fails to meet the spatial, organisation and design standards for Primary and Community Health Care premises and has no capacity for further growth. Major improvements to address maintenance and statutory standards will not facilitate significant improvements in space utilisation to meet patient quality, staff standards and efficiency objectives.

1.2.2 The Patient Perspective

It has been recognised for many years, service providers across Scotland and the UK have planned care separately in different parts of the system including primary, community, acute care and mental health. Services have often been planned around buildings, individual service providers or even clinicians.

What is now proposed is a shift toward an overarching whole systems model which focuses on the needs of people who use the different health and social care services within the Kincardine Practice. This is described as a more holistic community health and wellbeing approach.

The central underlying principle of the development of the new centre is to focus on the patient outcomes, their journey and experience. This will help to identify where service improvements are necessary and involve a wide range of service users and providers in analysing and redesigning improved patient pathways to positively impact on outcomes.

The agreed way forward was to develop patient personas and pathways to enable the patient perspective and journey to be captured. We have identified seven people (personas) who typify patients or people who use the Kincardine Practice and whose care represents key requirements and challenges for NHS Fife, FHSCP and partners. The personas and pathways in this document were developed in using local profile and practice data as well as in collaboration with a range of clinical services, community and voluntary sector partners.

We have used the personas to illustrate pathways and through mapping their care needs - we can agree how they can be met more effectively and efficiently. A designed and managed process of patient and service provider engagement including wider public involvement has taken place and is expected to shape development of the new centre – moving from the traditional medical model to a more holistic community health wellbeing service model of delivery.

The Health & Wellbeing Model was developed by change and improvement colleagues in NHS Fife and FHSCP. This is illustrated below.

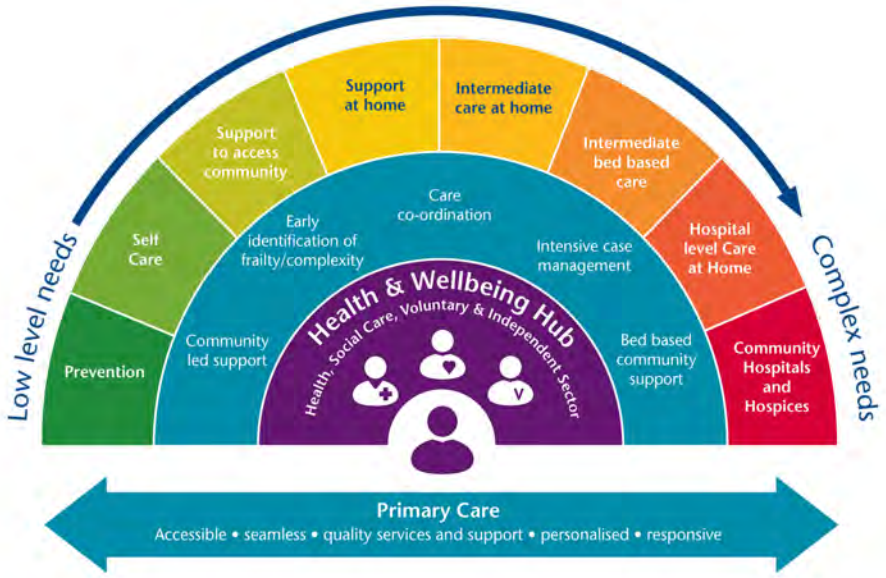


Figure 1 - Health and Wellbeing Model

The Project Team is using the Patient Personas & Pathways to look at possible improvements through a number of tests of change. This workstream has commenced but will continue through the FBC and construction stages of the project.

1.2.3 The Need for Change and Investment Objectives

The drivers for change and developed Investment Objectives to enable this change are set out in the table below. Associated benefits are set out in Section 2.4.4.

Effect of the need for change on the organisation:	Investment Objectives
Existing service arrangements are affected by lack of clinical support service facilities.	Ensure equal access to a patient centred approach by enabling delivery of and access to local anticipatory and preventative care for patients.
Implementation of integrated models of care is undeliverable locally in the current environment	Ensure equal access to modern integrated care with provision driven by patient need rather than limitations in physical capacity.
Pressure on existing staff, accommodation and services will inevitably increase.	Ensure the right staff skill mix and service capacity are available to deliver and strengthen local capacity to manage people's health within the local community.
The facilities available, 100% occupancy, combined with significant population change, restrict the ability of	Enable earlier access to proactive and anticipatory care through local delivery via

the parties to deliver the full range of integrated services locally.	integrated seamless service across health and social care.
Existing configuration, as a result of a 1930's building, being modified and extended with a 'best fit' approach. Current facilities have treatment rooms below minimum acceptable standards.	Delivery of safe and effective care with dignity –by providing facilities which comply with all legal standards and regulatory requirements and gives equality of access for all.
Increased safety risk from outstanding maintenance and inefficient service performance.	Improve safety and effectiveness of accommodation by improving the physical condition, quality and functional suitability of the healthcare estate.

Table 1 - Needs for Change and Investment Objectives

1.2.4 Fife Place Based Planning Tool

NHS Fife have recently been engaging with Scottish Government around their proposal to develop a longer-term primary care strategy. Scottish Government have recently developed a Place Based Needs Planning tool which helps Boards to understand their investment priorities based on community health, demographics, supporting infrastructure and the condition of the estate. Analysing the data for Fife in totality, Kincardine Health Centre has an Estate Need Score of 83 (top primary care priority), bolstering the case for change and intervention.

Property	Postcode	Intermediate Zone	Floor Area	Age	Estate Need Score
Kincardine Health Centre	FK10 4QX	Kincardine	254	91	83
Oakley Health Centre	KY12 9QH	Oakley Comrie and Blairhall	918	71	73
Lochgelly Health Centre	KY5 9QZ	Lochgelly West and Lumphinnans	822	81	70
Valleyfield Health Centre	KY12 8SJ	Valleyfield Culross and Torryburn	1,012	51	65
Path House Medical Practice	KY1 2PG	Kirkcaldy Pathhead	612	329	56
Strathmiglo Auchtermuchty Practice	KY14 7QA	Auchtermuchty and Gateside	50	59	55
Leven Health Centre	KY8 4ET	Leven East	1,624	56	53
Rosyth Health Centre	KY11 2SE	Rosyth East	946	39	47
Kelty Health Centre	KY4 0AE	Kelty East	754	60	44
Lundin Links Scoonie Medical Practice	KY8 6DB	Largo	48	59	43

Table 2 - Priority Order of Estate Need

1.3 The Economic Case

A wide range of options were developed and considered. These were then consolidated into a shortlist of options which were scored via a wide range of stakeholders. The option scores are presented below.

Investment Objective	Option 1: Status Quo	Option 2: Feregait	Option 3: Station Road	Option 4: Tuliallan School
Net present cost (NPC) - £m	723,705	6,307,702	6,368,662	6,368,662
Weighted benefit points (WBP)	221	539	509	739
BPC per WBP - £000	3,275	11,703	12,512	8,618
	Rejected	Possible	Possible	Preferred

Table 3 - Short-listed Option Scores

Option 4 scored highest in respect to benefit points. Once the net present costs were factored in, option 1 is highlighted at the lowest cost per benefits point – this is purely because of low net present cost owing to the limited capital that could be invested in the existing facility. As option 1 does nothing to tackle the needs for change as demonstrated, it is not a legitimate option but included for comparative purposes.

Given the balance of legitimate options, option 4 offers the highest benefits score and the lowest cost per benefits point, indicating that it is the strongest option. Option 4 is therefore the preferred option.

1.4 The Commercial Case

The Commercial Case has been developed significantly since IA. Key aspects contained within the commercial case are summarised below.

- The project is community focussed and more than £750k, therefore the Scottish Futures Trust hub initiative has been selected as the most appropriate route to deliver the project. The East Central hubCo have been appointed to deliver this public funded project under the design and build option.
- Currie & Brown have been appointed through the Frameworks Scotland Lead Advisor lot to support the Board with multiple services including Project Management, Cost Advisor, Technical Advisor and Clerk of Works.
- The design has been fully developed in conjunction with the Project Team and Stakeholders. With exception to the NHS NSS Design Quality Assurance and NDAP processes which are ongoing, the design has been well received through the HAI, AEDET and focussed design workshops.
- Discussions with Fife Council in respect to leasing the required land are advanced appropriately for the stage in the project. These will continue during the FBC stage with a view to concluding arrangements at the point of completing the FBC.
- The current key risks/issues facing the project are summarised in the table below:

Risk/issue	Mitigation
Brief inadequate/unreliable This issue relates to developments around the GMS contract and effect this has had on the area requirements for the building.	The required area increase from IA to OBC has been factored into the current design and corresponding cost plan.
Stop/start nature of the programme – keep people engaged through these periods.	Updates are being provided to community groups via newsletters and the public via press releases. NHS Fife's communication team are supporting this effort.
Project cost increases due to: ▪ Change in requirements ▪ Inflation / market conditions	This is a current issue where the cost increases have rose beyond the IA budget projection. Refer to Financial Case for further substantiation.
Programme delay The OBC programme has been affected because of COVID which has impacted resources, engagement activity and costs.	Potential to commence FBC activity in parallel with the OBC governance approval process. The project now has a full complement of resources to help drive the project forward.
Change of policy – NHS Assure Key Stage reviews Programme delays / cost increases arising	Key stage review process was implemented half-way through OBC and is required to achieve capital funding. Risk had to be accepted, but impact can be mitigated through collaboration.
Change of policy – SHTN 02-01 Sustainable Design and Construction Guide (SDaC) Programme delays / cost increases arising	Informed by HFS at OBC NDAP review that new guidance must be followed at FBC. Guidance is untested to impact is difficult to quantify. As such this risk has not currently been factored into OBC cost estimates.

Table 4 - Key Risk Summary

1.5 Financial Case

1.5.1 Capital Costs

A capital cost summary is provided in the table below demonstrating the total OBC estimated cost for the project, together with the movement in cost since IA.

IA	OBC	Movement
£4,656,975	£7,817,528	£3,160,553

Table 5 - Capital Cost Summary

The key reasons for the movement in cost since IA, are set out below:

- Building area increase to take account of service and GMS contract evolving requirements – accounts for circa 35% of the construction cost increase
- Inflation and extraordinary market conditions considered to driven by the COVID-19 pandemic and the resulting global effect on supply chains – accounts for circa 20% of the construction cost increase
- Site and design abnormals: this relates to site conditions, more onerous energy requirements and creating a building that satisfies the conditions of the brief and design statement – accounts for circa 45% of the construction cost increase
- Associated percentage mark-ups based on an increased construction cost
- Some further adjustments to the IA budget allowances, notably equipment and internal direct labour costs

A number of value engineering / cost saving opportunities have been identified and these have already been accounted for in the presented OBC figures above.

Notwithstanding the cost increases noted, given the current project environment, the costs are considered to represent value for money in the current marketplace and this view has been endorsed by our consultant Cost Advisor.

1.5.2 Revenue Costs

A summary of the revenue costs is provided in the table below.

Description	Baseline	Preferred Option	Difference
Property pays (NHSF)	£12,605	£33,474	£20,869
Property non-pays (NHSF)	£16,612	£76,550	£59,938
Property non-pays – GP offset (NHSF)	-£16,584	-£27,142	-£10,558
Net Increase (NHSF)	**£12,633**	**£82,882**	**£70,249**
Service model (FHSCP)	In development	£31,500	-

Table 6 - Revenue Cost Summary

The increase in cost from an NHS Fife perspective is largely associated with the increase in building area.

The revenue costs relating to the service model continues to be developed in consultation with the Scottish Government around MOU1/2 for urgent care and what MDT means for

Fife. The service model costs will have a nil impact on the revenue outturn position as funding sources have been identified.

1.6 Management Case

The Management Case identifies the actions that will be required to ensure the successful delivery of the scheme. The management case has been significantly updated for this the IA stage and demonstrates that the Board and Partnership are well prepared to deliver the project successfully during the construction phase and beyond. Key milestones for the project are identified in the table below:

Description / activity	Date
Full Business Case	
Commencement	February 2022
Completion	January 2022
Governance Approvals	April 2023
Construction & Handover	
Commencement	May 2023
Completion	June 2024
Operational	August 2024

Table 7 - Key Milestone Summary

2 Strategic Case

2.1 Introduction

The main purpose of the Strategic Case is to confirm the background and drivers for change for the proposition. It also sets out the key investment objectives and associated benefits.

2.2 Revisiting the Strategic Case

The Initial Agreement Document (IAD) was approved by Scottish Government in January 2020. The next phase involved undertaking a widespread engagement exercise with key stakeholders and the people of Kincardine. This process was paused as a result of the global pandemic and was eventually reinstated in November to December 2020. The outcome of the engagement exercise can be reviewed within the Economic Case. The recovery plan in relation to the pandemic also caused delay to timescales for the Outline Business Case and design process. However, these have since resumed at pace. There are new sections added which were not previously in the IAD including:

- The patient perspective and service integration in Section 2.4.1.2
- A summary of services (existing versus proposed) in Section 2.3.2
- A description of associated buildings and assets in Section 2.3.3

The critical success factors have been retained although are not reflected in the current Scottish Capital Investment Manual (SCIM) guidance. The residual balance of the Strategic Case has been retained and updated where necessary.

2.3 Current Arrangements

2.3.1 Service Arrangements

The holistic multi-disciplinary primary and community care services in Kincardine are currently delivered from the existing Kincardine Health Centre, a 1930's constructed facility – originally built as a residential property and then utilised as a police station - that has been considerably modified and extended throughout its lifetime. The building is owned by NHS Fife.

GP services in Kincardine are delivered as part of a two-centre practice, along with Clackmannan Health Centre, with each operational unit given equal standing and operating full time to meet their respective local needs. The GP Practice is contracted to NHS Forth Valley to provide General Medical Services.

The services delivered from the existing Kincardine Health Centre are primarily provided in support of the population needs of the people of Kincardine and surrounding areas, with 98% of the resident population registered (see figure 2 - map of Kincardine interzone) with the practice. In accordance with NHS Fife's statutory obligation to provide access to Primary Medical Services there is a requirement to continue provision of these services within this geographic area.

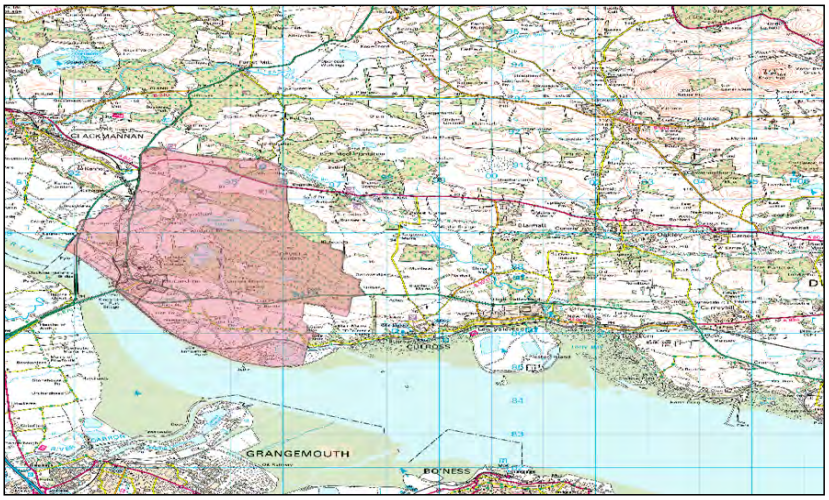


Figure 2 - Map of Kincardine Interzone

Aligned to the Practice there are a range of community health services provided from the current facility including District Nursing, Health Visiting, Midwifery and Podiatry. In addition, there are services working with the Practice and wider community team who cannot access accommodation locally, requiring patients to travel to them. This includes Mental Health Nursing and Physiotherapy. There are dependencies with the District General Hospital at Forth Valley Royal Hospital Larbert and Local General Hospital at Queen Margaret Hospital, Dunfermline, and other hospitals in the East Region for provision of diagnostic services, consultant advice, elective and unscheduled inpatient care and outpatients for a variety of specialties to meet the health care needs of their local population. The Forth Valley Primary Care Out of Hours Service and Fife's Primary Care Emergency Service provide out of hours care from other facilities.

The GPs together with the multi-disciplinary team manage the widest range of health problems; providing both systematic and opportunistic health promotion, diagnoses and risk assessments; dealing with multi-morbidity; coordinating long-term care; and addressing the physical, social and psychological aspects of patients' wellbeing throughout their lives.

The GPs and multidisciplinary team are integrally involved in deciding how health and social services should be organised to deliver safe, effective and accessible care to patients in their community. Practice based multi-disciplinary team working is identifying people who could benefit from a case management approach and supporting people to access the right support where there is:

- Complexity in their care and support arrangements through locality multi-disciplinary teams, or
- Clinical complexity rapid access to assessment through the locality community health and wellbeing hub teams

Kincardine Health Centre has a current practice population of 3285 (July 2021), which has grown by 3% over the past 18 months. The current demographic of the population are[2]:

- 50.7% female: 49.3% male
- 24% are over the age of 65 and 13.4% are 0-15 years
- 9.1% of the population are income deprived, 10.8% of the population are employment deprived and 14.4% of children (under 16) live in poverty
- 0.1% of the practice population live in the most deprived quintile and 0% on the least deprived
- 25.9% of patients of the practice have at least one long term condition

Since long-term condition data was previously not available in the IAD and the Quality Outcome Framework (QOF) is no longer in use, up-to-date long-term condition data was sourced from the Practices and Public Health Scotland using the SPARRA[3] (Scottish Patients at Risk of Readmission and Admission) tool.

Local Profile & Practice Data - Kincardine

Long Term Condition Rates	Kincardine	Fife
Arterial Fibrillation	1.78%[1]	1.92%[1]
Asthma	6.34%[1]	4.61%[1]
Cancer	2.22%[1]	4.25%[1]
CHD	3.61%[1]	3.97%[1]
COPD	1.61%[1]	1.7%[1]
Dementia	0.88%[1]	0.81%[1]
Depression	6.53%[1]	9.54%[2]
Diabetes	4.71%[1]	2.94%[1]
Hypertension	13.47%[1]	15.43%[1]
Mental Health	0.65%[1]	0.87%[1]
Psychiatric Admissions	n/a	24.5 per 1,000[2]

Data sourced from:

1. Public Health Scotland (PHS), SPARRA at 1 December 2020 - the percentage of people with each Long Term Condition are calculated by dividing the number of people with each Long Term Condition by the number of people registered at the GP practices (i.e. the "Population Register") then multiplying by 100.
2. Initial Agreement Documents, approved by Scottish Government in January 2020 data via QOF calculator 1 April 2019.

Figure 3 - Local Profile and Practice Data - Kincardine

Mental health conditions including addictions have been exacerbated and impacted during the global pandemic. Therefore, the need for mental health and related services has significantly increased during this period.

Projections for future demand for primary care and community services with Kincardine are driven by the population projections which see the older population growing by 52% by 2041. This would therefore see the practice population who have severe and moderate frailty grow significantly. It is this group whom Community Nursing are seeking to work with to maintain and improve their position on the life curve through the care management intervention and the wider hub programme is seeking to support through local delivery of rehabilitation programmes.

[2] Based on 2011 census, 2016 SIMD datazone data and ISD Practice data 2019
[3] https://www.isdscotland.org/Health-Topics/Health-and-Social-Community-Care/SPARRA/SPARRA-Model/

The current workforce delivering services is outlined below along with potential future workforce required to deliver primary care and community services. Recent and continuing changes to the workforce are being phased in line with population growth and service model developments which take into account the requirements to implement the GMS (2018) contract[4] and enhance the primary healthcare team, community health and social care teams and Health Visitor pathway. The Practice is also a training practice with a GP trainee and provides training placements for 5th year medical students.

	Existing Provision (WTE)	**Recent Change (WTE)**	**Future provision * Incl. new roles**
General Practitioners (7)	2.35	0.25	
Advanced Nurse Practitioner (2)	0.6	0.6	
Practice Nursing (2)	0.78	0.05	
Practice Phlebotomist	0.1		
Practice Manager (shared with Clack)	1		
Admin staff (10)	4.1	1.46	
District Nursing Team (3 shared with High Valleyfield)	2.2		Treatment room service extension Hosiery / Doppler follow up clinics Extending the range of treatment for patients who could attend the centre
Community Phlebotomist (2)	0.12	12 sessions per month	
Community Teams Admin Staff	0.2		
GP Trainee	(1)		
Visiting teams	WTE	Sessions	Future provision * Incl. new roles
Primary Care Pharmacist	Circa 0.5 WTE		
Midwifery Team	(0.1)	2 per month	

[4] https://www.gov.scot/publications/gms-contract-scotland/

Health Visiting clinic Baby weighing	0.05 0.05	1 per month HV also arrange ad hoc appointments	Opportunity to hold child wellbeing meetings locally
Physiotherapy		4 per month	
Podiatry	0.3	12 per month	
Mental Health Nursing (Primary Care)		4 per month	
Smoking Cessation specialist	(0.13)	See patients in Clacks.	Opportunity to deliver locally
Child immunisation clinic		4 per month	Potential future flu clinic
Social Workers / Social Care Workers	0		MDT time
Continence Nurse		4 per month	
Dermatology Nurse		4 per month	

Table 8 - Kincardine Staffing

2.3.2 Service Details

The accommodation in Kincardine is provided over one level with a total floor area of 237m^2, supports:

- GP activity associated with the Kincardine Health Centre (circa. 13,000 appts PA and a practice population of circa. 3,200)
- Nurse activity associated with the Kincardine Health Centre (circa. 6,400 appts PA)
- Practice employed Phlebotomist activity associated with the Kincardine Health Centre(circa. 2260 appts PA)
- Community nursing treatment room activity (circa. 1,500 episodes[5] PA)
- Community Phlebotomy services (circa. 1,325 episodes PA)
- Midwifery ante-natal clinic activity (circa. 200 appts PA)
- Podiatry services (circa 410 appts. PA)
- Health Visiting
- Stop Smoking sessions (circa. 200 appts PA)

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[5] Episode refers to inpatient, outpatient or Allied Heathcare Profession treatment as defined by https://www.ndc.scot.nhs.uk/Dictionary-A-Z/Definitions/index.asp?ID=241&Title=Episode%20of%20Care

- Mental Health
- Health Visiting Clinic
- Physiotherapist

The primary care and community services have been developed as far as possible however the development of the clinical (Health & Wellbeing) model and increasing demand for services has exacerbated the issues of an inefficient layout, internal and external envelope deterioration. Whilst the GP Practice and Health and Social Care Partnership are working collaboratively to modernise and expand services to improve outcomes and support the population growth, development is severely constrained by the existing premises.

Services delivered from the existing Kincardine Health Centre amount to a total of circa 25,000 attendances per annum, 96 attendances per day or around 23 patients / clinical room activity per day.

Patients initial experience is very poor with one small reception hatch and reception area of $10m^2$ (NB no separate records area now exists as all GP records are held electronically). There is one waiting area (total $22m^2$) with no age-specific provision. Local Politicians have indicated their concern about the fabric of the building and the constraints it places on the local delivery of integrated health and social care.

Clinical care is delivered through five poorly configured consulting rooms which also support administrative activity. These are distributed throughout the current facility and, for the most part, used very flexibly. With 100% utilisation of the available capacity it is clear that a lack of available space is impacting upon the provision of local care. Mixed function means sub optimal use of clinical space. The AEDET review exercise confirmed that the layout and fabric of the building place considerable limitations on effective and safe service delivery (Section 2.3.3).

The office accommodation available for the administrative functions is well below the minimum standards and staff facilities are insufficient for the 21 staff working in the building on a daily basis as well as the wide range of visiting colleagues.

Although all possible reasonable changes have been made to the building Kincardine Health Centre fails to meet the spatial, organisation and design standards for Primary Health Care Premises and has no capacity for further growth. It has reached the end of its economic life as a clinical facility. Major improvements to address maintenance and statutory standards are not feasible due to structural and layout constraints.

A number of services are only available from the Clackmannan Health Centre because of capacity constraints. Resulting in patients from Kincardine travelling to Clackmannan to see a health professional, with best estimates indicating that this may be as many as 2,000 times per annum. People may be asked to attend Clackmannan for stop smoking support, CTAC, physiotherapy, mental health nurse consultation, coil insertion/removal, implant insertion/removal and joint injections as well as medicals such as fostering or DVLA medicals. It is extremely difficult to put an actual figure on this, as the baseline number has not been recorded historically and there is good anecdotal evidence to suggest that Kincardine patients would rather cancel / delay an appointment rather than travel to Clackmannan – further masking the true extent of the problem.

Local and proactive care is further confounded by problematic public transport to Clackmannan from Kincardine; there are no direct public transport (bus) routes. One appointment may take up to three hours out of a patient's day.

Where services are not/cannot be delivered locally in Kincardine, patients are referred to different locations – mostly within the NHS Forth Valley Board area - that include:

- Clackmannan Health Centre (GP overflow activity)
- Forth Valley Royal (Out-patient activity) (unless specifically requested by patient to be referred to a Fife hospital)
- NHS Fife provided services e.g. Physiotherapy provided in other Fife locations
- Community Nursing provide home based support for people who are not housebound, meaning that fewer patients are being seen than could be seen within a clinic setting, with wider MDT input potential

Out of Hours Primary Care is delivered from Urgent Care Centres in Forth Valley. Both Health Boards do not have current plans to extend the number of Urgent Care Centres. Kincardine Health Centre does not routinely deliver out of hours services, but offers a small number of clinics over an extended period. It is not feasible to deliver evening services including extended hours from the health centre.

The model of care is developing in line with the new GP Contract, with the Primary Care Development implementation plan progressing along with the Business Planning process. Historical re-development of the facility has meant that many areas originally designed to provide essential support functions have been lost in a drive to maximise clinical consultation space. This means that the facility no longer has any meaningful storage (with a consequential impact on consulting rooms, staff morale and patient experience); does not have: a utility room; a disposal hold; cleaner's room/facilities; a quiet/interview room; or an effective disabled WC.

This is effectively demonstrated by comparing the baseline Schedule of Accommodation of the current Kincardine Health Centre with that proposed for a replacement facility that has been developed based on the current and developing clinical model, future capacity requirements and relevant health planning guidance. Such a comparison shows that, even although the number of consulting rooms has only increased by three from the baseline, the actual area now required is 1,013m^2 compared to the existing area of 237m^2.

The table below summarises the services using the current facility and also a list of services that could be provided from the new as a result of a lager functional facility.

No:	Name of Service	Currently in Health Centre	Will be based in (or using) the new CH&W Centre
1	Fife Young Carers		X
2	Community Nursing		X
3	The Well		X
4	Complex Care Team		X
5	Clinical Psychology		X
6	Speech & Language Therapy		X
7	Health Promotion		X
8	Children's Services		X
9	Community Nurse Respiratory Team		X
10	Nursing	X	X
11	Occupational Therapy		X
12	Pharmacy		X
13	ADAPT/FASS (Addictions Services)		X
14	NHS Addictions Service		X
15	Local Area Coordinators (Locality Planning)		X
16	Frailty & Older People's Service		X
17	Immunisations Service		X
18	Podiatry Service	X	X
19	Mental Health Services		X
20	MSK Physiotherapy	X	X
21	Nutrition & Dietetics		X
22	Obstetrics and Gynaecology		X
23	Fife Carers Centre		X
24	Mental Health Nursing		X
25	Dementia Friendly Fife		X
26	Diabetes MCN		X
27	Midwifery	X	X
28	Diabetic Retinopathy		X
29	Physiotherapy		X
30	Orthoptics		X
31	Coalfields Regeneration Trust & Fife Voluntary Action services		X
32	Social Work		X
33	Multi-Disciplinary Team meetings		X

Table 9 - Kincardine Services

Approximately 35+ services were engaged prior to lockdown in March 2020 and all re-engaged in September and again in November 2020, to develop a service schedule and see if anything had changed or additional requirements were needed due to Covid-19: requirement of space in the centres, days of use and frequency, any special requirements etc. An exact number has not been provided as there are numerous services which sit under

single or multiple providers. This data has however been collated into a spreadsheet that has informed an updated schedule of accommodation.

2.3.3 Associated Buildings and Assets

The current facility is based centrally in the village of Kincardine. Established in 1930 and previously used originally as a residential property and then utilised as a police station. As a health facility the property has been considerably modified and extended throughout its lifetime. The accommodation in Kincardine is provided over one level with a total floor area of 237m^2. The building is owned by NHS Fife.

Figure 4 - Kincardine Practice

The building block condition is category C and the risk adjusted back-log cost is £85,000.

Condition, space and functionality of the facility are best summarised within the AEDET benchmark assessment which is outlined below.

Category	Benchmark
Use	1.0
Access	1.1
Space	2.0
Performance	1.3
Engineering	1.4
Construction	0.0
Character & Innovation	1.3
Form & Materials	2.1
Staff & Patient Environment	1.3
Urban & Social Integration	2.6

1 = virtually no agreement / poor *6 = virtually total agreement / excellent*

Table 10 - AEDET Benchmark Score - Kincardine

2.4 Strategic Context

2.4.1 Drivers for Change

2.4.1.1 Local Context

NHS Fife Clinical Strategy[6] sets the strategic direction with Fife Health & Social Care Partnership (FHSCP) that is focused on local early, preventative care. In working with partners to improve the health of local people and the services they receive, while ensuring that national clinical and service standards are delivered across the NHS system we will strengthen primary care and community services.

Our vision requires a flexible and responsive model that works with people to define the outcomes they want to achieve, enabling people to maximise their health and wellbeing by utilising their own and community assets, adding and adapting services responsively to meet and sustain outcomes.

Our development of community health and wellbeing hubs is designed to flexibly and responsively layer services where required, adjusting support and care incrementally. In light of the changing demography this has focused on supporting people to minimise and modify the impact of frailty (including younger people frail because of long term conditions, addictions etc). Providing holistic assessment and care management, focused on individual outcomes, anticipatory planning and supporting a reduction in unscheduled care. Fife has a population of 371,910[7], (midyear estimate 2018), with slightly above the Scottish average for the over 65's age group described in Table 11.

	Total Population	65+	75+	85+
Fife	371,910	20%	9%	2%
Scotland	5,438,100	19%	8%	2%

Table 11 - Population Demographic Summary

Fife H&SCP has seven localities. Kincardine is in the South West Fife locality. The South West Fife locality sits within the West Division of the H&SCP. The H&SCP is developing a locality clinical model with GP Clusters focused on the needs of the locality population. Table 12 demonstrates the percentage of locality populations over 75.

	Population >75	
City of Dunfermline	3928	7%
Cowdenbeath	3360	8%
Glenrothes	4109	8%

[6] https://www.nhsfife.org/media/32112/c64_cs-finalforintranet.pdf

[7] Mid-Year Population Estimates Scotland, Mid-2018, National Records of Scotland. Publication (nrscotland.gov.uk)

Kirkcaldy	5549	9%
Levenmouth	3560	10%
North East Fife	7192	10%
South West Fife	3845	8%

Table 12 - Locality Demographic Summary

Over the next 25 years the total population within South West Fife is projected to increase by 9% by just around 4,600 by the year 2041. Most of the areas' population growth is expected to take place in the older people age group, an increase of circa 52% which will place and increasing demand on health and social care.

Population Projections		
	2016	2041
Overall	49,777	54,400
0-15 years	17.1%	17.5%
16-64 years	63%	55%
>65 years	19.7%	27.5%

Table 13 - Population Projections

The Local Development Plan indicates that housing developments will see circa 317 new homes built by 2032 (potentially an additional 790 people). The local development plan includes potential for the development of a further 259 homes within the Kincardine Health Centre catchment area.

The local and national goal, supported by NHS Fife's Clinical Strategy (2016-21)[8], NHS Forth Valley Healthcare Strategy (2016-21)[9] and the Fife Health and Social Care Partnership's Strategic Plan for Fife 2019-2022[10] is to provide safe, effective and sustainable care at home or as close to home whenever possible. The model being implemented will support robust, integrated health (primary and community), social care and third sector services with a strong focus on early intervention, prevention, anticipatory care and supported self-management.

The proposal for investment into fit for purpose health and social care facilities in Kincardine will not only address the current restrictions upon local delivery of clinical services and deficiencies in facilities at the existing Kincardine Health Centre but also enable the delivery of the above key areas within the Kincardine area.

The well-rehearsed pressures in General Practice in Scotland can be illustrated by the following indicators:

- 10% of the population consults with a GP practice clinician every week
- 34% of all GPs are aged 50 and over in 2015, compared with 29% in 2005

[8] https://www.nhsfife.org/media/32112/c64_cs-finalforintranet.pdf
[9] NHS-Forth-Valley-Healthcare-Strategy-2016-21.pdf (nhsforthvalley.com)
[10] https://www.fifehealthandsocialcare.org/__data/assets/pdf_file/0028/188263/HSCP_Strategic_Plan_2019-2022.pdf

- 37% increase in female GPs and 15% decrease in male GPs over the ten-year period to 2015
- 2015 – 1 in 5 GP training posts unfilled

Fife's Primary Care Improvement Plan sets out how primary care and General Practice are reshaping to implement the new GMS 2018 Contract. This is facilitating the development of GPs as expert medical generalists within expanded Primary Health Care Teams, by implementing new roles and ways of working. This is underpinned by the guiding principles of:

- Contact: accessible care for individuals and communities
- Comprehensiveness: holistic care of people – physical and mental health
- Continuity: long term continuity of care enabling an effective therapeutic relationship
- Co-ordination: overseeing care from a range of service providers

Care pathways are patient (not disease) centred to meet the challenge of shifting the balance of care, realising Realistic Medicine and enabling people to remain at or near home wherever possible. Local accessibility and the need to provide a wider range of services to people in their local communities and to develop greater local integration is being hampered by the accommodation available within the Kincardine area. The effect of which is evidenced in the continued reliance upon the traditional medical model of relatively high acute hospital attendance and admission rates. Section 2.4.1.2 below highlights the patient journey using personas.

Local accessibility and improved joint working with other Health and Social Care Partners as part of wider whole system will facilitate integration of health and social care and enable more effective delivery of health and wellbeing outcomes. This will be underpinned by practice multi-disciplinary team working, supported by responsive wider locality teams in reaching to deliver local care. This is further illustrated in Section 2.4.1.3 below.

2.4.1.2 The Patient Perspective

It has been recognised for many years, service providers across Scotland and the UK have planned care separately in different parts of the system including primary, community, acute care and mental health. Services have often been planned around buildings, individual service providers or even clinicians.

What is now proposed is a shift toward an overarching whole systems model which focuses on the needs of people who use the different health and social care services within the Kincardine Practice. This is described as a more holistic community health and wellbeing approach.

The central underlying principle of the development of the new centre is to focus on the patient outcomes, their journey and experience. This will help to identify where service improvements are necessary and involve a wide range of service users and providers in analysing and redesigning improved patient pathways to positively impact on outcomes. To support this work seven patient personas have been developed which serve to inform key considerations when designing new pathways and the integration of services. Full details of

this work is contained in the supplementary document, “The Patient perspective” (Appendix J).

2.4.1.3 Sustainable Workforce and Staff – Health & Wellbeing

Since the launch of Everyone Matters 2018-2020[11], key priorities and actions have been identified which are contributing greatly to achieving a healthy organisational culture. Everyone Matters Implementation Plan actions will be integrated into the new centre where appropriate – initial considerations include:

- Health & Wellbeing and Healthy Organisational Culture – take action to promote the health, wellbeing and resilience of the workforce. Create an environment which supports working across teams, open office space, bookable quiet space and hot-desks, collaborative spaces, wellbeing space, access to support services – these are considered vital to staff wellbeing and morale. Wellbeing Hubs have been established in various sites to support staff, particularly during the global pandemic. Bookable peaceful indoor and outdoor spaces could be established within the centre for both (practice-based and visiting) staff and community use. Providing opportunities for staff to take part in wellbeing-related sessions as appropriate including mindfulness, kindness, resilience and self-care related activities. Sessions are planned with the local Health Psychologist to provide some of these activities within GP clusters, Lunchtime Bytes, Community Health & Wellbeing Services (CHaWS) Subgroup and with practice staff. Other elements will include Staff Cycle to Work Scheme, bike racks, outdoor gym, community garden with covered area, showers and changing facilities etc.

- Sustainable workforce: over 35 clinical and non-clinical services engaged in relation to: requirement of space in the new centre, days of use, frequency, special requirements etc. A service schedule was developed from the feedback which formed the Schedules of Accommodation and this information was used to start the early design of the new building. This will ensure that local services can be planned, coordinated and delivered within the new centre as close to home for people as possible. The new centre will have the space to accommodate a wider range of services as per GMS (General Medical Services) contract and aforementioned drivers for change. There is ongoing engagement with the Kincardine Practice and services throughout the process including via the CHaWS Subgroup, the Design Team meetings etc.

- Capable workforce:

    - NHS Fife and FHSCP offer a suite of development opportunities for their workforce. Educational support services include: Health Promotion, Organisational Development, Learning & Development and Practice & Professional Development (PPD). The PDD is embedded below and includes: managerial coaching, observational visits to support recruitment, clinical skills,

[11] Everyone matters: 2020 workforce vision implementation plan 2018-2020 - gov.scot (www.gov.scot)

leadership, dementia awareness, palliative and end of life care. PPD provision and training is offered to all staff including those working in residential, nursing and care homes in Fife. HR, Patient Relations, Infection Prevention & Control, Pastoral, Resuscitation and Manual Handling all offer training to NHS staff.

- Work across organisational and professional boundaries (i.e. between primary and secondary care, across sectors etc) to share good practice in Learning & Development (L&D), evidence-informed practice and organisational development. Facility available regarding L&D space e.g. face to face training or a computer room where staff can participate in virtual training, update their core skills, LearnPro, Turas etc. Engaging with the staff regarding what they would like and to ensure they feel included as part of the process in relation to the new building.

- Workforce to deliver integrated services: Working with partners to develop workforce planning capacity and capability in the integrated setting including ways of working – exploring opportunities to work differently before the building completion e.g. using the Patient Personas & Pathways in order to establish a service coordination approach and tests of change.

- Change management – ensuring change is managed appropriately and providing opportunities to keep all key staff and stakeholders informed, involved and engaged in the process where possible. The Staffside representative also attends Project Team meetings and has had input into these sections of the OBC. This will be organised through a range of methods such as Subgroup meetings, staff updates, Blink, websites, newsletters and ongoing communications with key stakeholders etc. It is important to give staff ownership particularly if the new building is to be their main base. How and when to ask staff for views is important - all views need to have equal importance.

- Longer opening hours – these will be considered as part of the new building where designated areas could potentially be 'locked-down' for out-of-hour use as a community asset.

- Health & Social Care and Design & Construction Career Pathways – work with L&D to ensure links with local schools and education providers are established to showcase Health & Social Care and Design & Construction as career pathways including options for apprenticeships, internships, student placements and work experience etc.

2.4.1.4 National and Local Strategies

Key national and local documents have influenced the development of our health and care model and thereby this proposal, although this is not an exhaustive list. It should be noted that along with Caithness and Ayrshire Fife's Community Health and Wellbeing Hub programme has been selected as a national pathfinder site to support a Once for Scotland approach to delivering the shift in the balance of care from hospital to community.

<u>National</u>

- Commission on the Future Delivery of Public Services (The Christie Report) (June 2011)
- 2020 Vision for Health and Social Care (September 2011)
- Healthcare Quality Strategy (2012)
- A National Clinical Strategy for Scotland (February 2016)
- Health and Social Care Delivery Plan (December 2016)
- Property Asset Management Strategy (2017)
- NHS in Scotland 2016 – Audit Scotland Report (October 2016)
- Achieving Excellence in Pharmaceutical Care: A Strategy for Scotland (August 2017)
- General Medical Services Contract (2018)
- Health and Social Care Integration – Audit Scotland (November 2018)
- Nursing 2030 Vision: Promoting Confident, Competent and Collaborative Nursing for Scotland's Future (2017)

Local

- Health and Social Care Partnership Strategic Plan for Fife Plan (2019-2022)
- NHS Fife Clinical Strategy (2016-21)
- NHS Fife Property and Asset Management Strategy (2022)
- NHS Fife Operational Delivery Plan (2018/19)
- Let's really raise the bar: Fife Mental Health Strategy (2019-2023)

This proposal interacts with these key local and national strategies in terms of:

Quality Strategy ambitions in relation to:

- Person centred care - through improving access to Primary Care and providing more care closer to home
- Safe – reducing risk of infection through provision of modern fit for purpose accommodation
- Effective – bringing together a wider range of health and care services to make more effective use of resources

2020 Vision aspirations are that everyone can live longer healthier lives at home, or in a homely setting with focus on improving quality of care, improving the health of the population and providing better value and sustainability.

Technology Enabled Care projects are being tested within the current service model to modernise primary care, support earlier identification and self-management.

NHS Fife's Clinical Strategy and **Operational Delivery Plan** are focused on delivering person centred care, closer to home where possible. The proposed development will support the local provision of health and social care services within Kincardine, facilitating person centred care and support.

The **2018 General Medical Services Contract** refocuses the role of General Practitioners as expert medical generalists and recognises that general Practice requires collaborative working, with enhanced multidisciplinary teams that are required to deliver effective care, joint working between GP Practices in clusters and as part of the wider integrated health and social care landscape. Better care for patients will be achieved through:

- Maintaining and improving access
- Introducing a wider range of health professionals to support the expert medical generalist
- Enabling more time with the GP for patients when it is really needed
- Providing more information and support to patients

The **Public Bodies (Joint Working) (Scotland)** Act 2014[12] aims to improve outcomes for people by creating services that allow people to stay safely at home for longer with a focus on prevention, anticipation and supported self-management, and provide opportunities to co-locate health and care services working together for the local population. Fife's local Health and Social Care Strategy describes how the nine National Outcomes for Integration can be met through prevention, local earlier integrated working focused on peoples own outcomes.

Promoting the wellbeing of children is central to the work of Health Visitors and this is supported by the new **Universal Health Visiting Pathway**[13] and the Named Person role conferred by the **Children and Young People (Scotland) Act** (2014)[14]. The Universal Health Visiting Pathway sets the standard for health visiting and the minimum core visits that families with children aged 0-5 years can expect from their Health Visitor, regardless of where they live. This will require an increase in the Health Visiting establishment and new ways of working for full implementation.

The Scottish Government's **Nursing 2030 Vision: Promoting Confident, Competent and Collaborative Nursing for Scotland's Future** (2017)[15] sets the direction for nursing in Scotland through to 2030 and focuses on personalising care, preparing nurses for future needs and roles, and supporting nurses. Within this framework redesign in community nursing is supporting the implementation of the Chief Nursing Officer Directorates paper on

[12] Public Bodies (Joint Working) (Scotland) Act 2014 (legislation.gov.uk)
[13] Universal Health Visiting Pathway in Scotland: pre-birth to pre-school - gov.scot (www.gov.scot)
[14] Children and Young People (Scotland) Act 2014: National Guidance on Part 12: Services in relation to Children at Risk of Becoming Looked After, etc - gov.scot (www.gov.scot)
[15] Nursing 2030 vision - gov.scot (www.gov.scot)

Practice and Community Nursing to integrate locally to support prevention and early intervention.

Fife Health and Social Care Partnership, established on 1 April 2016, is refreshing its strategic plan, this includes revised Vision, Mission and Values. The plan is focused on delivering proactive, integrated support and therefore will seek to secure an outcome focused model delivered locally aimed at securing improved outcomes through early identification and intervention:

- ***The Vision is*** To enable the people of Fife to live independent and healthier lives.
- **The Mission is** "We will deliver this (vision) by working with individuals and communities, using our collective resources effectively. We will transform how we provide services to ensure these are safe, timely, effective and high quality and based on achieving personal outcomes."
- Our **Values** are: Person-focused - Integrity – Caring - Respectful - Inclusive - Empowering

2.4.2 Need for Change Summary

The following is a full list of the main drivers causing the need for change, the effect that these issues are having on the current service provision and an assessment of why it is believed action is required now.

Driver for change:	What effect is it having, or likely to have, on the organisation?	Why action now:
The clinical and social care model have developed and implementation is being circumscribed.	Primary, Community and Voluntary sector services cannot provide the integrated model of care they and the community recognise is required now and for the future.	The model of care is being undermined now: preventing locally based, integrated proactive care. Time from Initial Agreement to occupation of a new facility could take circa 4 years.
	Services cannot be delivered locally for local patient need; instead are based where it is possible to deliver services.	NHS Fife/Fife H&SCP will fail to deliver the GMS (2018) and community health and wellbeing hub model within Kincardine unless this is planned for.
	Pressure on existing staff, accommodation and services will inevitably increase.	Sustainability of primary care is a key priority for the IJB and NHS Fife. There is a need to plan to provide a sustainable service for the future.
Poor clinical and non-clinical	Existing facilities fall far below the required standards in terms	Existing facility configuration and layout presents unacceptable risks,

Driver for change:	What effect is it having, or likely to have, on the organisation?	Why action now:
functionality and space restrictions in existing accommodation (configuration)	of how they are configured and laid out. The Equalities Act 2010 compliance within the building is poor.	as well as poor local performance, functional in-efficiency and suboptimal patient experience.
	Premises are functionally inadequate and compromise pro-active, integrated care.	No scope exists to re-organise parts of the service to improve the experience.
	Some consulting rooms are very small and do not meet current standards. These are very restrictive / unsuitable for patients and staff.	Poor patient and staff experience. Does not meet current recommended standards.
Clinical and social care functionality (capacity) issues	Capacity is unable to cope with current, let alone future projections of need. Patients are required to make repeated appointment to meet with different members of their multi disciplinary team and to access healthcare out-with the local area.	Service sustainability and development is at risk and an increasing number of patients will travel from Kincardine to Clackmannan for basic Primary Care.
	Facilities lack the number and range of support areas necessary to deliver modern, integrated, safe and effective services	A lack of essential support areas represents a real and unacceptable risk to the Board in key areas such as HAI and patient safety.
Building issues (Including statutory compliance and backlog maintenance)	Increased safety risk from outstanding maintenance and inefficient service performance	Building condition and associated risks will continue to deteriorate if action is not taken now, affecting performance. Redesign of building will allow for improved care, staff experience and financial performance.

Table 14 - Need for Change

2.4.3 Investment Objectives

This section identified the 'business need' in relation to the current arrangements described in Section 2.1. These were discussed at the Architecture & Design Scotland (A&DS)

facilitated workshop to develop the project design statement. A wide range of stakeholders including clinical and managerial staff along with community representatives were involved in a workshop to describe the difference between 'where we are now' and 'where we want to be'.

Effect of the need for change on the organisation:	Investment Objectives
Existing service arrangements are affected by lack of clinical support service facilities.	Ensure equal access to a patient centred approach by enabling delivery of and access to local anticipatory and preventative care for patients.
Implementation of integrated models of care is undeliverable locally in the current environment	Ensure equal access to modern integrated care with provision driven by patient need rather than limitations in physical capacity.
Pressure on existing staff, accommodation and services will inevitably increase.	Ensure the right staff skill mix and service capacity are available to deliver and strengthen local capacity to manage people's health within the local community.
The facilities available, 100% occupancy, combined with significant population change, restrict the ability of the parties to deliver the full range of integrated services locally.	Enable earlier access to proactive and anticipatory care through local delivery via integrated seamless service across health and social care.
Existing configuration, as a result of a 1930's building, being modified and extended with a 'best fit' approach. Current facilities have treatment rooms below minimum acceptable standards.	Delivery of safe and effective care with dignity –by providing facilities which comply with all legal standards and regulatory requirements and gives equality of access for all.
Increased safety risk from outstanding maintenance and inefficient service performance.	Improve safety and effectiveness of accommodation by improving the physical condition, quality and functional suitability of the healthcare estate.

Table 15 - Investment Objectives

2.4.4 Proposed Benefits

There is a clear emphasis on General Practice provision and the development of the community health and wellbeing hub model within the IJBs' Strategic Plans and NHS Fife and Forth Valley's Clinical Strategies. The proposed investment in infrastructure will enable the Kincardine Medical Practice to fully participate in the required programmes of care, enable full access to the Primary Care Improvement Plan and thereby improve outcomes for individuals, experience for staff and the reputation of the organisation.

Benefits for each of the investment objectives described in Section 2.4.3 above are mapped to the expected benefits in the context of the Scottish Government's five Strategic Investment Priorities (Safe; Person-Centred; Effective Quality of Care; Health of Population; Efficient: Value and Sustainability).

To ensure that resources are effectively exploited and that any investment made provides agreed benefits a register has been developed. The benefits register (see Appendix E) identifies the expected benefits, indicates a baseline and target measurement and also gives a priority level to each benefit. The Benefits Realisation Plan demonstrating how the benefits can be secured is included at Appendix F.

Investment Objective	Benefit	Investment Priority
Ensure equal access to a patient centred approach by enabling delivery of and access to local anticipatory and preventative care for patients.	GP Practice Multi Disciplinary Team and wider community hub team have access to accommodation to meet population needs locally	Person Centred Health of Population Integrated Care Quality of Care
Ensure equal access to modern integrated care with provision driven by patient need rather than limitations in capacity.	Services delivered locally based on need	Person Centred Efficient Effective Integrated Care
Ensure the right staff skill mix and service capacity are available to deliver and strengthen local capacity to manage people's health within the local community.	Higher staff retention levels Higher staff morale/lower absence rates Increased flexibility of roles Career progression Improved workforce planning across the health and social care pathway Supports training, education and development	Person Centred Efficient Effective Value and Sustainability Integrated Care
Enable earlier access to proactive and anticipatory care through local delivery via integrated seamless service across health and social care.	Access to wider staff skills and experience on one site Reduces unnecessary hospital referrals / multiple appointments Reduces patient risk	Effective Quality of Care Person Centred Integrated Care

Investment Objective	Benefit	Investment Priority
Delivery of safe and effective care with dignity – by providing facilities which comply with all legal standards and regulatory requirements and gives equality of access for all.	Improves patient experience addressing privacy and dignity issues Improves staff safety through provision of primary care & community services on one site allowing for available support for patients and staff. Ease of compliance with standards e.g. Equalities Act 2010[16], HAI Fit for purpose flexible accommodation meeting all guidelines e.g. room sizes	Safe Person Centred Quality of Care Integrated Care
Improve safety and effectiveness of accommodation by improving the physical condition, quality and functional suitability of the healthcare estate.	Increased local provision and access to treatment making best use of available resources by having the infrastructure to deliver more proactive prevention and early intervention focused support, maximising MDT working to facilitate access for people and thereby reducing the call upon unscheduled care.	Effective Quality of Care Efficient: Value and Sustainability

Table 16 - Benefits

2.4.5 Risks

Risk is now covered within the Commercial Case (Section 4) and Management Case (Section 6). The project's Risk Register can be found at Appendix G.

2.4.6 Constraints and Dependencies

2.4.6.1 Constraints

Constraints are limitations on the investment proposal. Key constraints relating to this particular investment proposal are noted below:

- Financial – given the current climate it is recognised that the project is likely to be constrained financially. Once the project budget it is set, the project will require to be delivered within this.
- Programme – given the needs for change relating to the current arrangements, there is a need to deliver the project as quickly as possible.

[16] https://www.gov.uk/guidance/equality-act-2010-guidance

- Quality – the project will require to comply with all applicable healthcare guidance and achieve the AEDET pre-defined target criteria across all categories. The project will also be subject to NDAP and Design Assure key stage reviews.
- Sustainability – as the preferred option is a new-build there will be a requirement to achieve and agreed BREEAM rating.
- Site – site constraints have been investigated during the OBC and factored into the OBC cost projections. Planning constraints will be investigated during the FBC stage.

2.4.6.2 Dependencies

Dependencies are where action from others is required to ensure success of the investment proposal. Key dependencies include:

- Acquisition of the site for development. Discussions with Fife Council are ongoing in this regard, although initial indications are that Fife Council are supportive of the proposals. Engagement will continue through the FBC stage with a view to concluding a long lease arrangement at the end of this stage.
- Service re-design to maximise the opportunities of bookable spaces, agile working and service integration.
- E-health initiatives as outlined at Section 4.4.14.

2.4.6.3 Critical Success Factors

In addition to the Investment Objectives set out in Section 2.4.3, the stakeholders have identified several factors which, while not direct objectives of the investment, will be critical for the success of the project.

Requirement	Description	Critical Success Factor

Strategic fit	Meets agreed clinical and investment objectives, related business needs and service requirements	• Promotes sustainability of Primary Care provision and delivery of 2018 GMS Contract
		• Consistent with NHS Board's Clinical Strategy
		• Supports delivery of NHS Scotland Quality Strategy
		• Facilitates integration of health and social care services, delivered locally
		• From Patient perspective:
		  • a facility that is easily accessible, bright, friendly and airy.
		  • designed so that patients can be treated with dignity particularly in terms of confidentiality.

Value for money	Maximise the return on the required investment and minimise risks	• Service model maintains or reduces revenue costs in the longer term through earlier intervention • Service model enables effective decision making in allocation of resources • Building design maximises efficiency and sustainability
Potential achievability	Is likely to be delivered in relation to the required level of change Matches the available skills required for successful delivery	• The skills and resources are available to implement new ways of working • The H&SCP and the Practice are able to embed new ways of working • NHS Fife are able to deliver the programme to agreed budget and timescales • Technology enablers are available and utilised
Supply side capacity and capability	Matches the ability of service providers to deliver required services	• Service providers are available with skills, materials and knowledge • The project is likely to attract market interest from credible developers

Potential affordability	Available capital and revenue resources are sufficient to support the successful delivery of the proposed facility and services	• Solution is affordable to all stakeholders

Table 17 - Critical Success Factors

3 Economic Case

3.1 Introduction

The purpose of the Economic Case is to undertake a detailed analysis of the costs and benefits of a short list of options, including a do nothing and/or do minimum option, for implementing the preferred strategic / service solution(s) identified within the IA.

The objective is to demonstrate the relative value for money of the chosen option in delivering the required outcomes and services.

3.2 Revisiting the Economic Case

Since the IA, the Economic Case has been updated to provide details of stakeholder engagement activity undertaken during the stage.

3.3 The Do Nothing/Do Minimum Option

It is not feasible to continue with the existing arrangements ('Do Nothing'), because the building is not fit for purpose. The backlog maintenance required while supporting minimum safety and the building to be water-tight will not make it fit for purpose. The do nothing option scored lowest throughout the option appraisal process. The building and footprint likewise mean that a do minimum option is not feasible.

Strategic Scope	**Do Nothing / Do Minimum**
Service Provision:	Primary Care services in Kincardine are delivered from the existing Kincardine Health Centre. This former Police Station has been considerably modified and extended throughout its lifetime. Continue with existing service provision with no changes to service provided as outlined in Section 2.11. This will result in insufficient capacity to meet future demand for treatment, restrict proactive integrated care and maintain inequity of access.
Service Arrangements:	The service arrangements will continue as existing with Kincardine Medical Practice; Primary General Medical Services being provided alongside Community, District Nursing and Children's Services. There will be the risk of being unable to implement GMS (2018) and community health and wellbeing hub model and potential requirement for patients to register with practices outwith their catchment area.

Strategic Scope	Do Nothing / Do Minimum
Service Provider and workforce arrangements (at the time of the Option Appraisal):	Workforce arrangements will continue as the existing situation with GP services Community, District Nursing and Children's Services delivered in the building. The developing integrated Mutli disciplinary mode will be circumscribed with inequity of access and travel implications for both patients and staff. Poor accommodation will continue to be managed as a risk in terms of staff health and safety. Areas originally designed to provide essential support functions have been lost in a drive to maximise clinical consultation space. The facility no longer has any meaningful storage (impacting on consulting rooms); does not have the following: a clean utility room; a dirty utility room; a disposal hold; any cleaner's room/facilities; a quiet/interview room; or an effective disabled toilet.
Supporting assets:	The building presently does not meet the required standards (particularly around spacing and access). The condition of the building will continue to deteriorate. Decant of community services may be required to support practice provision and reducing access for community services.
Public & service user expectations:	Public consultation indicates a strong desire for the delivery of effective GP & Primary Care/Community Care services in Kincardine from one building in a good central location which is all on one level. Services delivered by a wide range of professionals. Strong desire to increase targeted delivery to address inequalities. Single shared staff room. Suitable space for patients who become unwell and need transfer to acute services. This option will not deliver this in the future and will perpetuate a poor environment with limited facilities and also reduce access to primary and community care services for local residents. It will also continue to impact negatively on confidentiality and dignity, and the organisations reputation.

Table 18 - Do Nothing Option Summary

3.4 Stakeholder Engagement

3.4.1 Initial Agreement

It was important to have the support of key stakeholders from health and social care staff and leaders from the local community to define the change required and create the vision for change.

Stakeholders supported this through their participation in the Option Appraisal Exercises and Design Statement workshops. This ensured that the vision was shared and communicated to all who will be impacted by the change. It also encouraged support from those who have an emotional commitment to the services provided in their community.

3.4.2 **Outline Business Case**

This section focuses on the outcome of the subsequent OBC engagement exercise undertaken with the people of Kincardine. In light of the restrictions, all engagement activities were planned mostly online or with appropriate measures such as social distancing in place. Key stakeholders were involved in developing a Covid-19 safe engagement approach including the Kincardine Practice, Fife Young Carers, The Coalfields Regeneration Trust (CRT), Equality & Diversity, Participation & Engagement Team and their related networks.

The communication and engagement framework was approved by the Partnership and Engagement Network: Advisory Group in October 2020. This plan sought to maximise engagement with local stakeholders via a range of networks to gather the citizen voice to inform the development of the business case. Online materials were hosted by the NHS Fife website.

3.4.2.1 Key Communication and Engagement Activities

The main communication and engagement methods included: websites and social media; press release and posters; cascading via local health care providers, schools, services and politician colleagues; Peoples Panel; Public Directory; patient texting service; online discussion forums; online and paper surveys.

Activities included:

- A press release was issued to initiate the engagement process through local newspapers and then an update partway through the engagement process
- December Localities Newsletter was sent across the 7 Localities (800+ members), SW Fife and Cowdenbeath Localities (189 members)
- Cowdenbeath Area Cluster
- Peoples Panel (1700 members)
- Public Directory (62 members)
- FVA Health & Social Care e-bulletin was sent to 653 members
- All communications included a link to the online survey and paper versions were made available in local sites
- Additional to this, the survey link and information was also sent out numerous times over the engagement period via social media by the NHS Fife and Fife Health & Social Care Partnership (FHSCP) Communication Teams as well as via local groups and organisations including twitter, Facebook etc
- The patient texting service was utilised by the practices on a number of occasions and this proved to be the most successful method
-

3.4.2.2 Stakeholder Engagement and Surveys

Approximately 70 local groups and organisations were successfully engaged. This included:

- 1 school in Kincardine

- Public Directory
- Fife Young Carers
- FVA
- NHS Fife and Equality Groups
- Cowdenbeath Cluster
- Centre for Equalities
- Carers Link
- Fife Carers Centre
- Dementia Friendly Fife (STAND Fife)
- HIS Community Engagement
- Disabled Persons Housing Association
- Saje Scotland
- Community Teams
- Community Learning & Development
- Scottish Stammering Network
- The Coalfields Regeneration Trust
- Go Forth
- Gala Committee
- West Fife Villages Forum (WFVF)

3.4.2.3 Survey Design

The survey was developed to provide participants with ample opportunity to share their thoughts and views in relation to their new Community Health & Wellbeing Centres. The following question ranges were outlined in the survey:

- health and wellbeing related services people would like to see in their new centre
- changes introduced since the pandemic would people like to keep
- changes introduced since the pandemic would people not like to keep
- order of importance e.g. support services, wellbeing services, increased opening times, outdoor gym, community spaces etc
- environmental factors to consider e.g. recycling, solar panels, electric car-charging points
- anything additional requirements or information not previously mentioned

- biographical information

This survey has been fully analysed and the information received from the engagement exercise has helped to support the OBC process, inform the options appraisal and building design processes, as well as help shape future service delivery in the new Kincardine Community Health and Wellbeing Centre. Full details of the approach taken to the survey and this analysis are detailed in the supporting document Kincardine Community Health and Wellbeing Centre Engagement Feedback Summary Report (available upon request).

3.4.2.4 Quick Wins

Using the thoughts, comments and ideas shared in the engagement feedback above, considerable work has taken place with the Kincardine practice and other service providers to identify potential changes or improvements that can be put in place with immediate effect. Other longer term or more complex changes will be considered as the programme progresses with the development of the new centre.

These changes or improvements include:

- Ensuring a wide range of health and wellbeing services – the Clinical Services Subgroup was expanded further to include non-clinical services and renamed as the Community Health & Wellbeing Services (CHaWS) Subgroup
- Coordination and collaborative approach – working with the CHaWS Subgroup to test a coordination approach to improve patient pathways by ensuring people are accessing the most appropriate services when they need them most
- Mental Health Services – the engagement exercise highlighted a real need for mental health services, particularly during the pandemic. People will be better supported and enabled to access their local mental health services e.g. counselling, befriending, The Well etc
- Access to Carers Support – raising awareness of the needs of Carers of all ages and the appropriate support to access key services such as Fife Young Carers or Fife Carers Centre e.g. including benefits, short breaks (respite)
- Use of technology:
    - Encouraging or enabling people to access clinical and/or non-clinical appointments using technology where appropriate e.g. video calls/Whatsapp
    - Development and better use of practice websites where this isn't already available
    - Development and better use of the patient texting service
- Volunteering opportunities - public participation groups have been established to provide community representation to help shape the new centre
- Improved repeat prescription process – working with patients, carers and families, local pharmacists, doctors and administration staff are committed to ensuring easier access to safe, high quality repeat prescription systems

- Improved appointment systems – all the practices are considering how to best provide appointments, improve access and reduce waiting times for patients and will be taking the engagement feedback into consideration

3.4.3 Ongoing Stakeholder Engagement

The Project Team worked closely with practices and local organisations to identify members of the community who were interested in being involved in the development of their new centre. Local participation groups are set up and members of these groups feed into project meetings to share a representative view and feedback to the main group. There are also engagement events and activities being planned. Other options to increase community involvement and ownership will include the community/sensory garden and art work for the new centre.

The Stakeholder Engagement and Communication Plan is located at Appendix H.

3.5 Service Change Proposals

The initial scope for the Kincardine Health Centre project was to explore design and scope options to provide a suitable health and social care facility in Kincardine which was of a suitable size and condition to meet with the growing needs of the existing practice and community health and social care team.

3.5.1 Long List of Options

The theoretical long list of options was initially generated by the NHS and Local Authority teams with the support of hubCo and its advisers and was reviewed throughout the process. This long-list was based on the cross-referencing of strategic theoretical service options available with local site / facility considerations.

Strategic theoretical option themes included:

Strategic Scope	Summary
1 Service Provision	• Do nothing (The status quo) • Centralise (currently separate) health care facilities in Fife (Kincardine), Forth Valley (Clackmannan) or somewhere in-between recognising that these sites are staffed by the same practice • Build entirely new and minimise any use of existing buildings (full build)
2 Service Arrangements	• Don't have any specific GP / health facilities locally
3 Service provider/ workforce	• Utilise only 'operational' solutions to address existing problems
4 Supporting Assets	• Build new but also make use of existing facilities to support the overall model (reduced build)

	• Combine a new build or refurbishment proposal with other new / existing developments across the public sector
5 User Expectations	• The expectations of the public and service users

Table 19 – Strategic Theoretical Service Options

The following core long-list of options, in addition to Option 1 do nothing/minimum described above at Section 3.3, was agreed:

Option	Description	Commentary
2	Don't have any Health Centre building – use existing available public sector estate.	This option was not short-listed as it was completely incapable of delivering the preferred service model, would not deliver the community health and wellbeing hub required and result in an even more fragmented service than at present. It was also reliant upon finding existing spaces that do not exist.
3a	An operational solution utilising only the existing Health Centre	Whilst a number of operational solutions are being considered by the Board to address acute short-term crises – and this option is not 'mutually exclusive' – it is not capable of addressing anything other than capacity concerns in the very short-term and certainly not any of the physical/facility issues identified. It was consequently not short-listed.
3b	An operational solution utilising the existing Health Centre plus space in other local facilities.	This option was assessed as a variation on option 3a), that also sought to access space in other local facilities. It was not short-listed for the same reasons.
4a	Refurbish & extend the existing Health Centre facility	This option was not deemed feasible as the current Health Centre building covers the entire curtilage meaning no options for extension or adequate refurbishment exist. It was consequently proven unfeasible and not short-listed.
4b	Refurbish other existing facilities.	This option acknowledged the possibility of identifying and refurbishing another local facility however, in the event, no such facility could be found. It was consequently proven unfeasible and not short-listed.

Option	Description	Commentary
5a	Reduced new build on existing Health Centre site (plus use of space in other facilities to be confirmed).	This option involved building a reduced new facility on the existing site that made use of space in other local buildings. It was rejected as not feasible for a number of reasons including the cost/disruption associated with decant and lack of facilities to support either the reduced new build element or decant. The option was consequently not short-listed.
5b	Reduced new build on land at Feregait (plus use of space in other (?) facilities)	This option was rejected as no additional suitable facilities could be identified.
5c	Reduced new build on land at Station Road (plus use of space in other (?) facilities)	This option was rejected as no additional suitable facilities could be identified.
5d	Reduced new build on land at Tulliallan Primary School (plus use of space in other (?) facilities)	This option was rejected as no additional suitable facilities could be identified and no way could be found to link into the existing school facility.
6a	Full new build on existing site for Kincardine services only	This option involved a full new build on the existing site that was entirely self-contained and intended to deliver Kincardine services only. It was not short-listed as the site is too small for the required area as well as having significant cost, disruption and operational challenges associated with decant to support demolition and re-building.
6b	Full new build on the Feregait site for Kincardine services only	This option involved a full (self-contained) new build on the Local Authority owned Feregait site. It was deemed feasible and consequently short-listed.
6c	Full new build on the Station Road site for Kincardine services only	This option involved a full (self-contained) new build on the Local Authority owned Station Road site. It was deemed feasible and consequently short-listed.

Option	Description	Commentary
6d	Full new build on the Tulliallan School site for Kincardine services only	This option involved a full (self-contained) new build on part of the Local Authority owned Tulliallan Primary School site. It was deemed feasible and consequently short-listed.
7a	Full (combined) new build on existing site for Kincardine & Clackmannan services	This option involved a full new build on the existing site that was entirely self-contained and intended to deliver the combined services currently delivered separately in Kincardine and Clackmannan by the same GP practice. It was not short-listed as any option that involved centralising existing services in any single location was not deemed acceptable by any of the stakeholders involved. This included NHS Fife and NHS Forth Valley in recognition of the fact that the practice and its delivery locations straddle both Board areas.
7b	Full (combined) new build at Feregait site	This option was not short-listed as any option that involved centralising existing services in any single location was not deemed acceptable by any of the stakeholders involved.
7c	Full (combined) new build at Station Road site	This option was not short-listed as any option that involved centralising existing services in any single location was not deemed acceptable by any of the stakeholders involved.
7d	Full (combined) new build at another site in Kincardine	This option was not short-listed as any option that involved centralising existing services in any single location was not deemed acceptable by any of the stakeholders involved.
7e	Full (combined) new build at ANOther site in Clackmannan.	This option was not short-listed as any option that involved centralising existing services in any single location was not deemed acceptable by any of the stakeholders involved.

Option	Description	Commentary
7f	Full (combined) new build at ANOther site “between” Kincardine & Clackmannan.	This option was not short-listed as any option that involved centralising existing services in any single location was not deemed acceptable by any of the stakeholders involved.

Table 20 - Long-list of Options

The benefits criteria against which the long list were assessed were initially drafted by the wider planning team in light of the strictures placed upon the clinical model by the facility associated challenges identified. These were refined during the option appraisal events into an agreed list based on global stakeholder opinion.

Importantly, this list was also developed with the support of the stakeholder group reviewing options related to a similar business case being developed for Lochgelly in order to ensure that both projects, which have similar objectives and timescales, were able to benefit from each other’s work through the development of an agreed list of benefits criteria that were weighted independently.

In summary, the benefits criteria reflected the ability of each identified option to, noted in order of highest to lowest weighting:

- Deliver an optimal physical environment
- Be readily accessible
- Support flexibility and sustainability
- Support local and national service strategies
- Deliver wider community & public benefits

The Partnership is committed to delivering services that are integrated and maximise opportunities for local delivery. It has been formally confirmed that there is an on-going requirement to continue to deliver GP, primary care and local clinical services separately from Kincardine and Clackmannan in recognition of population, local clinical needs and geographical considerations. Consequently all option 7s, were not taken forward to the short-list.

Specific site/facility considerations included:

- The existing NHS owned Health Centre site in Kincardine
- A Local Authority owned site at Feregait
- A Local Authority owned site at Station Road
- Part of the Local Authority owned Tulliallan Primary School site

Whilst a number of other potential sites were raised and considered, they were all excluded at this stage as they were either demonstrably too small and / or not in public sector ownership. On this latter point it was noted that a site that was not currently in the ownership

of the public sector would only be considered if none of the public sector sites was deemed appropriate based on the appraisal process.

It was acknowledged by all concerned at the outset and throughout the appraisal process that sites are extremely limited in the Kincardine area and that this would inevitably present a significant challenge to the project.

3.5.2 Short List of Options

The short-list was largely shaped by:

- A complete lack of suitability/options regarding the current site
- A complete lack of facilities in the Kincardine area to present refurbishment opportunities or additional supportive capacity for the integrated health and social care model
- A very limited range of additional sites/opportunities

The short list consequently included four options:

Option	Description
1	1 - Do Nothing (The Status Quo)
2	6b - New build at Feregait site in Kincardine (for Kincardine services only)
3	6c - New build at Station Road site in Kincardine (for Kincardine services only)
4	6d - New build at Tulliallan Primary School in Kincardine (for Kincardine services only)

Table 21 – Short-list of Options

3.5.3 Indicative Costs

Indicative costs for each of the options on the Short List have been prepared as per guidance in the Scottish Capital Investment Manual by hubCo. The non-preferred options are based on BCIS Tender Price Indices – updated to 4th quarter 2020. The preferred option is based on elemental cost/m^2 from other recent health centre projects and the current Schedules of Accommodation (updated to 4th quarter 2020). Figures are calculated over a 60 year period.

	Description	Capital Costs (£) *	Whole Life Capital Costs (£)	Whole Life Operating Costs (£)	Est. NPV (£)	Est. EUV (£)
1	**Do Nothing/Base**	-	-	1,749,291	723,705	28,520
2	**(6b) Feregait**	3,846,621	758,689	10,220,763	6,307,702	248,577
3	**(6c) Station Road**	3,903,627	769,948	10,293,636	6,368,662	250,979
4	**(6d) Tulliallan School**	3,903,627	769,948	10,293,636	6,368,662	250,979

Table 22 - Option Costs

3.5.4 Option Advantages and Disadvantages

The following table outlines how the advantages and disadvantages of the short list were assessed against the benefits criteria. This was undertaken through a process of discussion / debate within groups with the intention of seeking consensus agreement around the relative merits of each option and scores to be applied.

	Option1: Status Quo	**Option 2: Feregait**	**Option 3: Station Road**	**Option 4: Tuliallan School**
Advantages (Strengths & Opportunities)	Established location.	Purpose built facility. Good central location. Good pedestrian and vehicle access. Secure location. Good service access. Good parking.	Relatively close to town centre. Relatively flat site, for 1 level building. Good pedestrians and vehicle access. Secure location. Good community setting. Flexibility – with potential expansion options. Ease of segregated access.	Central location. Good physical site. Good local and physical access. Community Campus opportunity. High visibility. Increased flexibility. Ability to segregate access for staff/patients/ servicing. Access from A977.
Disadvantages (Weaknesses & Threats)	Building and curtilage not suitable for further developme nt	Potential flood risk. Site investigation required (mining?). Ground conditions make development expensive. Infrastructure issues.	Potentially too overlooked. Impacts on village green. Potential flood risk. Site investigation required (mining?). Ground conditions make development expensive. Infrastructure issues. Public transport – slight walk.	Loss of school / community amenity space. Potentially contentious road issues. Potential flood risk. Site investigation required (mining?) Ground conditions make development expensive. Infrastructure issues.

			Access road may not be suitable for construction traffic.	

3.5.5 Does the Option meet the Investment Objectives?

The table below summarises the extent to which the shortlisted options meet the Investment Objectives.

Table 23 - Option Advantages and Disadvantages

Investment Objective	Option 1: Status Quo	Option 2: Feregait	Option 3: Station Road	Option 4: Tuliallan School
Ensure equal access to a patient centred approach by enabling delivery of and access to local anticipatory and preventative care for patients.	No	Yes	Yes	Yes
Ensure equal access to modern integrated care with provision driven by patient need rather than limitations in physical capacity.	No	Yes	Yes	Yes
Ensure the right staff skill mix and service capacity are available to deliver and strengthen local capacity to manage people's health within the local community.	No	Yes	Yes	Yes
Enable earlier access to proactive and anticipatory care through local delivery via integrated seamless service across health and social care.	No	Yes	Yes	Yes
Delivery of safe and effective care with dignity –by providing facilities which comply with all legal standards and regulatory requirements and gives equality of access for all.	No	Yes	Yes	Yes
Improve safety and effectiveness of accommodation by improving the physical	No	Yes	Yes	Yes

Investment Objective	Option 1: Status Quo	Option 2: Feregait	Option 3: Station Road	Option 4: Tuliallan School
condition, quality and functional suitability of the healthcare estate.				

Table 24 - Does the Option Meet the Investment Objectives?

3.5.6 Cost / Benefit

This section presents the case for the selection of the preferred option. In line with HM Treasury guidance, the NPC is divided by the weighted benefits (WBP) score to determine the cost per benefit point for each option. The lowest cost per benefit point is considered to be the most attractive option.

	Option 1: Status Quo	Option 2: Feregait	Option 3: Station Road	Option 4: Tuliallan School
Net present cost (NPC) - £m	723,705	6,307,702	6,368,662	6,368,662
Weighted benefit points (WBP)	221	539	509	739
BPC per WBP - £000	3,275	11,703	12,512	8,618
	Rejected	Possible	Possible	Preferred

Table 25 - Option Benefit Scores

3.5.7 Preferred Option

From table 25 it can be seen that option 4 scores highest in respect to benefit points. Once the net present costs are factored in, option 1 is highlighted at the lowest cost per benefits point – this is purely because of low net present cost owing to the limited capital that could be invested in the existing facility. As option 1 does nothing to tackle the needs for change as demonstrated within the strategic case and benefits appraisal, it is not a legitimate option.

Given the balance of legitimate options, option 4 offers the highest benefits score and the lowest cost per benefits point, indicating that it is the strongest option. Option 4 is therefore the preferred option as favoured by all stakeholders (consensus), with little to choose between options 2 and 3 for second place.

The proposal has the support of representative service users, carers, staff, the GP Practice and all other key stakeholders.

Through further dialogue with Fife Council during the OBC the site location was selected to the North of the playing fields. This allowed future expansion for the School, whilst protecting the primary football pitch.

4 Commercial Case

4.1 Introduction

This section outlines the commercial arrangements and implications for the Project. This is done by responding to the following points:

- The procurement strategy and appropriate procurement route for the Project
- The scope and content of the proposed commercial arrangement
- Risk allocation and apportionment between public and private sector
- The payment structure and how this will be made over the lifetime of the Project
- The contractual arrangements for the Project

4.2 Revisiting the Commercial Case

The commercial case has generally been updated and expanded since IA in accordance with SCIM OBC guidance. In particular, the design of the preferred option has been progressed allowing for a detailed overview on the status of the design to be provided.

4.3 Procurement Strategy

4.3.1 Procurement Route

NHS Fife will lead on the procurement whilst being supported by the Fife Health and Social Care Partnership.

The project is community focussed and more than £750k, therefore the Scottish Futures Trust hub initiative has been selected as the most appropriate route to deliver the project. The East Central hubCo have been appointed to deliver this public funded project under the design and build option.

The following further procurements have been undertaken to support the Board and these will be procured through Frameworks Scotland Lead Advisor lot.

Lead Advisor

- Project Manager services
- Cost Advisor services
- Technical Advisor services (M&E)
- Authority's Representative (for contract purposes)
- Clerk of Works

4.3.2 Procurement Rules and Regulations

As the proposed procurements have already been tendered they are in compliance with the procurement rules and regulations.

4.3.3 Procurement Plan

The summary table below provides an overview in respect to procurements to date:

Service	Appointment	Status
Contractor, Designers and Principal Designer	East Central hubCo	New Project Request (NPR) agreed. Stage 1 Approved.
Lead Advisor	Currie & Brown	Appointed

Table 26 - Procurements

4.4 Scope and Content of Proposed Commercial Arrangements

4.4.1 Overview

The project involves providing a new health and wellbeing centre within Kincardine at the preferred Tulliallan site. The new centre will replace the existing facility and will be developed further to accommodate future growth within the local area whilst taking cognisance of the Scottish General Medical Services (GMS) contract. The new facility will focus on providing core GP and other health services whilst offering broader flexibility for the promotion of interconnected health and wellbeing opportunities within the local community – this is in-keeping with NHS Fife's ambition to become an anchor institution within Fife.

4.4.2 Project Brief

The project brief is reflected within the following documents which can be provided upon request:

Document	Date	Revision
New Project request (including appendices)		4
Authority's Construction Requirements (ACR)	12.08.21	1

Table 27 - Project Brief

The brief for the design process is that the proposal must conform to all statutory requirements. In addition, the design proposals must meet all relevant Healthcare Guidance as published by HFS on their website.

The PSCP is required to schedule all relevant healthcare guidance and identify any associated derogations against that guidance. This process is ongoing in parallel with the development of the design and will be concluded and presented during the FBC stage of the project.

In respect to governance, the Project Team will be charged with reviewing and agreeing proposed derogations. Thereafter the Project Board have assumed responsibility for sanctioning any proposed derogations. This will be an iterative process culminating in formal acceptance of derogations in advance of contract execution. The Project Team will liaise with Health Facilities Scotland for support and guidance where necessary when contemplating derogations.

4.4.3 Current Design Status

The design has been completed to RIBA Stage 2 which aligns with OBC and NDAP requirements. The table referenced below provides an overview of how the project is performing against predefined OBC requirements.

OBC Design Requirements	Project Status
Concept Design incl. Arch, M&E, C&S, Fire, Landscape	Complete
Outline drawings (≥1:200, key ≥1: 50) & specifications	Complete
Outline sustainability strategy	BREEAM Pre-assessment completed
Outline construction strategy incl. HAI, CDM H&S Plan	Ongoing and will be continued into FBC
3D sketches of key Design Statement spaces	Complete
Completed Design Statement OBC self-assessment	Complete – assessed through AEDET workshop
Completed AEDET OBC self-assessment	Complete
Photographs of site showing broader context	Complete
Evidence of Local Authority Planning consultation and/or alignment with Local Development Plan.	Pre-planning engagement has been sought from Fife Council via a formal application and fee. Consultation and feedback will be received early within the FBC period.

OBC Design Requirements	Project Status
Extract of draft OBC detailing benefits & risks analysis	Provided within this OBC.
Evidence of HAI & CDM consultation	HAI SCRIBE Stage 1 has been completed
Evidence Sustainability commitments will be met. e.g. accurate & NCM models (DSM). BREEAM, .CAB files and BRUKL; show how design will be optimised	Design development ongoing but briefing requirements set out in NPR and ACR
Evidence Equality & access commitments will be met	EQIA Stage 1 complete
Evidence of VfM e.g. WLC on key design options	Ongoing process through design workshops
Evidence Activity Data Base (ADB) use optimised	Will be used at FBC. Standard HFS repeatable layouts will be utilised where appropriate
Evidence NHS guidance & technical standards will be met; list any derogations, with their technical reasons	Ongoing – to be evidenced and concluded within the FBC stage
OBC design report evidencing all above & IA brief met ≥1:500, ≥1:200, key ≥1: 50; diagrams, sections plans, 3Ds, specs, comfort & energy DSMs, to RIBA Stage 2 Concept plus key elements developed to Stage 3	Complete – NDAP submission made on 23 December 2021

Table 28 - Design Status

4.4.4 Schedule of Accommodation (SoA) Development

A SoA was developed at the IA stage of the project. Whilst the schedule was tested with stakeholders at this stage to inform budgetary costings it was very much a working draft. The status of the SoA was offset by the optimism bias allocation factored into the Financial Case at IA.

The SoA was developed further at commencement of the OBC stage following a detailed review of health services to be accommodated within the building. When the IA was first developed, the GMS contract was in its infancy. Changes to the SoA largely relate to emerging requirements from the GMS contract.

The table below compares the IA SoA to the OBC “as drawn” outturn. As it can be seen there is an increase of 180m^2 overall.

IA SoA (m²)	OBC "as drawn" (m²)	FBC "as drawn" (m²)	Difference (m²)
833	1,013		180

Table 29 - Area (m²) Summary

4.4.5 Flexible Space

Given the order of investment, it is important that use of the asset is maximised with rooms being utilised to their full potential. It is also important for the asset to be used successfully at the outset whilst being capable of withstanding future change with minimal disruption and cost. For these reasons the following themes and workstreams are being progressed.

- HFS standardised rooms are being incorporated wherever practicable
- The building configuration is being designed to withstand future changes in GP practice arrangements – i.e. consolidation of GP practices
- A bookable room system is being developed to support transient services
- The building layout and landscape is being designed to afford and promote "out of hours" use for health and wellbeing initiatives and community use
- An agile working policy is being developed to support agile workstations within open plan office areas
- The building design is being considerate to possible constraints caused by pandemics and how the building may cope with these temporary situations

4.4.6 Community Engagement

In December 2020 a community engagement exercise was undertaken to reach out to the local community to establish what was important for them within their new health and wellbeing centre over and beyond core requirements. Aspects relating to the physical building are listed below together with detail on how these themes will be taken forward and where applicable incorporated into the design. Feedback in respect to the community engagement exercise has been undertaken with the community separately.

Theme	Project Action
Flexible spaces to allow the provision of services and for community use out of hours	Carried forward into design proposals
Near-me booths to support accessibility and digital poverty	Being carried forward into design proposals
Community gym	No space allowance for an internal gym currently. External space is being incorporated for community use which could include provision for gym related equipment. Space allocation only at OBC.

Theme	Project Action
Needle exchange	Being considered within design proposals
Community garden	External space is being incorporated for community use which may include provision for a community garden. Space allocation only at OBC
Accessibility - space for external mobility scooter parking plus space for wheelchair and pram storage/parking internally	Being carried forward into design proposals
Covered external area	Being considered and where possible incorporated, but needs to be balanced with anti-social behaviour which covered areas can often attract
Community café	It is considered that the health centre is too small to benefit from a community café. This amenity is already provided locally
Community fridge	This amenity could/is be provided by the local community centre

Table 30 - Engagement Feedback

4.4.7 NHSScotland Design Assessment Process (NDAP)

The purpose of NDAP is to promote design quality and service. It does this by mapping design standards to the key investment deliverables, including Scottish Government objectives and expectations for public investment, then demonstrating their delivery via self, and independent assessments. NDAP is made up of personnel from Health Facilities Scotland (HFS) and Architecture Design Scotland (A&DS).

During the IA Stage, A&DS helped to facilitate a Design Statement workshop. This document forms part of the Project Brief, setting out design objectives for the Project Team. The project's design statement is located at Appendix B.

At commencement of OBC shortly after hubCo appointment, the Project Team met with HFS to discuss the project, principles and expectations. This helped to provide a framework for development of the design during the OBC Stage.

The OBC NDAP submission was issued on 23 December 2021. The review process is ongoing at the time of concluding this OBC for governance approvals, although it is anticipated that the NDAP report will be available in advance of the project being considered by the Scottish Capital Investment Group.

4.4.8 NHS Assure

NHS Assure is a technical key stage review process set up and administered by NHS NSS. Their remit is to provide knowledge and expertise through the lifecycle of projects to provide confidence within the public sector that projects are being procured, designed and delivered in a compliant manner ensuring operational safety for building users.

NHS Fife submitted their OBC key stage review pack to NHS Assure on 23 December 2021.The review process is ongoing at the time of concluding this OBC for governance approvals, although it is anticipated that the NDAP report will be available in advance of the project being considered by the Scottish Capital Investment Group.

4.4.9 Achieving Excellence Design Evaluation Toolkit (AEDET)

In accordance with SCIM guidance and the investment objectives, AEDET will be used throughout the development of the Project to help NHS Fife manage the design from initial proposals through to detailed design and will continue to do so through to Project Evaluation.

The AEDET toolkit has three key dimensions (functionality, build quality and impact) and outlines 10 assessment criteria. Each of the 10 areas is assessed using a series of questions which are scored on a scale of 1 - 6.

AEDET assessments are to be undertaken at predefined stages throughout the project's lifecycle. The stages are outlined in the table below together project progress against these to date.

Stage	Project Progress
Benchmark – assessment of current asset(s)	Completed at IA
Target – aspiration for project	Completed at IA
OBC – assessment of design proposals	Complete
FBC – assessment of design proposals	To be completed at FBC

Table 31 - AEDET Progress

On 8 September 2021, an AEDET workshop was held to review the OBC stage design against the agreed target scores. This workshop involved a wide range of participants including staff, service users and hubCo. The OBC AEDET scores are included in the table below together with the benchmark and target scores. Whilst some of the scores are lower than the target, this is mostly connected to the maturity of the design and it is envisaged the scoring will be improved further during the FBC AEDET workshop.

Category	Benchmark	Target	OBC	FBC
Use	1.0	4.3	4.1	
Access	1.1	4.4	3.1	
Space	2.0	4.2	3.7	
Performance	1.3	4.4	2.7	
Engineering	1.4	3.4	3.4	
Construction	0.0	4.0	0.0	
Character & Innovation	1.3	4.4	3.9	
Form & Materials	2.1	4.4	3.6	
Staff & Patient Environment	1.3	4.5	4.3	
Urban & Social Integration	2.6	4.3	3.6	

Table 32 - AEDET Scores

4.4.10 **BREEAM**

Projects requiring capital investment through the Scottish Government are required to demonstrate sustainable credentials to contribute towards the development of a sustainable NHS estate.

The project has been assessed using BREEAM UK New Construction 2018, sub-group healthcare. A target score of 45% was set at the briefing stage which equates to a BREEAM "good" rating. The project is currently targeting credits equating to 52.21% which is beyond the briefing target.

Note: the project commenced in advance of new sustainability guide being mandated / published so proceeded on the basis of mandated guidance at that point in time

4.4.11 **Energy**

Following a meeting with HFS, project specific energy targets were agreed. The energy targets took cognisance of project budgetary constraints set at IA (pre zero carbon policy) whilst still aiming to ensure that the facility will be very energy efficient. The following criteria was agreed:

- >59% emissions reduction against 2015 benchmarking to be sought
- Electricity target not more than 60 kWh/m^2 pa; and max demand not to exceed 20 Watts/m^2
- Thermal target not more than 120 kWh/m^2 pa

The criteria will be achieved through the development of the design.

4.4.12 Healthcare Associated Infection System for Controlling Risk in the Built Environment (HAI SCRIBE)

HAI SCRIBE is a risk management process aiding the identification and mitigation of design and construction related infection risks within the built environment. There are four stages within the process – these are identified in the table below together with project progress against these stages to date.

Stage	Project Progress
Stage 1 – Site Selection	Complete
Stage 2 – Design	To be completed at FBC stage.
Stage 3 – Construction	To be completed at FBC stage.
Stage 4 – Occupation	To be completed post completion.

Table 33 - HAI SCRIBE Summary

4.4.13 Building Information Modelling (BIM)

BIM describes the process of designing and constructing a building collaboratively using one coherent system of digital models and linked non graphical data, as opposed to separate sets of drawings and documents. These models and data also incorporate information which will be carried over and used in the operational phase.

NHSScotland is supporting the adoption of Level 2 BIM maturity following the SG mandate in support of the recommendations of the "Review of Scottish Public Sector Procurement in Construction" which endorsed that "BIM will be introduced in central government with a view to encouraging adoption across the public sector. The objective states that, where appropriate, projects across the public sector adopt BIM level 2 by April 2017."

The NHSScotland BIM strategy is intended to ensure the creation of a digitised information management process which all Boards and teams working on NHSScotland programmes should follow to maintain consistency and facilitate collaborative working, which will in turn reduce waste and non-conformances.

The Project will use BIM as a key design tool during the design and construction phases of the project helping to facilitate coordination and mitigate risks. Another benefit of BIM is that NHS Fife will have true "as built" records along with the project specific asset tagging that will assist with the operation, maintenance and replacement of components.

An NHS Fife Employers Information Requirements (EIR) has been developed and offered hubCo as part of the Project Brief. The EIR in turn has helped to inform the BIM Execution Plan (BEP) which has been developed by the hubCo. These two documents control how BIM will be utilised on the project.

4.4.14 E-health

Consultation has been ongoing with eHealth during the OBC phase of the project. Initial efforts have focussed on ensuring the IT infrastructure meets e-health's standard requirements. E-health systems will be provided in line the department's wider strategy for GP premises. E-health suggestions flowing from the stakeholder consultation are as follows

and these will be considered by the project team in further detail at the next stage of the process (**subject to separate funding and business cases where appropriate**).

- A patient appointment system
- A consultant room with near me facilities
- A GP text messaging system
- A self check-in facility
- Subject to security considerations, public access to IT equipment to combat digital poverty
- A room booking system

4.5 Risk Allocation

4.5.1 Key Principles

At conclusion of the FBC NHS Fife will enter a contract with hubCo to deliver the facility. The contract will be based on the Hub standard form Project Agreement (Design Build Direct Agreement) and will be subject to amendment through agreement between Legal Advisers.

Having worked through the pre-construction stage and mitigated the construction risks through surveys and investigations most of the residual construction risk is taken by hubCo.

The risk allocation table below is driven by the Design Build and Direct procurement methodology described above. Note: the percentage allocations are indicative of a project of this nature.

	Allocation of risk		
Risk Category	**Public**	**Private**	**Notes**
Title	100%	0%	
Design	0%	100%	
Development and Construction	5%	95%	√
Ground conditions below existing structures that could not be surveyed	100%	0%	There are no existing buildings on the proposed site.
Transition and implementation	100%	0%	Commissioning and migration Board responsibility
Operation of the facility	100%	0%	
Revenue	100%	0%	
Termination of Project	40%	60%	

	Allocation of risk		
Risk Category	**Public**	**Private**	**Notes**
Technology and obsolescence	100%	0%	√
Financing	100%	0%	Capital funding
Legislative	100%	0%	

Table 34 - Risk Allocation Summary

4.5.2 Key Risks

The key risks/issues currently encountered on the project are outlined in the table below. The risk register can be located at Appendix G.

Risk/issue	Mitigation
Brief inadequate/unreliable This issue relates to developments around the GMS contract and effect this has had on the area requirements for the building.	The required area increase from IA to OBC has been factored into the current design and corresponding cost plan.
Stop/start nature of the programme – keep people engaged through these periods.	Updates are being provided to community groups via newsletters and the public via press releases. NHS Fife's communication team are supporting this effort.
Project cost increases due to: ▪ Change in requirements ▪ Inflation / market conditions	This is a current issue where the cost increases have rose beyond the IA budget projection. Refer to Financial Case for further substantiation.
Programme delay The OBC programme has been affected because of COVID which has impacted resources, engagement activity and costs.	Potential to commence FBC activity in parallel with the OBC governance approval process. The project now has a full complement of resources to help drive the project forward.
Change of policy – NHS Assure Key Stage reviews Programme delays / cost increases arising	Key stage review process was implemented half-way through OBC and is required to achieve capital funding. Risk had to be accepted, but impact can be mitigated through collaboration.

Risk/issue	Mitigation
Change of policy – SHTN 02-01 Sustainable Design and Construction Guide (SDaC) Programme delays / cost increases arising	Informed by HFS at OBC NDAP review that new guidance must be followed at FBC. Guidance is untested to impact is difficult to quantify. As such this risk has not currently been factored into OBC cost estimates.

Table 35 - Key Risk Summary

4.6 Payment Structure

During the pre-construction stage hubCo are paid on a monthly lump sum basis in line with an agreed drawdown schedule. At construction the Board will be obliged to pay hubCo a lump sum one-off Development Fee for their services. Thereafter applications for payment will be processed and settled monthly in accordance with the form of contract.

Directly appointed consultants will be paid on a monthly basis in accordance with their agreed NEC4 Option A activity schedules.

4.6.1 Project Bank Account

The Project will operate a Project Bank Account (PBA), consistent with Scottish Government Guidance for public sector construction projects. A Project Bank Account is a ring-fenced bank account from which prompt payments are made directly and simultaneously to hubCo, the lead contractor and members of the supply chain. PBA's improve subcontractors' cashflow and ring-fence it from upstream insolvency.

The PBA will become operational during the construction stage of the project. The documentation and contractual arrangements associated with setting up the PBA will be developed during the FBC stage. Recent board experience in setting up a project bank account for a separate capital project will be beneficial for this project.

4.6.2 Risk Contingency Management

A project risk register was created at IA and this has since been developed further during OBC. It is used as an active management tool to identify and mitigate risks progressively as the design is developed. The risks have been fairly allocated to the party best able to manage them.

The risk register will continue to be used through FBC and the construction stage to enable risks to be identified and managed. From a commercial perspective hubCo risk is capped at 1% prior to entering the construction stage. Variations are managed in accordance with the terms of the contract. Although the opportunity for risk and variations is restricted during the construction stage, it is prudent for the NHS Fife to retain a reasonable contingency provision to cover this risk. The contingency provision will be developed and informed by the risk register during FBC but is likely to be in the order of 3-5%.

4.6.3 Contract Variations

Variations will be managed in accordance with the terms of the contract. The contract will be based on the standard SFT DBDA template with agreed amendments.

4.6.4 Disputed Payments

Disputed payments will be managed in accordance with the terms of the contract. The contract will be based on the standard SFT DBDA template with agreed amendments.

4.6.5 Inflation

Inflation will be taken account of when developing the price using the BCIS indices. HubCo and NHS Fife's Lead Advisor will ensure that the correct indices are utilised to identify the correct inflation to be applied to the project. Any deviation to the agreed inflation allowance rest with hubCo as an opportunity/risk.

4.6.6 Utilities and Service Connection Charges

Responsibility for utility and service connections charges will be identified and confirmed at Stage 2 (FBC).

4.6.7 Performance Incentives

No performance incentives will be utilised.

4.7 Contractual Arrangements

4.7.1 Type of Contract

The contract will be based on the standard SFT DBDA template with agreed amendments.

4.7.2 Key Contractual Issues

No key contractual issues have been identified at this stage, however should any arise through development and completion of the contract documentation, then these will be presented within the FBC.

4.7.3 Dispute Resolution and Termination

Procedures for contract administration, dispute resolution and termination are clearly set out within the proposed contract form.

4.7.4 Asset Ownership

In respect to asset ownership, the project is being procured using traditional capital funding. hubCo will be responsible for delivering the facilities. At Completion, NHS Fife will take possession of the building and will be responsible for the ongoing operation and maintenance of the facilities.

4.7.5 Land Ownership

The land is likely to be leased on a long-terms basis (100 years) from Fife Council. This is a similar arrangement to many of Fife's existing health centres and comparably demonstrates far greater value for money than purchasing the land outright. Initial discussions have already taken place with Fife Council and these will be advanced during the FBC stage of the project.

4.7.6 Personnel Implications

There are no employees who are wholly or substantially employed on services that will be transferred to the private sector under the proposals for this Project, and therefore the Transfer of Undertakings (Protection of Employment) Regulations 1981[17] (TUPE) will not apply.

[17] https://www.legislation.gov.uk/uksi/2006/246/contents/made

5 Financial Case

5.1 Introduction

The Financial Case considers the affordability of the scheme. This section sets out all associated capital and revenue costs, assesses the affordability of the preferred option and considers the impact on NHS Fife's and the FHSCP's finances. The affordability model assessment has been developed to cover all aspects of projected costs including estimates for:

- Capital costs for the option considered (including construction and equipment)
- Non-recurring revenue costs associated with the project
- Recurring revenue costs (pay and non-pay) for current model i.e. baseline
- Recurring revenue costs (pay and non-pay) for the preferred option

For clarity it should be noted that NHS Fife will take ownership and financial responsibility for all property related costs (capital and revenue). The FHSCP will be financial responsible for all service-related costs – i.e. costs to provide the required clinical services.

5.2 Revisiting the Financial Case

The IA was approved by Scottish Government Health and Social Care Department (SGHSCD) in November 2019 and no specific conditions were outlined in the approval letter in relation to the Financial Case.

NHS Fife have considered the affordability of this proposal by undertaking a review of the financial implications of investment, both capital and revenue.

5.3 Financial Model (costs and associated funding for the project)

5.3.1 Capital Costs

5.3.1.1 Capital Cost Summary

Capital costs have been produced by East Central hubCo and have been summarised in Table 36 below.

Description	IA Costs	OBC Costs	Difference
Design Fees	£322,666	£473,265	£150,599
Construction Price	£2,370,203	£4,400,070	£2,029,867
Surveys/Investigations	£20,000	£50,000	£30,000
Statutory Fees	£20,000	£75,000	£55,000
Contingency	£151,739	£212,970	£61,231
Inflation	£68,073	£119,574	£51,501
Optimism Bias	£708,643	£703,676	-£4,967
Client Consultants	£136,888	£139,788	£2,900
Equipment	£82,209	£266,544	£184,335
Decant	£14,643	£14,643	£0
BIM Fees	£0	£0	£0
E-health	£8,563	£0	-£8,563
Direct Labour Costs	£0	£98,848	£98,848

Description	IA Costs	OBC Costs	Difference
Total ex. VAT	**£3,903,627**	**£6,554,380**	**£2,650,753**
VAT	**£753,348**	**£1,263,149**	**£509,801**
Total	**£4,656,975**	**£7,817,528**	**£3,160,553**

Table 36 - Capital Costs

The total updated cost of the preferred option, which is to develop Kincardine Health Centre for NHS Fife is £7,817,528.

It is important to recognise that whilst the capital cost has increased since Initial Agreement, the other feasible options presented within the Economic Case would have increased in the same way given that the underlying factors driving cost would have been the same. This means that the preferred option, despite being subject to significant cost increase, remains the preferred option in respect to benefit realisation and cost.

5.3.1.2 Capital Cost Key Movements

Table 37 below provides a summary of key project cost adjustments. The adjustments are described further beneath the table from a budgetary perspective.

Description	IA Cost	OBC Cost	Difference	Notes
Hubco	£2,884,607	£5,211,306	£2,326,699	Area increase: 180m^2 Inflation: extraordinary conditions Site & design abnormals
Inflation	£68,073	£119,574	£51,501	Based on BCIS indices to construction
Optimism bias	£708,643	£703,676	-£4,967	Updated for OBC based on project maturity at this stage (13%)
Consultants	£136,888	£139,788	£2,900	Contract now awarded – firm cost
Decant	£14,643	£14,643	-	
Equipment	£82,209	£266,544	£184,335	Equipment allowance too low at IA – increased in consultation with HFS (5%)
E-health	£8,563	-	-£8,563	Included in equipment line
Direct costs	-	£98,848	£98,848	None allowed for at IA
Total ex. VAT	**£3,888,983**	**£6,539,736**	**£2,650,753**	
VAT	**£753,348**	**£1,263,149**	**£509,801**	
Total	**£4,656,975**	**£7,817,529**	**£3,160,555**	

Table 37 - Key Capital Cost Movements

In respect to the OBC cost plan, there is a difference amounting to £3,160,553 when compared to the agreed IA allocation (£4,656,975). This difference is primary attributed to the construction costs where increases have been realised through:

- Building area increase to take account of service and GMS contract evolving requirements – accounts for circa 35% of the construction cost increase
- Inflation and extraordinary market conditions considered to driven by the COVID-19 pandemic and the resulting global effect on supply chains – accounts for circa 20% of the construction cost increase
- Site and design abnormals: this relates to specific site conditions, more onerous energy requirements and creating a building that satisfies the conditions of the brief and design statement – accounts for circa 45% of the construction cost increase

It should be noted and acknowledged that the construction costs figures provided make allowance for realistic value engineering targets/savings within the FBC stage of the project – without this, the construction cost element and associated overall OBC budget cost estimate would have been higher.

Whilst our Lead Advisors have yet to formally report on hubCo's Stage 1 (OBC) report, they have been working hand in hand with hubCo and their Tier 1 contractor in recent weeks to agree the OBC costs. They concur with hubCo that given the current nature of the market and evolving more onerous briefing requirements the costs represent value for money.

The other costs movements are either percentage mark-ups based on the increased construction cost or adjusted/new provisions (equipment and direct costs) to take the opportunity to make the overall budget more deliverable and realistic.

In the OBC cost plan the inflation assumptions have been rebased to ensure they are as current as possible, and inflation relating to the period between IA and OBC is now historical, and therefore now included in the current construction costs. There is a forecast inflation allowance built in from the period January 2022 to construction. Inflationary forecasting is difficult during these current times so there is an inherent risk in respect to project inflation – that said, whilst inflation increases are still forecast from 2022 to 2023, consultancy Cost Advisors generally believe that there should be some stabilisation given the significant movement in 2021.

5.3.1.3 Capital Clarification and Assumptions

The OBC capital cost estimate noted under Section 5.3.1.1 should be read with reference to the following assumptions.

Description	Note
Professional Fees	Professional services contract for Lead Advisor has been awarded
Equipment	Estimated 5% cost based on HFS advice. Transferable equipment will be moved to the new unit. Equipment budget only allows for items of equipment to be identified on the room layouts (conventional arrangement) and does not take account of any specialist equipment to be provided by the GP's or others

Contingency	Optimism bias at OBC stage has been calculated using a standard build template
Inflation	Based on Qtr 1 2022 Indices to construction
VAT	VAT has been applied where applicable. No VAT recovery estimates have been built into the cost plan for construction – this will to be confirmed with VAT Advisors and HMRC after contract is awarded
E-health	The project will cover the cost of e-health infrastructure within the building and key items of equipment as referenced on the room layouts. The budget does not allow for capital/revenue funded e-health projects.
Enhancements	Landscaping treatments around the health centre are currently quite standard. Any community garden, community gym or enhanced scheme is likely to require additional financial support.
Peppercorn Lease	The lease for the land is currently in discussion with Fife Council with the likely outcome that it will be considered a peppercorn rent. This will have an impact on leased depreciation figures under IFRS16 for right of use assets.

Table 38 - Capital Assumptions

5.3.2 Revenue Costs

5.3.2.1 Revenue Cost Summary

In order to confirm the revenue implications of the project the baseline costs (do nothing/minimum option) have been thoroughly reviewed and then compared to the projected costs of the preferred option to assess the financial implications. A summary of the revenue costs is provided in the table below.

Description	Baseline	Preferred Option	Difference
Property pays (NHSF)	£12,605	£33,474	£20,869
Property non-pays (NHSF)	£16,612	£76,550	£59,938
Property non-pays – GP offset (NHSF)	-£16,584	-£27,142	-£10,558
Net Increase (NHSF)	**£12,633**	**£82,882**	**£70,249**
Service model (FHSCP)		£31,500	-

Table 39 - Revenue Cost Summary

NHS Fife Revenue Costs

The OBC identifies overall net recurring revenue impact of £0.07m (excluding depreciation) for the preferred option against the baseline costs. Total revenue costs have been adjusted to reflect the GP rechargeable revenue costs associated with the health centre.

There are staff costs associated with this development - staffing, non-pay and consumable costs will continue to be reviewed as the FBC develops.

FHSCP Revenue Costs

The table below provides a breakdown of the FHSCP's anticipated revenue costs at OBC. The service model will evolve once decisions are received from Scottish Government on what the full implementation of MOU1/2 for urgent care and what MDT means for Fife.

All these costs will have a nil impact on the revenue outturn position as funding sources have been identified.

Staff group	WTE	Cost	Funding Source	Additional Information
Band 7 (Primary Care Pharmacist	0.50	£31,500	Funded through Primary Care Investment Fund	Per OBC
Total	**0.50**	**£31,500**		

Table 40 – FHSCP Service Model Costs

5.3.2.2 Property non-pays breakdown

A breakdown of the property non-pays is provided in the table below for information.

Property Cost	Baseline	Preferred Option	Increase
Equipment	£40	£2,172	£2,132
Heating Fuel & Power	£5,385	£29,016	£23,631
Property Maintenance	£1,131	£5,175	£4,044
Property Rates	£5,439	£28,140	£22,700
Water Charges	£711	£3,065	£2,354
Bedding & Linen	£128	£550	£422
Cleaning	£21	£647	£626
General Services	£135	£1,556	£1,421
Surgical sundries	£77	£332	£255
GP Clinical Waste	£3,545	£5,897	£2,352
Net Cost Increase	**£16,612**	**£76,550**	**£59,938**

Table 41 - Property Non-pays Breakdown

5.3.2.3 Depreciation

An outline of the changes in both running costs and depreciation is summarised below:

Depreciation	Life	Value £000's	Proposed Dprchg £000's	Baseline Dprchg £000's	Net Increase Dprchg £000's
Buildings	60	£7,497,676	£124,961	£9,111	£115,851
Equipment	10	£319,853	£31,985	£0	£31,985
Total		**£7,817,529**	**£156,947**	**£9,111**	**£147,836**

Table 42 - Depreciation

The depreciation for the preferred option is £0.157m based on an asset building life of 60yrs and 10yrs for equipment on an overall capital cost of £7.818m. The overall increase in depreciation is £0.148m based on 21/22 full depreciation charges - which will be met from the current ring-fenced NHS Fife non-core depreciation budget. The buildings depreciation charge is pre any Valuation Office valuation being done after completion – there is an expectation that any non-value works will reduce the value held in the balance sheet once the valuation is carried out and therefore reduce the depreciation charge going forward.

5.3.2.4 Revenue Clarification and Assumptions

A number of assumptions have been made at the OBC stage which will be further evaluated and revised throughout the development of the FBC. These assumptions are as detailed in the table below.

Description	Note
Costs	Costs are calculated using 2020/21 prices and using 2020/21 budgetary information.
Pays (NHSF)	The support costs for the existing Kincardine Health Centre have been calculated as the baseline and then used as a benchmark against which any changes are considered. Estimated costs for the preferred option reflect forecast demand from 2024/25. Calculations include allowances for on-costs, enhancements, sick leave, public holidays and annual leave. Workforce increases are based on increased health centre sqm increase.
Non-Pay (NHSF)	Non-pay costs assumed to increase in line with increased health centre sqm.
Depreciation	Building – 60 years and equipment 10yrs.

Table 43 - Revenue Assumptions

5.4 Accounting Treatment

The traditional funding route for the project will impact on NHS Fife's Balance Sheet - both the capital cost of the development and the associated capital equipment will be added as non-current assets to the balance sheet and depreciated over the life of the assets in line with accounting policies.

5.5 Financial Situation and Statement of Affordability

NHS Fife confirm that this project remains affordable in both revenue and capital terms. The capital costs of the investment will be met through a capital contribution from the Scottish Government Health and Social Care Division capital budget.

Additional recurring revenue costs for Kincardine Health Centre will be incorporated into NHS Fife's Annual Operational Plan for future years.

FHSCP funding in respect to their service model is ongoing and will be articulated within the FBC stage.

5.6 Stakeholder Support

As the project will be delivered by NHS Fife for Fife, written agreement of Stakeholder support from other NHS Scotland / public sector organisations is not required in this instance.

5.7 Resources

The project is fully resourced from both NHS Fife and the FHSCP's perspective. Any associated costs have been built into the updated OBC budget. Further clarity on resourcing and project structure can be found at Section 6.3.

5.8 Capital and Revenue Constraints

NHS Fife's capital funding commitments mean that the project cannot exceed the available budget. Any additional revenue costs will be met within NHS Fife's overall revenue resource envelope.

FHSCP?

5.9 Financial Contributions

Other than capital funding from the Scottish Government, there will be no financial contributions from external partners in respect to this project.

6 Management Case

6.1 Introduction

The main purpose of the Management Case is to demonstrate that NHS Fife is ready and capable of delivering the project successfully.

6.2 Revisiting the Management Case

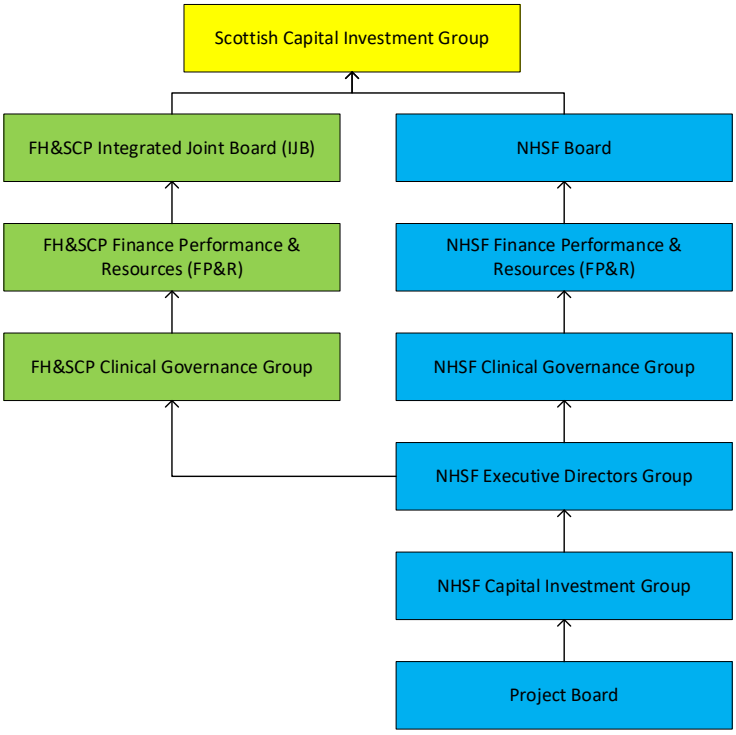
The management case has generally been updated and expanded since OBC in accordance with SCIM FBC guidance. The main sections remain the same and text has been updated where appropriate to reflect the current status of the project.

6.3 Reporting Structure and Governance Arrangements

To deliver the project successfully, good governance is required to monitor and direct it. An understanding of the structure and mechanisms for escalation and reporting is set out on the organograms below.

6.3.1 Governance

The strategic and business case governance controlling the project is set out below.



6.3.2 Project Structure

The project structure taking account of the Project Board, FHSCP and Capital Planning functions is set out below. NHS Fife are responsible to delivering the facilities whilst FHSCP are responsible for delivery of the services from the facilities.

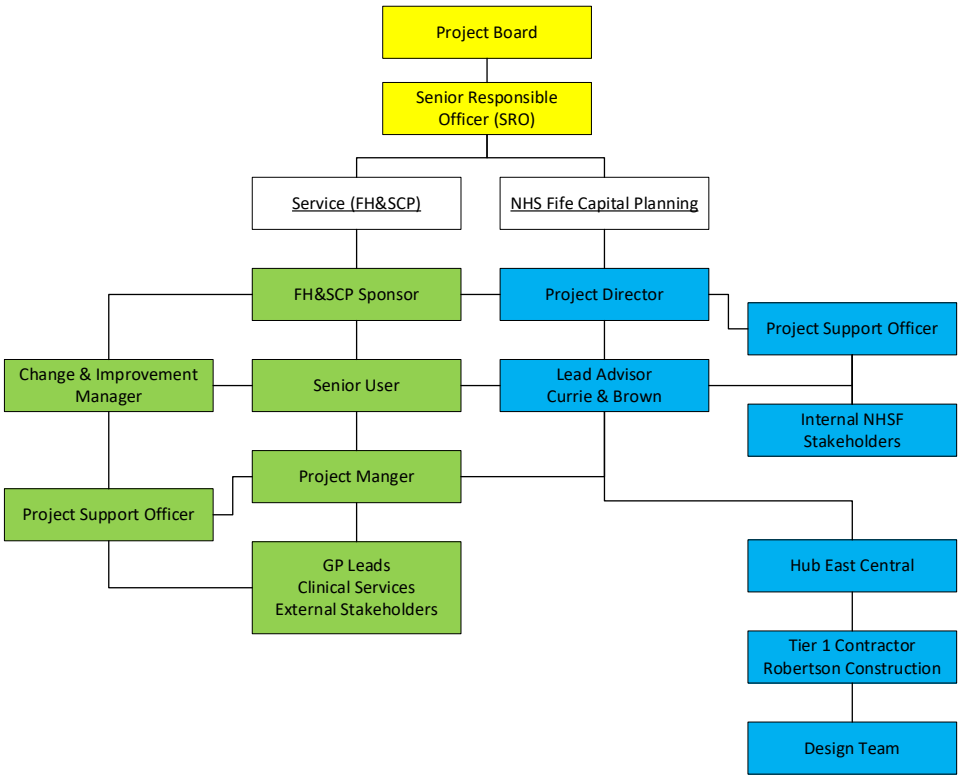


Figure 5 - Project Organisation

6.4 Project Board

A Project Board has been established to oversee the project. The Project Board was set up at commencement of the OBC and Terms of Reference have been agreed. The Project Board meets monthly where they receive a regular project update report from the FHSCP Sponsor and the Capital Planning Project Director. Necessary matters are escalated as required whilst the Project Board offers direction to the Project Team.

Project Board membership and experience is outlined in the table below:

Name/Role	Experience
Joy Tomlinson Director of Public Health Project role: Senior Responsible Officer (SRO) with overall responsibility and accountability for the project	Joy joined NHS Fife in May 2021, having worked within the NHS for 27 years. She has a clinical background, having trained in General Practice prior to working in Public Health. Prior to joining NHS Fife, she was joint Interim Director of Public Health in Ayrshire & Arran and has experience of departmental budgetary management with the additional complexities of rapid workforce and service development during the pandemic. She chairs the national 'place and wellbeing collaborative' which has developed Place & Wellbeing principles to support the refreshed National Planning Framework (NPF4).

Name/Role	Experience
Neil McCormick Director of Property and Asset Management Project role: responsible for contributing towards general governance.	Neil joins NHS Fife with over 30 years' experience of working at a senior level across the public and private sector. Neil's previous role was with Robertson Capital Projects, where he was Managing Director with specific responsibility for delivering infrastructure projects and joint ventures with the public sector including NHS Frameworks. Prior to this, Neil was Director of Strategic Projects & Property at NHS Forth Valley and Project Director for the £300m Forth Valley Royal Hospital.
Margo McGurk Director of Finance Project role: responsible for contributing towards general governance.	Margo joined NHS Fife as Director of Finance in February 2020. She is a CCAB qualified accountant, with a broad range of experience across the public sector but particularly within the NHS in Scotland. She has significant experience of decision-making at strategic and operational levels and has a strong personal focus on developing strategy, supporting culture, delivering sound financial control and best value from the allocation of resources. Very experienced in delivering professional leadership to the finance function, she has held a number of senior roles across a number of NHS Boards. She is particularly interested in working in partnership across organisations and leading on the development and delivery of financial strategies to support delivery against agreed priorities.
Nicky Conner Director of Health and Social Care Project role: responsible for contributing towards general governance.	Nicky has been Chief Officer and Director of Health and Social Care since 2019. Nicky offers 25 years' experience covering a diversity of public service roles including nursing, acute, specialist and community roles along with professional and clinical leadership to services within Fife's communities and leading on regional and national work. In her current role Nicky leads Health and Social Care Services for all of Fife including Community Care, Complex and Critical Care and Primary and Preventative Care. Nicky champions Integration, Partnership Working to deliver high quality services for the people of Fife.
Simon Fevre Staff Side Representation Project role: responsible for contributing towards general governance.	Simon is the NHS Trade Union Co-Chair of the HSCP Local Partnership Forum. Simon was NHS Fife's Employee Director for 7 years and has worked on the Board's Staff Governance agenda for 20 years. He was a clinician working in the Nutrition and Dietetic Department as Clinical lead for Older Peoples Services.

Name/Role	Experience
Ben Johnston Head of Capital Planning Project role: Capital Planning Project Director	Ben joined NHS Fife in January 2021 with over 15 years construction consultancy experience having worked in a diverse range of sectors. Working predominantly as a Project Manager, Ben has been responsible for delivering multiple projects diligently from inception to completion. Over recent years, Ben has spent most of time operating specifically within the healthcare sector, helping to positively contribute towards creating a sustainable healthcare estate for current and future generations. Ben has helped to deliver several projects for NHS Fife including Muirview and Hollyview at Stratheden Hospital and is currently helping to deliver the Fife Elective Orthopaedic Centre Project at Victoria Hospital.
Bryan Davies Head of Primary and Preventative Care Services Project role: FHSCP Project Sponsor	Bryan has worked within health and social care for over 25 years with experience in local area co-ordination, planning, performance, change management, commissioning, mental health, addictions, learning disability and advocacy. Bryan feels very passionate about health and social care integration and is excited to be working with colleagues and stakeholders to make a positive difference for individuals, families and communities in what are currently very challenging times.
Audrey Valente FHSCP Chief Financial Officer Project role: responsible for contributing towards general governance	Audrey has more than 30 years' experience working in local government holding senior finance positions. As a local lass, raised in Kirkcaldy, she went on to study accountancy at Napier University following her high school years at Kirkcaldy High. Audrey's experiences have combined strategic and operational financial management along with significant change management.
Helen Hellewell Associate Medical Director Project role: responsible for contributing towards general governance	Helen originated from Motherwell and moved to Fife after marrying. She finished her medical training at the Victoria in Kirkcaldy and took up a GP position in a local practice in Kirkcaldy. She then joined the Markinch medical practice, and currently still works one and half days per week there. Helen has been involved with the Partnership for a number of years having been the cluster lead for Glenrothes, working on a number of initiatives including quality improvement and integrated working and was the

Name/Role	Experience
	clinical lead on a leadership programme for integration with GP Scotland.
Benjamin Hannan Deputy Director of Pharmacy & Medicines Project role: represents the Area Clinical Forum as well as contributing to towards general governance.	Benjamin is an experienced pharmacy leader, with broad professional, managerial and leadership experience. Benjamin is a Fellow of the Institute of Leadership and Management and is currently Vice-Chair of Fife's Area Clinical Forum and represents this forum on the Project Board. The Area Clinical Forum allows NHS Fife to draw on the full range of professional skills and expertise that exists in all parts of the NHS system for advice on clinical and other professional matters. Benjamin's current role of Deputy Director of Pharmacy & Medicines is integrated across Health and Social Care, and all sectors and settings of care delivery. Prior to his current role, Benjamin was a GP Federation Director, responsible for 31 GP practices in the North East of England. This broad experience of primary care and community working will enable Benjamin to provide valuable insight to this project.
Tracy Gardiner Capital Accountant Project role: Capital Planning Accountant	Tracy has worked within NHS Fife for 26 years within the capital branch of the finance department. Tracy has a wide range of knowledge and experience in the delivery of capital projects within NHS Fife.
Ruth Lonie Communications Manager Project role: responsible for project communications	Ruth joined NHS Fife as Communications Manager in 2009. She has been involved in the communications aspects of a number of similar projects within NHS Fife.
Eugene Clark Non-executive Member *Dec. 20 – Jul. 21* Project role: responsible for contributing towards general governance	Eugene has spent the last 14 years working as a self-employed consultant helping businesses and public sector organisations in the fields of internal communication and employee engagement. Eugene's community interests have included being a former member of Largo Community Council and being involved in several action groups relating to sports in the Levenmouth area, most recently having helped establish the Fifers for the Community charity. Eugene is an active member of the Fife Children's Panel. He is also currently the Chair of the Levenmouth Rail Campaign, which seeks to regenerate the local community through the restoration of the direct rail link to Edinburgh.

Name/Role	Experience
Alistair Grant Non-executive Member *From Jan. 22* Project role: responsible for contributing towards general governance	Alastair Grant is a qualified accountant with more than 30 years' experience working both in Scotland and the Middle East. Most recently Alastair worked for Sodexo Justice Services, until his recent retirement. Alastair brings to the Board proven commercial acumen, combined with good people management, team building, development, and mentoring skills.

Table 44 - Project Board Experience

6.5 Project Team

The project team sits below the Project Board and are responsible for delivering the project on a day-to-day basis. Responsibilities include:

- Facility design development
- Service change re-design
- Business case development
- Stakeholder communications and engagement
- Management of risks and issues
- Management of cost
- Construction and handover of the facilities

To discharge these responsibilities, there are a wide range of roles. These are outlined within the Project's Project Execution Plan.

6.5.1 External Advisors

Where necessary independent consultants have been procured by the Board to help with the management of the project. Consultants procured to date include:

Project Role	Organisation
Lead Advisor	Currie & Brown
▪ Project Manager	Currie & Brown
▪ Cost Advisor	Currie & Brown
▪ M&E Technical Advisor	Hulley & Kirkwood (sub-consulted)
▪ Clerk of Works	Currie & Brown + Hulley & Kirkwood
▪ Authority's Representative (contract)	Currie & Brown

Table 45 - External Advisors

6.5.2 Project Recruitment Needs

No additional recruitment needs are envisaged at this time, however this will be re-considered during the FBC phase of the project.

6.6 Project Plan and Key Milestones

The project plan and key milestones are set out in the table below.

Description / activity	Date
Full Business Case	
Commencement	February 2022
Completion	January 2022
Governance Approvals	April 2023
Construction & Handover	
Commencement	May 2023
Completion	June 2024
Operational	August 2024

Table 46 - Key Milestone Summary

6.7 Change Management Arrangements

6.7.1 Operational and Service Change Plan

The operational and service change plan proposals are outlined under Section 2.4.1.3. This work will continue through FBC and Construction in parallel with the soft landings process to ensure that the services are prepared to adopt new ways of working in advance of the facilities being made available for use. The FHSCP will ultimately assume responsibility for progressing this dependant workstream.

6.7.2 Facilities Change Plan

The new facility will be serviced by NHS Fife's in-house Facilities and Estates team in a similar way to the existing arrangements. Costs relating to the increase in area have been factored into the GP allocations. NHS Fife resource projections to maintain and upkeep the building have been taken account of in revenue projections (see the Financial Case).

6.7.3 Stakeholder Engagement and Communication Plan

A Stakeholder Engagement and Communication Plan has been developed and endorsed by the Project Board. The plan will continue to be developed and updated as the project progresses. A copy of the plan can be located at Appendix H.

In addition, an update in respect to stakeholder engagement during the OBC stage is outlined at Section 3.4.2.

6.8 Benefits Realisation

6.8.1 Benefits Register

The rationale for an investment needs to be reflected in the realisation of demonstrable benefits, as this will provide the evidence base that the proposal is worthwhile and that a successful outcome is achievable. The benefits to be achieved are discussed in the Strategic Case and have resulted in the creation of a Benefits Register and Benefit Realisation Plan for the Project. The Benefits Register is located at Appendix E.

The Benefits Register includes a range of benefits to be realised by the development. Each benefit includes a target that will be used to indicate the measure of success during the Post Project Evaluation (PPE).

Benefits are either assessed in a quantitative or qualitative manner.

For the quantitative benefits, the register indicates the baseline (current position) at the start of the project including the source. This will be compared with the same data source when the PPE is completed.

For benefits that are qualitative in nature, questionnaires will be developed, and a mix of patient and staff surveys/interviews will be undertaken to outline the baseline for these benefits. The same survey tools will be used during the PPE to examine to what degree the improvements sought were achieved.

Additionally, a Red, Amber, Green (RAG) score highlighting the relative importance of each benefit is indicated using the scale outlined below in the table below.

Scale / RAG	Relative importance
1	Fairly insignificant
2	↕
3	Moderately important
4	↕
5	Vital

Table 47 - Benefit Importance

6.8.2 Benefits Realisation Plan

A Benefits Realisation Plan has been produced to support the achievement of the benefits outlined in the Benefits Register, and it is included as Appendix F.

The benefits realisation process is a planned and systematic process consisting of four defined stages outlined below. The implementation of this plan will be reviewed regularly by the Project Board.

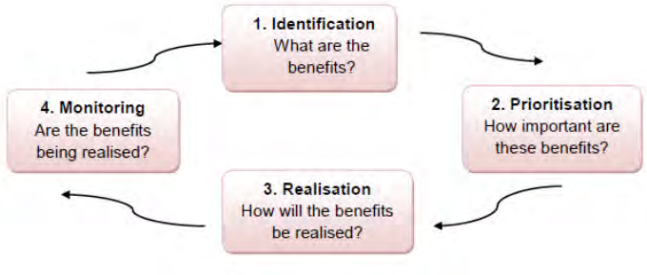


Figure 6 - Benefit Realisation Process

The Benefits Realisation Plan outlines:

- Which Investment Objective the benefit addresses
- Who will receive the benefit
- Who is responsible for delivering the benefit
- Any dependencies that could affect delivery of the benefit
- Any support needed from other agencies etc. to realise the benefit

Benefits monitoring will be ongoing over the life of the Project through the planning, procurement and implementation phases. Progress will be reported to the Project Board at regular intervals and will culminate in the Project Evaluation Report.

6.9 Risk Management

Risk management is a structured approach to identifying, assessing and controlling risks that emerge during the project lifecycle. It is a critical and continuous process throughout the planning, procurement and implementation journey of a project.

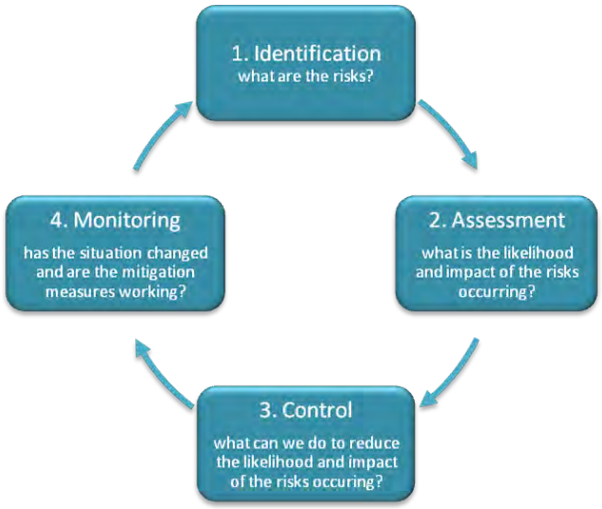


Figure 7 - Risk Management Process

6.9.1 Updated Risk Register

The Project Team have continued to develop the Risk Register provided at IA. The current FBC risk register can be located at Appendix G. The Risk Register is up to date and representative of the residual risks that may be encountered during the balance of the project. The headline items noted below, demonstrate how the risk register has been developed since IA.

- New risks have been identified and added to the register, whilst other risk have been closed
- Probability, impact and risk ratings have been updated progressively at risk workshops

- Mitigation measures have been agreed and updated
- Risk owners and managers have been allocated (a risk owner has overall responsibility for the risk, whilst a manager is responsible for helping to mitigate the risk)

The commercial arrangements associated with the Risk Register are set out within the Commercial Case.

6.9.2 Governance

The Project Board will assume overall responsibility for the risk register, however the Capital Planning Project Director will be responsible for ensuring it is maintained and updated regularly in line with the agreed project controls.

The risk register is updated and provided to the Project Board on a monthly basis as an appendix to the Capital Planning Project Manager's monthly progress report. Key risks are extracted from the risk register and highlighted within the Project Manager's monthly report for ease of reference. The Project Board provide direction to the Project Director and capital Planning Project Manager on risk matters as necessary.

6.10 Commissioning

The importance of the commissioning process cannot be underestimated, as failure to adequately consider this process is likely to cause increases to project costs and failure to deliver agreed service benefits and project outcomes. The Project Board and Capital Planning Director are fully committed to implementing a robust commissioning process, ensuring that the facilities are safe to use and operate from the outset.

The commissioning process will be treated as a distinct workstream, but fully integrated into the overall project to enable a smooth transition to the new working arrangements and realisation of the anticipated benefits. Workstreams will include Technical Commissioning and Operational Commissioning and these will be supported by BIM and Soft Landing processes.

Technical Commissioning concentrates on the readiness of the facility to support operational activity. As such the mechanical and electrical systems all need to be operating satisfactorily at handover of the facility and beyond. Operational Commissioning on the other hand is involved with getting the clinical services transferred into the facility with minimal disruption to business continuity. Given these separate requirements requiring different expertise, it is considered that there is value in assigning these roles to separate individuals with the necessary knowledge and expertise – these roles will be confirmed during the FBC stage.

The Commissioning Managers will report to the Capital Planning Project Manager on a day to day basis but will maintain lines of communication with the wider team to deliver against the agreed plans.

A Commissioning Strategy and detailed commissioning programme will be developed during the FBC stage of the project.

6.11 Post Project Evaluation

The arrangements for post implementation review and project evaluation reviews have been established in accordance with best practice. These reviews will determine whether the

anticipated benefits identified at the outset have been delivered. The project will be evaluated in stages:

Stage 1 – Procurement Process Evaluation

An evaluation of the procurement process will be undertaken following the signing of the contract to assess the effectiveness of the procurement process in meeting the project objectives. This will identify any issues and lessons to be learned that will benefit future projects. This evaluation can take place shortly after commencement of the construction phase.

Stage 2 – Monitoring Construction

During the construction period progress will be monitored to ensure delivery of the project to time, cost, and quality to identify issues and actions arising. On completion of the construction phase the actual project outputs achieved will be reviewed and assessed against requirements, to ensure these match the project's intended outputs and deliver its objectives.

Following completion, the Project Manager's and Supervisor's monthly reports will be reviewed and summarised to represent a holistic view of how the project performed during the construction period.

Stage 3 – Initial Project Evaluation of the Service Outcomes

This will be undertaken 6 to 12 months after the new facility has been commissioned. The objective is to determine the success of the commissioning phase and the transfer of services into the new facilities and what lessons may be learned from the process.

Stage 4 – Follow-up Project Evaluation

This will be undertaken 2 years into the operational phase by the Evaluation Team to assess the longer-term service outcomes and ensure that the project's objectives continue to be delivered.

The following questions will be asked at each stage:

- Have relevant project objectives been achieved?
- Has the project progressed as planned?
- If the plan was not followed, why did this occur?
- If appropriate, how should plans for future projects be amended?

The process will be led by evaluators, independent of the delivery team, who will meet with representatives of the user groups and other key stakeholders. The Project Sponsor, on behalf of the Project Board, will receive reports at each stage of the evaluation process.

Appendix A - Strategic Assessment

Appendix B – Design Statement

Appendix C – Design Pack

Appendix D – Benefits Register

Appendix E – Benefits Realisation Plan

Appendix F – Risk Register

Appendix G – Stakeholder Engagement & Communication Plan

Appendix H – The Patient Perspective

Lochgelly Health and Wellbeing Centre

Outline Business Case

20 April 2022, Rev. 5

VERSION CONTROL

Draft R.0	29.09.21	First OBC Draft
Draft R.1	03.12.21	Updated Draft
Draft R.2	17.01.22	Updated Draft – Ben Johnston
Draft R.3	16.02.22	Updated Draft to incorporate FCIG comments – Ben Johnston
Draft R.4	28.03.22	Updated Section 4.4.14 – Ben Johnston
Draft R.5	20.04.22	Updated risk Section 1.4 and 4.5.2 – Ben Johnston

Contents

Glossary of Terms

ADAPT	Alcohol and Drug Abuse Prevention & Treatment
ADB	Activity Data Base
AEDET	Achieving Excellence Design Evaluation Toolkit
A&DS	Architecture & Design Scotland
BEP	Building Information Modelling Execution Plan
BIM	Building Information Modelling
BPC	Benefit Point Cost
BREEAM	Building Research Establishment Environmental Assessment Method
BRUKL	Building Regulations UK Part L
BSL	British Sign Language
CAB	Change Advisory Board
CDM	Construction (Design and Management)
CHaWS	Community Health and Wellbeing Sub-group
CHD	Coronary Heart Disease
CLD	Community Learning & Development
COPD	Chronic Obstructive Pulmonary Disease
CTAC	Community Treatment & Care
DBDA	Design and Build Development Agreement
DSM	Dynamic Simulation Model
DSR	Domestic Services Room
DVLA	Driver and Vehicle Licensing Agency
EIR	Employers Information Requirements
FASS	Fife Alcohol Support Service
FBC	Full Business Case
FHSCP	Fife Health & Social Care Partnership
FVA	Fife Voluntary Action
GMS	General Medical Services
GP	General Practitioner
HAI	Healthcare Associated Infection
HAI SCRIBE	HAI System for Controlling Risk in the Built Environment
HFS	Health Facilities Scotland
HHG	High Health Gain

HIS	Healthcare Improvement Scotland
HR	Human Resources
HV	Health Visiting
IA(D)	Initial Agreement (Document)
IJB	Integration Joint Board
ISD	Information Services Division
LAC	Local and Community
L&D	Learning & Development
M&E	Mechanical and Electrical
MDT	Multi Disciplinary Team
MOU	Memorandum of Understanding
MDT	Multi-disciplinary Teams
NCM	National Calculation Methodology
NDAP	NHSScotland Design Assessment Process
NPC	Net Present Cost
NSS	National Services Scotland
OBC	Outline Business Case
PA	Per Annum
PBA	Project Bank Account
PPD	Practice & Professional Development
PPE	Post Project Evaluation
PSCP	Principal Supply Chain Partners
QOF	Quality Outcome Framework
RAG	Red Amber Green
RIBA	Royal Institute of British Architects
SA	Strategic Assessment
SCIM	Scottish Capital Investment Manual
SCOTPHO	Scottish Public Health Observatory
SFT	Scottish Futures Trust
SIMD	Scottish Index of Multiple Deprivation
SoA	Schedule of Accommodation
SPARRA	Scottish Patients at Risk of Readmission and Admission
SRO	Senior Responsible Officer
STAND	Dementia Friendly Fife

STAR	Stop Think Assess Respond/Report/Refer Method
TUPE	Transfer of Undertakings (Protection of Employment) Regulations 1981
VfM	Value for Money
WBP	Weighted Benefit Points
WLC	Whole Life Cost
WTE	Whole Time Equivalent

1 Executive Summary

1.1 Introduction

Fife Health and Social Care Partnership is working with local communities, teams and stakeholders to support the delivery of a fully integrated 24/7 community health and social care model that ensures sustainable, safe, individual partnerships of care. The purpose of this outline business case (OBC) is to seek approval to develop the full business case (FBC) to re-provide Lochgelly Health Centre in purpose designed facilities whilst making provision for a holistic offer of local health and wellbeing services to fulfil the General Medical Services (GMS) contract[1] requirements.

The OBC establishes the need for investment, building on the NHS Fife and Fife Health and Social Care Partnership (FHSCP) strategic goals to deliver a model of local care, focused on individual outcomes, supported by health and social care delivered by the right person in the right place at the right time. It describes the appraisal of a long list of options, identifies the short list, and recommends a preferred way forward to enable the delivery of Fife's Community Health and Wellbeing Hub model within the Lochgelly community. The OBC's commercial, financial and management cases have been developed further to identify how the project can be practically delivered.

The vision for primary care and community services in NHS Fife and Fife Health and Social Care Partnership is to enable the people of Fife to live independent and healthier lives. We will deliver this by working with people to transform services to ensure these are safe, timely, effective and high quality, focused on achieving personal outcomes. This requires access to the right professional at the right time in the right place; where services can be provided within a community setting, closer to where service users live. Care should be provided in an environment that supports staff to provide an excellent experience and has modern facilities that meet the needs and expectations of service users, carers and staff well into the late 21st century.

1.2 Strategic Case

1.2.1 Current Arrangements

Lochgelly Health Centre, located in the heart of the town, provides General Medical Services to 79% of the resident population of Lochgelly and the surrounding areas of Lochgelly East, Lochgelly West & Lumphinnans, Ballingry, Cardenden and Lochore & Crosshill, through three Medical Practices based within the Health Centre. Community services are provided by NHS Fife including for example Community Nursing, Health Visiting, Mental Health, Sexual Health and Podiatry. Services work together to deliver high quality person-centred health and social care in a way which promotes and enhances the health and wellbeing of the people of the area.

The three practice populations total circa 10,728 people. The practice area is in the highest income deprived deciles of Scotland and therefore faces significant health inequalities. The locality population is predicted to grow by 5% in the next 25 years. Most of this population growth is anticipated to be in the older people age group, circa 45%, with both children and working age populations predicted to decrease. These changes will significantly increase

[1] GMS contract: 2018 - gov.scot (www.gov.scot)

the level of frailty the practices are supporting within a community which has a significantly higher disease burden associated with intergenerational income inequalities.

The current facility is a 1970's construction, with every effort made to modify the building to support the delivery of modern integrated health and social care. However, it is no longer fit for purpose, our new model of working requires accommodation that enables the delivery of our vision of multi-disciplinary and group working, which supports the community and partners to deliver collaboratively. A model which is being delivered in other communities which have access to modern facilities which do not have the same complexity of intergenerational inequalities and disease burden of the Lochgelly Community. Healthcare has been identified through local community planning as one of the major issues for the area.

The development of the community health and wellbeing model and delivery of the new GMS contact is being held back by structural and layout constraints. All possible reasonable changes have been made to the existing building and alternative premises accessed. Lochgelly Health Centre fails to meet the spatial, organisation and design standards for Primary and Community Health Care premises and has no capacity for further growth. Major improvements to address maintenance and statutory standards will not facilitate significant improvements in space utilisation to enable local integrated care to meet patient quality, staff standards and efficiency objectives.

1.2.2 The Patient Perspective

It has been recognised for many years, service providers across Scotland and the UK have planned care separately in different parts of the system including primary, community, acute care and mental health. Services have often been planned around buildings, individual service providers or even clinicians.

What is now proposed is a shift toward an overarching whole systems model which focuses on the needs of people who use the different health and social care services within the Lochgelly facility. This is described as a more holistic community health and wellbeing approach.

The central underlying principle of the development of the new centre is to focus on the patient outcomes, their journey and experience. This will help to identify where service improvements are necessary and involve a wide range of service users and providers in analysing and redesigning improved patient pathways to positively impact on outcomes.

The agreed way forward was to develop patient personas and pathways to enable the patient perspective and journey to be captured. We have identified seven people (personas) who typify patients or people who use the Lochgelly Health Centre and whose care represents key requirements and challenges for NHS Fife, FHSCP and partners. The personas and pathways in this document were developed in using local profile and practice data as well as in collaboration with a range of clinical services, community and voluntary sector partners.

We have used the personas to illustrate pathways and through mapping their care needs - we can agree how they can be met more effectively and efficiently. A designed and managed process of patient and service provider engagement including wider public involvement has taken place and is expected to shape development of the new centre – moving from the

traditional medical model to a more holistic community health wellbeing service model of delivery.

The Health & Wellbeing Model was developed by change and improvement colleagues in NHS Fife and FHSCP. This is illustrated below.

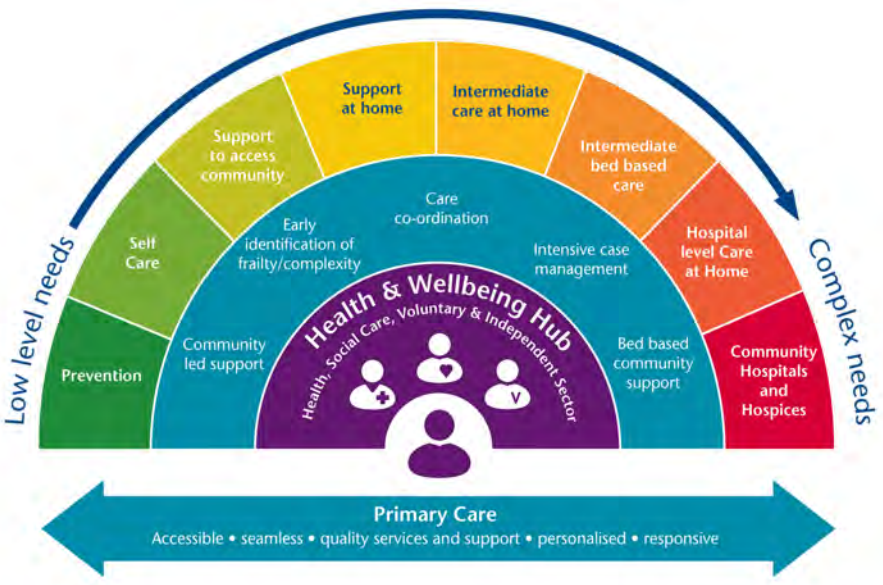


Figure 1 - Health and Wellbeing Model

The Project Team is using the Patient Personas & Pathways to look at possible improvements through a number of tests of change. This workstream has commenced but will continue through the FBC and construction stages of the project.

1.2.3 The Need for Change and Investment Objectives

The drivers for change and developed Investment Objectives to enable this change are set out in the table below. Associated benefits are set out in Section 2.4.4.

Effect of the need for change on the organisation:	Investment Objectives
Existing service arrangements are affected by lack of clinical support service facilities.	Ensure equal access to a patient centred approach by enabling delivery of and access to local integrated anticipatory and preventative care for patients. Secure accommodation to deliver required group based activities.
Implementation of integrated models of care is undeliverable locally in the current environment	Ensure equal access to modern integrated care with provision driven by patient need rather than limitations in capacity.

Effect of the need for change on the organisation:	Investment Objectives
Pressure on existing staff, accommodation and services will inevitably increase.	Ensure the right staff skill mix and service capacity are available to deliver and strengthen local capacity to manage people's health within the local community.
The facilities available, 100% occupancy, combined with significant population change, restrict the ability of the parties to deliver the full range of integrated services locally.	Enable earlier access to proactive and anticipatory care through local delivery via integrated seamless service across health and social care. This will reduce referrals to other services. Care will be driven by patient need rather than limitations on capacity.
Existing configuration, as a result of a 1970's building, being modified and extended with a 'best fit' approach means poor accommodation e.g. service users who rely on wheelchair access or have a mobility problem have extreme difficulty in both accessing and traversing the facility.	Delivery of safe and effective care with dignity by providing facilities which comply with all legal standards and regulatory requirements and gives equality of access for all. Improved staff wellbeing.
Increased safety risk from outstanding maintenance and inefficient service performance.	Improve safety and effectiveness of accommodation by improving the physical condition, quality and functional suitability of the healthcare estate.

Table 1 - Needs for Change and Investment Objectives

1.2.4 Fife Place Based Planning Tool

NHS Fife have recently been engaging with Scottish Government around their proposal to develop a longer-term primary care strategy. Scottish Government have recently developed a Place Based Needs Planning tool which helps Boards to understand their investment priorities based on community health, demographics, supporting infrastructure and the condition of the estate. Analysing the data for Fife in totality, Lochgelly Health Centre has an Estate Need Score of 70 (3rd highest priority), bolstering the case for change and intervention.

Property	Postcode	Intermediate Zone	Floor Area	Age	Estate Need Score
Kincardine Health Centre	FK10 4QX	Kincardine	254	91	83
Oakley Health Centre	KY12 9QH	Oakley Comrie and Blairhall	918	71	73
Lochgelly Health Centre	KY5 9QZ	Lochgelly West and Lumphinnans	822	81	70
Valleyfield Health Centre	KY12 8SJ	Valleyfield Culross and Torryburn	1,012	51	65
Path House Medical Practice	KY1 2PG	Kirkcaldy Pathhead	612	329	56
Strathmiglo Auchtermuchty Practice	KY14 7QA	Auchtermuchty and Gateside	50	59	55
Leven Health Centre	KY8 4ET	Leven East	1,624	56	53
Rosyth Health Centre	KY11 2SE	Rosyth East	946	39	47
Kelty Health Centre	KY4 0AE	Kelty East	754	60	44
Lundin Links Scoonie Medical Practice	KY8 6DB	Largo	48	59	43

Table 2 - Fife Priority of Estate Need

1.3 The Economic Case

A wide range of options were developed and considered. These were then consolidated into a shortlist of options which were scored via a wide range of stakeholders. The option scores are presented below.

	1 Do Nothing/ Base	2 (5c) Car park	3 (4b) Jenny Grey Refurb	4 (6d) Jenny Grey New Build	5 (5d) Lochgelly School New Build	6 (6e) Francis Street New Build
Net present cost (NPC) - £m	2,311,661	11,871,118	-	11,799,393	12,763,618	11,666,192
Weighted benefit points (WBP)	256	431	435	632	431	879
BPC per WBP - £000	9,029	27,543	-	18,669	29,613	13,272
	Reject	Possible	NA	Possible	Possible	Preferred

Table 3 - Short-listed Option Scores

Option 6 scored highest in respect to benefit points. Once the net present costs were factored in, option 1 is highlighted at the lowest cost per benefits point – this is purely because of low net present cost owing to the limited capital that could be invested in the existing facility. As option 1 does nothing to tackle the needs for change as demonstrated, it is not a legitimate option but included for comparative purposes.

Given the balance of legitimate options, option 6 offers the highest benefits score and the lowest cost per benefits point, indicating that it is the strongest option. Option 6 is therefore the preferred option.

1.4 The Commercial Case

The Commercial Case has been developed significantly since IA. Key aspects contained within the commercial case are summarised below.

- The project is community focussed and more than £750k, therefore the Scottish Futures Trust hub initiative has been selected as the most appropriate route to deliver the project. The East Central hubCo have been appointed to deliver this public funded project under the design and build option.
- Currie & Brown have been appointed through the Frameworks Scotland Lead Advisor lot to support the Board with multiple services including Project Management, Cost Advisor, Technical Advisor and Clerk of Works.
- The design has been fully developed in conjunction with the Project Team and Stakeholders. With exception to the NHS NSS Design Quality Assurance and NDAP processes which are ongoing, the design has been well received through the HAI, AEDET and focussed design workshops.
- Discussions with Fife Council in respect to leasing the required land are advanced appropriately for the stage in the project. These will continue during the FBC stage with a view to concluding arrangements at the point of completing the FBC.
- The current key risks/issues facing the project are summarised in the table below:

Risk/issue	**Mitigation**
Brief inadequate/unreliable This issue relates to developments around the GMS contract and effect this has had on the area requirements for the building.	The required area increase from IA to OBC has been factored into the current design and corresponding cost plan.
Stop/start nature of the programme – keep people engaged through these periods.	Updates are being provided to community groups via newsletters and the public via press releases. NHS Fife's communication team are supporting this effort.
Project cost increases due to: ▪ Change in requirements ▪ Inflation / market conditions	This is a current issue where the cost increases have rose beyond the IA budget projection. Refer to Financial Case for further substantiation.
Programme delay The OBC programme has been affected because of COVID which has impacted resources, engagement activity and costs.	Potential to commence FBC activity in parallel with the OBC governance approval process. The project now has a full complement of resources to help drive the project forward.
Change of policy – NHS Assure Key Stage reviews	Key stage review process was implemented half-way through OBC and is required to achieve capital

Risk/issue	Mitigation
Programme delays / cost increases arising	funding. Risk had to be accepted, but impact can be mitigated through collaboration.
Change of policy – SHTN 02-01 Sustainable Design and Construction Guide (SDaC) Programme delays / cost increases arising	Informed by HFS at OBC NDAP review that new guidance must be followed at FBC. Guidance is untested to impact is difficult to quantify. As such this risk has not currently been factored into OBC cost estimates.

Table 4 - Key Risk Summary

1.5 Financial Case

1.5.1 Capital Costs

A capital cost summary is provided in the table below demonstrating the total OBC estimated cost for the project, together with the movement in cost since IA.

IA	OBC	Movement
£8,155,615	£13,031,178	£4,875,563

Table 5 - Capital Cost Summary

The key reasons for the movement in cost since IA, are set out below:

- Building area increase to take account of service and GMS contract evolving requirements – accounts for circa 41% of the construction cost increase
- Inflation and extraordinary market conditions considered to driven by the COVID-19 pandemic and the resulting global effect on supply chains – accounts for circa 20% of the construction cost increase
- Site and design abnormals: this relates to site conditions, more onerous energy requirements and creating a building that satisfies the conditions of the brief and design statement – accounts for circa 39% of the construction cost increase
- Associated percentage mark-ups based on an increased construction cost
- Some further adjustments to the IA budget allowances, notably equipment and internal direct labour costs

A number of value engineering / cost saving opportunities have been identified and these have already been accounted for in the presented OBC figures above.

Notwithstanding the cost increases noted, given the current project environment, the costs are considered to represent value for money in the current marketplace and this view has been endorsed by our consultant Cost Advisor.

1.5.2 Revenue Costs

A summary of the revenue costs is provided in the table below.

Description	Baseline	Preferred Option	Difference
Property pays (NHSF)	£24,467	£75,566	£51,099
Property non-pays (NHSF)	£61,920	£178,330	£116,409
Property non-pays – GP offset (NHSF)	-£37,718	-£83,165	-£45,448
Net Increase (NHSF)	**£48,670**	**£170,731**	**£122,061**
Service model (FHSCP)		£724,500	

Table 6 - Revenue Cost Summary

The increase in cost from an NHS Fife perspective is largely associated with the increase in building area.

The revenue costs relating to the service model continues to be developed in consultation with the Scottish Government around MOU1/2 for urgent care and what MDT means for Fife. The service model costs will have a nil impact on the revenue outturn position as funding sources have been identified.

1.6 Management Case

The Management Case identifies the actions that will be required to ensure the successful delivery of the scheme. The management case has been significantly updated for this the IA stage and demonstrates that the Board and Partnership are well prepared to deliver the project successfully during the construction phase and beyond. Key milestones for the project are identified in the table below:

Description / activity	Date
Full Business Case	
Commencement	February 2022
Completion	January 2022
Governance Approvals	April 2023
Construction & Handover	
Commencement	May 2023
Completion	June 2024
Operational	August 2024

Table 7 - Key Milestone Summary

2 Strategic Case

2.1 Introduction

The main purpose of the Strategic Case is to confirm the background and drivers for change for the proposition. It also sets out the key investment objectives and associated benefits.

2.2 Revisiting the Strategic Case

The Initial Agreement Document (IAD) was approved by Scottish Government in January 2020. The next phase involved undertaking a widespread engagement exercise with key stakeholders and the people of Lochgelly. This process was paused as a result of the global pandemic and was eventually reinstated in November to December 2020. The outcome of the engagement exercise can be reviewed within the Economic Case. The recovery plan in relation to the pandemic also caused delay to timescales for the Outline Business Case and design process. However, these have since resumed at pace. There are new sections added which were not previously in the IAD including

- The patient perspective and journey using personas in Section 2.4.1.2
- A summary of services (existing versus proposed) in Section 2.3.2
- A description of associated buildings and assets in Section 2.3.3

The critical success factors have been retained although are not reflected in the current Scottish Capital Investment Manual (SCIM) guidance. The residual balance of the Strategic Case has been retained and updated where necessary.

2.3 Current Arrangements

2.3.1 Service Arrangements

The holistic multi-disciplinary primary and community care services in Lochgelly are currently delivered from the existing Lochgelly Health Centre, a 1970's constructed facility, which has been considerably modified and extended throughout its lifetime. The building is owned by NHS Fife.

General Practitioner (GP) services in Lochgelly and the surrounding area are delivered by three Practices operating full time to meet their respective Practice population needs. The Practices are contracted to NHS Fife to provide General Medical Services:

- Lochgelly Meadows Practice (Primary care services) General Medical Services
- Lochgelly Medical Practice (Primary care services) General Medical Services
- Lochgelly (Dr Thomson) Medical Practice (Primary care services) General Medical Services

Aligned to the Practices there are a wide range of permanent and visiting community health services provided from the current facility. Fife Health & Social Care Partnership (FHSCP) and NHS Fife are responsible for the provision of Community Nursing, and managed services (treatment room support, Primary Care Nurse, Health Visiting, Clinical Psychology, Sexual Health, Pharmacy, Allied Health Professionals, Child Health, Stop Smoking, Community Midwifery, Mental Health & Addictions, Out-Patient Services and Facility Management).

A constrained range of Voluntary Sector activity is delivered from the Health Centre, including drug and alcohol support services (supporting clinic activity etc) and the Local Area Coordinator. The constraining factor is accommodation availability.

The local Community Council supported by Councillors and Members of the Scottish and UK Parliament have a local campaign group to support the realisation of a new health centre. The campaign notes the need for modern infrastructure to enable the local delivery of an integrated model to meet the significant health and wellbeing needs of the community.

The services provided from the existing three Practices are primarily provided in support of the population needs of the people of Lochgelly and surrounding areas, with 79% of the resident population registered with the Practices (see figure 2 - interzone map). In accordance with NHS Fife's statutory obligation to provide access to Primary Medical Services there is a formal requirement to continue provision of these services within this geographic area.

Map of Lochgelly East, Lochgelly West, Lumphinnans,
Ballingry, Lochore & Crosshill Interzones

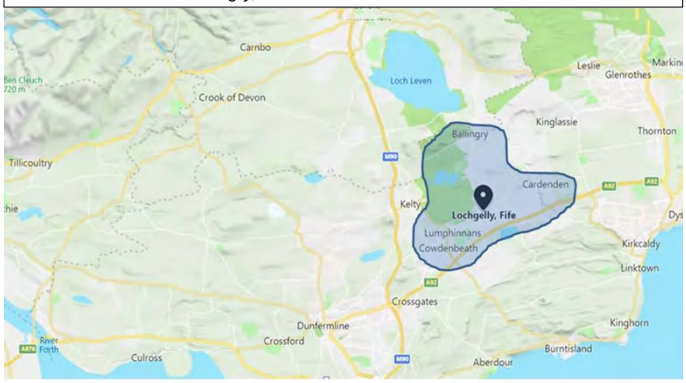


Figure 2 - Map of Lochgelly Interzone

The General Practitioners together with the multi-disciplinary team manage the widest range of health problems; providing both systematic and opportunistic health promotion, diagnoses and risk assessments; dealing with multi-morbidity; coordinating long-term care; and addressing the physical, social and psychological aspects of patients' wellbeing throughout their lives.

The General Practitioners and multidisciplinary team working in the hub model are integrally involved in deciding how health and social services should be organised to deliver safe, effective and accessible care to patients in their community. Practice based multi-disciplinary team working is identifying people who could benefit from a case management approach and supporting people to access the right support where there is:

- Complexity in their care and support arrangements through locality multi-disciplinary teams, or
- Clinical complexity providing rapid access to assessment through the locality community health and wellbeing hub teams

The combined Practice population of 10,728 (April 2019), has grown by 1.6% over the past 18 months. The current demographics of the population are[2]:

- 50.9% female: 49.1% male
- 18.0% are over the age of 65 and 18.2% are 0-15 years (slightly higher than the average for Fife)
- 45.4% of patients live in the most deprived quintile, with 0.9% living in the least deprived quintile
- 20.9% of the wider locality population are income deprived, compared to the Fife average of 12.4%, 24.3% of children (under 16) live in poverty compared to the Fife average of 17.9%
- 27.6% of the Practice's patients have one or more long term condition compared to Fife rate of 7.16%
- Fife has the highest rate of under 18 and under 20 pregnancy rates in Scotland. The Cowdenbeath locality has the second highest rate of teenage pregnancy under 18 (three year aggregates to 2017) within Fife

Since the QOF (Quality Outcome Framework) is no longer in use, up-to-date long-term condition data was sourced from the Practices and Public Health Scotland using the SPARRA[3] (Scottish Patients at Risk of Readmission and Admission) tool.

Local Profile & Practice Data - Lochgelly

Long Term Condition Rates	Lochgelly	Fife
Arterial Fibrillation	1.87%[1]	1.92%[1]
Asthma	6.22%[1]	4.61%[1]
Cancer	4.58%[1]	4.25%[1]
CHD	4.87[1]	3.97%[1]
Chronic Liver Disease	1.15%[1]	0.88%[1]
COPD	2.48%[1]	1.70%
Dementia	0.67%[1]	0.81%[1]
Depression	13.50%[2]	9.54%[2]
Diabetes	3.72%[1]	2.94%[1]
Hypertension	18.53%[2]	15.43%[1]
Mental Health	1.03%[2]	0.87%[1]
Psychiatric Admissions	29.7 per 1,000[2]	24.5 per 1,000[2]

Data sourced from:

1. Public Health Scotland (PHS), SPARRA at 1 December 2020 - the percentage of people with each Long Term Condition are calculated by dividing the number of people with each Long Term Condition by the number of people registered at the GP practices (i.e. the "Population Register") then multiplying by 100.
2. Initial Agreement Documents, approved by Scottish Government in January 2020 data via QOF calculator 1 April 2019.

Figure 3 - Local Profile and Practice Data - Lochgelly

Previous QOF data has been incorporated from the IAD in this section including to provide a fuller picture and a pre-pandemic comparison where possible. Table 8 below notes a range of health indicators for the Lochgelly practice population (where available, or the wider locality where not available) compared to seven localities in Fife. This demonstrates the relative poor health of the population. The health outcomes for the people supported by the

[2] Based on 2011 census, 2016 SIMD datazone data and ISD Practice data 2019
[3] https://www.isdscotland.org/Health-Topics/Health-and-Social-Community-Care/SPARRA/SPARRA-Model/

Lochgelly practices are consistently lower than the rates for Fife. In a number of instances of these are the highest rates / poorest outcomes in Fife.

The Lochgelly area populations experience higher rates of emergency hospital and multiple admissions. Along with higher rates of admission related to COPD, coronary heart disease and alcohol related hospital stays.

In Scottish Public Health Observatory (SCOTPHO) analysis of QOF data 2017/18 the Lochgelly area comes out in the top three in 12 of 17 measures when compared with the seven Fife localities.

Mental Health is the fourth highest of the health impacts on the population of Fife (after Cancer, Cardiovascular disease and Neurological conditions); those who are socially disadvantaged have an increased probability of experiencing mental ill health. For example, in 2010/2011, there were twice as many GP consultations for anxiety in areas of deprivation than in more affluent areas in Scotland (62 consultations vs. 28 per 1,000 patients). The impact of mental health difficulties in the Lochgelly community is evidenced in the data below and the current range of services seeking to access accommodation in the health centre (detailed in Table 10).

Mental health conditions including addictions have been exacerbated and impacted during the global pandemic. Therefore, the need for mental health and related services has significantly increased during this period.

Indicator	Lochgelly Area	Wider Locality	Fife	Comparative Notes
Premature mortality		337 per 100,000		(5th of 7)
Cancer related		180 per 100,000		(2nd of 7)
CHD related		70 per 100,000		(2nd of 7)
Patients (65+) with multiple emergency admissions		6,087 per 100,000		(1st of 7)
New and unplanned repeat A&E attends	297.4 per 1,000		264 per 1,000	
Potentially avoidable admissions		20.2 per 100,000		(2nd of 7)
Median 11/15-5/19 Falls		2.5 per 1,000	2.05 per 1,000	(1st of 7)

Indicator	Lochgelly Area	Wider Locality	Fife	Comparative Notes
related admissions (65+)				
Cancer rate (QOF)	3.06	2.85	2.85	(Lochgelly has the 3rd highest compared to the 7 localities)
CHD rate (QOF)	4.65	4.67	3.94	(Lochgelly has the 3rd highest compared to the 7 localities)
Hypertension rate (QOF)	18.45	17.54	15.36	(Lochgelly has the highest compared to the 7 localities)
Asthma Rate (QOF)	7.17	7.58 (2nd of 7)	6.94	(Lochgelly has the 3rd highest compared to the 7 localities)
COPD rate (QOF)	3.4	3.61 (2nd of 7)	2.58	(Lochgelly has the 3rd highest compared to the 7 localities)
COPD admissions (standardised rate)	Prac. 1 - 2.7			
Prac. 2 - 7.2				
Prac. 3 - 5.6				
	5.3	3.1	Two of the three practices are above Fife levels (Crude & standardised rates).	
Diabetes rate (QOF)	7.11	6.51 (2nd of 7)	5.56	(Lochgelly has the highest

Indicator	Lochgelly Area	Wider Locality	Fife	Comparative Notes
				compared to the 7 localities)
Alcohol related mortality		17.1 per 100,000		(3rd of 7)
Mental Health rate (QOF)	0.96	0.85	0.86	(Lochgelly has the highest compared to the 7 localities)
Mental Health Prevalence		5,132 per 100,000 (1st of 7)		
Psychiatric Admissions (episodes[4])	29.7 per 1,000 (2018)	25.7 per 1,000 (2018)	24.5 per 1,000 (2018)	Lochgelly levels are above all Fife localities for both patients and episodes
Depression rate (QOF)	12.47	11.57	8.93	(Lochgelly has the highest compared to the 7 localities)
Dementia rate (QOF)	1.00	1.09	0.81	(Lochgelly has the 2nd highest compared to the 7 localities)
Stroke and TIA rate (QOF)	2.81	2.7	2.46	(Lochgelly has the 2nd highest compared to the 7 localities)
Developmental disorders		856 per 100,000 (2nd of 7)		

Table 8 - Local Indicators

Projections for future demand for primary care and community services within Lochgelly are driven by the population increase, which see the older population growing by 45% by 2041 and by the known negative impact on health of the relative socio economic deprivation the

[4] Episode refers to inpatient, outpatient or Allied Heathcare Profession treatment as defined by https://www.ndc.scot.nhs.uk/Dictionary-A-Z/Definitions/index.asp?ID=241&Title=Episode%20of%20Care

community experiences. Housing developments are seeing the construction of circa 420 new homes by 2025 (potentially an additional 1,050 people). The local development plan includes potential for the development of a further 4070 homes within the catchment area of the Practices. The infrastructure is therefore required to enable services to develop the community health and wellbeing model, to support the anticipated increase in the needs detailed in table 8 rather than seeking to continue to do more of the same.

The current workforce delivering services, health, social and voluntary sector activity is outlined below at table 9 along with potential future workforce required to deliver integrated primary care and community services. Recent and continuing changes to the workforce are being phased in line with population growth and service model developments and are taking into account the requirements to implement the GMS (2018) contract[5] and enhance the primary healthcare team, community health and social care teams and health visitor pathway. The Meadows Practice provides training placements for medical students.

	Existing Provision (WTE)	**Recent Change (WTE)**	**Future provision * Incl. new roles**
General Practitioners (5)	4.5	-1	
Advanced Nurse Practitioner (2) + trainee	2	1	
Nurse Practitioner (1)	0.8	0.8	
Practice Nursing (3)	1.7	-1.05	
Primary Care Mental Health Nurse	1	1	
Practice Phlebotomist (1)	0.39		
Practice Manager (3)	2.9		
Admin staff (11)	9.6	-0.27	
Community Nursing Team (9 + 2 student/rotational intermediate care team colleague)	6.87 (+2)		Redesign of Community Nursing + caseload weighting necessitate change
Community Phlebotomist (2)	0.5	12 sessions per month	
Community Teams Admin Staff	0.2		
Primary Care Pharmacist	1		+4 requiring an office and access to

[5] https://www.gov.scot/publications/gms-contract-scotland/

			consultation accommodation
Visiting teams	**WTE**	**Sessions**	**Future provision * Incl. new roles**
Addiction Services	12		
Clinical Psychology	33		
Fife Intensive Rehabilitation and Substance Misuse Team	16		
Phlebotomy (Bloods)	16		
Respiratory Nurse Base + Clinic	1 WTE + 3 clinics		
Paediatric Clinic	6		
Asthma Clinic	4		
Fife Forum	8		
Continence Clinic	4		
ADAPT (Alcohol and drug triage service)	4		
Stop Smoking	4		
Psychiatry	8		
Health Visitors Baby Clinic	4		
Health Visitor Review Clinic	12 + Wellbeing meetings when required		13 staff and the full range of centre based Health Visiting activity: majority currently delivered from an adjacent smaller village
Immunisation Team	8		Potentially evening Flu clinics
Midwife Clinic	12		
Safe Space	4		
Dietician	2		

Orthoptic Clinic	4		
Podiatry	16		
Diabetic Foot Check (DAR's)	6		
Dermatology	4		
Minor Surgery Clinic	As required circa 2 per week		
Depot Clinic (QMH Nurses)	1 hr per week		
Treatment Room	20		
Fife Alcohol Advisory Service	4		
Social Workers / Social Care Workers			MDT time Child Protection meetings
Mental Health Nursing	8		
Contraception and Sexual Health	4		
Alcohol and Drug Drop in	4 (evenings)		
Wider voluntary sector			A wider range of voluntary sector services e.g. citizens advice supporting income maximisation
First Contact Physiotherapist			0.55 WTE

Table 9 - Lochgelly Staffing

2.3.2 Service Details

The accommodation in Lochgelly is provided over one level with a total floor area of 760m^2, supports:

- GP activity associated with the Lochgelly Meadows Practice (Circa. 19,000 appts PA and a Practice population of circa. 5,011)
- Nurse activity associated with the Lochgelly Meadows Practice (Circa. 4,000 appts PA)
- GP activity associated with the Lochgelly Medical Practice (Circa. 10,000 appts PA and a Practice population of circa. 3,511)
- Nurse activity associated with the Lochgelly Medical Practice (Circa. 7,000 appts PA)

- GP activity associated with the Lochgelly (Dr Thomson) Practice (Circa. 5,400 appts PA and a Practice population of circa. 2,206)
- Nurse activity associated with the Lochgelly (Dr Thomson) Practice (Circa. 900 appts PA)
- Community nursing “treatment room” activity (16 appts per day, 22 at busiest times, Circa. 4,100 appts PA), Phlebotomy provide 37 appts 4 days per week, Circa 6,500 PA) with the team visiting about 30 people at home per day
- Primary Care nursing activity (Average 30 appts per week - 1560 PA)
- Minor surgical procedures undertaken by a specialist GP (Circa. 100 episodes PA)
- Practice Phlebotomy services (Circa. 5,500 episodes PA)
- Midwifery ante-natal clinic activity (Circa. 750-800 appts PA)
- Psychology out-patient services (Circa. 1000 appts PA)
- Targeted sexual health services for younger people (Circa. 300 appts PA)
- Dietetic consultations (Circa. 204 episodes PA)
- Podiatry services (Circa. 1010 appts PA)
- Stop Smoking sessions (Circa. 470 appts PA)
- Paediatric consultation activity (Circa. 170 appts PA)
- Mental Health: Nursing Psychiatry and Psychology
    - West Fife Community Outreach Team (Circa. 200 appts PA)
    - Addictions – sessions outlined above
    - Psychiatry – sessions outlined above
- Voluntary Sector services – sessions outlined above

The Practices have access to a known number of consulting rooms/areas on a daily basis, with visiting services scheduled ahead as far as possible, based on room availability. Often, rooms are booked in advance for services. However, due to lack of attendance etc, they are then not utilised and the bookings are not cancelled so rooms are unoccupied.

Whilst the Practices and FHSCP are working collaboratively to modernise, integrate and expand services to improve outcomes and support the population growth, development is severely constrained by the existing premises. For example the respiratory nurse would be able to see circa three times more patients if clinic space was available, supporting more proactive case management with medical colleagues, and thereby reduce emergency admissions further.

In summary, baseline data indicates that services delivered from the existing Lochgelly Health Centre amount to a total of circa 70,000 attendances per annum; circa 270 attendances per day or around 15 patients / clinical room activity per day. Whilst this is considerably less than the theoretical capacity associated with these clinical spaces, this situation occurs as a result of an overall lack of administrative / support areas within the building and the resultant extensive use of consulting space for administrative and clinical support activities. For example GPs use their consulting rooms also as office space, meaning the rooms cannot be used by another clinician outwith their clinical sessions.

As the Health Centre runs at 100% capacity services often double book rooms in case cancellations arise – this includes clinical services, voluntary sector support groups, teams seeking to deliver mandatory staff training and centre based teams seeking to meet together. The AEDET review exercise confirmed that the layout and fabric of the building place considerable limitations on effective and safe service delivery (Section 2.3.3).

Where services are not / cannot be delivered locally in Lochgelly, patients are referred to different locations that include: Queen Margaret Hospital, Dunfermline; Victoria Hospital, Kirkcaldy; Rosewell Clinic, Lochore. For example the majority of Health Visiting activity including Wellbeing Meetings is delivered from Rosewell Clinic; impacting on access inequities.

Out of Hours Primary Care is delivered from four Urgent Care Centres in Fife. The Partnership does not have plans to extend the number of Urgent Care Centres. The Community Teams offer a small number of clinics / sessions into the evening. The restrictions of the building do not lend themselves to safe and simple access in the evening.

The model of care is developing in line with the new GP Contract, with the Primary Care Development implementation plan progressing along with the Business Planning process. Accommodation is not available to support the local delivery of physiotherapy, mental health nursing, primary care pharmacists, social prescribing, etc. For example the Local Area Co-ordinator (voluntary sector member of the team sign posting people to local community provision) is not able to work from Lochgelly as frequently as required. To meet the areas needs within the GMS (2018) there will be three levels of pharmacotherapy input, this will see the resource based in Lochgelly grow from 1 whole time equivalent to 5.

Nationally, a re-provisioning exercise is in process to replace existing GP IT systems, with suppliers having until February 2020 to complete development of their respective systems in line with NHS National Services Scotland requirements. After this, a transition exercise will commence across all boards, with Fife's transition scheduled to commence summer 2020. This will facilitate the Lochgelly practices to be paperlite.

The table below summarises the services using the current facility and also a list of services that could be provided from the new as a result of a lager functional facility.

No:	Name of Service	Currently in Health Centre	Will be based in (or using) the new CH&W Centre
1	Fife Young Carers		X
2	Community Nursing	X	X
3	The Well		X
4	Complex Care Team		X
5	Clinical Psychology		X
6	Speech & Language Therapy		X
7	Health Promotion		X
8	Children's Services		X
9	Community Nurse Respiratory Team		X
10	Nursing	X	X
11	Occupational Therapy		X
12	Pharmacy	X	X
13	ADAPT/FASS (Addictions Services)	X	X
14	NHS Addictions Service	X	X
15	Local Area Coordinators (Locality Planning)	X	X
16	Frailty & Older People's Service		X
17	Immunisations Service	X	X
18	Podiatry Service	X	X
19	Mental Health Services		X
20	MSK Physiotherapy	X	X
21	Nutrition & Dietetics		X
22	Obstetrics and Gynaecology		X
23	Fife Carers Centre		X
24	Mental Health Nursing	X	X
25	Dementia Friendly Fife		X
26	Diabetes MCN		X
27	Midwifery	X	X
28	Diabetic Retinopathy		X
29	Physiotherapy	X	X
30	Orthoptics	X	X
31	Fife Voluntary Action		X
32	Social Work		X
33	Multi-Disciplinary Team meetings		X

Table 10 - Lochgelly Services

Approximately 35+ services were engaged prior to lockdown in March 2020 and all re-engaged in September and again in November 2020, to develop a service schedule and see if anything had changed or additional requirements were needed due to Covid-19: requirement of space in the centres, days of use and frequency, any special requirements etc. An exact number has not been provided as there are numerous services which sit under single or multiple providers. This data has been collated into a spreadsheet that will inform the design and construction of the new building to ensure that all services can be

accommodated appropriately. NHS Facilities contacted all services again to reaffirm requirements and develop a Schedule of Accommodation – this information has since been extrapolated to develop the early building design.

2.3.3 Associated Buildings and Assets

The current facility is based centrally in the village of Lochgelly and was established in the 1970s. The property has been considerably modified and extended throughout its lifetime. The accommodation in Lochgelly is provided over one level with a total floor area of 760m^2. The building is owned by NHS Fife.

Figure 4 – Lochgelly Health Centre

The building block condition is category B and the risk adjusted back-log cost is £247,000.

Condition, space and functionality of the facility are best summarised within the AEDET benchmark assessment which is outlined below.

Category	Benchmark
Use	1.4
Access	1.1
Space	1.0
Performance	1.4
Engineering	1.3
Construction	0.0
Character & Innovation	1.0

Form & Materials	1.3
Staff & Patient Environment	1.1
Urban & Social Integration	1.3
1 = virtually no agreement / poor *6 = virtually total agreement / excellent*	

Table 11 - AEDET Benchmark Score – Lochgelly

2.4 Strategic Context

2.4.1 Drivers for Change

2.4.1.1 Local Context

NHS Fife Clinical Strategy[6] sets the strategic direction with Fife Health & Social Care Partnership (FHSCP) that is focused on local early, preventative care. In working with partners to improve the health of local people and the services they receive, while ensuring that national clinical and service standards are delivered across the NHS system we will strengthen primary care and community services.

Commented [BJ(F1]: Is this correct? Is it not the Partnership's strategy?

Commented [CK(F2R2]: Spoke to Garry this refs Workforce and Estate more than partnership document, so we think it is correct to lead with it and ref both in subsequent para:

Our vision requires a flexible and responsive model that works with people to define the outcomes they want to achieve, enabling people to maximise their health and wellbeing by utilising their own and community assets, adding and adapting services responsively to meet and sustain outcomes.

Our development of community health and wellbeing hubs is designed to flexibly and responsively layer services where required, adjusting support and care incrementally. In light of the changing demography this has focused on supporting people to minimise and modify the impact of frailty (including younger people frail because of long term conditions, addictions etc). Providing holistic assessment and care management, focused on individual outcomes, anticipatory planning and supporting a reduction in unscheduled care. Fife has a population of 371,910[7] (midyear estimate 2018), with slightly above the Scottish average for the over 65's age group described in Table 12.

	Total Population	65+	75+	85+
Fife	371,910	20%	9%	2%
Scotland	5,438,100	19%	8%	2%

Table 12 - Population Demographic Summary

Fife H&SCP has seven localities. Lochgelly is within the Cowdenbeath locality. The Cowdenbeath locality sits within the West Division of the H&SCP. The H&SCP is developing a locality clinical model with GPClusters focused on the needs of the locality population. Table 13 demonstrates the percentage of locality populations over 75.

	Population >75

[6] https://www.nhsfife.org/media/32112/c64_cs-finalforintranet.pdf

[7] Mid-Year Population Estimates Scotland, Mid-2018, National Records of Scotland. Publication (nrscotland.gov.uk)

City of Dunfermline	3928	7%
Cowdenbeath	3360	8%
Glenrothes	4109	8%
Kirkcaldy	5549	9%
Levenmouth	3560	10%
North East Fife	7192	10%
South West Fife	3845	8%

Table 13 - Locality Demographic Summary

Table 14 notes the anticipated change in the localities population over the next 25 years. The total population within Cowdenbeath Locality is projected to increase by 5% by just around 2,000 by the year 2041. Most of the areas' population growth is expected to take place in the older people age group, an increase of circa 45% which will place an increasing demand on health and social care.

Population Projections		
	2016	2041
Overall	41,228	43,300
0-15 years		(600) -8%
16-64 years		(1000) -4%
>65 years		(3,600) +45%

Table 14 - Population Projections

The local and national goal, supported by NHS Fife's Clinical Strategy (2016-21)[8], and the Fife Health and Social Care Partnership's Strategic Plan for Fife 2019-2022[9] is to provide safe, effective and sustainable care at home or as close to home whenever possible. The integrated model being implemented will support robust, holistic health (primary and community) and social care, with third sector services having a strong focus on early intervention, prevention, anticipatory care and supported self management.

The proposal for investment into fit for purpose health and social care facilities in Lochgelly will not only address the current restrictions upon local delivery of clinical, community and third sector services and deficiencies in facilities at the existing Lochgelly Health Centre, but also enable the delivery of the above integrated model within the Lochgelly area.

The well rehearsed pressures in General Practice in Scotland can be illustrated by the following indicators:

- 10% of the population consults with a GP Practice clinician every week
- 34% of all GPs are aged 50 and over in 2015, compared with 29% in 2005

[8] https://www.nhsfife.org/media/32112/c64_cs-finalforintranet.pdf
[9] https://www.fifehealthandsocialcare.org/__data/assets/pdf_file/0028/188263/HSCP_Strategic_Plan_2019-2022.pdf

- 37% increase in female General Practitioners and 15% decrease in male GPs over the ten-year period to 2015
- 2015 – 1 in 5 GP training posts unfilled

Fife's Primary Care Improvement Plan sets out the ambitions for reshaping primary care and General Practice in implementing the new GMS 2018 Contract. This is facilitating the development of General Practitioners as expert medical generalists within expanded Primary Health Care Teams, by implementing new roles and ways of working. This is underpinned by the guiding principles of:

- Contact: accessible care for individuals and communities
- Comprehensiveness: holistic care of people – physical and mental health
- Continuity: long term continuity of care enabling an effective therapeutic relationship
- Co-ordination: overseeing care from a range of service providers

Care pathways are patient (not disease) centred to meet the challenge of shifting the balance of care, realising Realistic Medicine and enabling people to remain at or near home wherever possible. Local accessibility and the need to provide a wider range of services to people in their local communities and to develop greater local integration is being hampered by the accommodation available within the Lochgelly area. The effect of which is evidenced in the continued reliance upon the traditional medical model of relatively high acute hospital attendance and admission rates. Section 2.4.1.2 below highlights the patient journey using personas.

Local accessibility and improved joint working with other health and social care partners as part of a wider whole system will facilitate integration of health and social care and enable more effective delivery of health and wellbeing outcomes. This will be underpinned by Practice multi-disciplinary team working, supported by responsive wider locality teams in reaching to deliver local care. This is further illustrated through the patient pathways in Section 2.4.1.3 below.

2.4.1.2 The Patient Perspective

It has been recognised for many years, service providers across Scotland and the UK have planned care separately in different parts of the system including primary, community, acute care and mental health. Services have often been planned around buildings, individual service providers or even clinicians.

What is now proposed is a shift toward an overarching whole systems model which focuses on the needs of people who use the different health and social care services within the Lochgelly Practice. This is described as a more holistic community health and wellbeing approach.

The central underlying principle of the development of the new centre is to focus on the patient outcomes, their journey and experience. This will help to identify where service improvements are necessary and involve a wide range of service users and providers in analysing and redesigning improved patient pathways to positively impact on outcomes. To support this work seven patient personas have been developed which serve to inform key

considerations when designing new pathways and the integration of services. Full details of this work is contained in the supplementary document, “The Patient perspective” (Appendix J).

2.4.1.3 Sustainable Workforce and Staff – Health & Wellbeing

Since the launch of Everyone Matters 2018-2020[10], key priorities and actions have been identified which are contributing greatly to achieving a healthy organisational culture. Everyone Matters Implementation Plan actions will be integrated into the new centre where appropriate – initial considerations include:

- Health & Wellbeing and Healthy Organisational Culture – take action to promote the health, wellbeing and resilience of the workforce. Create an environment which supports working across teams, open office space, bookable quiet space and hot-desks, collaborative spaces, wellbeing space, access to support services – these are considered vital to staff wellbeing and morale. Wellbeing Hubs have been established in various sites to support staff, particularly during the global pandemic. Bookable peaceful indoor and outdoor spaces could be established within the centre for both (practice-based and visiting) staff and community use. Providing opportunities for staff to take part in wellbeing-related sessions as appropriate including mindfulness, kindness, resilience and self-care related activities. Sessions are planned with the local Health Psychologist to provide some of these activities within GP clusters, Lunchtime Bytes, Community Health & Wellbeing Services (CHaWS) Subgroup and with practice staff. Other elements will include Staff Cycle to Work Scheme, bike racks, outdoor gym, community garden with covered area, showers and changing facilities etc.

- Sustainable workforce: over 35 clinical and non-clinical services engaged in relation to: requirement of space in the new centre, days of use, frequency, special requirements etc. A service schedule was developed from the feedback which formed the Schedules of Accommodation and this information was used to start the early design of the new building. This will ensure that local services can be planned, coordinated and delivered within the new centre as close to home for people as possible. The new centre will have the space to accommodate a wider range of services as per GMS (General Medical Services) contract and aforementioned drivers for change. There is ongoing engagement with the Lochgelly Practice and services throughout the process including via the CHaWS Subgroup, the Design Team meetings etc.

- Capable workforce:

    - NHS Fife and FHSCP offer a suite of development opportunities for their workforce. Educational support services include: Health Promotion, Organisational Development, Learning & Development and Practice & Professional Development (PPD). The PDD is embedded below and includes: managerial coaching, observational visits to support recruitment, clinical skills, leadership, dementia awareness, palliative and end of life care. PPD provision and training is offered to all staff including those working in residential, nursing

[10] Everyone matters: 2020 workforce vision implementation plan 2018-2020 - gov.scot (www.gov.scot)

and care homes in Fife. HR, Patient Relations, Infection Prevention & Control, Pastoral, Resuscitation and Manual Handling all offer training to NHS staff.

  - Work across organisational and professional boundaries (i.e. between primary and secondary care, across sectors etc) to share good practice in Learning & Development (L&D), evidence-informed practice and organisational development. Facility available regarding L&D space e.g. face to face training or a computer room where staff can participate in virtual training, update their core skills, LearnPro, Turas etc. Engaging with the staff regarding what they would like and to ensure they feel included as part of the process in relation to the new building.

- Workforce to deliver integrated services: Working with partners to develop workforce planning capacity and capability in the integrated setting including ways of working – exploring opportunities to work differently before the building completion e.g. using the Patient Personas & Pathways in order to establish a service coordination approach and tests of change.

- Change management – ensuring change is managed appropriately and providing opportunities to keep all key staff and stakeholders informed, involved and engaged in the process where possible. The Staffside representative also attends Project Team meetings and has had input into these sections of the OBC. This will be organised through a range of methods such as Subgroup meetings, staff updates, Blink, websites, newsletters and ongoing communications with key stakeholders etc. It is important to give staff ownership particularly if the new building is to be their main base. How and when to ask staff for views is important - all views need to have equal importance.

- Longer opening hours – these will be considered as part of the new building where designated areas could potentially be 'locked-down' for out-of-hour use as a community asset.

- Health & Social Care and Design & Construction Career Pathways – work with L&D to ensure links with local schools and education providers are established to showcase Health & Social Care and Design & Construction as career pathways including options for apprenticeships, internships, student placements and work experience etc.

2.4.1.4 National and Local Strategies

Key national and local documents have influenced the development of our health and care model and thereby this proposal, although this is not an exhaustive list. It should be noted that along with Caithness and Ayrshire Fife's Community Health and Wellbeing Hub programme has been selected as a national pathfinder site to support a Once for Scotland approach to delivering the shift in the balance of care from hospital to community.

National

- Commission on the Future Delivery of Public Services (The Christie Report) (June 2011)

- 2020 Vision for Health and Social Care (September 2011)

- Healthcare Quality Strategy (2012)
- A National Clinical Strategy for Scotland (February 2016)
- Health and Social Care Delivery Plan (December 2016)
- Property Asset Management Strategy (2017)
- NHS in Scotland 2016 – Audit Scotland Report (October 2016)
- Achieving Excellence in Pharmaceutical Care: A Strategy for Scotland (August 2017)
- General Medical Services Contract (2018)
- Health and Social Care Integration – Audit Scotland (November 2018)
- Nursing 2030 Vision: Promoting Confident, Competent and Collaborative Nursing for Scotland's Future (2017)

Local

- Health and Social Care Partnership Strategic Plan for Fife Plan (draft 2019-2022)
- NHS Fife Clinical Strategy (2016-21)
- NHS Fife Property and Asset Management Strategy (2022)
- NHS Fife Operational Delivery Plan (2018/19)
- Let's really raise the bar: Fife Mental Health Strategy (draft) (2019-2023)

This proposal interacts with these key local and national strategies in terms of:

Quality Strategy ambitions in relation to:

- Person centred care - through improving access to Primary Care and providing more care closer to home
- Safe – reducing risk of infection through provision of modern fit for purpose accommodation
- Effective – bringing together a wider range of health and care services to make more effective use of resources

2020 Vision aspirations are that everyone can live longer healthier lives at home, or in a homely setting with focus on improving quality of care, improving the health of the population and providing better value and sustainability.

Technology Enabled Care projects are being tested within the current service model to modernise primary care, support earlier identification and self management.

NHS Fife's Clinical Strategy and Operational Delivery Plan are focused on delivering person centred care, closer to home where possible. The proposed development will support the local provision of health and social care services within Lochgelly, facilitating person centred care and support.

The **2018 General Medical Services Contract** refocuses the role of General Practitioners as expert medical generalists and recognises that general Practice requires collaborative working, with enhanced multidisciplinary teams that are required to deliver effective care, joint working between GP Practices in clusters and as part of the wider integrated health and social care landscape. Better care for patients will be achieved through:

- Maintaining and improving access
- Introducing a wider range of health professionals to support the expert medical generalist
- Enabling more time with the GP for patients when it is really needed
- Providing more information and support to patients

The **Public Bodies (Joint Working) (Scotland**) Act 2014[11] aims to improve outcomes for people by creating services that allow people to stay safely at home for longer with a focus on prevention, anticipation and supported self-management, and provide opportunities to co-locate health and care services working together for the local population. Fife's local Health and Social Care Strategy describes how the nine National Outcomes for Integration can be met through prevention, local earlier integrated working focused on peoples own outcomes.

Promoting the wellbeing of children is central to the work of Health Visitors and this is supported by the new **Universal Health Visiting Pathway**[12] and the Named Person role conferred by the Children **and Young People (Scotland) Act** (2014)[13]. The Universal Health Visiting Pathway sets the standard for health visiting and the minimum core visits that families with children aged 0-5 years can expect from their Health Visitor, regardless of where they live. This will require an increase in the Health Visiting establishment and new ways of working for full implementation.

The Scottish Government's **Nursing 2030 Vision: Promoting Confident, Competent and Collaborative Nursing for Scotland's Future** (2017)[14] sets the direction for nursing in Scotland through to 2030 and focuses on personalising care, preparing nurses for future needs and roles, and supporting nurses. Within this framework redesign in community nursing is supporting the implementation of the Chief Nursing Officer Directorates paper on Practice and Community Nursing to integrate locally to support prevention and early intervention.

Fife Health and Social Care Partnership, established on 1 April 2016, is refreshing its strategic plan, this includes revised Vision, Mission and Values. The plan is focused on delivering proactive, integrated support and therefore will seek to secure an outcome focused model delivered locally aimed at securing improved outcomes through early identification and intervention:

[11] Public Bodies (Joint Working) (Scotland) Act 2014 (legislation.gov.uk)
[12] Universal Health Visiting Pathway in Scotland: pre-birth to pre-school - gov.scot (www.gov.scot)
[13] Children and Young People (Scotland) Act 2014: National Guidance on Part 12: Services in relation to Children at Risk of Becoming Looked After, etc - gov.scot (www.gov.scot)
[14] Nursing 2030 vision - gov.scot (www.gov.scot)

- ***The Vision is*** To enable the people of Fife to live independent and healthier lives.
- **The Mission is** "We will deliver this (vision) by working with individuals and communities, using our collective resources effectively. We will transform how we provide services to ensure these are safe, timely, effective and high quality and based on achieving personal outcomes."
- Our **Values** are: Person-focused - Integrity – Caring - Respectful - Inclusive - Empowering

2.4.2 Need for Change Summary

The following is a full list of the main drivers causing the need for change, the effect that these issues are having on the current service provision and an assessment of why it is believed action is required now.

Driver for change:	What effect is it having, or likely to have, on the organisation?	Why action now:
The clinical and social care model have developed and implementation is being circumscribed.	Primary, Community and Voluntary sector services cannot provide the integrated model of care they and the community recognise is required now and for the future. Existing facilities lack the number and range of support areas necessary to deliver safe and effective services, the physical capacity of the building is 100% utilised and oversubscribed.	The model of integrated care is being undermined now: preventing locally based, proactive care. Lack of essential support areas (e.g. clean and dirty utility areas) represents a real and unacceptable risk to the Board in key areas such as Healthcare Associated Infections and patient safety that can only be addressed through significant investment. Time from Initial Agreement to occupation of a new facility could take circa 4 years.
	Services cannot be delivered locally for local patient need; existing physical capacity is unable to deliver essential baseline change and re-design.	Local health inequality issues will continue to be difficult to support. NHS Fife/Fife H&SCP will fail to deliver the GMS (2018) and the community health and wellbeing hub model within Lochgelly unless this is planned for.
	Pressure on existing staff, accommodation and services will inevitably increase.	Sustainability of primary care is a key priority for the Partnership and NHS Fife.

Driver for change:	What effect is it having, or likely to have, on the organisation?	Why action now:
		There is a need to plan to provide a sustainable service for the future
Poor clinical and non-clinical functionality and space restrictions in existing accommodation (configuration)	Existing facilities fall far below the required standards in terms of how they are configured and laid out. The Equalities Act 2010 compliance within the building is poor.	Existing facility configuration and layout presents unacceptable risks, as well as poor local performance, functional in-efficiency and suboptimal patient experience. Wheelchairs, mobility scooters and double buggies cannot access parts of the building, including the waiting area. The waiting areas are too small.
	Premises are functionally inadequate and compromise pro-active, integrated care.	No scope exists to re-organise parts of the service to improve the experience.
	Some consulting rooms are very small and do not meet current standards. These are very restrictive / unsuitable for patients and staff.	Poor patient and staff experience. Does not meet current recommended standards.
Clinical and social care functionality (capacity) issues	Capacity is unable to cope with current, let alone future projections of need. Patients are required to make repeated appointment to meet with different members of their multi disciplinary team and to access healthcare out-with the local area.	Service sustainability and development is at risk and an increasing number of patients will travel to other venues for appointments.
	Facilities lack the number and range of support areas necessary to deliver modern, integrated, safe and effective services	There are no rooms available to deliver training, accommodate local multi disciplinary team meetings, etc. There is no accommodation to support local access to a wider range of visiting community services to support for example income maximisation.

Driver for change:	What effect is it having, or likely to have, on the organisation?	Why action now:
Building issues (Including statutory compliance and backlog maintenance)	Existing facilities fall far below the required standards in terms of how they are configured and laid out. Physical characteristics of the building prevent safe and effective patient care: small treatment rooms below minimum standards. Increased safety risk from outstanding maintenance and inefficient service performance.	Building configuration and layout present unacceptable risks as well as poor performance and functional inefficiency. Redesign of building will allow for improved care, staff experience and financial performance. Building condition, performance and associated risks will continue to deteriorate if action is not taken now.

Table 15 - Need for Change

2.4.3 Investment Objectives

This section identified the 'business need' in relation to the current arrangements described in Section 2.1. These were discussed at the Architecture & Design Scotland (A&DS) facilitated workshop to develop the project design statement. A wide range of stakeholders including clinical and managerial staff along with community representatives were involved in a workshop to describe the difference between 'where we are now' and 'where we want to be'.

Effect of the need for change on the organisation:	Investment Objectives
Existing service arrangements are affected by lack of clinical support service facilities.	Ensure equal access to a patient centred approach by enabling delivery of and access to local integrated anticipatory and preventative care for patients. Secure accommodation to deliver required group based activities.
Implementation of integrated models of care is undeliverable locally in the current environment	Ensure equal access to modern integrated care with provision driven by patient need rather than limitations in capacity.
Pressure on existing staff, accommodation and services will inevitably increase.	Ensure the right staff skill mix and service capacity are available to deliver and strengthen local capacity to manage people's health within the local community.
The facilities available, 100% occupancy, combined with significant population change, restrict the ability of	Enable earlier access to proactive and anticipatory care through local delivery via integrated seamless service across health

the parties to deliver the full range of integrated services locally.	and social care. This will reduce referrals to other services. Care will be driven by patient need rather than limitations on capacity.
Existing configuration, as a result of a circa 1970's building, which has been modified and extended with a 'best fit' approach means poor accommodation e.g. service users who rely on wheelchair access or have a mobility problem have extreme difficulty in both accessing and traversing the facility.	Delivery of safe and effective care with dignity by providing facilities which comply with all legal standards and regulatory requirements and gives equality of access for all. Improved staff wellbeing.
Increased safety risk from outstanding maintenance and inefficient service performance.	Improve safety and effectiveness of accommodation by improving the physical condition, quality and functional suitability of the healthcare estate.

Table 16 - Investment Objectives

2.4.4 Proposed Benefits

There is a clear emphasis on General Practice provision and the development of the community health and wellbeing hub model within the Partnership's Strategic Plan and NHS Fife Clinical Strategy. The proposed investment in infrastructure will enable the Lochgelly Medical Practices to fully participate in the required programmes of care, enable full access to the Primary Care Improvement Plan and thereby improve outcomes for individuals, experience for staff and the reputation of the organisation.

Benefits for each of the investment objectives described in Section 2.4.3 above are mapped to the expected benefits in the context of the Scottish Government's five Strategic Investment Priorities (Safe; Person-Centred; Effective Quality of Care; Health of Population; Efficient: Value and Sustainability).

To ensure that resources are effectively utilised and that any investment made provides agreed benefits a register has been developed. The benefits register (see Appendix E) identifies the expected benefits, indicates a baseline and target measurement and also gives a priority level to each benefit. The Benefits Realisation Plan demonstrating how the benefits can be secured is included at Appendix F.

Investment Objective	Benefit	Investment Priority
Ensure equal access to a patient centred approach by enabling delivery of and access to local integrated anticipatory and preventative care for patients. Secure accommodation to deliver required group based activities.	GP Practice Multi-Disciplinary Team, wider community hub team and voluntary sector have access to accommodation to meet population needs locally.	Person-Centred Health of Population Integrated Care

Investment Objective	Benefit	Investment Priority
Ensure equal access to modern integrated care with provision driven by patient need rather than limitations in capacity.	Services delivered locally based on need.	Person Centred Efficient Effective Integrated Care
Ensure the right staff skill mix and service capacity are available to deliver and strengthen local capacity to maximise and improve people's health and wellbeing within the local community.	Higher staff retention levels. Higher staff morale/lower absence rates. Increased flexibility of roles. Career progression. Improved workforce planning across the health and social care pathway. Supports training, education and development. Improved patient centred communication within the wider team.	Person Centred Efficient Effective Value and Sustainability Integrated Care
Enable earlier access to proactive and anticipatory care through local delivery via integrated, seamless services across health and social care. This will reduce referrals to other services. Care will be driven by patient need rather than limitations on capacity.	Access to wider staff skills, support and experience on one site. Reduces unnecessary hospital referrals and admissions. Reduces patient risk. Cost effectiveness of service provision – ensuring patients can access services as close to home as possible	Effective Quality of Care Person Centred Integrated Care
Delivery of safe and effective care with dignity – by providing facilities which comply with all legal standards and regulatory requirements and gives equality of access for all. This will improve the patient and staff experience.	Improves patient experience addressing privacy and dignity issues. Improves staff safety through provision of primary care and community services on one site allowing for available support for patients and staff.	Safe Person Centred Quality of Care Integrated Care

Investment Objective	Benefit	Investment Priority
	Ease of compliance with standards e.g. Equality Act (2010)[15], HAI Fit For Purpose, flexible accommodation meeting all guidelines e.g. room sizes.	
Improve safety and effectiveness of accommodation by improving the physical condition, quality and functional suitability of the healthcare estate.	Increased local provision and access to treatment making best use of available resources by having the infrastructure to deliver more proactive, prevention and early intervention focused support; maximising MDT working to facilitate access for people and thereby reducing the call upon unscheduled care.	Effective Quality of Care Efficient: Value and Sustainability

Table 17 - Benefits

2.4.5 Risks

Risk is now covered within the Commercial Case (Section 4) and Management Case (Section 6). The project's Risk Register can be found at Appendix G.

2.4.6 Constraints and Dependencies

2.4.6.1 Constraints

Constraints are limitations on the investment proposal. Key constraints relating to this particular investment proposal are noted below:

- Financial – given the current climate it is recognised that the project is likely to be constrained financially. Once the project budget it is set, the project will require to be delivered within this.
- Programme – given the needs for change relating to the current arrangements, there is a need to deliver the project as quickly as possible.
- Quality – the project will require to comply with all applicable healthcare guidance and achieve the AEDET pre-defined target criteria across all categories. The project will also be subject to NDAP and Design Assure key stage reviews.
- Sustainability – as the preferred option is a new-build there will be a requirement to achieve and agreed BREEAM rating.

[15] https://www.gov.uk/guidance/equality-act-2010-guidance

- Site – site constraints have been investigated during the OBC and factored into the OBC cost projections. Planning constraints will be investigated during the FBC stage.

2.4.6.2 Dependencies

Dependencies are where action from others is required to ensure success of the investment proposal. Key dependencies include:

- Acquisition of the site for development. Discussions with Fife Council are ongoing in this regard, although initial indications are that Fife Council are supportive of the proposals. Engagement will continue through the FBC stage with a view to concluding a long lease arrangement at the end of this stage.
- Service re-design to maximise the opportunities of bookable spaces, agile working and service integration.
- E-health initiatives as outlined at Section 4.4.14.

2.4.6.3 Critical Success Factors

In addition to the Investment Objectives set out in Section 2.4.3, the stakeholders have identified several factors which, while not direct objectives of the investment, will be critical for the success of the project.

Requirement	Description	Critical Success Factor

Strategic fit	Meets agreed clinical and investment objectives, related business needs and service requirements	• Promotes sustainability of Primary Care provision and delivery of 2018 GMS Contract
		• Consistent with NHS Board's Clinical Strategy
		• Supports delivery of NHS Scotland Quality Strategy
		• Facilitates integration of health and social care services, delivered locally
		• From Patient perspective:
		  • a facility that is easily accessible, bright, friendly and airy.
		  • designed so that patients can be treated with dignity particularly in terms of confidentiality.

Value for money	Maximise the return on the required investment and minimise risks	• Service model maintains or reduces revenue costs in the longer term through earlier intervention • Service model enables effective decision making in allocation of resources • Building design maximises efficiency and sustainability
Potential achievability	Is likely to be delivered in relation to the required level of change Matches the available skills required for successful delivery	• The skills and resources are available to implement new ways of working • The H&SCP and the Practice are able to embed new ways of working • NHS Fife are able to deliver the programme to agreed budget and timescales • Technology enablers are available and utilised
Supply side capacity and capability	Matches the ability of service providers to deliver required services	• Service providers are available with skills, materials and knowledge • The project is likely to attract market interest from credible developers
Potential affordability	Available capital and revenue resources are sufficient to support the successful delivery of the proposed facility and services	• Solution is affordable to all stakeholders

Table 18 - Critical Success Factors

3 Economic Case

3.1 Introduction

The purpose of the Economic Case is to undertake a detailed analysis of the costs and benefits of a short list of options, including a do nothing and/or do minimum option, for implementing the preferred strategic / service solution(s) identified within the IA.

The objective is to demonstrate the relative value for money of the chosen option in delivering the required outcomes and services.

3.2 Revisiting the Economic Case

Since the IA, the Economic Case has been updated to provide details of stakeholder engagement activity undertaken during the stage.

3.3 The Do Nothing/Do Minimum Option

It is not feasible to continue with the existing arrangements ('Do Nothing'), because the building is not fit for purpose. The backlog maintenance required while supporting minimum safety and the building to be water-tight will not make it fit for purpose. The do nothing option scored lowest throughout the option appraisal process. The building and footprint likewise mean that a do minimum option is not feasible.

Strategic Scope	Do Nothing / Do Minimum
Service Provision:	Primary Care services in Lochgelly are delivered from the existing Lochgelly Health Centre. The facility has previously been considerably modified and extended.
Service Arrangements:	Three separate Primary General Medical Services practices, Community Health and Voluntary Sector services
Service Provider and workforce arrangements (at the time of the Option Appraisal):	For the services detailed above at section 2 the workforce arrangements will continue with General Practitioner services Community Health and Social Care and Voluntary Sector services delivered in the building. The developing integrated multi disciplinary model will be circumscribed with inequity of access and travel implications for patients. Poor accommodation will continue to be managed as a risk in terms of staff health and safety.
Supporting assets:	The existing Lochgelly Health Centre has a baseline area of 760m^2 and features a mixture of traditional General Practitioner/consulting spaces that includes:4 x restricted separate reception and records areas at a total of 100m^2 (Associated with the 3 x separate Practices and NHS consulting elements) 2 x waiting areas (total 26 m^2) with inadequate space to meet even baseline needs and no age-specific provision 17 x (reasonably sized but poorly configured) consultant/treatment rooms located throughout the facility with little/no functional relationship to each other or the different patient groups they relate to 1 x interview room 1 x group room, although this is in effect a former waiting area with no windows that is far from fit for purpose and can consequently only be used for very short periods, therefore this has virtually no capacity for e.g. staff meetings, staff training and group work (e.g. breastfeeding support) 5 x small and disparate offices (total 74 m^2) 1 x staff room (23m m^2) servicing the whole facility and all staff groups

Strategic Scope	Do Nothing / Do Minimum
	Clinical Functionality Capacity issues have been identified as those problems associated with a lack of local space (area) that is essential to safe, effective and appropriately compliant service delivery. Areas originally designed to provide essential support functions have been lost in a drive to maximise clinical consultation space. Whilst the facility technically has sufficient space to support baseline clinical activity, in reality it is unable to do this as a consequence of a chronic lack of storage, waiting, quiet / interview, phlebotomy, administrative and office space. In addition, the existing facility lacks any form of clean utility room, dirty utility room, disposal hold, Domestic Services Room (DSR) or clinical storage facilities. There is no dedicated teaching, group space nor consulting rooms capable of supporting a GP training function. There are no administration areas capable of supporting wider staff teaching and learning or undertaking on-line training and assessment packages. The facility has nowhere that a patient can be managed should their visit become protracted; they become unwell; and / or they require acute management prior to transfer out to another facility by ambulance. This results in delays to clinical activity as it means consultations being delayed or suspended and is compounded due to the extremely poor access to all existing clinical areas. (None of these can be accessed by a trolley through the main entrance should this be required, with the only other entrance – at the rear – only being accessible by a number of steps. This impacts poorly on patient dignity and confidentiality). The building configuration is poor from access, service configuration, safety and security perspectives.
Public & service user expectations:	Delivery of effective General Practitioner and Primary Care, physical and mental health services in Lochgelly from one building in a good central location which is all on one level. Services delivered by a wide range of professionals. Strong desire to increase ‘targeted’ delivery to address inequalities. Single shared staff room Access to adjacent car parking spaces in a free Council car park.

Table 19 - Do Nothing Option Summary

3.4 Stakeholder Engagement

3.4.1 Initial Agreement

It was important to have the support of key stakeholders from health and social care staff and leaders from the local community to define the change required and create the vision for change.

Stakeholders supported this through their participation in the Option Appraisal Exercises and Design Statement workshops. This ensured that the vision was shared and communicated to all who will be impacted by the change. It also encouraged support from those who have an emotional commitment to the services provided in their community.

3.4.2 Outline Business Case

This section focuses on the outcome of the initial engagement exercise undertaken with the people of Lochgelly in November to December 2020. In light of the restrictions, all engagement activities were planned mostly online or with appropriate measures such as social distancing in place. Key stakeholders were involved in developing a Covid-19 safe engagement approach including the Lochgelly Practices, Fife Young Carers, Fife Voluntary Action (FVA), Equality & Diversity, Participation & Engagement Team and their related networks.

The communication and engagement framework was approved by the Fife Partnership and Engagement Network: Advisory Group in October 2020. This plan sought to maximise engagement with local stakeholders via a range of networks to gather the citizen voice to inform the development of the Outline Business Case (OBC). Online materials were hosted by the NHS Fife website.

3.4.2.1 Key Communication and Engagement Activities

The main communication and engagement methods included:

- websites and social media
- press releases and posters
- cascading via local health care providers, schools, services and politician colleagues
- Peoples Panel
- Public Directory
- patient texting service
- online discussion forums, online and paper surveys

Activities included:

- Press releases were issued to initiate the engagement process through local newspapers and then an update partway through the engagement process
- The Localities Newsletter (December 2020) was sent across the seven localities (800+ members), SW Fife and Cowdenbeath Localities (189 members)
- Cowdenbeath Area Cluster

- Peoples Panel (1700 members)
- Public Directory (62 members)
- FVA Health & Social Care e-bulletin was sent to 653 members
- All communications included a link to the online survey and paper versions were made available in local sites
- Additional to this, the survey link and information was also sent out numerous times over the engagement period via social media by the NHS Fife and FHSCP Communication Teams as well as via local groups and organisations including Twitter, Facebook etc
- The patient texting service was utilised by the practices on a number of occasions and this proved to be the most successful method

3.4.2.2 Stakeholder Engagement and Surveys

Approximately 70 local groups and organisations were successfully engaged. This included:

- 12 schools in Cowdenbeath and Lochgelly
- Public Directory
- Fife Young Carers
- FVA
- Lochgelly Community Council
- NHS Fife and Equality Groups
- Cowdenbeath Cluster
- Centre for Equalities
- Carers Link
- Fife Carers Centre
- Dementia Friendly Fife (STAND Fife)
- HIS Community Engagement
- Disabled Persons Housing Association
- Benarty Response Team
- Lochgelly Beat Corona
- Lochgelly Community Development Forum
- Lochgelly Lunches
- Benarty Group

- Saje Scotland
- Community Teams
- Community Learning & Development
- Scottish Stammering Network

3.4.2.3 Survey Design

The survey was developed to provide participants with ample opportunity to share their thoughts and views in relation to their new Community Health & Wellbeing Centres. The following question ranges were outlined in the survey:

- health and wellbeing related services people would like to see in their new centre
- changes introduced since the pandemic would people like to keep
- changes introduced since the pandemic would people not like to keep
- order of importance e.g. support services, wellbeing services, increased opening times, outdoor gym, community spaces etc
- environmental factors to consider e.g. recycling, solar panels, electric car-charging points
- anything additional requirements or information not previously mentioned
- biographical information

This survey has been fully analysed and the information received from the engagement exercise has helped to support the OBC process, inform the options appraisal and building design processes, as well as help shape future service delivery in the new Lochgelly Community Health and Wellbeing Centre. Full details of the approach taken to the survey and this analysis are detailed in the supporting document Lochgelly Community Health and Wellbeing Centre Engagement Feedback Summary Report (available upon request).

3.4.2.4 Quick Wins

Using the thoughts, comments and ideas shared in the engagement feedback above, considerable work has taken place with the Lochgelly practice and other service providers to identify potential changes or improvements that can be put in place with immediate effect. Other longer term or more complex changes will be considered as the programme progresses with the development of the new centre.

These changes or improvements include:

- Ensuring a wide range of health and wellbeing services – the Clinical Services Subgroup was expanded further to include non-clinical services and renamed as the Community Health & Wellbeing Services (CHaWS) Subgroup
- Coordination and collaborative approach – working with the CHaWS Subgroup to test a coordination approach to improve patient pathways by ensuring people are accessing the most appropriate services when they need them most

- Mental Health Services – the engagement exercise highlighted a real need for mental health services, particularly during the pandemic. People will be better supported and enabled to access their local mental health services e.g. counselling, befriending, The Well etc
- Access to Carers Support – raising awareness of the needs of Carers of all ages and the appropriate support to access key services such as Fife Young Carers or Fife Carers Centre e.g. including benefits, short breaks (respite)
- Use of technology:
    - Encouraging or enabling people to access clinical and/or non-clinical appointments using technology where appropriate e.g. video calls/Whatsapp
    - Development and better use of practice websites where this isn't already available
    - Development and better use of the patient texting service
- Volunteering opportunities - public participation groups have been established to provide community representation to help shape the new centre
- Improved repeat prescription process – working with patients, carers and families, local pharmacists, doctors and administration staff are committed to ensuring easier access to safe, high quality repeat prescription systems
- Improved appointment systems – all the practices are considering how to best provide appointments, improve access and reduce waiting times for patients and will be taking the engagement feedback into consideration

3.4.3 Ongoing Stakeholder Engagement

The Project Team worked closely with practices and local organisations to identify members of the community who were interested in being involved in the development of their new centre. Local participation groups are set up and members of these groups feed into project meetings to share a representative view and feedback to the main group. There are also engagement events and activities being planned. Other options to increase community involvement and ownership will include the community/sensory garden and art work for the new centre.

The Stakeholder Engagement and Communication Plan is located at Appendix H.

3.5 Service Change Proposals

The initial scope for the Lochgelly Health Centre project was to explore design and scope options to provide a suitable health and social care facility in Lochgelly which was of a suitable size and condition to meet with the growing needs of the existing Practices, community health and social care team and voluntary sector services.

3.5.1 Long List of Options

The theoretical long list of options was initially generated by the NHS and Local Authority teams with the support of hubCo and its advisers and was reviewed throughout the process. This long-list was based on the cross-referencing of strategic theoretical service options available with local site / facility considerations.

Strategic theoretical option themes included:

Strategic Scope	Summary
1 Service Provision	• Do nothing (The status quo) • Build entirely new, minimise any use of existing buildings (full build)
2 Service Arrangements	• Don't have any specific GP / health facilities locally
3 Service provider/ workforce	• Utilise only 'operational' solutions to address existing problems
4 Supporting Assets	• Build new but also make use of existing facilities to support the overall model (reduced build) • Combine a new build or refurbishment proposal with other new / existing developments across the public sector • Use and/or refurbish one or more existing local buildings/facilities
5 User Expectations	• The expectations of the public and service users

Table 20 – Strategic Theoretical Service Options

The following core long-list of options, in addition to Option 1 do nothing/minimum described above at Section 3.3, was agreed:

Option	Description	Commentary
2	Don't have any Health Centre building – use existing available public sector estate.	This option was not short-listed as it was completely incapable of delivering the preferred service model, would not deliver the health & social care hub required and result in an even more fragmented service than at present. It was also reliant upon making use of existing spaces that lack both the capacity and functionality to deliver any of the services being delivered now and in the future.
3a	An operational solution utilising only the existing Health Centre	Whilst a number of operational solutions are being considered by the Board to address acute short-term crises – and this option is not mutually exclusive – it is not capable of addressing anything other than capacity concerns in the very short-term and certainly not any of the

Option	Description	Commentary
		physical/facility issues identified. It was consequently not short-listed.
3a	An operational solution utilising only the existing Health Centre	Whilst a number of operational solutions are being considered by the Board to address acute short-term crises – and this option is not mutually exclusive – it is not capable of addressing anything other than capacity concerns in the very short-term and certainly not any of the physical/facility issues identified. It was consequently not short-listed.
3b	An operational solution utilising the existing Health Centre plus space in the adjacent Lochgelly Centre	This option was assessed as a variation on option 3a), with space in the Lochgelly Centre providing potential additional scope to improve capacity concerns in the short-term. It was not short-listed for the same reasons.
4a	Refurbish & extend the existing Health Centre facility	This option was originally agreed for short-listing and was subsequently developed into drawings. Unfortunately this work-up highlighted that there was insufficient space to support the required extension (which would have to be on a single level on the adjacent car park site). It was consequently proven unfeasible and not short-listed.
4b	Refurbish the existing Jenny Grey facility	In contrast to the previous option, refurbishment of the Jenny Grey facility was not initially thought feasible, however architect work up developed a scheme that appeared credible with good use of space and only minimal compromise. This option was consequently short-listed.
5a	Reduced new build on existing Health Centre site (plus use of space in the existing health centre facility)	This option involved building a reduced new facility on the existing site that retained the existing facility. It was a theoretical option only and clearly not feasible as the existing Health Centre occupies its entire curtilage. The option was consequently not short-listed.

Option	Description	Commentary
5b	Reduced new build on existing Health Centre site (plus use of space in Lochgelly Centre)	This option involved building a reduced new facility on the existing site that also made use of space in the adjacent Lochgelly Centre. The option was not short-listed as it offered no benefits over a reduced new build on the adjacent car park site but introduced significant cost, disruption and operational challenges associated with de-cant to support demolition and re-building. The option was consequently not short-listed.
5c	Reduced new build on adjacent (car park) site (plus use of space in Lochgelly Centre)	This option involved a reduced new build on the adjacent car park site that made use of space (primarily group rooms) in the adjacent Lochgelly Centre. It was deemed feasible and consequently short-listed.
5d	Reduced new build on Lochgelly North School site (plus use of space in shared new development)	This option involved a reduced new build on the existing (disused) Lochgelly North School site that would be aligned to potential (very early stage) local authority proposals relating to the construction of a pre-school nursery on the site. It was deemed feasible and consequently short-listed.
5e	Reduced new build on Jenny Grey site (plus use of space in other facilities TBC)	This option involved building a reduced new facility on the existing Jenny Grey site that also made use of space in appropriate existing local facilities. In the event, no such facilities could be found and consequently the option was not short-listed.
6a	Full new build on existing site	This option involved a full new build on the existing site that was entirely self-contained. It was not short-listed as it offered no benefits over a full new build on the adjacent car park site but introduced significant cost, disruption and operational challenges associated with de-cant to support demolition and re-building.

Option	Description	Commentary
6b	Full new build on adjacent car park site	This option involved a full (self-contained) new build on the adjacent car park site. It was deemed feasible and consequently short-listed.
6c	Full new build at Lochgelly North School site	This option involved a full (self-contained) new build on the Lochgelly North School site. It was deemed feasible and consequently short-listed.
6d	Full new build at Jenny Grey	This option involved a full (self-contained) new build on the existing Jenny Grey site. It was deemed feasible and consequently short-listed.
6e	Full new build at Francis Street	This option involved a full (self-contained) new build on the Francis Street site. It was deemed feasible and consequently short-listed.

Table 21 - Long-list of Options

The benefits criteria against which the long list were assessed were initially drafted by the wider planning team in light of the strictures placed upon the clinical model by the facility associated challenges identified. These were refined during the option appraisal events into an agreed list based on global stakeholder opinion.

Importantly, this list was also developed with the support of the stakeholder group reviewing options related to a similar business case being developed for Kincardine in order to ensure that both projects, which have similar objectives and timescales, were able to benefit from each other's work through the development of an agreed list of benefits criteria that were weighted independently.

In summary, the benefits criteria reflected the ability of each identified option to, noted in order of highest to lowest weighting:

- Deliver an optimal physical environment
- Be readily accessible
- Support flexibility and sustainability
- Support local and national service strategies
- Deliver wider community & public benefits

The Partnership is committed to delivering services that are integrated and maximise opportunities for local delivery. It has been formally confirmed that there is an on-going requirement to continue to deliver GP, primary care and local clinical services from Lochgelly.

Specific site/facility considerations included:

- The existing NHS owned Health Centre site in Lochgelly
- The adjacent Local Authority owned (car park) site in Lochgelly
- A site at the Local Authority owned Lochgelly North School
- The Jenny Grey site (A Local Authority care home recently reprovided)
- A Local Authority owned site at Francis Street

Whilst a number of other potential sites were raised and considered, they were all excluded at this stage as they were either demonstrably too small and / or not in public sector ownership. On this latter point it was noted that a site that was not currently in the ownership of the public sector would only be considered if none of the public sector sites was deemed appropriate based on the appraisal process.

3.5.2 Short List of Options

The short list initially included Options 1, 4b, 5c, 5d, 6b, 6c, 6d and 6e. 4. In reflection of the complexity of the process and relatively early stage in the development it was however agreed to combine a number of these options. Specifically:

- Option 6b was combined with option 5c for evaluation purposes, with the amended option 5c becoming new build on adjacent (car park) site plus/minus use of space in Lochgelly Centre. This combined option referenced the fact that the required land take for both options was the same, with only the volume of accommodation required on a second floor different, whilst acknowledging the significant additional work still required to understand the actual opportunities and threats associated with potentially accessing the Lochgelly Centre.
- Option 6c was combined with option 5d for evaluation purposes, with the amended option 5d becoming new build on the Lochgelly North Schools site that 'had the potential to make use of space in a shared new development' if this is taken forward by the Local Authority. This combined option referenced the fact that the area available was capable of delivering both options whilst acknowledging that the nursery proposal was still only embryonic.

The short list options finally agreed and short-listed for scoring (by location) were:

Option	Description
1	1 – Current: Do Nothing (The Status Quo)
2	5c – Site/Adjacent Car Park Area: Build a new Health Centre on the adjacent (car park) site (plus/minus make use of space in Lochgelly Centre)
3	4b – Jenny Grey Site: Create a new Health Centre by refurbishing the existing Jenny Grey facility *Option no longer available as demolished*

4	6d – Jenny Grey Site: Build a new Health Centre on the Jenny Grey site by demolishing the existing facility
5	5d – Lochgelly North School Site: Build a new Health Centre on the Lochgelly North School site (with potential to make use of space in a shared new nursery development)
6	6e – Francis Street Site: Build a new Health Centre on the Francis Street site

3.5.3 Indicative Costs

Indicative costs for each of the options on the Short List have been prepared as per guidance in the Scottish Capital Investment Manual by hubCo. The non-preferred options are based on BCIS Tender Price Indices – updated to 4th quarter 2020. The preferred option is based on elemental cost/m^2 from other recent health centre projects and the current Schedules of Accommodation (updated to 4th quarter 2020). Figures are calculated over a 60 year period.

Table 22 – Short-list of Options

	Description	Capital Costs (£) *	Whole Life Capital Costs (£)	Whole Life Operating Costs (£)	Est. NPV (£)	Est. EUV (£)
1	**Do Nothing/Base**	-	-	5,465,940	2,311,661	91,099
2	**(5c) Car park**	7,025,717	1,639,332	19,613,953	11,871,118	467,823
3	**(4b) Jenny Grey Refurb**	-	-	-	-	-
4	**(6d) Jenny Grey New Build**	6,959,207	1,623,802	19,526,538	11,799,393	464,996
5	**(5d) Lochgelly School New Build**	7,244,244	1,690,358	21,488,830	12,763,618	502,995
6	**(6e) Francis Street New Build**	6,835,692	1,594,962	19,364,198	11,666,192	459,747

Table 23 - Option Costs

3.5.4 Option Advantages and Disadvantages

The following table outlines how the advantages and disadvantages of the short list were assessed against the benefits criteria. This was undertaken through a process of discussion / debate within groups with the intention of seeking consensus agreement around the relative merits of each option and scores to be applied.

Option	Advantages: Strengths and Opportunities	Disadvantages: Weaknesses and Threats
1 Do Nothing/Base	Established location	Building and curtilage no longer fit for purpose Not suitable for further development
2 (5c) Car park	Central, established location Accessible site. Overlooked- supports security Visible site Community setting Improves town landscape Community setting	Two storey Further site investigations required due to mining Constrained town centre site Loss of car parking during construction Reduced car parking Access roads may be unsuitable for construction traffic Site ground conditions make development very expensive Infrastructure issues – sewers do not support new development /network issues
3 (4b) Jenny Grey Refurb	Relatively close to town centre Reuse of existing public sector estate Space for optimum parking / site servicing Good access Overlooked- supports security Potential capital savings Community setting Flexibility of expansion options on site Potential complimentary use of site	Decant costs Possibly too overlooked. Further site investigations required due to mining Access roads may be unsuitable for construction traffic Does not meet more detailed briefing requirements due to restrictions of existing structure

	Potential to have segregated staff access	
4 (6d) Jenny Grey New Build	Relatively close to town centre Large flat site, optimum parking/site servicing Good access. Overlooked- supports security Adjacent to open amenity site Community setting Flexibility of expansion options on site Potential complimentary use of site Potential to have segregated staff access	Overlooking could impact on patient privacy Further site investigations required due to mining Access roads may be unsuitable for construction traffic Perceived impact on local amenity space
5 (5d) Lochgelly School New Build	Relatively close to town centre Large flat site, optimum parking/site servicing Good access. Overlooked - supports security. Potential complimentary use of site Uses a site with established community function Uses infrastructure of potentially suitable capacity of site	Access roads may be unsuitable for construction traffic Site ground conditions make development very expensive Infrastructure issues – sewers do not support new development /network issues Hidden from primary routes Demolitions required on site Potential impact on programme/approvals from adjacent developments
6 (6e) Francis Street New Build	Central location Accessible, ample site Overlooked- supports security Visible site Community setting Increased flexibility	Possibly too overlooked Further site investigations required due to mining Access roads may be unsuitable for construction traffic Site ground conditions make development very expensive

	Enables segregated access	Infrastructure issues – sewers do not support new development /network issues

3.5.5 Does the Option meet the Investment Objectives?

The table below summarises the extent to which the shortlisted options meet the Investment Objectives.

Table 24 - Option Advantages and Disadvantages

Investment Objective	1 Do Nothing /Base	2 (5c) Car park	3 (4b) Jenny Grey Refurb	4 (6d) Jenny Grey New Build	5 (5d) Lochgelly School New Build	6 (6e) Francis Street New Build
Ensure equal access to modern integrated care with provision driven by patient need rather than limitations in capacity.	No	Yes	No	Yes	Yes	Yes
Ensure the right staff skill mix and service capacity are available to deliver and strengthen local capacity to maximise and improve people's health and wellbeing within the local community.	No	Yes	No	Yes	Yes	Yes
Enable earlier access to proactive and anticipatory care through local delivery via integrated, seamless services across health and social care. This will reduce referrals to other services. Care will be driven by patient need rather than limitations on capacity.	No	Yes	No	Yes	Yes	Yes
Delivery of safe and effective care with dignity – by providing facilities which comply	No	Yes	No	Yes	Yes	Yes

Investment Objective	1 Do Nothing /Base	2 (5c) Car park	3 (4b) Jenny Grey Refurb	4 (6d) Jenny Grey New Build	5 (5d) Lochgelly School New Build	6 (6e) Francis Street New Build
with all legal standards and regulatory requirements and gives equality of access for all. This will improve the patient and staff experience.						
Improve safety and effectiveness of accommodation by improving the physical condition, quality and functional suitability of the healthcare estate.	No	Yes	No	Yes	Yes	Yes
Ensure equal access to modern integrated care with provision driven by patient need rather than limitations in capacity.	No	Yes	No	Yes	Yes	Yes

Table 25 - Does the Option Meet the Investment Objectives?

3.5.6 Cost / Benefit

This section presents the case for the selection of the preferred option. In line with HM Treasury guidance, the NPC is divided by the WBP score to determine the cost per benefit point for each option. The lowest cost per benefit point is considered to be the most attractive option.

	1 Do Nothing/ Base	2 (5c) Car park	3 (4b) Jenny Grey Refurb	4 (6d) Jenny Grey New Build	5 (5d) Lochgelly School New Build	6 (6e) Francis Street New Build
Net present cost (NPC) - £m	2,311,661	11,871,118	-	11,799,393	12,763,618	11,666,192
Weighted benefit points (WBP)	256	431	435	632	431	879
BPC per WBP - £000	9,029	27,543	-	18,669	29,613	13,272

	1 Do Nothing/ Base	2 (5c) Car park	3 (4b) Jenny Grey Refurb	4 (6d) Jenny Grey New Build	5 (5d) Lochgelly School New Build	6 (6e) Francis Street New Build
	Reject	Possible	NA	Possible	Possible	Preferred

Table 26 - Option Benefit Scores

3.5.7 Preferred Option

From table 26 it can be seen that option 6 scores highest in respect to benefit points. Once the net present costs are factored in, option 1 is highlighted at the lowest cost per benefits point – this is purely because of low net present cost owing to the limited capital that could be invested in the existing facility. As option 1 does nothing to tackle the needs for change as demonstrated within the strategic case and benefits appraisal, it is not a legitimate option.

Given the balance of legitimate options, option 6 offers the highest benefits score and the lowest cost per benefits point, indicating that it is the strongest option. Option 6 is therefore the preferred option as favoured by all stakeholders (consensus).

The proposal has the support of representative service users, carers, staff, the GP Practice and all other key stakeholders.

4 Commercial Case

4.1 Introduction

This section outlines the commercial arrangements and implications for the Project. This is done by responding to the following points:

- The procurement strategy and appropriate procurement route for the Project
- The scope and content of the proposed commercial arrangement
- Risk allocation and apportionment between public and private sector
- The payment structure and how this will be made over the lifetime of the Project
- The contractual arrangements for the Project

4.2 Revisiting the Commercial Case

The commercial case has generally been updated and expanded since IA in accordance with SCIM OBC guidance. In particular, the design of the preferred option has been progressed allowing for a detailed overview on the status of the design to be provided.

4.3 Procurement Strategy

4.3.1 Procurement Route

NHS Fife will lead on the procurement whilst being supported by the Fife Health and Social Care Partnership.

The project is community focussed and more than £750k, therefore the Scottish Futures Trust hub initiative has been selected as the most appropriate route to deliver the project. The East Central hubCo have been appointed to deliver this public funded project under the design and build option.

The following further procurements have been undertaken to support the Board and these will be procured through Frameworks Scotland Lead Advisor lot.

Lead Advisor

- Project Manager services
- Cost Advisor services
- Technical Advisor services (M&E)
- Authority's Representative (for contract purposes)
- Clerk of Works

4.3.2 Procurement Rules and Regulations

As the proposed procurements have already been tendered they are in compliance with the procurement rules and regulations.

4.3.3 Procurement Plan

The summary table below provides an overview in respect to procurements to date:

Service	Appointment	Status
Contractor, Designers and Principal Designer	East Central hubCo	New Project Request (NPR) agreed. Stage 1 Approved.
Lead Advisor	Currie & Brown	Appointed

Table 27 - Procurements

4.4 Scope and Content of Proposed Commercial Arrangements

4.4.1 Overview

The project involves providing a new health and wellbeing centre within Lochgelly at the preferred Francis Street site. The new centre will replace the existing facility and will be developed further to accommodate future growth within the local area whilst taking cognisance of the Scottish General Medical Services (GMS) contract. The new facility will focus on providing core GP and other health services whilst offering broader flexibility for the promotion of interconnected health and wellbeing opportunities within the local community – this is in-keeping with NHS Fife's ambition to become an anchor institution within Fife.

4.4.2 Project Brief

The project brief is reflected within the following documents which can be provided upon request:

Document	Date	Revision
New Project request (including appendices)		4
Authority's Construction Requirements (ACR)	12.08.21	1

Table 28 - Project Brief

The brief for the design process is that the proposal must conform to all statutory requirements. In addition, the design proposals must meet all relevant Healthcare Guidance as published by HFS on their website.

The PSCP is required to schedule all relevant healthcare guidance and identify any associated derogations against that guidance. This process is ongoing in parallel with the development of the design and will be concluded and presented during the FBC stage of the project.

In respect to governance, the Project Team will be charged with reviewing and agreeing proposed derogations. Thereafter the Project Board have assumed responsibility for sanctioning any proposed derogations. This will be an iterative process culminating in formal acceptance of derogations in advance of contract execution. The Project Team will liaise with Health Facilities Scotland for support and guidance where necessary when contemplating derogations.

4.4.3 Current Design Status

The design has been completed to RIBA Stage 2 which aligns with OBC and NDAP requirements. The table referenced below provides an overview of how the project is performing against predefined OBC requirements.

OBC Design Requirements	Project Status
Concept Design incl. Arch, M&E, C&S, Fire, Landscape	Complete
Outline drawings (≥1:200, key ≥1: 50) & specifications	Complete
Outline sustainability strategy	BREEAM Pre-assessment completed
Outline construction strategy incl. HAI, CDM H&S Plan	Ongoing and will be continued into FBC
3D sketches of key Design Statement spaces	Complete
Completed Design Statement OBC self-assessment	Complete – assessed through AEDET workshop
Completed AEDET OBC self-assessment	Complete
Photographs of site showing broader context	Complete
Evidence of Local Authority Planning consultation and/or alignment with Local Development Plan.	Pre-planning engagement has been sought from Fife Council via a formal application and fee. Consultation and feedback will be received early within the FBC period.
Extract of draft OBC detailing benefits & risks analysis	Provided within this OBC.

OBC Design Requirements	Project Status
Evidence of HAI & CDM consultation	HAI SCRIBE Stage 1 has been completed
Evidence Sustainability commitments will be met. e.g. accurate & NCM models (DSM). BREEAM, .CAB files and BRUKL; show how design will be optimised	
Evidence Equality & access commitments will be met	Design development ongoing but briefing requirements set out in NPR and ACR
Evidence of VfM e.g. WLC on key design options	EQIA Stage 1 complete
Evidence Activity Data Base (ADB) use optimised	Ongoing process through design workshops
Evidence NHS guidance & technical standards will be met; list any derogations, with their technical reasons	Will be used at FBC. Standard HFS repeatable layouts will be utilised where appropriate
OBC design report evidencing all above & IA brief met ≥1:500, ≥1:200, key ≥1: 50; diagrams, sections plans, 3Ds, specs, comfort & energy DSMs, to RIBA Stage 2 Concept plus key elements developed to Stage 3	Ongoing – to be evidenced and concluded within the FBC stage

Table 29 - Design Status

4.4.4 Schedule of Accommodation (SoA) Development

A SoA was developed at the IA stage of the project. Whilst the schedule was tested with stakeholders at this stage to inform budgetary costings it was very much a working draft. The status of the SoA was offset by the optimism bias allocation factored into the Financial Case at IA.

The SoA was developed further at commencement of the OBC stage following a detailed review of health services to be accommodated within the building. When the IA was first developed, the GMS contract was in its infancy. Changes to the SoA largely relate to emerging requirements from the GMS contract.

The table below compares the IA SoA to the OBC “as drawn” outturn. As it can be seen there is an increase of 339m^2 overall.

IA SoA (m^2)	OBC "as drawn" (m^2)	FBC "as drawn" (m^2)	Difference (m^2)
1,478	1,817		339

Table 30 - Area (m^2) Summary

4.4.5 Flexible Space

Given the order of investment, it is important that use of the asset is maximised with rooms being utilised to their full potential. It is also important for the asset to be used successfully at the outset whilst being capable of withstanding future change with minimal disruption and cost. For these reasons the following themes and workstreams are being progressed.

- HFS standardised rooms are being incorporated wherever practicable
- The building configuration is being designed to withstand future changes in GP practice arrangements – i.e. consolidation of GP practices
- A bookable room system is being developed to support transient services
- The building layout and landscape is being designed to afford and promote "out of hours" use for health and wellbeing initiatives and community use
- An agile working policy is being developed to support agile workstations within open plan office areas
- The building design is being considerate to possible constraints caused by pandemics and how the building may cope with these temporary situations

4.4.6 Community Engagement

In December 2020 a community engagement exercise was undertaken to reach out to the local community to establish what was important for them within their new health and wellbeing centre over and beyond core requirements. Aspects relating to the physical building are listed below together with detail on how these themes will be taken forward and where applicable incorporated into the design. Feedback in respect to the community engagement exercise has been undertaken with the community separately.

Theme	Project Action
Flexible spaces to allow the provision of services and for community use out of hours	Carried forward into design proposals
Near-me booths to support accessibility and digital poverty	Being carried forward into design proposals
Community gym	No space allowance for an internal gym currently. External space is being incorporated for community use which could include provision for gym related equipment. Space allocation only at OBC.

Theme	Project Action
Needle exchange	Being considered within design proposals
Community garden	External space is being incorporated for community use which may include provision for a community garden. Space allocation only at OBC
Accessibility - space for external mobility scooter parking plus space for wheelchair and pram storage/parking internally	Being carried forward into design proposals
Covered external area	Being considered and where possible incorporated, but needs to be balanced with anti-social behaviour which covered areas can often attract
Community café	It is considered that the health centre is too small to benefit from a community café. This amenity is already provided locally
Community fridge	This amenity could/is be provided by the local community centre

Table 31 - Engagement Feedback

4.4.7 NHSScotland Design Assessment Process (NDAP)

The purpose of NDAP is to promote design quality and service. It does this by mapping design standards to the key investment deliverables, including Scottish Government objectives and expectations for public investment, then demonstrating their delivery via self, and independent assessments. NDAP is made up of personnel from Health Facilities Scotland (HFS) and Architecture Design Scotland (A&DS).

During the IA Stage, A&DS helped to facilitate a Design Statement workshop. This document forms part of the Project Brief, setting out design objectives for the Project Team. The project's design statement is located at Appendix B.

At commencement of OBC shortly after hubCo appointment, the Project Team met with HFS to discuss the project, principles and expectations. This helped to provide a framework for development of the design during the OBC Stage.

The OBC NDAP submission was issued on 23 December 2021. The review process is ongoing at the time of concluding this OBC for governance approvals, although it is anticipated that the NDAP report will be available in advance of the project being considered by the Scottish Capital Investment Group.

4.4.8 NHS Assure

NHS Assure is a technical key stage review process set up and administered by NHS NSS. Their remit is to provide knowledge and expertise through the lifecycle of projects to provide confidence within the public sector that projects are being procured, designed and delivered in a compliant manner ensuring operational safety for building users.

NHS Fife submitted their OBC key stage review pack to NHS Assure on 23 December 2021.The review process is ongoing at the time of concluding this OBC for governance approvals, although it is anticipated that the NDAP report will be available in advance of the project being considered by the Scottish Capital Investment Group.

4.4.9 Achieving Excellence Design Evaluation Toolkit (AEDET)

In accordance with SCIM guidance and the investment objectives, AEDET will be used throughout the development of the Project to help NHS Fife manage the design from initial proposals through to detailed design and will continue to do so through to Project Evaluation.

The AEDET toolkit has three key dimensions (functionality, build quality and impact) and outlines 10 assessment criteria. Each of the 10 areas is assessed using a series of questions which are scored on a scale of 1 - 6.

AEDET assessments are to be undertaken at predefined stages throughout the project's lifecycle. The stages are outlined in the table below together project progress against these to date.

Stage	Project Progress
Benchmark – assessment of current asset(s)	Completed at IA
Target – aspiration for project	Completed at IA
OBC – assessment of design proposals	Complete
FBC – assessment of design proposals	To be completed at FBC

Table 32 - AEDET Progress

On 8 December 2021, an AEDET workshop was held to review the OBC stage design against the agreed target scores. This workshop involved a wide range of participants including staff, service users and hubCo. The OBC AEDET scores are included in the table below together with the benchmark and target scores.

Category	Benchmark	Target	OBC	FBC
Use	1.4	4.5	3.8	
Access	1.1	4.4	3.1	
Space	1.0	4.2	3.1	
Performance	1.4	4.4	2.7	
Engineering	1.3	3.4	3.4	

Construction	0.0	4.0	0.0	
Character & Innovation	1.0	4.4	3.4	
Form & Materials	1.3	4.4	3.0	
Staff & Patient Environment	1.1	4.3	3.5	
Urban & Social Integration	1.3	4.5	3.4	

Table 33 - AEDET Scores

4.4.10 BREEAM

Projects requiring capital investment through the Scottish Government are required to demonstrate sustainable credentials to contribute towards the development of a sustainable NHS estate.

The project has been assessed using BREEAM UK New Construction 2018, sub-group healthcare. A target score of 45% was set at the briefing stage which equates to a BREEAM "good" rating. The project is currently targeting credits equating to 53.71% which is beyond the briefing target.

Note: the project commenced in advance of new sustainability guide being mandated / published so proceeded on the basis of mandated guidance at that point in time

4.4.11 Energy

Following a meeting with HFS, project specific energy targets were agreed. The energy targets took cognisance of project budgetary constraints set at IA (pre zero carbon policy) whilst still aiming to ensure that the facility will be very energy efficient. The following criteria was agreed:

- >59% emissions reduction against 2015 benchmarking to be sought
- Electricity target not more than 60 kWh/ m^2 pa; and max demand not to exceed 20 Watts/ m^2
- Thermal target not more than 120 kWh/ m^2 pa

The criteria will be achieved through the development of the design.

4.4.12 Healthcare Associated Infection System for Controlling Risk in the Built Environment (HAI SCRIBE)

HAI SCRIBE is a risk management process aiding the identification and mitigation of design and construction related infection risks within the built environment. There are four stages within the process – these are identified in the table below together with project progress against these stages to date.

Stage	Project Progress
Stage 1 – Site Selection	Complete

Stage	Project Progress
Stage 2 – Design	To be completed at FBC stage.
Stage 3 – Construction	To be completed at FBC stage.
Stage 4 – Occupation	To be completed post completion.

Table 34 - HAI SCRIBE Summary

4.4.13 Building Information Modelling (BIM)

BIM describes the process of designing and constructing a building collaboratively using one coherent system of digital models and linked non graphical data, as opposed to separate sets of drawings and documents. These models and data also incorporate information which will be carried over and used in the operational phase.

NHSScotland is supporting the adoption of Level 2 BIM maturity following the SG mandate in support of the recommendations of the "Review of Scottish Public Sector Procurement in Construction" which endorsed that "BIM will be introduced in central government with a view to encouraging adoption across the public sector. The objective states that, where appropriate, projects across the public sector adopt BIM level 2 by April 2017."

The NHSScotland BIM strategy is intended to ensure the creation of a digitised information management process which all Boards and teams working on NHSScotland programmes should follow to maintain consistency and facilitate collaborative working, which will in turn reduce waste and non-conformances.

The Project will use BIM as a key design tool during the design and construction phases of the project helping to facilitate coordination and mitigate risks. Another benefit of BIM is that NHS Fife will have true "as built" records along with the project specific asset tagging that will assist with the operation, maintenance and replacement of components.

An NHS Fife Employers Information Requirements (EIR) has been developed and offered hubCo as part of the Project Brief. The EIR in turn has helped to inform the BIM Execution Plan (BEP) which has been developed by the hubCo. These two documents control how BIM will be utilised on the project.

4.4.14 E-health

Consultation has been ongoing with eHealth during the OBC phase of the project. Initial efforts have focussed on ensuring the IT infrastructure meets e-health's standard requirements. E-health systems will be provided in line the department's wider strategy for GP premises. E-health suggestions flowing from the stakeholder consultation are as follows and these will be considered by the project team in further detail at the next stage of the process (**subject to separate funding and business cases where appropriate**).

- A patient appointment system
- A consultant room with near me facilities
- A GP text messaging system
- A self check-in facility

- Subject to security considerations, public access to IT equipment to combat digital poverty
- A room booking system

4.5 Risk Allocation

4.5.1 Key Principles

At conclusion of the FBC NHS Fife will enter a contract with hubCo to deliver the facility. The contract will be based on the Hub standard form Project Agreement (Design Build Direct Agreement) and will be subject to amendment through agreement between Legal Advisers.

Having worked through the pre-construction stage and mitigated the construction risks through surveys and investigations most of the residual construction risk is taken by hubCo.

The risk allocation table below is driven by the Design Build and Direct procurement methodology described above. Note: the percentage allocations are indicative of a project of this nature.

	Allocation of risk		
Risk Category	**Public**	**Private**	**Notes**
Title	100%	0%	
Design	0%	100%	
Development and Construction	5%	95%	√
Ground conditions below existing structures that could not be surveyed	100%	0%	There are no existing buildings on the proposed site.
Transition and implementation	100%	0%	Commissioning and migration Board responsibility
Operation of the facility	100%	0%	
Revenue	100%	0%	
Termination of Project	40%	60%	
Technology and obsolescence	100%	0%	√
Financing	100%	0%	Capital funding
Legislative	100%	0%	

Table 35 - Risk Allocation Summary

4.5.2 Key Risks

The key risks/issues currently encountered on the project are outlined in the table below. The risk register can be located at Appendix G.

Risk/issue	Mitigation
Brief inadequate/unreliable This issue relates to developments around the GMS contract and effect this has had on the area requirements for the building.	The required area increase from IA to OBC has been factored into the current design and corresponding cost plan.
Stop/start nature of the programme – keep people engaged through these periods.	Updates are being provided to community groups via newsletters and the public via press releases. NHS Fife's communication team are supporting this effort.
Project cost increases due to: ▪ Change in requirements ▪ Inflation / market conditions	This is a current issue where the cost increases have rose beyond the IA budget projection. Refer to Financial Case for further substantiation.
Programme delay The OBC programme has been affected because of COVID which has impacted resources, engagement activity and costs.	Potential to commence FBC activity in parallel with the OBC governance approval process. The project now has a full complement of resources to help drive the project forward.
Change of policy – NHS Assure Key Stage reviews Programme delays / cost increases arising	Key stage review process was implemented half-way through OBC and is required to achieve capital funding. Risk had to be accepted, but impact can be mitigated through collaboration.
Change of policy – SHTN 02-01 Sustainable Design and Construction Guide (SDaC) Programme delays / cost increases arising	Informed by HFS at OBC NDAP review that new guidance must be followed at FBC. Guidance is untested to impact is difficult to quantify. As such this risk has not currently been factored into OBC cost estimates.

Table 36 - Key Risk Summary

4.6 Payment Structure

During the pre-construction stage hubCo are paid on a monthly lump sum basis in line with an agreed drawdown schedule. At construction the Board will be obliged to pay hubCo a

lump sum one-off Development Fee for their services. Thereafter applications for payment will be processed and settled monthly in accordance with the form of contract.

Directly appointed consultants will be paid on a monthly basis in accordance with their agreed NEC4 Option A activity schedules.

4.6.1 Project Bank Account

The Project will operate a Project Bank Account (PBA), consistent with Scottish Government Guidance for public sector construction projects. A Project Bank Account is a ring-fenced bank account from which prompt payments are made directly and simultaneously to hubCo, the lead contractor and members of the supply chain. PBA's improve subcontractors' cashflow and ring-fence it from upstream insolvency.

The PBA will become operational during the construction stage of the project. The documentation and contractual arrangements associated with setting up the PBA will be developed during the FBC stage. Recent board experience in setting up a project bank account for a separate capital project will be beneficial for this project.

4.6.2 Risk Contingency Management

A project risk register was created at IA and this has since been developed further during OBC. It is used as an active management tool to identify and mitigate risks progressively as the design is developed. The risks have been fairly allocated to the party best able to manage them.

The risk register will continue to be used through FBC and the construction stage to enable risks to be identified and managed. From a commercial perspective hubCo risk is capped at 1% prior to entering the construction stage. Variations are managed in accordance with the terms of the contract. Although the opportunity for risk and variations is restricted during the construction stage, it is prudent for the NHS Fife to retain a reasonable contingency provision to cover this risk. The contingency provision will be developed and informed by the risk register during FBC but is likely to be in the order of 3-5%.

4.6.3 Contract Variations

Variations will be managed in accordance with the terms of the contract. The contract will be based on the standard SFT DBDA template with agreed amendments.

4.6.4 Disputed Payments

Disputed payments will be managed in accordance with the terms of the contract. The contract will be based on the standard SFT DBDA template with agreed amendments.

4.6.5 Inflation

Inflation will be taken account of when developing the price using the BCIS indices. HubCo and NHS Fife's Lead Advisor will ensure that the correct indices are utilised to identify the correct inflation to be applied to the project. Any deviation to the agreed inflation allowance rest with hubCo as an opportunity/risk.

4.6.6 Utilities and Service Connection Charges

Responsibility for utility and service connections charges will be identified and confirmed at Stage 2 (FBC).

4.6.7 Performance Incentives

No performance incentives will be utilised.

4.7 Contractual Arrangements

4.7.1 Type of Contract

The contract will be based on the standard SFT DBDA template with agreed amendments.

4.7.2 Key Contractual Issues

No key contractual issues have been identified at this stage, however should any arise through development and completion of the contract documentation, then these will be presented within the FBC.

4.7.3 Dispute Resolution and Termination

Procedures for contract administration, dispute resolution and termination are clearly set out within the proposed contract form.

4.7.4 Asset Ownership

In respect to asset ownership, the project is being procured using traditional capital funding. hubCo will be responsible for delivering the facilities. At Completion, NHS Fife will take possession of the building and will be responsible for the ongoing operation and maintenance of the facilities.

4.7.5 Land Ownership

The land is likely to be leased on a long-terms basis (100 years) from Fife Council. This is a similar arrangement to many of Fife's existing health centres and comparably demonstrates far greater value for money than purchasing the land outright. Initial discussions have already taken place with Fife Council and these will be advanced during the FBC stage of the project.

4.7.6 Personnel Implications

There are no employees who are wholly or substantially employed on services that will be transferred to the private sector under the proposals for this Project, and therefore the Transfer of Undertakings (Protection of Employment) Regulations 1981[16] (TUPE) will not apply.

[16] https://www.legislation.gov.uk/uksi/2006/246/contents/made

5 Financial Case

5.1 Introduction

The Financial Case considers the affordability of the scheme. This section sets out all associated capital and revenue costs, assesses the affordability of the preferred option and considers the impact on NHS Fife's and the FHSCP's finances. The affordability model assessment has been developed to cover all aspects of projected costs including estimates for:

- Capital costs for the option considered (including construction and equipment)
- Non-recurring revenue costs associated with the project
- Recurring revenue costs (pay and non-pay) for current model i.e. baseline
- Recurring revenue costs (pay and non-pay) for the preferred option

For clarity it should be noted that NHS Fife will take ownership and financial responsibility for all property related costs (capital and revenue). The FHSCP will be financial responsible for all service-related costs – i.e. costs to provide the required clinical services.

5.2 Revisiting the Financial Case

The IA was approved by Scottish Government Health and Social Care Department (SGHSCD) in November 2019 and no specific conditions were outlined in the approval letter in relation to the Financial Case.

NHS Fife have considered the affordability of this proposal by undertaking a review of the financial implications of investment, both capital and revenue.

5.3 Financial Model (costs and associated funding for the project)

5.3.1 Capital Costs

5.3.1.1 Capital Cost Summary

Capital costs have been produced by East Central hubCo and have been summarised in Table 37 below.

Description	IA Costs	OBC Costs	Difference
Design Fees	£285,522	£802,972	£517,450
Construction Price	£4,464,850	£7,496,286	£3,031,436
Surveys/Investigations	£20,000	£50,000	£30,000
Statutory Fees	£16,000	£75,000	£59,000
Contingency	£267,677	£363,124	£95,447
Inflation	£119,270	£209,907	£90,637
Optimism Bias	£1,241,597	£1,187,642	-£53,955
Client Consultants	£236,078	£139,788	-£96,290
Equipment	£144,037	£449,864	£305,827
Decant	£25,657	£25,657	£0
BIM Fees	£0	£0	£0
E-health	£15,004	£0	-£15,004
Direct Labour Costs	£0	£98,848	£98,848

Description	IA Costs	OBC Costs	Difference
Total ex. VAT	**£6,835,692**	**£10,899,088**	**£4,063,396**
VAT	**£1,319,923**	**£2,132,090**	**£812,168**
Total	**£8,155,615**	**£13,031,178**	**£4,875,563**

Table 37 - Capital Costs

The total updated cost of the preferred option, which is to develop Lochgelly Health Centre for NHS Fife is £13,031,178.

It is important to recognise that whilst the capital cost has increased since Initial Agreement, the other feasible options presented within the Economic Case would have increased in the same way given that the underlying factors driving cost would have been the same. This means that the preferred option, despite being subject to significant cost increase, remains the preferred option in respect to benefit realisation and cost.

5.3.1.2 Capital Cost Key Movements

Table 37 below provides a summary of key project cost adjustments. The adjustments are described further beneath the table from a budgetary perspective.

Description	IA Cost	OBC Cost	Difference	Notes
HubCo	£5,054,049	£8,787,381	£3,733,332	Area increase: 339m^2 Inflation: extraordinary conditions Site & design abnormals
Inflation	£119,270	£209,907	£90,637	Based on BCIS indices to construction
Optimism bias	£1,241,597	£1,187,642	-£53,955	Updated for OBC based on project maturity at this stage (13%)
Consultants	£236,078	£139,788	-£96,290	Contract now awarded – firm cost
Equipment	£144,037	£449,864	£305,827	Equipment allowance too low at IA – increased in consultation with HFS (5%)
Decant	£25,657	£25,657	£0	
E-health	£15,004	£0	-£15,004	Included in equipment line
Direct costs	£0	£98,848	£98,848	None allowed for at IA
Total ex. VAT	**£6,835,692**	**£10,899,088**	**£4,063,396**	
VAT	**£1,319,923**	**£2,132,090**	**£812,168**	
Total	**£8,155,615**	**£13,031,178**	**£4,875,563**	

Table 38 - Key Capital Cost Movements

In respect to the OBC cost plan, there is a difference amounting to £4,875,563 when compared to the agreed IA allocation (£8,155,615). This difference is primary attributed to the construction costs where increases have been realised through:

- Building area increase to take account of service and GMS contract evolving requirements – accounts for circa 41% of the construction cost increase
- Inflation and extraordinary market conditions considered to driven by the COVID-19 pandemic and the resulting global effect on supply chains – accounts for circa 20% of the construction cost increase
- Site and design abnormals: this relates to specific site conditions, more onerous energy requirements and creating a building that satisfies the conditions of the brief and design statement – accounts for circa 39% of the construction cost increase

It should be noted and acknowledged that the construction costs figures provided make allowance for realistic value engineering targets/savings within the FBC stage of the project – without this, the construction cost element and associated overall OBC budget cost estimate would have been higher.

Whilst our Lead Advisors have yet to formally report on hubCo's Stage 1 (OBC) report, they have been working hand in hand with hubCo and their Tier 1 contractor in recent weeks to agree the OBC costs. They concur with hubCo that given the current nature of the market and evolving more onerous briefing requirements the costs represent value for money.

The other costs movements are either percentage mark-ups based on the increased construction cost or adjusted/new provisions (equipment and direct costs) to take the opportunity to make the overall budget more deliverable and realistic.

In the OBC cost plan the inflation assumptions have been rebased to ensure they are as current as possible, and inflation relating to the period between IA and OBC is now historical, and therefore now included in the current construction costs. There is a forecast inflation allowance built in from the period January 2022 to construction. Inflationary forecasting is difficult during these current times so there is an inherent risk in respect to project inflation – that said, whilst inflation increases are still forecasts from 2022 to 2023, consultancy Cost Advisors generally believe that there should be some stabilisation given the significant movement in 2021.

5.3.1.3 Capital Clarification and Assumptions

The OBC capital cost estimate noted under Section 5.3.1.1 should be read with reference to the following assumptions.

Description	Note
Professional Fees	Professional services contract for Lead Advisor has been awarded
Equipment	Estimated 5% cost based on HFS advice. Transferable equipment will be moved to the new unit. Equipment budget only allows for items of equipment to be identified on the room layouts (conventional arrangement) and does not take account of any specialist equipment to be provided by the GP's or others

Contingency	Optimism bias at OBC stage has been calculated using a standard build template
Inflation	Based on Qtr 1 2022 Indices to construction
VAT	VAT has been applied where applicable. No VAT recovery estimates have been built into the cost plan for construction – this will to be confirmed with VAT Advisors and HMRC after contract is awarded
E-health	The project will cover the cost of e-health infrastructure within the building and key items of equipment as referenced on the room layouts. The budget does not allow for capital/revenue funded e-health projects.
Enhancements	Landscaping treatments around the health centre are currently quite standard. Any community garden, community gym or enhanced scheme is likely to require additional financial support.
Peppercorn Lease	The lease for the land is currently in discussion with Fife Council with the likely outcome that it will be considered a peppercorn rent. This will have an impact on leased depreciation figures under IFRS16 for right of use assets.

Table 39 - Capital Assumptions

5.3.2 Revenue Costs

5.3.2.1 Revenue Cost Summary

In order to confirm the revenue implications of the project the baseline costs (do nothing/minimum option) have been thoroughly reviewed and then compared to the projected costs of the preferred option to assess the financial implications. A summary of the revenue costs is provided in the table below.

Description	Baseline	Preferred Option	Difference
Property pays (NHSF)	£24,467	£75,566	£51,099
Property non-pays (NHSF)	£61,920	£178,330	£116,409
Property non-pays – GP offset (NHSF)	-£37,718	-£83,165	-£45,448
Net Increase (NHSF)	**£48,670**	**£170,731**	**£122,061**
Service model (FHSCP)		£724,500	-

Table 40 - Revenue Cost Summary

NHS Fife Revenue Costs

The OBC identifies overall net recurring revenue impact of £0.122m (excluding depreciation) for the preferred option against the baseline costs. Total revenue costs have been adjusted to reflect the GP rechargeable revenue costs associated with the health centre.

There are staff costs associated with this development - staffing, non-pay and consumable costs will continue to be reviewed as the FBC develops.

FHSCP Revenue Costs

The table below provides a breakdown of the FHSCP's anticipated revenue costs at OBC. The service model will evolve once decisions are received from Scottish Government on what the full implementation of MOU1/2 for urgent care and what MDT means for Fife.

All these costs will have a nil impact on the revenue outturn position as funding sources have been identified.

Staff group	WTE	Cost	Funding Source	Additional Information
Band 5	2.00	£86,000	This resource would be provided from the core vaccination workforce.	Rota across both Lochgelly and Kincardine HC
Band 3	4.00	£122,000	This resource would be provided from the core vaccination workforce.	Rota across both Lochgelly and Kincardine HC
Band 5 (Nurse)	3.00	£129,000	CTAC - funded through Primary Care Investment Fund	
Band 2 (phlebotomy)	1.70	£47,000	CTAC - funded through Primary Care Investment Fund	
Band 6 (Health Visitor)	1.00	£53,500	Funded through Primary Care Investment Fund	Per OBC
Band 7 (Primary Care Pharmacist	4.00	£252,000	Funded through Primary Care Investment Fund	Per OBC
Band 7 (First Contact Physiotherapist)	0.55	£35,000	Funded through Primary Care Investment Fund	Per OBC
Total	**16.25**	**£724,500**		

Table 41 - FHSCP Service Model Costs

5.3.2.2 Property non-pays breakdown

A breakdown of the property non-pays is provided in the table below for information.

Property Cost	Baseline	Preferred Option	Increase
Equipment	£309	£4,400	£4,091
Heating Fuel & Power	£18,019	£52,536	£34,517
Property Maintenance	£5,198	£27,562	£22,364
Property Rates	£27,278	£65,293	£38,015
Water Charges	£1,577	£6,209	£4,632
Bedding & Linen	£650	£1,516	£866
Cleaning	£57	£1,124	£1,067
General Services	£1,237	£2,125	£888
Surgical sundries	£504	£1,176	£672
GP Clinical Waste	£7,092	£16,389	£9,297
Net Cost Increase	**£61,920**	**£178,330**	**£116,409**

Table 42 - Property Non-pays Breakdown

5.3.2.3 Depreciation

An outline of the changes in both running costs and depreciation is summarised below:

Depreciation	Life	Value £000's	Proposed Dprchg £000's	Baseline Dprchg £000's	Net Increase Dprchg £000's
Buildings	60	£12,491,341	£208,189	£39,251	£168,938
Equipment	10	£539,837	£53,984	£0	£53,918
Total		**£13,031,178**	**£262,173**	**£39,251**	**£222,922**

Table 43 - Depreciation

The depreciation for the preferred option is £0.262m based on an asset building life of 60yrs and 10yrs for equipment on an overall capital cost of £13.031m. The overall increase in depreciation is £0.223m based on 21/22 full depreciation charges - which will be met from the current ring-fenced NHS Fife non-core depreciation budget. The buildings depreciation charge is pre any Valuation Office valuation being done after completion – there is an expectation that any non-value works will reduce the value held in the balance sheet once the valuation is carried out and therefore reduce the depreciation charge going forward.

5.3.2.4 Revenue Clarification and Assumptions

A number of assumptions have been made at the OBC stage which will be further evaluated and revised throughout the development of the FBC. These assumptions are as detailed in the table below.

Description	Note
Costs	Costs are calculated using 2020/21 prices and using 2020/21 budgetary information.
Pays (NHSF)	The support costs for the existing Kincardine Health Centre have been calculated as the baseline and then used as a benchmark against which any changes are considered. Estimated costs for the preferred option reflect forecast demand from 2024/25. Calculations include allowances for on-costs, enhancements, sick leave, public holidays and annual leave. Workforce increases are based on increased health centre sqm increase.
Non-Pay (NHSF)	Non-pay costs assumed to increase in line with increased health centre sqm.
Depreciation	Building – 60 years and equipment 10yrs.

Table 44 - Revenue Assumptions

5.4 Accounting Treatment

The traditional funding route for the project will impact on NHS Fife's Balance Sheet - both the capital cost of the development and the associated capital equipment will be added as non-current assets to the balance sheet and depreciated over the life of the assets in line with accounting policies.

5.5 Financial Situation and Statement of Affordability

NHS Fife confirm that this project remains affordable in both revenue and capital terms. The capital costs of the investment will be met through a capital contribution from the Scottish Government Health and Social Care Division capital budget.

Additional recurring revenue costs for Kincardine Health Centre will be incorporated into NHS Fife's Annual Operational Plan for future years.

FHSCP funding in respect to their service model is ongoing and will be articulated within the FBC stage.

5.6 Stakeholder Support

As the project will be delivered by NHS Fife for Fife, written agreement of Stakeholder support from other NHS Scotland / public sector organisations is not required in this instance.

5.7 Resources

The project is fully resourced from both NHS Fife and the FHSCP's perspective. Any associated costs have been built into the updated OBC budget. Further clarity on resourcing and project structure can be found at Section 6.3.

5.8 Capital and Revenue Constraints

NHS Fife's capital funding commitments mean that the project cannot exceed the available budget. Any additional revenue costs will be met within NHS Fife's overall revenue resource envelope.

FHSCP?

5.9 Financial Contributions

Other than capital funding from the Scottish Government, there will be no financial contributions from external partners in respect to this project.

6 Management Case

6.1 Introduction

The main purpose of the Management Case is to demonstrate that NHS Fife is ready and capable of delivering the project successfully.

6.2 Revisiting the Management Case

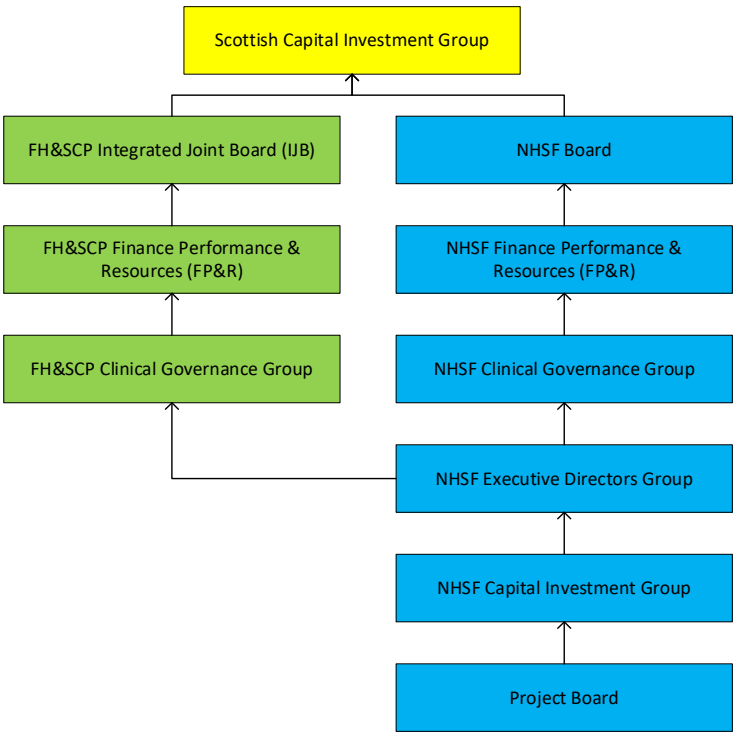
The management case has generally been updated and expanded since OBC in accordance with SCIM FBC guidance. The main sections remain the same and text has been updated where appropriate to reflect the current status of the project.

6.3 Reporting Structure and Governance Arrangements

To deliver the project successfully, good governance is required to monitor and direct it. An understanding of the structure and mechanisms for escalation and reporting is set out on the organograms below.

6.3.1 Governance

The strategic and business case governance controlling the project is set out below.



6.3.2 Project Structure

The project structure taking account of the Project Board, FHSCP and Capital Planning functions is set out below. NHS Fife are responsible to delivering the facilities whilst FHSCP are responsible for delivery of the services from the facilities.

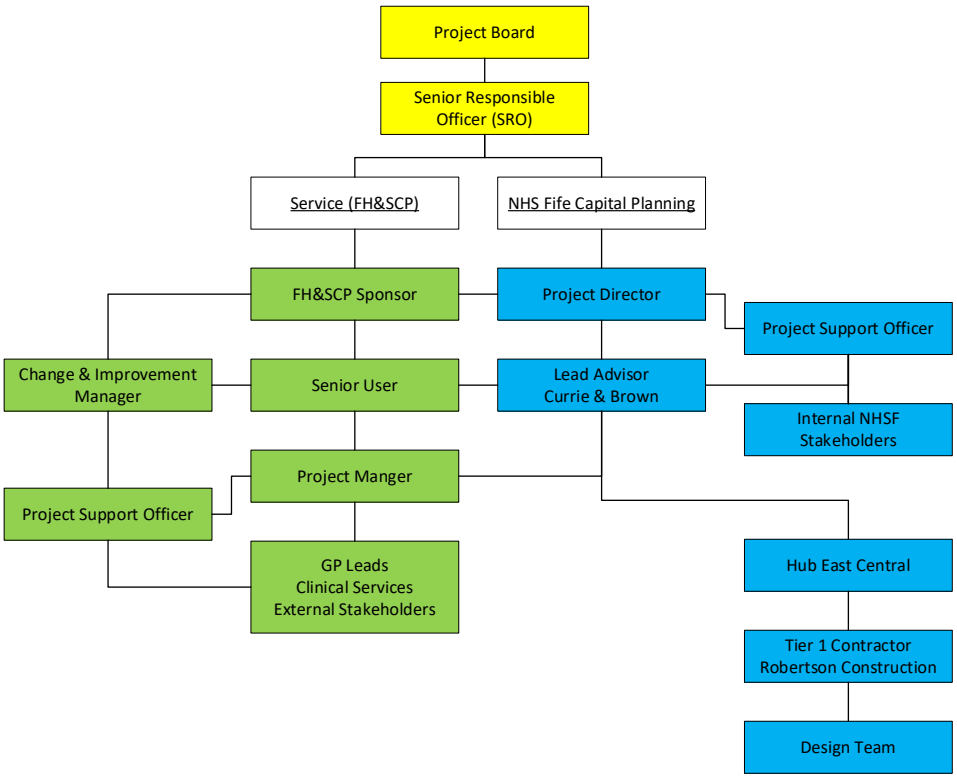


Figure 5 - Project Organisation

6.4 Project Board

A Project Board has been established to oversee the project. The Project Board was set up at commencement of the OBC and Terms of Reference have been agreed. The Project Board meets monthly where they receive a regular project update report from the FHSCP Sponsor and the Capital Planning Project Director. Necessary matters are escalated as required whilst the Project Board offers direction to the Project Team.

Project Board membership and experience is outlined in the table below:

Name/Role	Experience
Joy Tomlinson Director of Public Health Project role: Senior Responsible Officer (SRO) with overall responsibility and accountability for the project	Joy joined NHS Fife in May 2021, having worked within the NHS for 27 years. She has a clinical background, having trained in General Practice prior to working in Public Health. Prior to joining NHS Fife, she was joint Interim Director of Public Health in Ayrshire & Arran and has experience of departmental budgetary management with the additional complexities of rapid workforce and service development during the pandemic. She chairs the national 'place and wellbeing collaborative' which has

Name/Role	Experience
	developed Place & Wellbeing principles to support the refreshed National Planning Framework (NPF4).
Neil McCormick Director of Property and Asset Management Project role: responsible for contributing towards general governance.	Neil joins NHS Fife with over 30 years' experience of working at a senior level across the public and private sector. Neil's previous role was with Robertson Capital Projects, where he was Managing Director with specific responsibility for delivering infrastructure projects and joint ventures with the public sector including NHS Frameworks. Prior to this, Neil was Director of Strategic Projects & Property at NHS Forth Valley and Project Director for the £300m Forth Valley Royal Hospital.
Margo McGurk Director of Finance Project role: responsible for contributing towards general governance.	Margo joined NHS Fife as Director of Finance in February 2020. She is a CCAB qualified accountant, with a broad range of experience across the public sector but particularly within the NHS in Scotland. She has significant experience of decision-making at strategic and operational levels and has a strong personal focus on developing strategy, supporting culture, delivering sound financial control and best value from the allocation of resources. Very experienced in delivering professional leadership to the finance function, she has held a number of senior roles across a number of NHS Boards. She is particularly interested in working in partnership across organisations and leading on the development and delivery of financial strategies to support delivery against agreed priorities.
Nicky Conner Director of Health and Social Care Project role: responsible for contributing towards general governance.	Nicky has been Chief Officer and Director of Health and Social Care since 2019. Nicky offers 25 years' experience covering a diversity of public service roles including nursing, acute, specialist and community roles along with professional and clinical leadership to services within Fife's communities and leading on regional and national work. In her current role Nicky leads Health and Social Care Services for all of Fife including Community Care, Complex and Critical Care and Primary and Preventative Care. Nicky champions Integration, Partnership Working to deliver high quality services for the people of Fife.
Simon Fevre Staff Side Representation	Simon is the NHS Trade Union Co-Chair of the HSCP Local Partnership Forum. Simon was NHS Fife's Employee Director for 7 years and has worked on the

Name/Role	Experience
Project role: responsible for contributing towards general governance.	Board's Staff Governance agenda for 20 years. He was a clinician working in the Nutrition and Dietetic Department as Clinical lead for Older Peoples Services.
Ben Johnston Head of Capital Planning Project role: Capital Planning Project Director	Ben joined NHS Fife in January 2021 with over 15 years construction consultancy experience having worked in a diverse range of sectors. Working predominantly as a Project Manager, Ben has been responsible for delivering multiple projects diligently from inception to completion. Over recent years, Ben has spent most of time operating specifically within the healthcare sector, helping to positively contribute towards creating a sustainable healthcare estate for current and future generations. Ben has helped to deliver several projects for NHS Fife including Muirview and Hollyview at Stratheden Hospital and is currently helping to deliver the Fife Elective Orthopaedic Centre Project at Victoria Hospital.
Bryan Davies Head of Primary and Preventative Care Services Project role: FHSCP Project Sponsor	Bryan has worked within health and social care for over 25 years with experience in local area co-ordination, planning, performance, change management, commissioning, mental health, addictions, learning disability and advocacy. Bryan feels very passionate about health and social care integration and is excited to be working with colleagues and stakeholders to make a positive difference for individuals, families and communities in what are currently very challenging times.
Audrey Valente FHSCP Chief Financial Officer Project role: responsible for contributing towards general governance	Audrey has more than 30 years' experience working in local government holding senior finance positions. As a local lass, raised in Kirkcaldy, she went on to study accountancy at Napier University following her high school years at Kirkcaldy High. Audrey's experiences have combined strategic and operational financial management along with significant change management.
Helen Hellewell Associate Medical Director Project role: responsible for contributing towards general governance	Helen originated from Motherwell and moved to Fife after marrying. She finished her medical training at the Victoria in Kirkcaldy and took up a GP position in a local practice in Kirkcaldy. She then joined the Markinch medical practice, and currently still works one and half days per week there. Helen has been involved with the Partnership for a number of years

Name/Role	Experience
	having been the cluster lead for Glenrothes, working on a number of initiatives including quality improvement and integrated working and was the clinical lead on a leadership programme for integration with GP Scotland.
Benjamin Hannan Deputy Director of Pharmacy & Medicines Project role: represents the Area Clinical Forum as well as contributing to towards general governance.	Benjamin is an experienced pharmacy leader, with broad professional, managerial and leadership experience. Benjamin is a Fellow of the Institute of Leadership and Management and is currently Vice-Chair of Fife's Area Clinical Forum and represents this forum on the Project Board. The Area Clinical Forum allows NHS Fife to draw on the full range of professional skills and expertise that exists in all parts of the NHS system for advice on clinical and other professional matters. Benjamin's current role of Deputy Director of Pharmacy & Medicines is integrated across Health and Social Care, and all sectors and settings of care delivery. Prior to his current role, Benjamin was a GP Federation Director, responsible for 31 GP practices in the North East of England. This broad experience of primary care and community working will enable Benjamin to provide valuable insight to this project.
Tracy Gardiner Capital Accountant Project role: Capital Planning Accountant	Tracy has worked within NHS Fife for 26 years within the capital branch of the finance department. Tracy has a wide range of knowledge and experience in the delivery of capital projects within NHS Fife.
Ruth Lonie Communications Manager Project role: responsible for project communications	Ruth joined NHS Fife as Communications Manager in 2009. She has been involved in the communications aspects of a number of similar projects within NHS Fife.
Eugene Clark Non-executive Member *Dec. 20 – Jul. 21* Project role: responsible for contributing towards general governance	Eugene has spent the last 14 years working as a self-employed consultant helping businesses and public sector organisations in the fields of internal communication and employee engagement. Eugene's community interests have included being a former member of Largo Community Council and being involved in several action groups relating to sports in the Levenmouth area, most recently having helped establish the Fifers for the Community charity. Eugene is an active member of the Fife Children's Panel. He is also currently the Chair of the Levenmouth Rail Campaign, which seeks to

Name/Role	Experience
	regenerate the local community through the restoration of the direct rail link to Edinburgh.
Alistair Grant Non-executive Member *From Jan. 22* Project role: responsible for contributing towards general governance	Alastair Grant is a qualified accountant with more than 30 years' experience working both in Scotland and the Middle East. Most recently Alastair worked for Sodexo Justice Services, until his recent retirement. Alastair brings to the Board proven commercial acumen, combined with good people management, team building, development, and mentoring skills.

Table 45 - Project Board Experience

6.5 Project Team

The project team sits below the Project Board and are responsible for delivering the project on a day-to-day basis. Responsibilities include:

- Facility design development
- Service change re-design
- Business case development
- Stakeholder communications and engagement
- Management of risks and issues
- Management of cost
- Construction and handover of the facilities

To discharge these responsibilities, there are a wide range of roles. These are outlined within the Project's Project Execution Plan.

6.5.1 External Advisors

Where necessary independent consultants have been procured by the Board to help with the management of the project. Consultants procured to date include:

Project Role	**Organisation**
Lead Advisor	Currie & Brown
▪ Project Manager	Currie & Brown
▪ Cost Advisor	Currie & Brown
▪ M&E Technical Advisor	Hulley & Kirkwood (sub-consulted)
▪ Clerk of Works	Currie & Brown + Hulley & Kirkwood
▪ Authority's Representative (contract)	Currie & Brown

Table 46 - External Advisors

6.5.2 Project Recruitment Needs

No additional recruitment needs are envisaged at this time, however this will be re-considered during the FBC phase of the project.

6.6 Project Plan and Key Milestones

The project plan and key milestones are set out in the table below.

Description / activity	Date
Full Business Case	
Commencement	February 2022
Completion	January 2022
Governance Approvals	April 2023
Construction & Handover	
Commencement	May 2023
Completion	June 2024
Operational	August 2024

Table 47 - Key Milestone Summary

6.7 Change Management Arrangements

6.7.1 Operational and Service Change Plan

The operational and service change plan proposals are outlined under Section 2.4.1.3. This work will continue through FBC and Construction in parallel with the soft landings process to ensure that the services are prepared to adopt new ways of working in advance of the facilities being made available for use. The FHSCP will ultimately assume responsibility for progressing this dependant workstream.

6.7.2 Facilities Change Plan

The new facility will be serviced by NHS Fife's in-house Facilities and Estates team in a similar way to the existing arrangements. Costs relating to the increase in area have been factored into the GP allocations. NHS Fife resource projections to maintain and upkeep the building have been taken account of in revenue projections (see the Financial Case).

6.7.3 Stakeholder Engagement and Communication Plan

A Stakeholder Engagement and Communication Plan has been developed and endorsed by the Project Board. The plan will continue to be developed and updated as the project progresses. A copy of the plan can be located at Appendix H.

In addition, an update in respect to stakeholder engagement during the OBC stage is outlined at Section 3.4.2.

6.8 Benefits Realisation

6.8.1 Benefits Register

The rationale for an investment needs to be reflected in the realisation of demonstrable benefits, as this will provide the evidence base that the proposal is worthwhile and that a successful outcome is achievable. The benefits to be achieved are discussed in the Strategic Case and have resulted in the creation of a Benefits Register and Benefit Realisation Plan for the Project. The Benefits Register is located at Appendix E.

The Benefits Register includes a range of benefits to be realised by the development. Each benefit includes a target that will be used to indicate the measure of success during the Post Project Evaluation (PPE).

Benefits are either assessed in a quantitative or qualitative manner.

For the quantitative benefits, the register indicates the baseline (current position) at the start of the project including the source. This will be compared with the same data source when the PPE is completed.

For benefits that are qualitative in nature, questionnaires will be developed, and a mix of patient and staff surveys/interviews will be undertaken to outline the baseline for these benefits. The same survey tools will be used during the PPE to examine to what degree the improvements sought were achieved.

Additionally, a Red, Amber, Green (RAG) score highlighting the relative importance of each benefit is indicated using the scale outlined below in the table below.

Scale / RAG	Relative importance
1	Fairly insignificant
2	↕
3	Moderately important
4	↕
5	Vital

Table 48 - Benefit Importance

6.8.2 Benefits Realisation Plan

A Benefits Realisation Plan has been produced to support the achievement of the benefits outlined in the Benefits Register, and it is included as Appendix F.

The benefits realisation process is a planned and systematic process consisting of four defined stages outlined below. The implementation of this plan will be reviewed regularly by the Project Board.

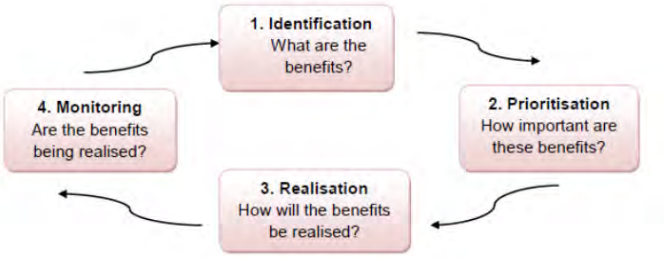


Figure 6 - Benefit Realisation Process

The Benefits Realisation Plan outlines:

- Which Investment Objective the benefit addresses
- Who will receive the benefit
- Who is responsible for delivering the benefit
- Any dependencies that could affect delivery of the benefit
- Any support needed from other agencies etc. to realise the benefit

Benefits monitoring will be ongoing over the life of the Project through the planning, procurement and implementation phases. Progress will be reported to the Project Board at regular intervals and will culminate in the Project Evaluation Report.

6.9 Risk Management

Risk management is a structured approach to identifying, assessing and controlling risks that emerge during the project lifecycle. It is a critical and continuous process throughout the planning, procurement and implementation journey of a project.

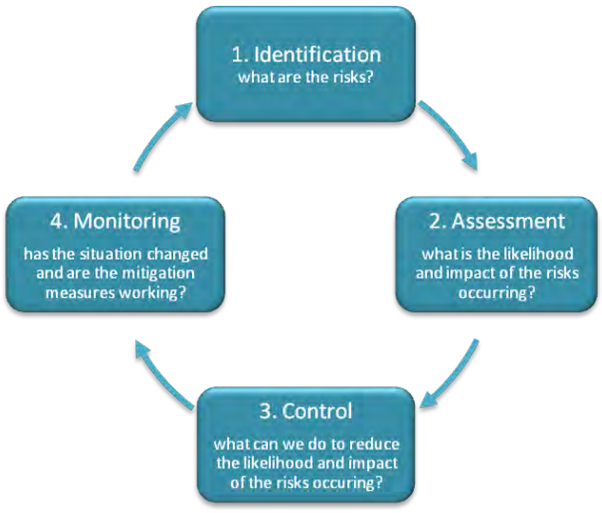


Figure 7 - Risk Management Process

6.9.1 Updated Risk Register

The Project Team have continued to develop the Risk Register provided at IA. The current FBC risk register can be located at Appendix G. The Risk Register is up to date and representative of the residual risks that may be encountered during the balance of the project. The headline items noted below, demonstrate how the risk register has been developed since IA.

- New risks have been identified and added to the register, whilst other risk have been closed
- Probability, impact and risk ratings have been updated progressively at risk workshops
- Mitigation measures have been agreed and updated
- Risk owners and managers have been allocated (a risk owner has overall responsibility for the risk, whilst a manager is responsible for helping to mitigate the risk)

The commercial arrangements associated with the Risk Register are set out within the Commercial Case.

6.9.2 Governance

The Project Board will assume overall responsibility for the risk register, however the Capital Planning Project Director will be responsible for ensuring it is maintained and updated regularly in line with the agreed project controls.

The risk register is updated and provided to the Project Board on a monthly basis as an appendix to the Capital Planning Project Manager's monthly progress report. Key risks are extracted from the risk register and highlighted within the Project Manager's monthly report for ease of reference. The Project Board provide direction to the Project Director and capital Planning Project Manager on risk matters as necessary.

6.10 Commissioning

The importance of the commissioning process cannot be underestimated, as failure to adequately consider this process is likely to cause increases to project costs and failure to deliver agreed service benefits and project outcomes. The Project Board and Capital Planning Director are fully committed to implementing a robust commissioning process, ensuring that the facilities are safe to use and operate from the outset.

The commissioning process will be treated as a distinct workstream, but fully integrated into the overall project to enable a smooth transition to the new working arrangements and realisation of the anticipated benefits. Workstreams will include Technical Commissioning and Operational Commissioning and these will be supported by BIM and Soft Landing processes.

Technical Commissioning concentrates on the readiness of the facility to support operational activity. As such the mechanical and electrical systems all need to be operating satisfactorily at handover of the facility and beyond. Operational Commissioning on the other hand is involved with getting the clinical services transferred into the facility with minimal disruption to business continuity. Given these separate requirements requiring different expertise, it is

considered that there is value in assigning these roles to separate individuals with the necessary knowledge and expertise – these roles will be confirmed during the FBC stage.

The Commissioning Managers will report to the Capital Planning Project Manager on a day to day basis but will maintain lines of communication with the wider team to deliver against the agreed plans.

A Commissioning Strategy and detailed commissioning programme will be developed during the FBC stage of the project.

6.11 Post Project Evaluation

The arrangements for post implementation review and project evaluation reviews have been established in accordance with best practice. These reviews will determine whether the anticipated benefits identified at the outset have been delivered. The project will be evaluated in stages:

Stage 1 – Procurement Process Evaluation

An evaluation of the procurement process will be undertaken following the signing of the contract to assess the effectiveness of the procurement process in meeting the project objectives. This will identify any issues and lessons to be learned that will benefit future projects. This evaluation can take place shortly after commencement of the construction phase.

Stage 2 – Monitoring Construction

During the construction period progress will be monitored to ensure delivery of the project to time, cost, and quality to identify issues and actions arising. On completion of the construction phase the actual project outputs achieved will be reviewed and assessed against requirements, to ensure these match the project's intended outputs and deliver its objectives.

Following completion, the Project Manager's and Supervisor's monthly reports will be reviewed and summarised to represent a holistic view of how the project performed during the construction period.

Stage 3 – Initial Project Evaluation of the Service Outcomes

This will be undertaken 6 to 12 months after the new facility has been commissioned. The objective is to determine the success of the commissioning phase and the transfer of services into the new facilities and what lessons may be learned from the process.

Stage 4 – Follow-up Project Evaluation

This will be undertaken 2 years into the operational phase by the Evaluation Team to assess the longer-term service outcomes and ensure that the project's objectives continue to be delivered.

The following questions will be asked at each stage:

- Have relevant project objectives been achieved?
- Has the project progressed as planned?

- If the plan was not followed, why did this occur?
- If appropriate, how should plans for future projects be amended?

The process will be led by evaluators, independent of the delivery team, who will meet with representatives of the user groups and other key stakeholders. The Project Sponsor, on behalf of the Project Board, will receive reports at each stage of the evaluation process.

Appendix A - Strategic Assessment

Appendix B – Design Statement

Appendix C – Design Pack

Appendix D – Benefits Register

Appendix E – Benefits Realisation Plan

Appendix F – Risk Register

Appendix G – Stakeholder Engagement & Communication Plan

Appendix H – The Patient Perspective

NHS Fife

Meeting:	**Finance, Performance & Resources Committee**
Meeting date:	**10 May 2022**
Title:	**Integrated Performance & Quality Report**
Responsible Executive:	**Margo McGurk, Director of Finance & Strategy**
Report Author:	**Bryan Archibald, Head of Performance**

1 Purpose

This is presented to the Finance, Performance & Resources Committee for:

- Assurance

This report relates to the:

- Joint Fife Remobilisation Plan for 2021/22 (RMP4)

This aligns to the following NHSScotland quality ambition(s):

- Safe
- Effective
- Person Centred

2 Report Summary

2.1 Situation

This report informs the Finance, Performance & Resources (FPR) Committee of performance in NHS Fife and the Health & Social Care Partnership against a range of key measures (as defined by Scottish Government 'Standards' and local targets). The period covered by the performance data is (with certain exceptions due to a lag in data availability) up to the end of February 2022.

2.2 Background

The Integrated Performance & Quality Report (IPQR) is the main corporate reporting tool for the NHS Fife Board. It is produced monthly and made available to Board Members via Admin Control.

The report is presented at the meetings of the Clinical Governance, Staff Governance, Finance, Performance & Resources and Public Health & Wellbeing Committees, and an 'Executive Summary' IPQR (ESIPQR) is then produced as a formal NHS Fife Board paper.

2.3 Assessment

Performance, particularly in relation to Waiting Times across Acute Services and the Health & Social Care Partnership has been hugely affected during the pandemic. NHS Fife is working according to the Joint Fife Remobilisation Plan for 2021/22 (RMP4), and the IPQR provides a high-level activity summary on Page 4. This will be updated monthly until the end of the FY.

The FPR aspects of the report cover Operational Performance (in Acute Services/Corporate Services) and Finance. All measures apart from the two associated with Dementia PDS have performance targets and/or standards, and a summary of these is provided in the tables below.

WT = Waiting Times
RTT = Referral-to-Treatment
TTG = Treatment Time Guarantee (measured on Patient Waiting, not Patients Treated)
DTT = Decision-to-Treat-to-Treatment

Operational Performance – Acute Services / Corporate Services

Measure	Update	Target	Current Status
IVF WT	Monthly	100%	Achieving
4-Hour Emergency Access	Monthly	95%	Not achieving
New Outpatients WT	Monthly	95%	Not achieving
Diagnostics WT	Monthly	100%	Not achieving
Patient TTG	Monthly	100%	Not achieving
18 Weeks RTT	Monthly	90%	Not achieving
Cancer 31-Day DTT	Monthly	95%	Achieving
Cancer 62-Day RTT	Monthly	95%	Not achieving
Detect Cancer Early	Quarterly	29%	Not achieving
FOI Requests	Monthly	85%	Achieving

Finance

Measure	Update	Forecast	Current Status
Revenue Resource Limit	Monthly	Breakeven	Achieving
Capital Resource Limit	Monthly	£33.9m	Achieving

2.3.1 Quality/ Patient Care

IPQR contains quality measures.

2.3.2 Workforce

IPQR contains workforce measures.

2.3.3 Financial

Financial aspects are covered by the appropriate section of the IPQR.

2.3.4 Risk Assessment/Management

Not applicable.

2.3.5 Equality and Diversity, including health inequalities

Not applicable.

2.3.6 Other impact

None.

2.3.7 Communication, involvement, engagement and consultation

The NHS Fife Board Members and existing Standing Committees are aware of the approach to the production of the IPQR and the performance framework in which it resides.

The April IPQR will be available for discussion at the round of April/May Standing Committee meetings.

2.3.8 Route to the Meeting

The IPQR was ratified by EDG and approved for release by the Director of Finance & Strategy.

2.4 Recommendation

The FPR Committee is requested to **discuss** and take **assurance** from this report.

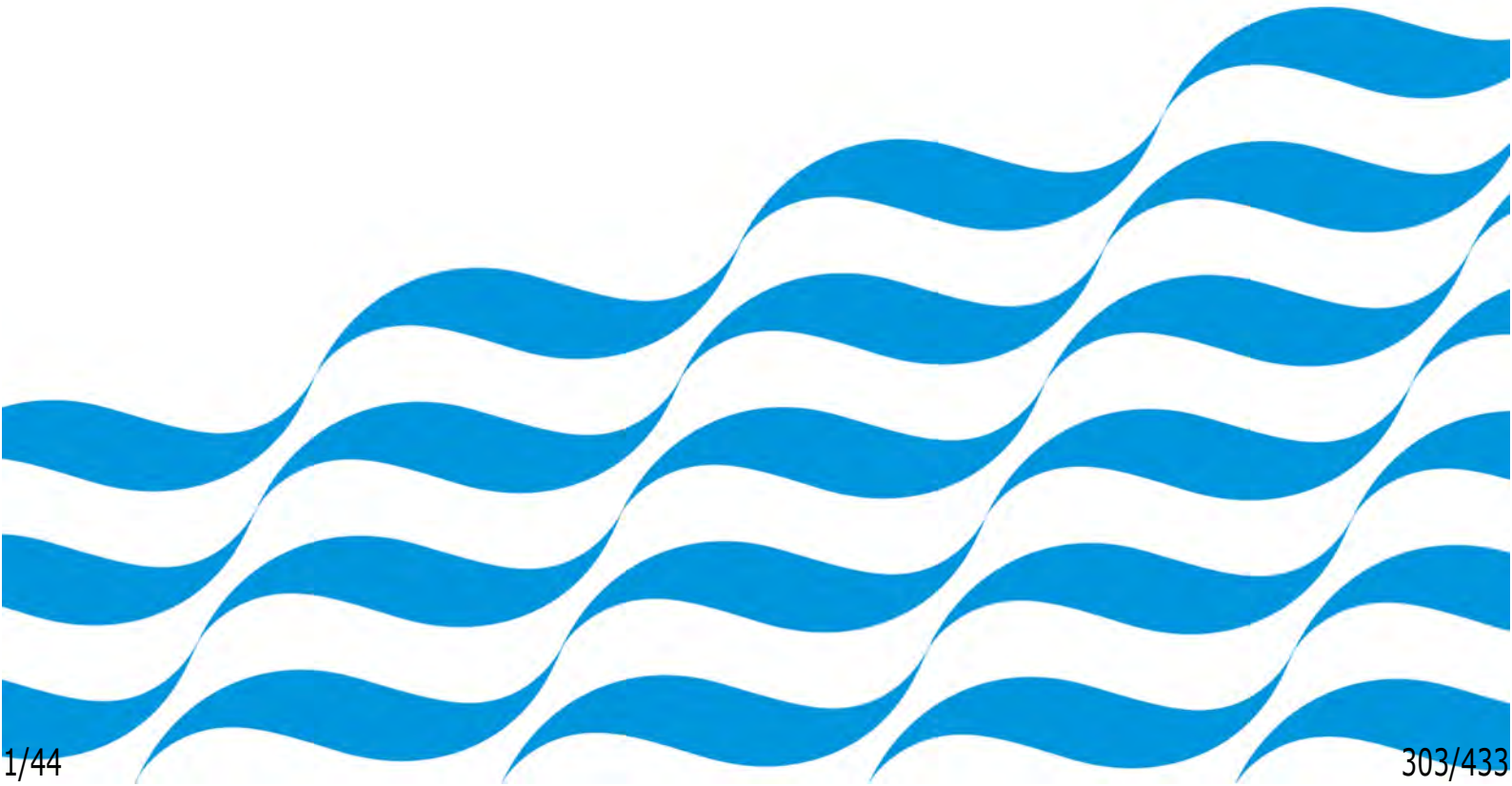
3 List of appendices

None

Report Contact
Bryan Archibald
Head of Performance
Email bryan.archibald@nhs.scot

Fife Integrated Performance & Quality Report

Produced in April 2022



Introduction

The purpose of the Integrated Performance and Quality Report (IPQR) is to provide assurance on NHS Fife's performance relating to National LDP Standards and local Key Performance Indicators (KPI).

A summary report of the IPQR, the Executive Summary IPQR (ESIPQR), is presented at each NHS Fife Board Meeting.

The IPQR comprises of the following sections:

I. Executive Summary

a. LDP Standards & Local Key Performance Indicators (KPI)

b. National Benchmarking

c. Indicatory Summary

d. Remobilisation Summary

e. Assessment

II. Performance Assessment Reports

a. Clinical Governance

b. Finance, Performance & Resources
   Operational Performance
   Finance

c. Staff Governance

d. Public Health & Wellbeing

Section II provides further detail for indicators of continual focus or those that are currently experiencing significant challenge. Each 'drill-down' contains data, displaying trends and highlighting key problem areas, as well as information on current issues with corresponding improvement actions.

MARGO MCGURK
Director of Finance & Strategy
19th April 2022

Prepared by:
SUSAN FRASER
Associated Director of Planning & Performance

I. Executive Summary

At each meeting, the Standing Committees of the NHS Fife Board consider targets and Standards specific to their area of remit. This section of the IPQR provides a summary of performance against LDP Standards and local Key Performance Indicators (KPI). These indicators are listed within the Indicator Summary, which shows current, previous and (where appropriate) 'Year Previous' performance as well as benchmarking against other mainland NHS Boards.

Health Boards are planning the recovery of services following the first and second waves of the COVID-19 Pandemic. NHS Fife agreed its Joint Remobilisation (RMP3) for 2021/22 at the start of 2021, and this effectively replaced the previous 1-year or 3-year Annual Operational Plans. It has now been superseded by RMP4, addressing the status and forecasts for the second half of the FY. Both RMP3 and RMP4 include forecasts for activity across key outpatient and inpatient services, and progress against these forecasts is included in this document by two methods:

- Update of monthly activity (Remobilisation Summary)
- Enhancement of drill-downs to illustrate actual v forecast activity

The RMP provides a detailed, strategic view of how NHS Fife will approach the recovery, while the IPQR drills down to a level where specific Improvement Actions are identified and tracked. In order to provide continuity between the IPQR from version to version (year to year), Improvement Actions carry a '20', '21' or '22' prefix, to identify their year of origin. They are shaded in **BLUE** if they are assessed as being complete or no longer relevant.

Action completion dates appear in **RED** text if they have slipped, but will revert to BLACK text in the next issue of the report, provided no further slips have been reported.

a. LDP Standards & Key Performance Indicators

The current performance status of the 29 indicators within this report is 12 (41%) classified as **GREEN**, 2 (7%) **AMBER** and 15 (52%) **RED**. This is based on whether current performance is exceeding standard/trajectory, within specified limits (mostly 5%) of standard/trajectory or considerably below standard/trajectory.

There were notable improvements in the following areas in February:

- Rate of Falls and Falls with Harm both reducing to be below their targets for FY 2021/22
- Closure of FOI requests above the local target after several challenging months
- % bed days lost due to patients in delay continuing a downward trend towards target

Additionally, it has now been 22 months since the Cancer-31 DTT performance fell below the 95% Standard, with 7 months out of 11 this FY reporting no breaches.

b. National Benchmarking

National Benchmarking is based on whether NHS Fife performance is in the upper quartile of the 11 mainland Health Boards (●), lower quartile (●) or mid-range (●). This benchmarking information indicates that whilst a number of areas continue to experience significant levels of challenge, in over 85% where we are able to compare our performance nationally we are delivering performance within either the upper quartile or the mid-range.

c. Indicator Summary

Performance
meets / exceeds the required Standard / on schedule to meet its annual Target
behind (but within 5% of) the Standard / Delivery Trajectory
more than 5% behind the Standard / Delivery Trajectory

Benchmarking	
●	Upper Quartile
●	Mid Range
●	Lower Quartile

Section	Measure	Target 2021/22	Reporting Period	Year Previous		Previous		Current			Trend	Reporting Period	Fife		Scotland
Clinical Governance	Major & Extreme Adverse Events	N/A	Month	Feb-21	24	Jan-22	23	Feb-22	36	↓		N/A			
	HSMR	N/A	Year Ending	Sep-20	1.01	Jun-21	1.03	Sep-21	1.04	↓		YE Sep-21	1.04	●	1.00
	Inpatient Falls	7.68	Month	Feb-21	9.51	Jan-22	8.33	Feb-22	7.30	↑		N/A			
	Inpatient Falls with Harm	1.65	Month	Feb-21	1.87	Jan-22	2.02	Feb-22	1.59	↑		N/A			
	Pressure Ulcers	0.42	Month	Feb-21	1.44	Jan-22	1.32	Feb-22	1.23	↑		N/A			
	Caesarean Section SSI	2.5%	Quarter Ending	Sep-20	2.2%	Jun-21	3.6%	Sep-21	2.5%	↑		QE Dec-19	2.3%	●	0.9%
	SAB - HAI/HCAI	18.8	Quarter Ending	Feb-21	19.4	Jan-22	15.0	Feb-22	15.4	↓		QE Dec-21	12.8	●	17.3
	SAB - Community	N/A	Quarter Ending	Feb-21	10.8	Jan-22	9.6	Feb-22	8.7	↑		QE Dec-21	8.5	●	9.9
	C Diff - HAI/HCAI	6.5	Quarter Ending	Feb-21	5.2	Jan-22	5.8	Feb-22	4.7	↑		QE Dec-21	4.6	●	13.3
	C Diff - Community	N/A	Quarter Ending	Feb-21	5.4	Jan-22	1.1	Feb-22	1.1	↔		QE Dec-21	1.1	●	5.0
	ECB - HAI/HCAI	33.0	Quarter Ending	Feb-21	33.6	Jan-22	28.9	Feb-22	27.3	↑		QE Dec-21	33.6	●	34.1
	ECB - Community	N/A	Quarter Ending	Feb-21	29.3	Jan-22	37.3	Feb-22	39.3	↓		QE Dec-21	39.2	●	39.8
	Complaints (Stage 1 Closure Rate)	80%	Quarter Ending	Feb-21	88.5%	Jan-22	61.2%	Feb-22	69.2%	↑		2020/21	80.2%	●	79.5%
	Complaints (Stage 2 Closure Rate)	65%	Quarter Ending	Feb-21	31.1%	Jan-22	12.2%	Feb-22	12.8%	↑		2020/21	32.8%	●	57.8%
Operational Performance	IVF Treatment Waiting Times	90%	Month	Feb-21	100.0%	Jan-22	100.0%	Feb-22	100.0%	↔		N/A			
	4-Hour Emergency Access	95%	Month	Feb-21	91.1%	Jan-22	76.1%	Feb-22	83.0%	↑		Feb-22	83.0%	●	74.2%
	Patient TTG (% of Total Waits <= 12 Weeks)	100.0%	Month	Feb-21	48.6%	Jan-22	56.6%	Feb-22	52.7%	↓		Dec-21	64.5%	●	34.6%
	New Outpatients (% of Total Waits <= 12 Weeks)	95%	Month	Feb-21	48.0%	Jan-22	50.1%	Feb-22	48.8%	↓		Dec-21	53.7%	●	46.5%
	Diagnostics (% of Total Waits <= 6 Weeks)	100%	Month	Feb-21	76.2%	Jan-22	52.7%	Feb-22	61.2%	↑		Dec-21	57.9%	●	49.6%
	18 Weeks RTT	90%	Month	Feb-21	73.6%	Jan-22	77.3%	Feb-22	71.4%	↓		QE Dec-21	71.2%	●	74.2%
	Cancer 31-Day DTT	95%	Month	Feb-21	97.5%	Jan-22	100.0%	Feb-22	100.0%	↔		QE Dec-21	100.0%	●	97.1%
	Cancer 62-Day RTT	95%	Month	Feb-21	80.7%	Jan-22	71.2%	Feb-22	83.6%	↑		QE Dec-21	82.3%	●	79.0%
	Detect Cancer Early	29%	Year Ending	Jun-20	22.0%	Mar-21	19.6%	Jun-21	21.4%	↑		2019, 2020	22.5%	●	24.1%
	Freedom of Information Requests	85%	Quarter Ending	Feb-21	85.8%	Jan-22	84.3%	Feb-22	86.9%	↑		N/A			
	Delayed Discharge (% Bed Days Lost)	5%	Month	Feb-21	6.2%	Jan-22	5.6%	Feb-22	7.0%	↓		QE Sep-21	10.4%	●	6.7%
	Delayed Discharge (# Standard Delays)	N/A	Month	Feb-21	54	Jan-22	50	Feb-22	55	↓		Feb-22	18.20	●	26.85
	Antenatal Access	80%	Month	Dec-20	85.7%	Nov-21	88.4%	Dec-21	90.0%	↑		2021	90.1%	●	88.5%
Finance	Revenue Resource Limit Performance	(£13.7m)	Month	Feb-21	N/A	Jan-22	(£13.7m)	Feb-22	Breakeven	↑		N/A			
	Capital Resource Limit Performance	£33.9m	Month	Feb-21	N/A	Jan-22	£13.8m	Feb-22	£19.2m	↑		N/A			
Staff Governance	Sickness Absence	3.89%	Month	Feb-21	5.03%	Jan-22	5.93%	Feb-22	5.63%	↑		YE Mar-21	4.77%	●	4.67%
Public Health & Wellbeing	Smoking Cessation	473	YTD	Dec-20	48.6%	Nov-21	57.1%	Dec-21	52.5%	↓		QE Sep-21	58.9%	●	82.0%
	CAMHS Waiting Times	90%	Month	Feb-21	88.1%	Jan-22	69.4%	Feb-22	68.0%	↓		QE Dec-21	71.9%	●	70.3%
	Psychological Therapies Waiting Times	90%	Month	Feb-21	84.0%	Jan-22	81.8%	Feb-22	79.2%	↓		QE Dec-21	80.6%	●	84.4%
	Alcohol Brief Interventions (Priority Settings)	80%	YTD	Mar-19	60.2%	Dec-19	75.7%	Mar-20	79.2%	↑		FY 2019/20	79.2%	●	83.2%
	Drugs & Alcohol Treatment Waiting Times	90%	Month	Dec-20	96.5%	Nov-21	88.4%	Dec-21	87.9%	↓		QE Dec-21	93.4%	●	93.1%
	Dementia Post-Diagnostic Support	N/A	Annual	2018/19	93.4%	2019/20	93.2%	2020/21	94.6%	↑		2019/20	93.2%	●	81.3%
	Dementia Referrals	N/A	Annual	2018/19	61.0%	2019/20	58.5%	2020/21	50.6%	↓		2019/20	58.5%	●	42.9%

d. NHS Fife Remobilisation Summary – Position at end of March 2022

Better than Projected | Worse than Projected | No Assessment
(NOTE: Better/Worse may be higher or lower, depending on context)

		Quarter End Jun-21	Quarter End Sep-21	Quarter End Dec-21	Month End Jan-22	Month End Feb-22	Month End Mar-22	Quarter End Mar-22
TTG Inpatient/Daycase Activity (Definitions as per Waiting Times Datamart)	Projected	2,981	3,120	3,400	1,203	1,269	1,268	3,740
	Actual	3,260	2,953	2,792	756	1,012	1,169	2,937
	Variance	279	-167	-608	-447	-257	-99	-803
New OP Activity (F2F, NearMe, Telephone, Virtual) (Definitions as per Waiting Times Datamart)	Projected	17,100	19,125	20,905	7,286	7,287	7,288	21,861
	Actual	19,488	20,161	19,600	5,073	6,358	7,501	18,932
	Variance	2,388	1,036	-1,305	-2,213	-929	213	-2,929
Elective Scope Activity (Definitions as per Diagnostic Monthly Management Information)	Projected	1,801	1,833	1,840	613	613	614	1,840
	Actual	1,406	1,511	1,381	446	433	497	1,376
	Variance	-395	-322	-459	-167	-180	-117	-464
Elective Imaging Activity (Definitions as per Diagnostic Monthly Management Information)	Projected	10,850	11,250	13,642	4,480	4,605	4,607	13,692
	Actual	12,971	12,629	11,733	3,962	4,149	4,569	12,680
	Variance	2,121	1,379	-1,909	-518	-456	-38	-1,012
A&E Attendance (Definitions as per Scottish Government Unscheduled Care Datamart)	Projected	17,110	19,110	20,620	7,110	6,450	6,780	20,340
	Actual	20,729	20,814	18,554	5,883	5,997	7,326	19,206
	Variance	3,619	1,704	-2,066	-1,227	-453	546	-1,134
A&E 4-Hour Performance (%) : ALL A&E and MIU (Definitions as per Core Sites, unplanned attendances only)	Projected			80.0%	85.0%	86.0%	87.0%	83.0%
	Actual			77.4%	77.1%	83.0%	79.6%	79.9%
	Variance			-2.6%	-7.9%	-3.0%	-7.4%	-3.1%
Emergency Admissions (Definitions as per Scottish Government Unscheduled Care Datamart)	Projected	8,040	8,320	10,680	3,520	3,190	3,410	10,120
	Actual	10,085	10,001	9,975	3,275	2,923		6,198
	Variance	2,045	1,681	-705	-245	-267		-3,922
Total Emergency Admission Mean Length of Stay (Definitions as per Discovery indicator attached)	Projected	5.82	5.85	5.63				5.73
	Actual	5.55	6.17	6.34				
	Variance	-0.27	0.32	0.71				
Urgent Suspicion of Cancer - Referrals Received (SG Management Information)	Projected	2,450	2,610	2,610	870	870	870	2,610
	Actual	2,885	3,047	2,820	973	928	1,044	2,945
	Variance	**435**	**437**	**210**	**103**	**58**	**174**	**335**
31 Day Cancer – Decision to treat to first treatment (Definitions as per published statistics)	Projected	415	435	384	128	128	128	384
	Actual	305	337	306	84	93		177
	Variance	-110	-98	-78	-44	-35		-207
62 Day Cancer - Referral to First treatment (Definitions as per published statistics)	Projected			200	70	70	70	210
	Actual			215	66	67		133
	Variance			15	-4	-3		-77
CAMHS - First Treatment Appointments (patients treated within 52 weeks of referral)(Definitions as per published statistics)	Projected			405	130	143	120	393
	Actual			350	126	150	152	428
	Variance			-55	-4	7	32	35
CAMHS - Backlog First Treatment Appointments (patients treated after waiting 52+ weeks, if applicable) (Definitions as per published statistics)	Projected			68	20	10	0	30
	Actual			13	8	6	11	25
	Variance			-55	-12	-4	11	-5
CAMHS - Performance against the 18 week standard (%) (Definitions as per published statistics)	Projected			69.3%	70.0%	75.0%	80.0%	75.0%
	Actual			71.9%	69.4%	68.0%	70.6%	69.4%
	Variance			2.6%	-0.6%	-7.0%	-9.4%	-5.6%
Psychological Therapies - First Treatment Appointments (patients treated within 52 weeks of referral) (Definitions as per published statistics)	Projected			1,941	768	799	630	2,197
	Actual			1,750	600	559		1,159
	Variance			-191	-168	-240		-1,038
Psychological Therapies - Backlog First Treatment Appointments (patients treated after waiting 52+ weeks, if applicable) (Definitions as per published statistics)	Projected			234	85	70	55	210
	Actual			113	22	29		51
	Variance			-121	-63	-41		-159
Psychological Therapies - Performance against the 18 week standard (%) (Definitions as per published statistics)	Projected			73.2%	67.5%	65.9%	70.9%	67.9%
	Actual			80.1%	81.8%	82.1%		80.1%
	Variance			6.9%	14.3%	16.2%		12.2%

		Month End Jun-21	Month End Sep-21	Month End Dec-21	Month End Jan-22	Month End Feb-22	Month End Mar-22	Month End Mar-22
Delayed Discharges at Month End (Any Reason or Duration, per the Definition for Published Statistics) [1]	Projected	65	63	84	81	73	66	66
	Actual	127	112	69	79	91	91	91
	Variance	62	49	-15	-2	18	25	25
Code 9 Delayed Discharges at Month End (Any Duration, per the Definition for Published Statistics) [1]	Projected	28	27	23	21	21	20	20
	Actual	47	29	26	29	36	45	45
	Variance	19	2	3	8	15	25	25
Standard Delayed Discharges at Month End (Any Duration, per the Definition for Published Statistics) [1]	Projected	37	36	61	60	52	46	46
	Actual	80	83	43	50	55	46	46
	Variance	43	47	-18	-10	3	0	0

[1] The data required is the estimated number of people delayed at each census point (the snapshot figure). Baseline figures used are the census point figures as at the end of each month

e. Assessment

CLINICAL GOVERNANCE		Target	Current
HSMR		**1.00**	**1.04**
Hospital Standardised Mortality Ratio (HMSR) is not intended for use in a pandemic situation. However, the increased HSMR will be closely monitored over the coming months, and appropriate action including target audit will be commenced if required.			
Inpatient Falls (with Harm)	*Reduce falls with harm rate by 10% in FY 2021/22 compared to rate in FY 2020/21*	**1.65**	**1.59**
Falls data/trends are reviewed continuously, and currently show a broadly static picture in the number of falls with harm over the last year, with a small decrease since December. As noted in the position paper at last CG committee a range of improvement work is ongoing in the continued challenges that the current pandemic presents and as previously described. Data continues to be reviewed with supported improvement action in focussed areas as required.			
Pressure Ulcers	*50% reduction by December 2020, continued for FY 2021/22*	**0.42**	**1.23**
Acute: Over the past year hospital acquired pressure ulcer rate has shown a random pattern, with no signs of improvement or deterioration to the process. Data over time continues to be monitored by senior nursing team and shared with clinical teams for discussion at a variety of forums, in order to drive improvement. Access to the newly developed Data and Insight Hub is being arranged for senior nurses, to assist with triangulation of data in order to develop a comprehensive understanding of the system. Clinical Teams continue to follow the process for Major and Extreme Adverse Events for shared learning. HSCP: The rate of hospital acquired pressure ulcers has increased from the last quarter. Data continues to be monitored weekly via the Quality Matters Assurance Safety Huddle, allowing for early identification of emerging themes. This is shared with services and teams across the partnership to inform change and improvement. Actions from LAERs also support key learning in relation to hospital and community acquired pressure ulcers.			
Caesarean Section SSI	*We will reduce the % of post-operation surgical site infections to 2.5%*	**2.5%**	**2.5%**
Mandatory SSI surveillance has been paused since the start of the Covid-19 pandemic. This remains the case until further instruction from the Scottish Government. Maternity services continue to monitor the SSI cases locally, and, where necessary (i.e Deep or Organ space infection), carry out Clinical Reviews. The performance data provided should be interpreted with caution as it is non-validated and does not follow the NHS Fife Methodology. There has been no national comparison data published since Q4 2019.			
SAB (MRSA/MSSA)	*We will reduce the rate of HAI/HCAI by 10% between March 2019 and March 2022*	**18.8**	**15.4**
NHS Fife continues to be on target to achieve the 10% reduction. There have been no Renal haemodialysis line SABs since October and no PVC SABs since August. There have been 2 PWID SABs in 2022 to date.			
C Diff	*We will reduce the rate of HAI/HCAI by 10% between March 2019 and March 2022*	**6.5**	**4.7**
NHS Fife is on target to achieve the 10% reduction. There have been only 3 health care associated CDI in 2022 to date. Reducing the incidence of CDI recurrence is pivotal to achieving the HCAI reduction target, and continues to be addressed. There has not been a recurrence of infection since August.			
ECB	*We will reduce the rate of HAI/HCAI by 25% between March 2019 and March 2022*	**33.0**	**27.3**
The target for NHS Fife is to achieve an initial 25% reduction of HCAI ECBs by March, and we are currently on target to achieve this. There were 17 ECBs in total for February, of which only 7 were HCAI and with no CAUTIs. Reducing CAUTI incidence remains the quality improvement focus to achieve a further 25% reduction of HCAI SABs, required by March 2024.			

CLINICAL GOVERNANCE		Target	Current
Complaints – Stage 2	*At least 65% of Stage 2 complaints are completed within 20 working days (50% by October 2021)*	**65%**	**12.8%**

There continues to be an ongoing challenge to investigate and respond to Stage 2 complaints within the national timescales due to the ongoing response to COVID-19 and current service pressures. There is an increase in the complexity and number of complaints received and numbers received continue to be high. PRD have seen a significant decrease in the number of concerns and Stage 1 complaints relating to COVID-19 vaccination appointments and/or booster vaccinations; however, the overall delays caused by managing the pandemic continues to feature within complaints.

OPERATIONAL PERFORMANCE		Target	Current
4-Hour Emergency Access	*95% of patients to wait less than 4 hours from arrival to admission, discharge or transfer*	**95%**	**83.0%**

Attendance has continued to be high, impacting on the 4-hour access target. Escalation actions include additional support through the Flow and Navigation Centre with additional primary care triage. Assessment pathways in AU1 continue to see high numbers compounding whole site high occupancy and demand for bed capacity. The emergency department continue with plans for remodelling to allow for expanded assessment provision.

Patient TTG (Waiting)	*All patients should be treated (inpatient or day case setting) within 12 weeks of decision to treat*	**100%**	**52.7%**

Performance in February has deteriorated further. Elective activity has been significantly less than projected with inpatient surgery in particular being restricted to urgent and cancer patients only in response to significant pressures in unscheduled care and the emergence of the Omicron variant. The waiting list continues to rise with 4,283 patients on list in February, 27% greater than in March 2021. There is a continued focus on clinical priorities whilst reviewing long waiting patients. A new recovery plan has been submitted to the Scottish Government and discussions are live around the additional resources needed to deliver additional capacity in the plan. It is anticipated that there will be a gradual resumption in non-urgent core activity in April, but this is heavily dependent on our ability to maintain access to beds for elective activity.

New Outpatients	*95% of patients to wait no longer than 12 weeks from referral to a first outpatient appointment*	**95%**	**48.8%**

Performance continued to deteriorate in February following the decision to cancel routine outpatients to support the response to the emergence of the Omicron variant and significant pressures in unscheduled care. The waiting list has increased with 21,654 on the outpatient waiting list which is 10% higher than in March 2021. There is a continued focus on urgent and urgent suspicion of cancer referrals along with those who have been waiting more than 52 weeks. The number waiting over 52 weeks has risen to 444 in February but has reduced by 55% since March 2021. Due to the ongoing need for physical distancing and the pressures of unscheduled care our outpatient capacity and therefore activity continues to be restricted. A new recovery plan has been submitted to the Scottish Government and discussions are live around the additional resources needed to deliver additional capacity in the plan. There has been a gradual resumption in routine activity and it is anticipated that this will continue, but this is heavily dependent on the demands on staff from unscheduled care activity and the impact on staffing from the Omicron variant.

Diagnostics	*100% of patients to wait no longer than 6 weeks from referral to key diagnostic test*	**100%**	**61.2%**

Performance improved slightly in February. The improvement has been in Radiology with 63.9% waiting less than 6 weeks whilst the performance in endoscopy has deteriorated to 44% of patients waiting less than 6 weeks. Activity continues to be restricted in Endoscopy due to the need for social distancing and enhanced infection control procedures. The overall waiting list for diagnostics has stabilised at 6,607 in February although the number waiting for an Endoscopy and Ultrasound has increased whilst the number waiting in CT and MRI has decreased. There is a continued focus on urgent and urgent suspicion of cancer referrals along with those routine patients who have been experiencing long waits. A new recovery plan has been submitted to the Scottish Government and discussions are live around the additional resources needed to deliver the additional capacity in the plan. It is anticipated that performance will continue to be challenged due to the demand for urgent diagnostics and the pressure from unscheduled care along with continued restrictions in activity due to enhanced infection control measures and staff absence due to COVID.

Cancer 62-Day RTT	*95% of those referred urgently with a suspicion of cancer to begin treatment within 62 days of receipt of referral*	**95%**	**83.6%**

February continued to see challenges in the 62-day performance. The number of USC referrals remains high, consistently exceeding pre pandemic numbers. Breaches are attributed to staffing issues in relation to COVID-19 and lack of resources, particularly radiology capacity over the festive period. Breast, Oncology and Urology (Prostate) are our current most challenged pathways. The majority of breaches continue to be seen in Prostate. The range of breaches was 4 to 55 days (average 18 days).

OPERATIONAL PERFORMANCE		Target	Current
FOI Requests	*At least 85% of Freedom of Information Requests are completed within 20 working days*	**85%**	**86.9%**

There were 62 FOI requests closed in February, 5 of which were late, a monthly closure performance of 91.8%.

The performance figure above reflects the performance for the 3-month period from December 2021 to February 2022 and is the highest 3-month figure since the period from April to June 2021. Provisional figures for March show a further improvement.

Delayed Discharges	*The % of Bed Days 'lost' due to Patients in Delay is to reduce*	**5%**	**7.0%**

The number of bed days lost due to patients in delay in the last 3 months has reduced significantly from the previous quarter, but has remained above the target of 5%. Increased hospital activity over the recent months has resulted in more people requiring social care; this demand has been unable to be met due to social care services experiencing significant workforce pressures. H&SCP have surged 65 downstream beds over the last 6 months to mitigate against the lack of care at home, care home and ward closures, and continue to recruit for care at home and commission additional interim beds. At the February census, approximately half of delays were coded as 51X (Adults With Incapacity) or 100 (Commissioning/Reprovisioning).

FINANCE		Forecast	Current
Revenue Expenditure	*Work within the revenue resource limits set by the SG Health & Social Care Directorates*	**Breakeven**	**Breakeven**

At the end of February the board's reported financial position is a **B**reak **E**ven position which is in line with the projected outturn for the financial year end. The position comprises an adverse variance for Acute Services Division of £17.4m and £2.2m for External Health Care Providers, offset by favourable variances across Corporate Functions of £6m and, of note this month, is the receipt of non recurring Scottish Government funding support of £13.7m to enable the Board to break even. The exceptional demand on unscheduled care capacity within Acute Services continues to be a challenge to available financial resources coupled with increased costs of External Health Care Providers. The savings target of £8.2m the board committed to delivering in year was delivered in full at the end of December with additional savings of £1.4m secured in January taking total savings secured to £9.6m.

Capital Expenditure	*Work within the capital resource limits set by the SG Health & Social Care Directorates*	**£33.9m**	**£19.2m**

The overall anticipated capital budget for 2021/22 is £33.9m. The capital position for the period to February records spend of £19.2m. The full capital budget is on track to be delivered in full by 31 March 2022.

STAFF GOVERNANCE		Target	Current
Sickness Absence	*To achieve a sickness absence rate of 4% or less*	**3.89%**	**5.63%**

The sickness absence rate in February was 5.63%, a reduction of 0.30% from the rate in January 2022. The average rate for COVID-19 related special leave, as a percentage of available contracted hours for the financial year to date was 1.71%.

Given on-going workforce pressures and service challenges, the March 2022 target set in relation to NHS Circular PCS (AfC) 2019/2 will not be achieved and we anticipate further NHSScotland guidance on sickness absence targets, which will reflect the circumstances of the last two years.

PUBLIC HEALTH & WELLBEING		Target	Current
Smoking Cessation	*Sustain and embed successful smoking quits at 12 weeks post quit, in the 40% most deprived SIMD areas*	**473**	**186**

Service provision continues to be delivered remotely by phone, Near Me appointments and use of translation service. We are regularly in contact with all the GP practices where we previously delivered a service. It has been a fluid situation over the last 3 months with practices keeping in touch with updates on clinic space, and we have two practices which are keen to have us start delivering a service starting in the first week of May. We are continuing to support pregnant mums as both midwives have retired. In March we tested some outreach work to assess community appetite to engage in community activity; both sessions were successful so plans to increase community outreach activity have been progressed. No Smoking Day activity saw a small uptake of interest and engagement in the service.

CAMHS Waiting Times	*90% of young people to commence treatment for specialist CAMH services within 18 weeks of referral*	**90%**	**68.0%**

Work on the CAMHS Referral to Treatment (RTT) continues with a lowered RTT as work on the longest waits increases. The amount of activity is increased as new staff capacity improves however is lower than projected due to ongoing vacancies, persistent levels of staff absence and patient cancellations as a result of Covid-19. Urgent and priority referrals remain high with an increased proportion of staff activity allocated to this client group. The process to fill vacant posts continues with a total of 21 posts either in development or out to advert.

Psychological Therapies	*90% of patients to commence Psychological Therapy based treatment within 18 weeks of referral*	**90%**	**79.2%**

The demand for PTs increased significantly in the latter half of 2021 compared to the first 6 months of the year and this remains the case in the first 2 months of 2022. This has resulted in an increase in numbers on the waiting list including, in February, an increase in the number of people waiting over 53 weeks. Issues of workforce availability have negatively impacted the increase in activity that was anticipated from October onwards.

II. Performance Exception Reports

Clinical Governance

Finance, Performance & Resources: Operational Performance

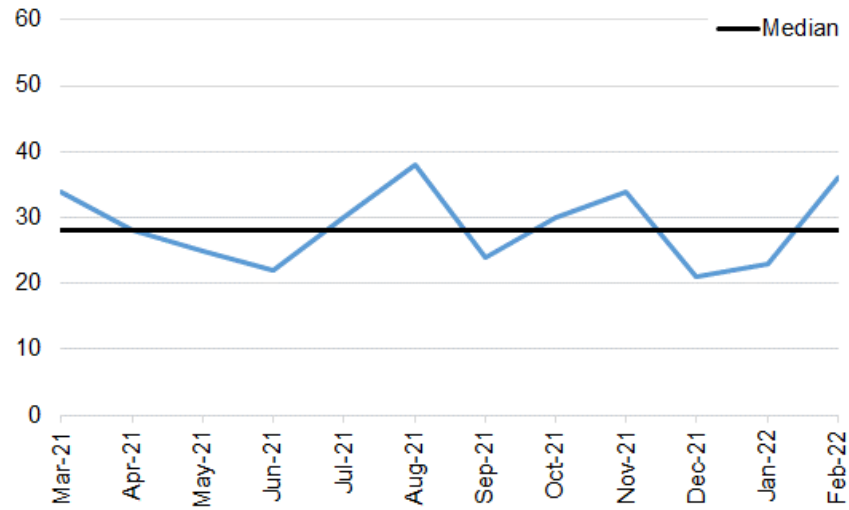
Finance, Performance & Resources: Finance

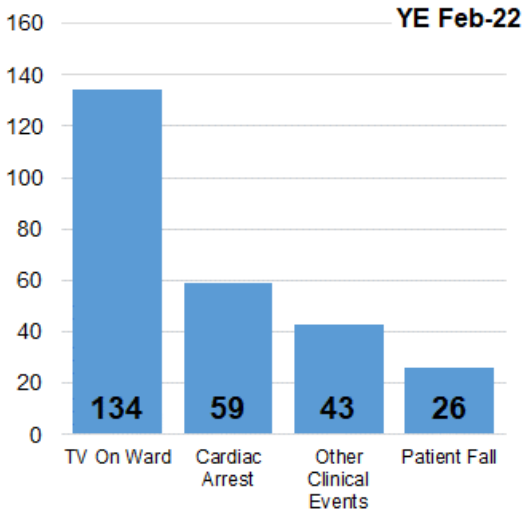
Staff Governance

Public Health & Wellbeing

Adverse Events

Major and Extreme Adverse Events





All Adverse Events

	Month	2020/21	2021/22										
		Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb
ALL	NHS Fife	1365	1358	1373	1351	1420	1453	1397	1392	1437	1492	1495	1230
	Acute Services	630	594	649	606	629	616	609	646	632	596	611	491
	HSCP	708	725	682	694	741	799	746	690	746	834	851	698
	Corporate	27	39	42	51	50	38	42	56	59	62	33	41
CLINICAL	NHS Fife	954	937	1012	936	1009	956	964	948	1015	974	938	842
	Acute Services	588	547	600	547	568	551	536	567	581	536	564	439
	HSCP	353	372	388	365	412	384	401	351	405	399	360	383
	Corporate	13	18	24	24	29	21	27	30	29	39	14	20

Commentary

Incident numbers in January were in keeping with normal variation, but although there was a significant overall decrease in February the number of incidents reported as Major or Extreme in this month increased.

The main categories of events showing decreases were:

- Other Clinical events – the most notable reduction is in 'Hypoglycaemia (BM<4)' which have seen a consistent reduction from 50 in March 2021 to 19 in February 2022
- Medication incidents decreased to <100 per month for the first time in this 12-month period, however the number of Major/Extremes in this category increased

Focused improvement work continues in relation to falls, pressure ulcers and deteriorating patient. Adverse Events improvement work is ongoing. A dedicated Adverse Events resource folder has been created within Blink, and this holds resources to facilitate adverse events incident management as well as including links to human factors training. Collaborative work on the adverse events improvement plan is ongoing.

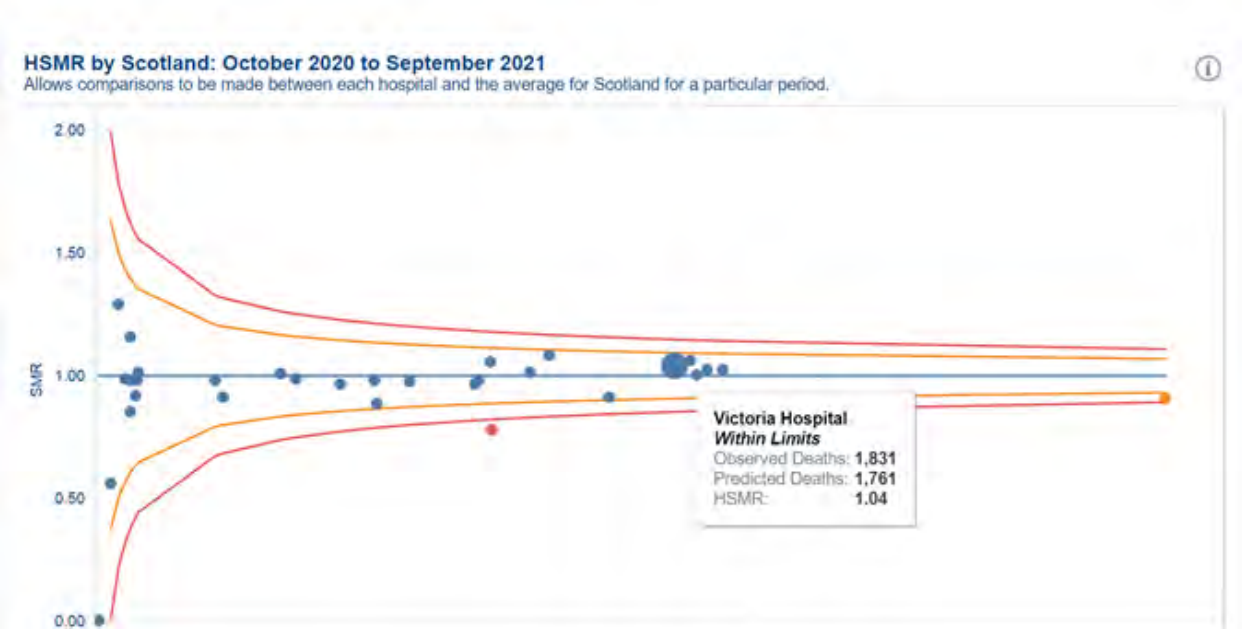
HSMR

Value is less than one, the number of deaths within 30 days of admission for this hospital is fewer than predicted. If value is greater than one, number of deaths is more than predicted.

Reporting Period; October 2020 to September 2021[p]

Please note that as of August 2019, HSMR is presented using a 12-month reporting period when making comparisons against the national average. This will be advanced by three months with each quarterly update.

The rate for Victoria Hospital is shown within the Funnel Plot.



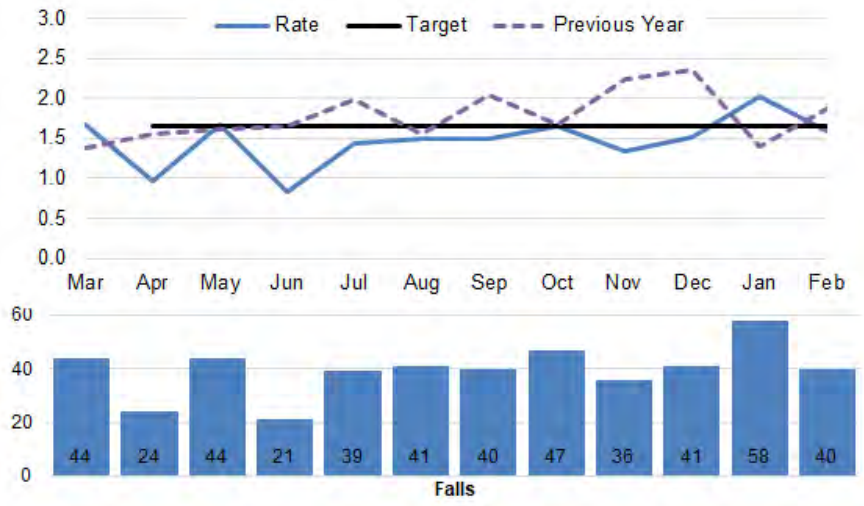
Commentary

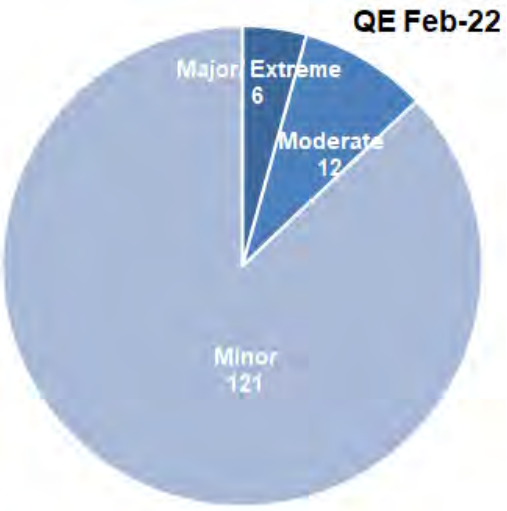
Hospital Standardised Mortality Ratio (HMSR) is not intended for use in a pandemic situation. However, the increased HSMR will be closely monitored over the coming months, and appropriate action including target audit will be commenced if required.

Inpatient Falls with Harm

Reduce Inpatient Falls with Harm rate per 1,000 Occupied Bed Days (OBD)
Target Rate (by end March 2022) = 1.65 per 1,000 OBD

Local Performance





Performance by Service Area

	2020/21	2021/22										
	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb
NHS Fife	1.68	0.98	1.68	0.82	1.45	1.50	1.50	1.66	1.33	1.52	2.02	1.59
Acute Services	0.98	0.35	0.88	0.33	0.79	1.26	0.81	1.44	1.11	0.64	1.80	1.14
HSCP	2.29	1.54	2.40	1.27	2.03	1.72	2.11	1.84	1.52	2.27	2.21	1.95
Target		1.65	1.65	1.65	1.65	1.65	1.65	1.65	1.65	1.65	1.65	1.65

KEY CHALLENGE(S) IN 2021/22

- Continued challenges in in-patient settings with patient placement, social distancing - the falls toolkit is continuing to be used to support assessment and local plans on care delivery and this will be reviewed in line with the national work expected later this year
- Ongoing combined challenges of the dynamic nature of provision of care while ensuring COVID measures are firmly in place, and remobilisation of services
- Re-establishing the Falls Champion Network across all in-patient areas to support local work and support how to address the challenges noted

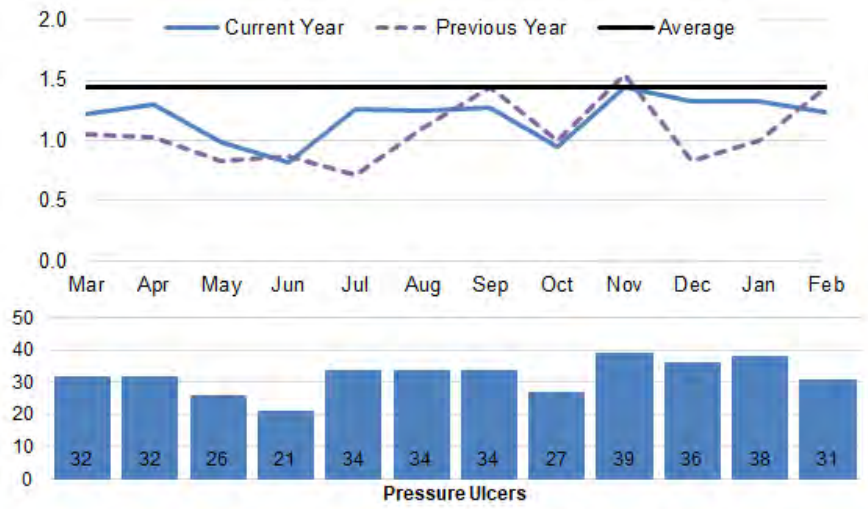
IMPROVEMENT ACTIONS	
20.3 Falls Audit	***By Aug-22***
As previously noted the expected new national driver diagram and measurement package are not yet finalised and the local audit programme will be fully developed following receipt of this; if further delayed, an interim audit programme will be commenced. This will be reviewed again in the Summer.	
20.5 Improve effectiveness of Falls Champion Network	***By Aug-22***
This work remains on hold due to staffing challenges, with contact being maintained with existing champions	
21.2 Falls Reduction Initiative	***Complete Nov-21***
21.3 Integrated Improvement Collaborative	***Complete Jan-22***

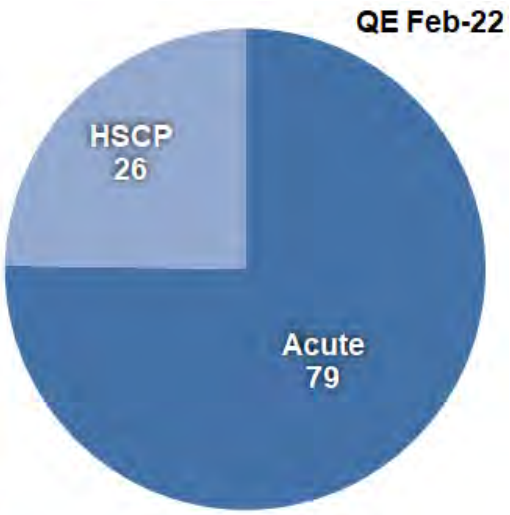
Pressure Ulcers

Reduce pressure ulcers (grades 2 to 4) developed in a healthcare setting

Target Rate (by end March 2022) = 0.42 per 1,000 OBD

Local Performance





Performance by Service Area

		2020/21	2021/22										
		Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb
Grade 2 to 4	NHS Fife	1.22	1.30	0.99	0.82	1.26	1.25	1.28	0.95	1.44	1.33	1.32	1.23
	Acute Services	2.12	2.51	1.60	1.58	2.13	2.36	2.18	1.44	2.54	2.24	2.25	1.84
	HSCP	0.43	0.23	0.44	0.15	0.49	0.27	0.49	0.53	0.49	0.55	0.52	0.72

KEY CHALLENGE(S) IN 2021/22

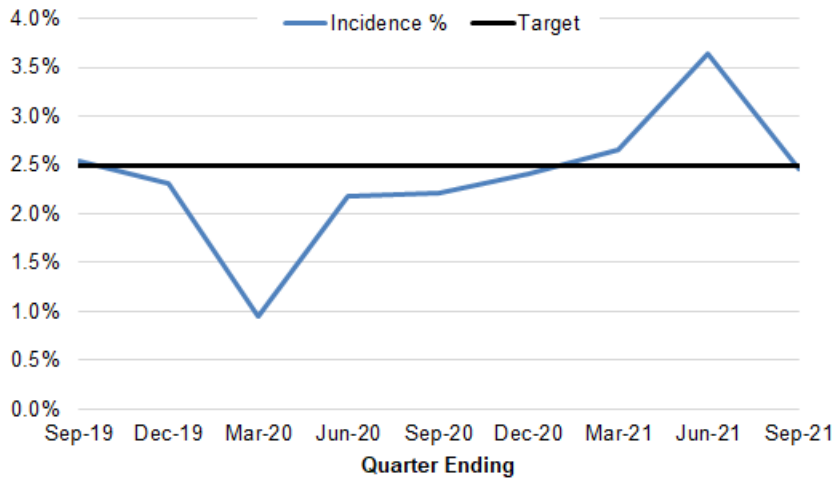
Analysing impact of COVID-19 on clinical pathway for handling Pressure Ulcers, and taking appropriate action to improve performance – this continues to require an agile response

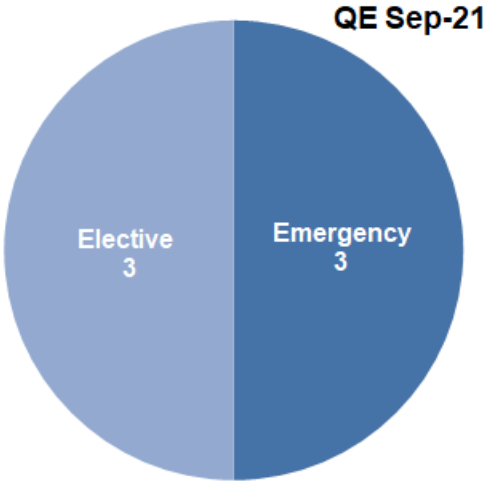
IMPROVEMENT ACTIONS	
21.2 Integrated Improvement Collaborative	**Complete Jun-21**
21.3 Implementation of robust audit programme for audit of documentation	**Complete Jun-21**
22.1 Improvement Collaboratives - HSCP	**Complete Mar-22**
The Tissue Viability Steering Group are reviewing the reporting framework. This involves forming an operational sub-group that will report directly into the Tissue Viability Steering group on developments and progress against key quality indicators, standards, relevant guidance and policies and quality improvement programmes. A number of improvement ideas have been identified, to be discussed and developed further at the next Tissue Viability Group meeting.	
22.2 Community Nursing QI Work	**Complete Mar-22**
One of the community nursing teams has implemented a focused piece of improvement work to ensure that all relevant skin and risk assessments are completed. This is having a positive impact on patient outcomes. Joint adverse event reviews and sharing learning have increased between services, including working collaboratively with care homes.	
22.3 ASD Pressure Ulcer Improvement Programme	**Complete Mar-22**
Due to the continued and significant workforce pressures and therefore inability to use a collaborative model for continuous quality improvement, a decision has been taken to terminate this programme and for clinical teams to own their own improvement activity.	
22.4 Implementation of Focused Improvement Activities	**Complete Mar-22**
ICU continue to test change ideas to prevent Medical Devise Related Pressure Ulcers, including prophylactic use of barrier creams and the development of a poster depicting preventative techniques. All mattresses have been replaced with specialist mattresses that have the technology to deflate individual cells under targeted areas of the body at particular risk. Ward 31 and ED continue to discuss pressure ulcer incidences at the Hip Fracture Meeting.	

Caesarean Section SSI

Sustain C-Section SSI incidence for inpatients and post discharge surveillance (day 10) below 2.5% during FY 2021/22

Local Performance





National Benchmarking

Quarter Ending	2018/19				2019/20		
	Jun-18	Sep-18	Dec-18	Mar-19	Jun-19	Sep-19	Dec-19
NHS Fife	3.1%	2.3%	1.7%	6.5%	2.0%	2.5%	2.3%
Scotland	1.5%	1.5%	1.4%	1.6%	1.0%	1.2%	0.9%

KEY CHALLENGE(S) IN 2021/22

Resumption of SSI surveillance (when instructed/agreed) will require a review of the previously established methodology (adopted in Q4 2019 and paused during Q1 2020 due to the pandemic response), with regards to possible subsequent changes both nationally and locally. Then training of staff in the definitions of C-section SSI and the surveillance programme, areas include; Maternity Assessment, Maternity Ward, Observation Ward and the Community Midwives.

IMPROVEMENT ACTIONS

20.1 Address ongoing and outstanding actions as set out in the SSI Implementation Group Improvement Plan	**Complete Mar-22**

The SSI Implementation Group de-mobilised in August 2020 as there were no outstanding actions, infection rates had improved and there was a robust system in place for reviewing (LAER/SAER) any Deep or Organ Space SSI cases. The group will re-establish if any future concerns develop.

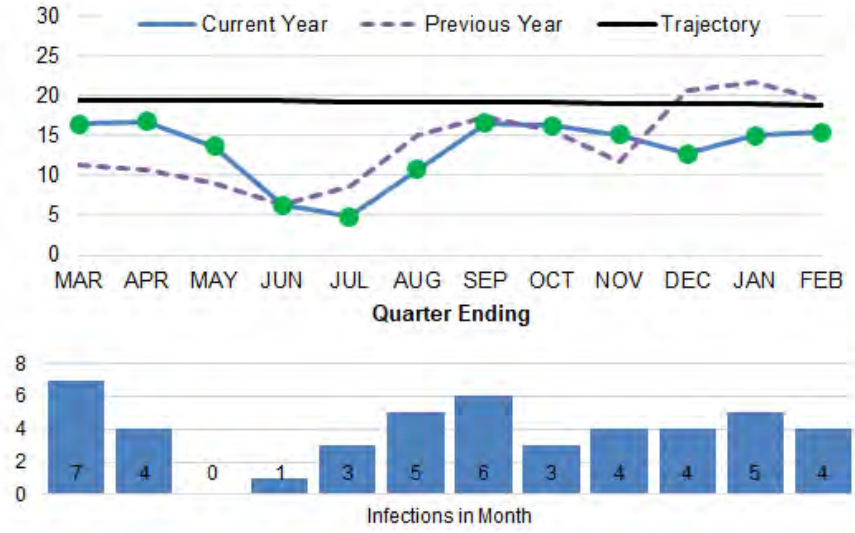
Due to the ongoing Covid-19 pandemic, there is currently no date (set by ARHAI) for resumption of SSI surveillance. Until such time, Maternity services will continue to monitor infection rates locally and will maintain links with the Infection Control Surveillance Team, for support and guidance.

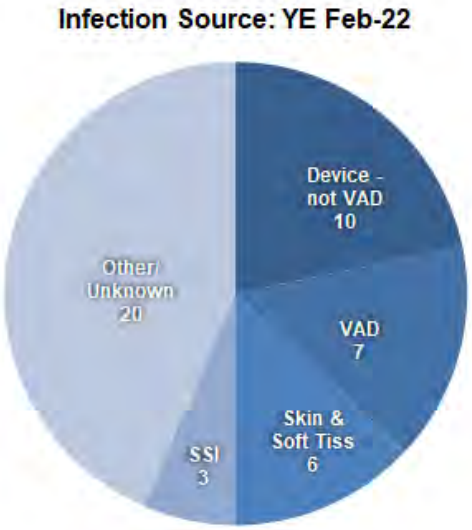
On resumption of the C-section SSI surveillance programme, the IPCT will review the surveillance methodology to capture any practice/patient pathway changes due to the pandemic response and/or any alterations to the case definition. This will ensure that the surveillance methodology remains the most effective means of capturing SSI cases.

SAB (HAI/HCAI)

Reduce Hospital Infection Rate by 10% (in comparison to FY 2018/19 rate) by the end of FY 2021/22

Local Performance





National Benchmarking

Quarter Ending	2020/21				2021/22		
	Jun	Sep	Dec	Mar	Jun	Sep	Dec
NHS Fife	6.3	18.7	20.6	17.8	6.3	16.6	12.8
Scotland	20.3	17.3	18.9	18.4	18.6	18.3	17.3

KEY CHALLENGE(S) IN 2021/22

Vascular access devices and medical devices such as urinary catheters are risk factors identified for SAB, and infections in these areas need to be minimised in order to achieve the 10% reduction by March 2022

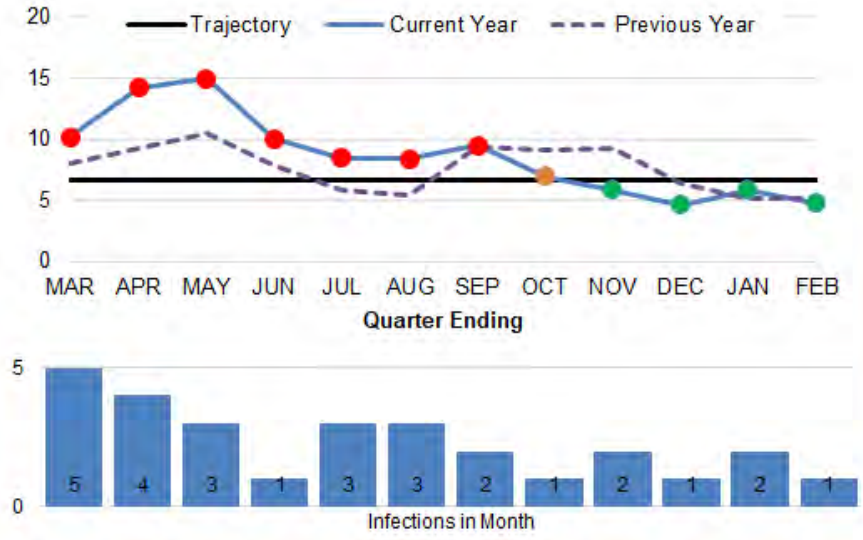
IMPROVEMENT ACTIONS

20.1 Reduce the number of SAB in PWIDs	***Complete Mar-22***
The incidence of SABs in PWIDs has continued to reduce although there has been 2 cases identified in 2022 up to February. IPC will continue to support Addiction Services with their QI work to reduce the rate further.	
20.2 Ongoing surveillance of all VAD-related infections	***Complete Mar-22***
Monthly charts are distributed to clinical teams to inform of incidence of VAD SABs - these demonstrate progress and promote quality improvement as well as raising triggers and areas of concern	
20.3 Ongoing surveillance of all CAUTI	***Complete Mar-22***
Bi-monthly meetings of the Urinary Catheter Improvement Group (UCIG) identify key issues and initiate appropriate corrective actions in regard to catheter and urinary care with ECB data presented to indicate CAUTI incidence and trends. The UCIG Driver Diagram continues to be reviewed. eCatheter insertion & maintenance bundles on Patientrack are currently being trialled within Urology services, before being rolled out across the whole AS & HSCP, to ensure optimum catheter care delivery.	
20.4 Optimise comms with all clinical teams in ASD & the HSCP	***Complete Mar-22***
Monthly SAB reports are distributed with Microbiology comments, to gain better understanding of disease process and those most at risk. This allows local resources to be focused on high-risk groups/areas and improve patient outcomes. 'Days since last SAB' data is emailed out to each directorate monthly for wards to display for public assurance	
22.1 Use Electronic insertion and maintenance bundles for PVC, CVC, urinary catheters	***Complete Mar-22***
Electronic insertion and maintenance bundles for PVCs are completed on Patientrack to support best practice. Compliance is reported weekly to ward Senior Charge Nurses if the ward failed to achieve 90% of all PVC being removed prior to the 72hr breach. Similar electronic insertion and maintenance bundles are being trialled currently for in-dwelling urinary catheters and planned for CVCs to promote and support best practice, reduce avoidable harm and improve quality of care.	

C Diff (HAI/HCAI)

Reduce Hospital Infection Rate by 10% (in comparison to FY 2018/19 rate) by the end of FY 2021/22

Local Performance



National Benchmarking

Quarter Ending	2020/21				2021/22		
	Jun	Sep	Dec	Mar	Jun	Sep	Dec
NHS Fife	7.9	9.3	7.7	14.0	10.0	9.5	4.6
Scotland	15.4	17.4	16.4	15.8	14.6	16.8	13.3

KEY CHALLENGE(S) IN 2021/22

Sustain and further reduce healthcare-associated CDI and recurrent CDI in order to achieve the 10% reduction target by March 2022

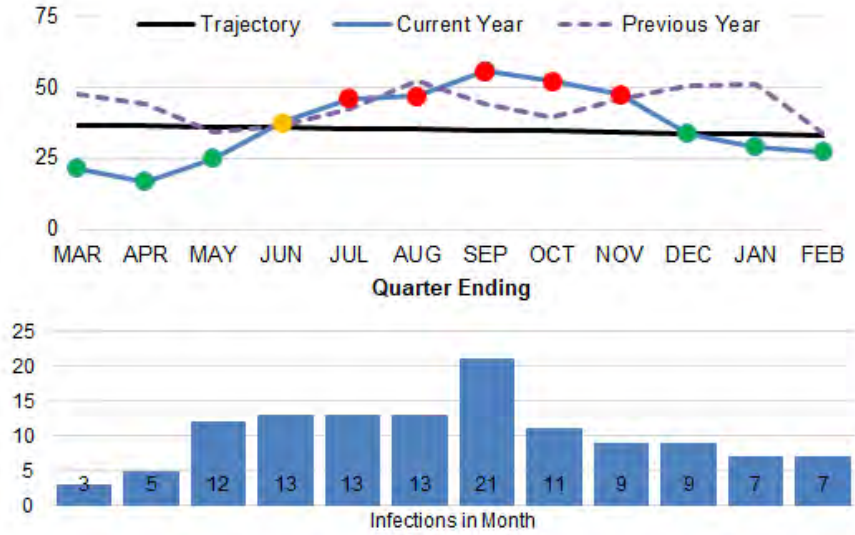
IMPROVEMENT ACTIONS

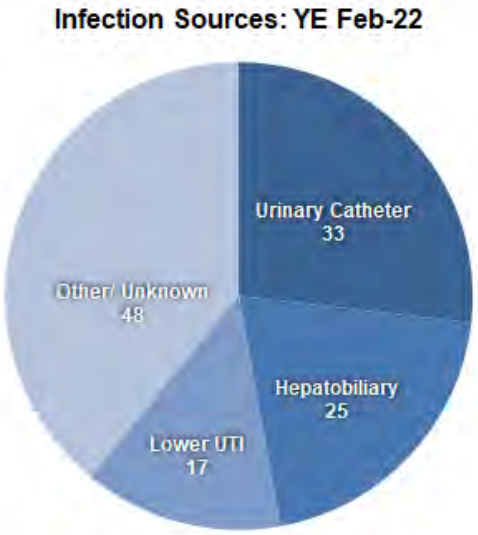
20.1 Reducing recurrence of CDI	***Complete Mar-22***
Each CDI occurrence is reviewed by a consultant microbiologist. The patient's clinician is then advised regarding patient treatment and management to optimize recovery and prevent recurrence of infection. To reduce recurrence of CDI Infection for patients at high risk of recurrent infection, two treatments are utilised in Fife, Fidaxomicin and Bezlotoxumab. The latter can be prescribed whilst faecal microbiota transplantation is unavailable during the COVID-19 pandemic.	
20.2 Reduce overall prescribing of antibiotics	***Complete Mar-22***
NHS Fife utilises National antimicrobial prescribing targets by NHS Fife microbiologists, working continuously alongside Pharmacists and GPs to improve antibiotic usage. Empirical antibiotic guidance and the revised Microguide app has been circulated to all GP practices.	
20.3 Optimise communications with all clinical teams in ASD & the HSCP	***Complete Mar-22***
Monthly CDI reports are distributed, to enable staff to gain a clearer understanding of the disease process, recurrences and rates. IPCN ward visits reinforce SICPs and transmission-based precautions, provide education to staff to promote optimum CDI management and daily Medical Management form completion. 'Days since last CDI' data is emailed monthly by IPC surveillance to each directorate for all wards to display for public assurance	

ECB (HAI/HCAI)

Reduce Hospital Infection Rate by 25% (in comparison to FY 2018/19 rate) by the end of FY 2021/22

Local Performance





National Benchmarking

Quarter Ending	2020/21				2021/22		
	Jun	Sep	Dec	Mar	Jun	Sep	Dec
NHS Fife	36.4	45.3	50.3	21.6	37.6	60.3	33.6
Scotland	39.7	42.0	40.9	34.7	38.2	41.4	34.1

KEY CHALLENGE(S) IN 2021/22

Lower Urinary tract Infections (UTIs) and Catheter associated UTIs (CAUTI) remain the prevalent source of ECBs and are therefore the areas to address to reduce the healthcare-associated inflection ECB rate

IMPROVEMENT ACTIONS

20.1 Optimise communications with all clinical teams in ASD & the HSCP	***By Mar-24***

Monthly ECB reports and charts are distributed to key clinical staff across the HSCP and ASD. Each CAUTI associated ECB undergoes IPC surveillance and a DATIX is submitted for all catheter associated ECBs, prompting an LAER by the patient`s clinical team. ECB rates reduced in Q4 of 2021 following NHS Fife receiving an exception report for HCAI & CAI rates in Q3, for which an Action Plan was submitted to ARHAI.
NHS Fife is currently on target for achieving the 25% target reduction by the end of March; a further 25% reduction of HCAI ECBs is to be achieved by March 2024.

20.3 Ongoing work of Urinary Catheter Improvement Group (UCIG)	***By Mar-24***

The UCIG meeting last met in November, two further meetings having been cancelled. Initiatives to promote hydration and provide optimum urinary catheter care (including continence care) across Fife continue. They cover analysis and update of process, training/education/promotion and quality improvement work.

A new eCatheter insertion & Maintenance bundle on Patientrack is currently being trialled by Urology before being rolled out across the AS & HSCP to ensure optimum catheter care is delivered across NHS Fife.

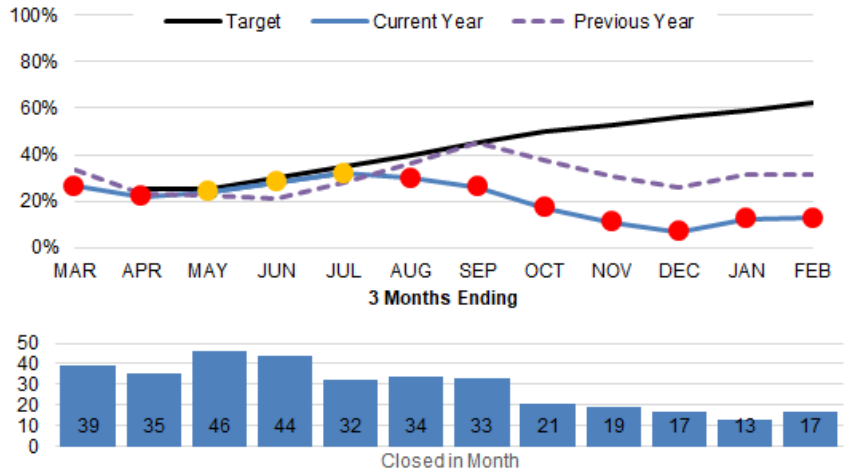
22.1 Develop ECB Strategy	***Complete Mar-22***

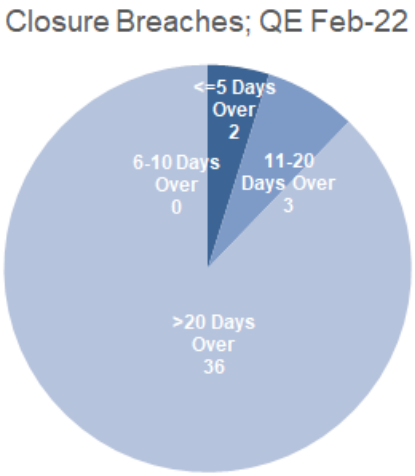
NHS Fife are collaborating with NHS Shetland and NHS Grampian to pioneer an enhanced ECB CAUTI surveillance tool. The aim is to gather data on all CAUTIs, identify risk factors and, where appropriate, make subsequent improvements to practice.

Complaints | Stage 2

At least 65% of Stage 2 complaints are completed within 20 working days (50% by October 2021)

Local Performance





Performance by Service Area

3-Month Ending	2020/21	2021/22										
	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb
NHS Fife	26.3%	21.9%	24.2%	28.0%	32.0%	30.0%	26.3%	17.0%	11.0%	7.0%	12.2%	12.8%
Ack <= 3 Days (Monthly)	94.9%	100.0%	93.5%	100.0%	96.9%	100.0%	100.0%	100.0%	100.0%	94.1%	100.0%	100.0%
ASD	19.3%	15.9%	15.7%	22.5%	23.5%	25.7%	26.2%	19.3%	14.0%	7.5%	17.1%	17.6%
HSCP	50.0%	38.1%	48.3%	31.4%	38.7%	23.3%	20.8%	13.0%	5.9%	8.3%	0.0%	0.0%

KEY CHALLENGE(S) IN 2021/22

- Service recovery following Covid-19 pandemic
- Improve the quality of complaint handling
- Complex complaints / Multi-Directorate Complaints

IMPROVEMENT ACTIONS

22.1 Review complaint handling process and agree measures to ensure quality	**By Sep-22**

Patient Relations have yet to recommence in-house QA checks on draft final responses; however, it is hoped we will be in a position to recommence this in the near future.

Review of the current complaint handling process by Clinical Governance and Patient Relations also continues to be on hold due to the ongoing response to COVID-19 and current capacity issues. This will be recommenced in the future.

In March, there was a focus within the Patient Relations team to work on the backlog of complaint response, which had been created due to the pressures on clinical services whilst managing Covid-19 measures. Over the course of 14 days, the team were able to clear the backlog of responses that were ready to draft and move these cases onward through the complaint's procedure.

22.2 Improve education of complaint handling	**By Sep-22**

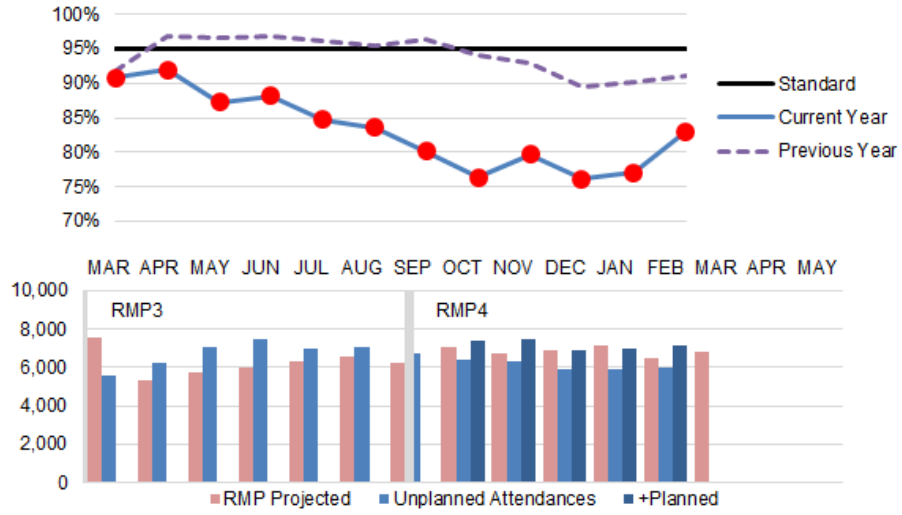
This action aims to improve overall quality by delivering education programmes at induction and bespoke training sessions across the Clinical Services. Unfortunately, training remains on hold due to the ongoing response to COVID-19 and current capacity issues; however, there have been some training sessions delivered virtually during the pandemic. It is hoped to recommence training once the picture in regard to Covid-19 settles somewhat and face-to-face training in large groups can be accommodated once again.

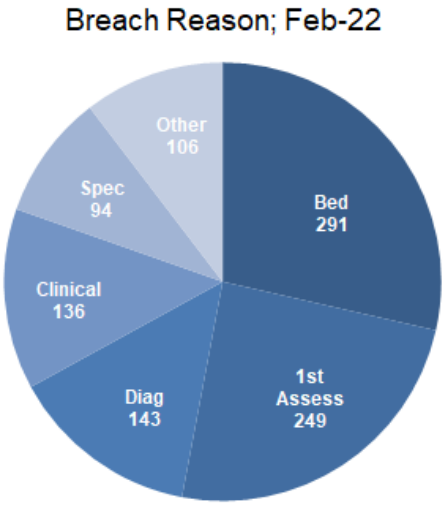
Although bespoke training sessions were due to be undertaken with Fife Wide & Fife East in May in 2021, this has not been possible to achieve for the reasons above. It is hoped there will be capacity to recommence this soon.

4-Hour Emergency Access

At least 95% of patients will wait less than 4 hours from arrival to admission, discharge or transfer for Accident & Emergency treatment

Local Performance





National Benchmarking

Month	2020/21	2021/22										
	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB
NHS Fife	90.8%	91.9%	87.2%	88.2%	84.7%	83.6%	80.1%	76.3%	79.7%	76.1%	77.0%	83.0%
Scotland	88.5%	88.7%	87.2%	85.0%	81.5%	77.8%	76.1%	73.5%	75.9%	75.7%	76.0%	

KEY CHALLENGE(S) IN 2021/22

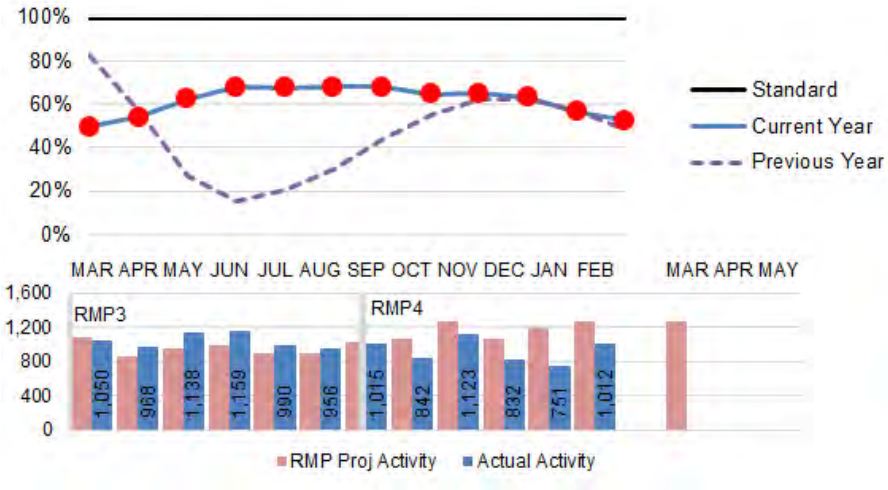
- Achievement of 4-hour access Standard
- Delivery of an integrated Flow and Navigation HUB
- Increased patient demand for urgent care

IMPROVEMENT ACTIONS	
21.2 Integration of the Redesign of Urgent Care model and the Flow & Navigation Hub	**Complete Mar-22**
Virtual Flow and Navigation appointments to ED are now in place and the Hub has expanded to handle GP calls previously taken by ANPs into AU1. Early indication shows decreased number of referrals with a re-direction rate of 26%. Expansion for 24/7 handling is in planning and the Clinical Director for Planned Care is reviewing surgical pathways through FNC with a focus on a more streamlined urology pathway. This will be picked up again in the refreshed IPQR.	
22.1 Co-produce (with NHS 24) patient criteria for access to ED via 1-hr and 4-hr pathways	**Complete Nov-21**
22.2 Reduce number of patients breaching at 4 hrs, 8 hrs, and waits for beds	**Complete Mar-22**
February saw an improvement in performance, however bed waits continue to be the principal reason for breaches with the knock on effect of holding patients within the department further impacting time to first assessment due to lack of space. Flow to downstream wards impacted on high acuity of patients and the impact that COVID staff absence has had on ward staffing numbers and management of workload to enable discharges. OPEL escalation tool now in daily use with actions in place for escalation and formal action cards under development. This will be picked up again in the refreshed IPQR.	
22.3 Develop re-direction policy for ED	**Complete Dec-21**

Patient TTG

We will ensure that all eligible patients receive Inpatient or Daycase treatment within 12 weeks of such treatment being agreed

Local Performance



National Benchmarking

	2020/21	2021/22										
	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB
NHS Fife	49.7%	54.1%	62.7%	67.9%	67.6%	68.2%	68.2%	64.9%	65.1%	63.1%	56.6%	52.7%
Scotland	34.7%	35.5%	37.2%	38.6%	36.7%	36.5%	34.0%	37.5%	37.3%	34.6%		

KEY CHALLENGE(S) IN 2021/22

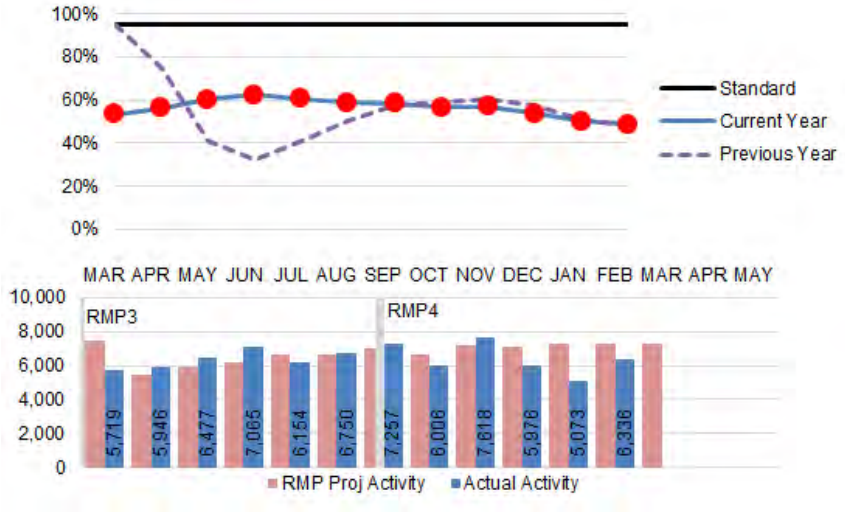
- Reduced Theatre Capacity due to current infection control and social distancing measures
- Clinical Prioritisation leading to long waits for lower priority patients
- Increased demand as a result of backlog in outpatients and change in case mix
- Increased unscheduled workload
- Staff vacancies, absence and fatigue

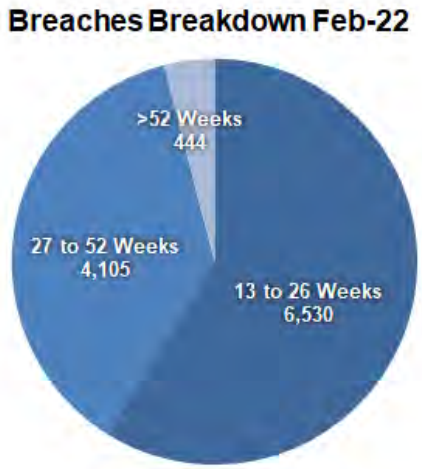
IMPROVEMENT ACTIONS	
22.1 Monitor and review DCAQ against waiting times improvement plan, secure additional funding from SG and amend plan prior to formal review in September	**Complete Sep-21**
22.2 Redesign Pre-assessment to increase capacity and flexibility around theatre scheduling	**By Sep-22**
Business case delayed awaiting decision on suitable IT system	
22.3 Undertake waiting list validation against agreed criteria	**Complete Mar-22**
Clinical teams continue to review lists and prioritise patients, Clinical Prioritisation Group meets regularly. This work will continue as clinical prioritisation remains essential when elective capacity is restricted due bed capacity and unscheduled care demand.	
22.4 Develop and deliver improvement actions in line with CFSD priority projects overseen by Integrated Planned Care Programme Board	**Complete Mar-22**
ACRT in place for 3 specialities and PIR in place for 6 specialities. The work for this year is complete. A new programme of improvements for 2022/23 will be agreed by the Integrated Planned Care Programme Board.	

New Outpatients

95% of patients to wait no longer than 12 weeks from referral to a first outpatient appointment

Local Performance





National Benchmarking

	2020/21	2021/22										
	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB
NHS Fife	53.4%	56.4%	60.3%	62.4%	60.7%	58.6%	58.3%	56.5%	57.1%	53.8%	50.1%	48.8%
Scotland	48.3%	50.5%	52.3%	53.4%	51.6%	49.7%	48.1%	48.0%	48.4%	46.5%		

KEY CHALLENGE(S) IN 2021/22

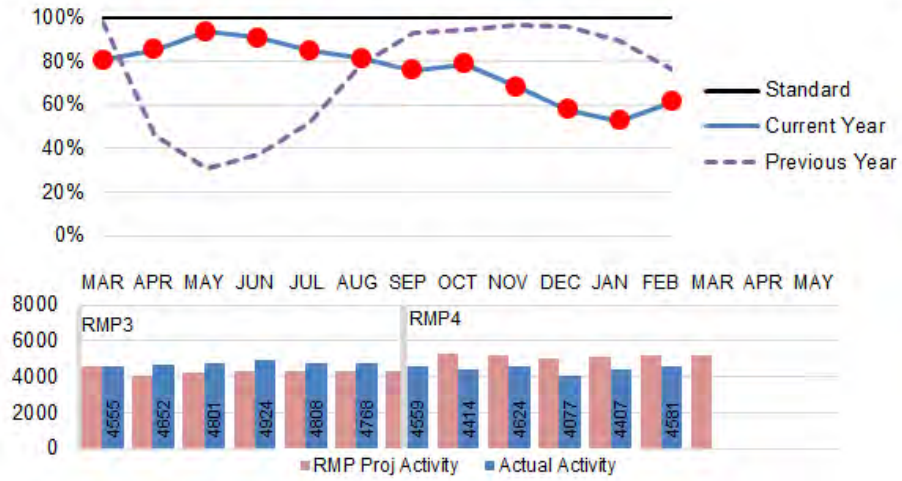
- Reduced Clinic capacity due to current infection control and social distancing measures
- Clinical Prioritisation leading to long waits for lower priority patients
- Increased demand as a result of unmet need and change in case mix of referrals
- Increased unscheduled workload
- Staff vacancies, absence and fatigue

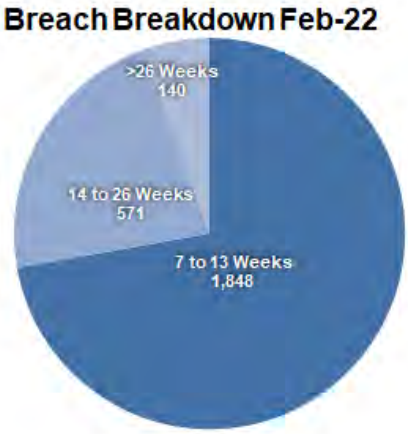
IMPROVEMENT ACTIONS	
22.1 Monitor and review DCAQ against waiting times improvement plan, secure additional funding from SG and amend plan prior to formal review in September	**Complete Sep-21**
22.2 Deliver appropriate elements of Modernising outpatients and unscheduled care redesign to reduce and manage demand and sustain capacity	**Complete Mar-22**
The work for this year is complete. A new programme of improvements for 2022/23 will be agreed by the Integrated Planned Care Programme Board.	
22.3 Actively promote and support staff wellbeing initiatives within the acute division	**Complete Mar-22**
Directorates promoting and supporting initiatives	
22.4 Understand impact of potential changes to guidance on social distancing and actions needed to implement	**Complete Dec-21**

Diagnostics Waiting Times

No patient will wait more than 6 weeks to receive one of the 8 Key Diagnostics Tests appointment

Local Performance





National Benchmarking

	2020/21	2021/22										
	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB
NHS Fife	80.6%	85.3%	93.5%	90.6%	84.9%	81.2%	75.7%	78.7%	68.3%	57.8%	52.7%	61.2%
Scotland	61.4%	61.8%	64.1%	62.6%	57.2%	56.5%	57.8%	55.2%	56.9%	49.6%		

KEY CHALLENGE(S) IN 2021/22

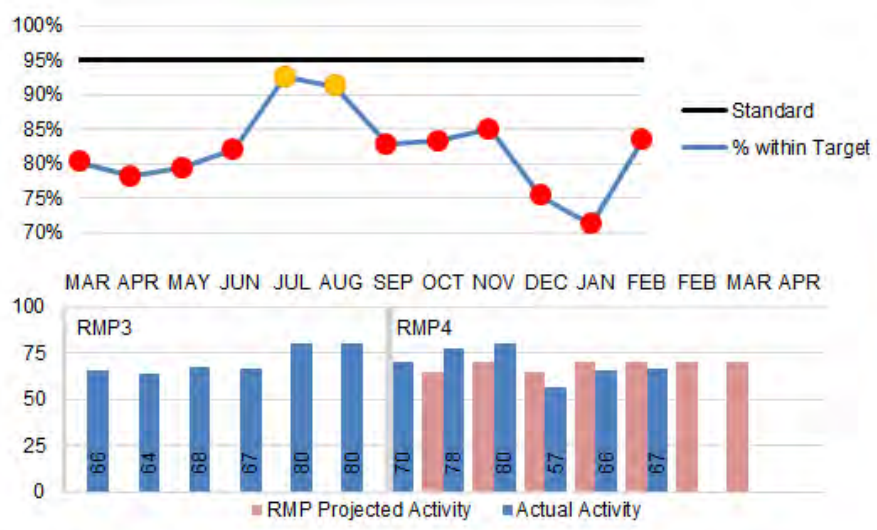
- Reduced diagnostic capacity due to current infection control and social distancing measures
- Clinical Prioritisation leading to long waits for lower priority patients
- Increased demand as a result of unmet need, backlog in outpatients and change in case mix of referrals
- Staff vacancies, absence and fatigue

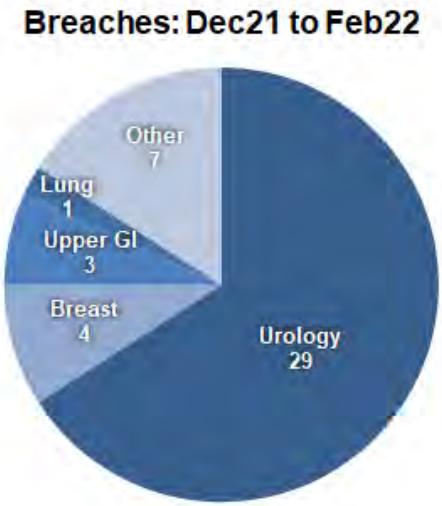
IMPROVEMENT ACTIONS	
22.1 Monitor and review DCAQ against waiting times improvement plan, secure additional funding from SG and amend plan prior to formal review in September	**Complete Sep-21**
22.2 Explore implementation of point of care testing in endoscopy	**Complete Mar-22**
System implemented	
22.3 Actively promote and support staff wellbeing initiatives within the acute division	**Complete Mar-22**
Directorates promoting and supporting initiatives	
22.4 Actively seek alternative sources of additional CT capacity to manage increasing waiting times for routine patients	**Complete Jan-22**

Cancer 62-Day Referral to Treatment

At least 95% of patients urgently referred with a suspicion of cancer will start treatment within 62 days

Local Performance





National Benchmarking

Month	2020/21	2021/22										
	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB
NHS Fife	80.3%	78.1%	79.4%	82.1%	92.5%	91.3%	82.9%	83.3%	85.0%	75.4%	71.2%	83.6%
Scotland	83.0%	84.5%	83.0%	83.6%	82.8%	83.5%	83.1%	78.8%	78.1%	78.3%	76.3%	77.4%

KEY CHALLENGE(S) IN 2021/22

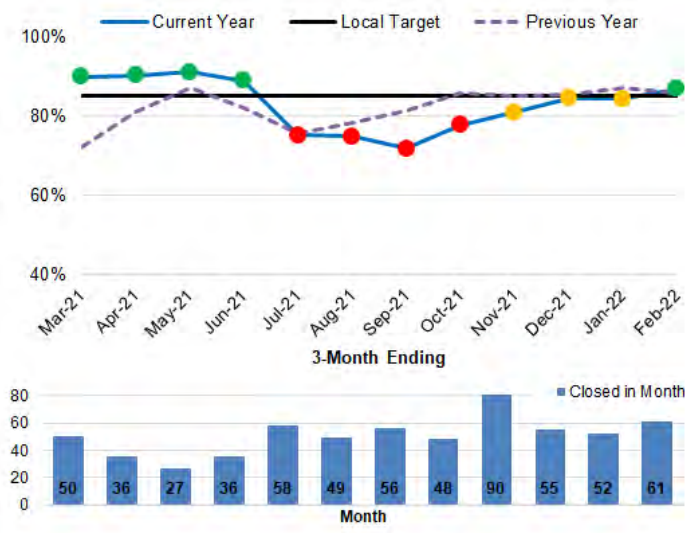
- Prostate cancer pathway (remains the most challenged pathway in NHS Fife)
- Increased number of referrals into the breast service, converting to cancers
- Catch up with the paused screening services (which will increase the number of patients requiring to be seen)
- Introduction of the robot may impact on waits to surgical treatment due to training requirements

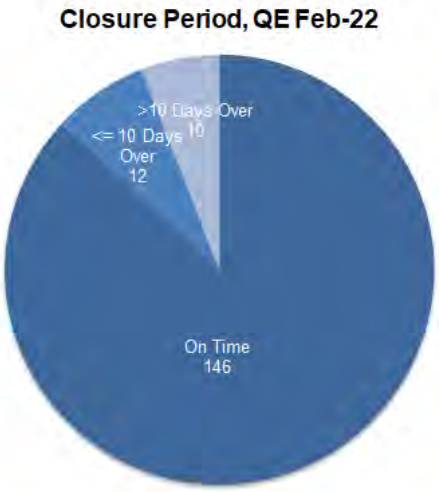
IMPROVEMENT ACTIONS	
20.3 Robust review of timed cancer pathways to ensure up to date and with clear escalation points	**By Mar-23**
This will be addressed as part of the overall recovery work and in line with priorities set within the Cancer Recovery Plan and by the leadership team. Priority will be given to the most challenging pathways.	
20.4 Prostate Improvement Group to continue to review prostate pathway	**By Mar-23**
This is ongoing work related to Action 20.3, with the specific aim being to improve the delays within the whole pathway. A national review of the prostate pathway will be undertaken as part of the Recovery Plan.	
21.2 Cancer Strategy Group to take forward the National Cancer Recovery Plan	**By May-22**
The National Cancer Recovery Plan was published in December 2020. A Strategic & Governance Cancer Group has been established with a Cancer Framework Core Group to develop and take forward the NHS Fife Cancer Framework and annual delivery plan for cancer services in Fife. Engagement sessions have been completed and the Framework and delivery plan is currently being drafted. The Framework is out for consultation.	
22.1 Effective Cancer Management Review	**By May-22**
The Scottish Government Effective Cancer Management Framework review to improve cancer waiting times performance is underway. The recommendations from the review will be addressed as part of the improvement process. The Scottish Government will be visiting NHS Fife to introduce the reviewed Framework. An action plan has been drafted and is to be sent to the relevant groups for ratification.	

Freedom of Information Requests

We will respond to a minimum of 85% of FOI Requests within 20 working days

Local Performance





Performance by Service Area

Monthly	2020/21	2021/22										
	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb
Health Board	93.5%	93.5%	79.2%	88.6%	58.0%	83.3%	74.5%	78.0%	84.1%	85.4%	85.7%	94.2%
IJB	100.0%	100.0%	100.0%	100.0%	100.0%	42.9%	77.8%	100.0%	87.5%	100.0%	60.0%	77.8%

KEY CHALLENGE(S) IN 2021/22

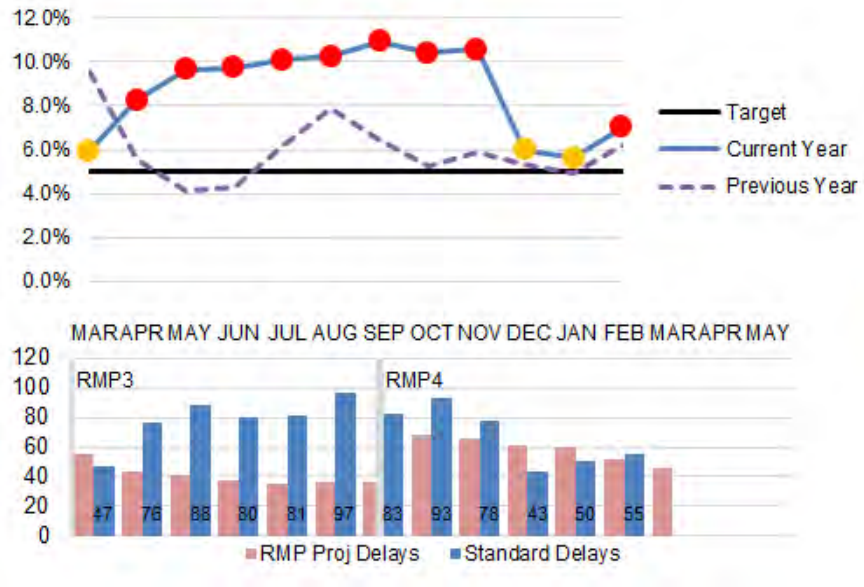
Establishment of a permanent resource level for all Information Governance and Security activities. Within the area of Freedom of Information, the temporary appointment has left the organisation and an Information Governance and Security Advisor is overseeing FOI administration. The route to a permanent post is still going through Human Resources and it is hoped that this will be ready for advertisement soon.

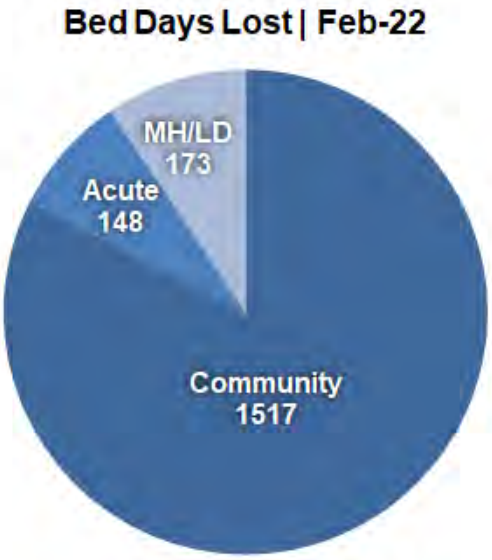
IMPROVEMENT ACTIONS	
21.1 Organisation-wide Publication Scheme to be introduced	**Complete Jun-21**
21.2 Improve communications relating to FOISA work	**Complete Dec-21**

Delayed Discharges (Bed Days Lost)

We will limit the hospital bed days lost due to patients in delay, excluding Code 9, to 5% of the overall beds occupied

Local Performance





National Benchmarking

Quarter Ending	2019/20			2020/21				2021/22	
	Sep	Dec	Mar	Jun	Sep	Dec	Mar	Jun	Sep
NHS Fife	8.0%	7.2%	8.3%	4.6%	6.8%	5.4%	5.7%	9.2%	10.4%
Scotland	7.2%	7.1%	7.3%	3.8%	5.1%	4.8%	4.6%	5.0%	6.7%

KEY CHALLENGE(S) IN 2021/22

- Capacity in the community – demand for complex packages of care has increased significantly
- Information sharing – H&SC workforce having access to a shared IT, for example Trak, Clinical Portal
- Workforce – Ensuring adequate and safe staffing levels to cover the additional demand to facilitate discharge from the acute setting to the community hospitals and social care provision

IMPROVEMENT ACTIONS	
21.1 Progress HomeFirst model / Develop a 'Home First' Strategy	**By Dec-22**
The Oversight "Home First" group continue to meet on a regular basis, and Project Management Office (PMO) support is in place. Seven subgroups are taking forward the operational actions to bring together the "Home First" strategy for Fife. Monthly meetings take place, and this action will continue for the remainder of 2022.	
22.1 Fully implement the "Moving On" Policy in Acute and Community Hospitals	**Complete Jul-21**
22.2 Test of Change – Trusted Assessor Model (or similar) to support more timely discharges to STAR/Assessment placements in the community	**By Sep-22**
The test of change is ongoing, however, the number of STAR beds available has been limited due to care home closures (COVID). This has resulted in a slip to the initial target completion date.	
22.3 Reduce number of delays due to awaiting the appointment of a Welfare Guardian	**Complete Mar-22**
A review of the guardianship paperwork and templates is complete, and the refreshed document has been approved by H&SC and NHS Fife (Acute). It will be held within patient notes to provide an overview and audit trail.	
22.4 Develop capacity within START plus additional investment to develop a programme of planning with the private agencies supported by Scottish Care	**Complete Mar-22**
Development of Care at Home Collaborative, supported by Scottish Care, started in late 2021, bringing together 10-12 Care at Home providers to work together, to maximise resources and capacity to help service user return to their own home, following a period in a care home interim placement. Commissioning of this resource is now complete.	
22.5 Surge capacity established to support admission demand	**Complete Mar-22**
Surge capacity has been established in QMH (Ward 3/8/8A), Glenrothes (Ward 1/2/3), Cameron (Balgonie/Balcurvie/Letham) and VHK (Ward 6/9)	

Revenue Expenditure

NHS Boards are required to work within the revenue resource limits set by the Scottish Government Health & Social Care Directorates (SGHSCD)

1. Executive Summary

At the end of February the board's reported financial position is a balanced position which is in line with the projected outturn for the financial year end. The position comprises an adverse variance for Acute Services Division of £17.433m and £2.224m for External Health Care Providers, offset by favourable variances across Corporate Functions and, of note this month, is the receipt of non recurring Scottish Government funding support of £13.7m to enable the Board to break even. Included in the Acute Services overspend is an adverse variance for Set Aside budgets of £5.8m and, as NHS Fife have current responsibility for the set aside budgets, this places additional financial pressure on the board and non-IJB health care services. The health services delegated to the Health & Social Care Partnership (H&SCP) report an underspend of £2.980m for the 11 months to February (following a non-recurring budget realignment payment made from Health Board to Fife Council of £3.734m in December).

Revenue Financial Position as at 28th February 2022

Budget Area	Annual Budget £'000	YTD Budget £'000	YTD Spend £'000	YTD Variance £'000
NHS Services (incl Set Aside)				
Clinical Services				
Acute Services Division	240,598	221,877	239,310	-17,433
IJB Non-Delegated	9,474	8,691	8,520	171
Non-Fife & Other Healthcare Providers	90,611	83,066	85,290	-2,224
Non Clinical Services				
Estates & Facilities	78,041	70,914	68,000	2,914
Board Admin & Other Services	91,789	84,474	83,129	1,345
Other				
Financial Flexibility & Allocations	30,077	15,153	0	15,153
Income	-39,132	-36,408	-36,482	74
SUB TOTAL	**501,458**	**447,767**	**447,767**	**0**
Health & Social Care Partnership				
Fife H & SCP	433,869	345,485	342,505	2,980
SUB TOTAL	**433,869**	**345,485**	**342,505**	**2,980**
TOTAL	**935,327**	**793,252**	**790,272**	**2,980**

1.2 Cost pressures within Acute Services continue to increase reflecting the exceptional demand on unscheduled care capacity and challenges with delayed discharges. The many actions being taken to manage demand pressures have increased the requirement for temporary staffing. Increasing expenditure across medicines budgets continues to add to the significant cost pressures within clinical directorates particularly with Haematology/Oncology drugs budgets and Biologics.

1.3 The financial impact of COVID-19, including direct additional costs for vaccination, testing and remobilisation plus indirect costs associated with the managing the wider impact and recovery measures continues to be regularly updated and shared through established reporting mechanisms through quarterly reporting returns. Details are contained within Appendix 1. A Scottish Government letter received in February 2022 set out details of a further tranche of Covid-19 funding available to Boards and Integrated Authorities. The available balance of funding remaining at year end, which is expected to total £34m subject to final review, will be carried forward

into 2022/23 as an earmarked Covid recovery reserve within Integration Joint Boards. Further guidance is expected on how the funding will require to be deployed in 2022/23 against key priorities in supporting Covid-19 recovery.

1.4 The February allocation letter was issued on 9 March 2022 and included ADP Task force funding of £0.409m, out of hours additional urgent support £0.168m and CSO support for Covid research infrastructure. We also received notification of further Covid funding of £64.908m on 25 February 2022 for both Health Board and HSCP additional costs. Anticipated core allocations total -£0.712m and, as is often the case as we near year end, reflects additional top slicing for services to NSD. Further allocation details are contained within Appendix 2.

1.5 At the beginning of the financial year the board was committed to delivering cost improvements in year of £8.181m which are now confirmed as delivered in full. Despite the challenges the pandemic has created in the delivery of cost improvement plans, the board has delivered savings totalling £9.618m at the end of February. Appendix 3 sets out the savings achieved including an analysis of recurring and non-recurring sources, and forms the basis of our additional monthly reporting to Scottish Government.

1.6 The overall anticipated capital budget for 2021/22 is £33.942m. The capital position for the period to February records spend of £19.233m. Therefore, 56.66% of the anticipated total capital allocation has been spent to month 11. The full capital programme is expected to deliver in full with significant activity in the final month of the year and a balanced capital position is expected.

2. Health Board Retained Services

Clinical Services financial performance at 28 February 2022

Budget Area	Annual Budget £'000	YTD Budget £'000	YTD Spend £'000	YTD Variance £'000
Acute Services Division	240,598	221,877	239,310	-17,433
IJB Non-Delegated	9,474	8,691	8,520	171
Non-Fife & Other Healthcare Providers	90,611	83,066	85,290	-2,224
Income	-39,132	-36,408	-36,482	74
SUB TOTAL	**301,551**	**277,226**	**296,638**	**-19,412**

2.1 Costs directly attributable to Covid-19 have been identified and matched with budget, on a non-recurring basis and work continues to develop the projected covid impact into the new financial year. The Quarter 3 financial return and projections included an update on the financial impact of Covid 19 and informed Scottish Government further funding allocations per 1.5 above.

2.2 The Acute Services Division reports an **overspend of £17.433m.** Acute Services are experiencing particularly challenging capacity pressures at the front door and downstream wards on top of existing historic cost pressures. Measures are underway to ease the pressures including increasing temporary over recruitment to unregistered nursing posts, admin posts and international recruitment. A significant proportion of the reported overspend to February relates to unachieved savings of £11.489m. As reported in other sections of this report, non repayable funding has been received from Scottish Government which is included within financial flexibility. The decision not to attribute to individual budget areas was made to retain focus on delivery of savings targets. The remainder of the reported overspend continues across Nursing, Senior and Junior Medical Pay budgets, non-pay pressures within Haematology/Oncology medicines budgets and growth demand on diabetic pumps. Growth in spend on Acute medicines has accelerated beyond available funding significantly and is an issue being reported across boards in Scotland. In preparation for next year, cost improvement programmes are being identified and documented which will help to close the financial gap.

2.3 The IJB Non-Delegated budget reports an **underspend of £0.171m.** This is mostly being driven by a pay underspend in the Daleview Regional Unit, resulting from occupational therapy and learning disabilities nursing vacancies.

2.4 The budget for healthcare services provided out-with NHS Fife is **overspent by £2.224m** and is broadly in line with the position reported last month. Further detail is contained in Appendix 4.

Corporate Functions and Other Financial performance at 28 February 2022

Budget Area	Annual Budget £'000	YTD Budget £'000	YTD Spend £'000	YTD Variance £'000
Non Clinical Services				
Estates & Facilities	78,041	70,914	68,000	2,914
Board Admin & Other Services	91,789	84,474	83,129	1,345
Other				
Financial Flexibility & Allocations	30,077	15,153	0	15,153
SUB TOTAL	**199,907**	**170,541**	**151,129**	**19,412**

2.5 The Estates and Facilities budgets report an **underspend of £2.914m.** This comprises an underspend in pay of £0.809m which is continuing the trend of previous months across several departments including estates services, catering, and portering. Non-pay costs continue to perform well except for property maintenance. The ongoing increases in energy prices will continue to be monitored, as will general price inflation and its resulting impact.

2.6 Within the Board's corporate services there is **an underspend of £1.345m**. The main driver for this underspend is the level of vacancies across the Finance Directorate (£0.296m), the Nursing Director budget (£0.297m), Medical Director (£0.211m) and Other (£0.351m). The latter covers areas such as legal, early retirements and injury benefits - which in the main are financial transactions.

2.7 As part of the financial planning process, expenditure uplifts including supplies, medical supplies and drugs uplifts were allocated to budget holders from the outset of the financial year as part of the respective devolved budgets. A number of residual uplifts and cost pressure/developments and new in-year allocations are held in a central budget; with allocations released on a monthly basis. The **financial flexibility of £15.153m** has been released at month 11, and includes receipt of non-repayable support received from SG. Further detail shown in Appendix 5.

3. Health & Social Care Partnership

3.1 Health services in scope for the Health and Social Care Partnership report an **underspend of £2.980m.** This underspend is net of a non-recurring payment on account of the Health Delegated in-year underspend to Social Care made in December.

Budget Area	Annual Budget £'000	YTD Budget £'000	YTD Spend £'000	YTD Variance £'000
Health & Social Care Partnership				
Fife H & SCP	433,869	345,485	342,505	2,980
SUB TOTAL	**433,869**	**345,485**	**342,505**	**2,980**

The Health and Social Care Partnership budget detailed above are Health budgets designated as in scope for HSCP integration, excluding services defined as Set Aside. The financial pressure related to 'Set Aside' services is currently held within the NHS Fife financial position. These services are currently captured within the Clinical Services areas of this report (Acute set aside £5.8m overspend to month 11 per 1.1 above).

4. Forecast

4.1 Our forecast outturn to the year end is a balanced position following receipt of non recurring funding support of £13.7m for Health Board retained services (representing our in-year deficit in our opening financial plan of £13.656m unachieved). Our forecast position assumes ADEL (Additional Departmental Expenditure Limit) funding of £0.950m re the replacement of obsolete equipment; and property and vehicle repair expenditure which we expect to receive in our final allocation letter this year.

4.2 The Health delegated underspend position is forecast at £3.748m following the non-recurring budget realignment transfer of £3.734m to Fife Council in December. It is anticipated the final year end underspend will be transferred as a non-recurring payment later in March. The H&SCP projected year end position is an underspend of c£0.573m as confirmed by the Chief Finance Officer following the roll out of the recovery plan and receipt of further funding.

4.3 Whilst details of funds held within Delegated Health Earmarked Reserves (created last financial year) are noted at Appendix 6; work is ongoing to finalise an additional significant Health Delegated earmarked reserve for the current financial year.

4.4 The projected NHS Fife forecast does not include any risk share with the Health and Social Care Partnership given Integration Authorities will also be provided with Scottish Government support to a balanced position. A cash transfer has been actioned in December from Health to Council to allow both organisations to report a balanced position; with a further transfer planned towards the end of the financial year.

5. Recommendation

5.1 Members are invited to approach the Director of Finance and Strategy for any points of clarity on the position reported and are asked to:

- **Note** the reported core breakeven position for the 11 months to date for Health Board retained;
- **Note** the forecast balanced position for Health Board retained, following non recurring, non repayable funding SG funding support;
- **Note** the Health delegated forecast core underspend position (net of a cash transfer made to Fife Council of £3.7m in December) of a further £3.7m which will be transferred to Fife Council as we approach the financial year end.

Appendix 1: Covid-19 Funding

COVID funding	Health Board	Health delegated	Social Care delegated	Total	Capital
	£000's	£000's	£000's	£000's	£000's
Allocations Q1	8,702	2,878		11,580	
Allocations Q2	6,815	6,831	192	13,838	
Final allocation in January	20,947	9,945		30,892	
HSCP ear marked reserve		3,399		3,399	
Additional		34,017		34,017	
Total funding	**36,464**	**57,070**	**192**	**93,726**	**0**
Allocations made for April to February					
Planned Care & Surgery	1,393			1,393	
Emergency Care & Medicine	8,144			8,144	
Women, Children & Clinical Services	2,838			2,838	
Acute Nursing	0			0	
Estates & Facilities	1,321			1,321	
Board Admin & Other Services	1,860			1,860	
Public Health Scale Up	957			957	
Test and Protect	4,881			4,881	
Primary Care & Prevention Serv		635		635	
Community Care Services		1,672		1,672	
Complex & Critical Care Serv		286		286	
Professional/Business Enabling		182		182	
Covid Vaccine/Flu		11,640		11,640	
Social Care			192	192	
Non-repayable support	13,656				
Exclude additional		34,017			
Total allocations made to M11	**35,050**	**48,432**	**192**	**36,001**	**0**
Balance In Reserves	**1,414**	**8,638**	**0**	**57,725**	**0**
Remaining funding c/fwd to 2022/23	**34,017**				

Appendix 2: Revenue Resource Limit

		Baseline Recurring	Earmarked Recurring	Non-Recurring	Total	Narrative
		£'000	£'000	£'000	£'000	
	Initial Baseline Allocation	712,534			712,534	
	June Letter	9,264	12,244	20,964	42,472	
	July Letter			8,002	8,002	
	August Letter	141	230	1,522	1,893	
	September Letter	-135	59,994	-1,931	57,928	
	October Letter		3,390	14,908	18,298	
	November Letter	2,042	1,704	4,333	8,079	
	December letter		23	3,126	3,149	
	January Letter reported at month 10	-178	6,274	2,995	9,091	
25 Feb 2022	Amendment to January letter					
	PPE			130	130	As per SG Correspondence
	Further Covid Funding 2021-22			61,147	61,147	As per SG Correspondence
	Covid & Extended Flu Vaccinations			3,979	3,979	As per SG Correspondence
	Test & Protect			-347	-347	As per SG Correspondence
Letter 9 March 2022	Task Force Funding to ADPs			409	409	As per SG Correspondence
	Distinction Awards for NHS Consultants		139		139	Annual Allocation
	CSO support for Covid research infrastructure			60	60	Additional Allocation
	Improvements to forensic medical services			2	2	Additional Allocation to previous allocation
	Afghan refugee healthcare provision			62	62	As per specific allocation letter
	Audiology Equipment			12	12	Specific Allocation
	Remote blood pressure monitoring (InHealthCare)			15	15	Specific Allocation
	Out of Hours additional Urgent Support 2021-22			168	168	As per specific allocation letter
	ScotSTAR Topslice	-345			-345	Annual Adjustment
	Purchase of audiology equipment			5	5	Specific Allocation
	GJNH - Top slice adjustment - Boards			-11	-11	Annual Adjustment
	National Distribution Centre - Top-slice		-780		-780	Annual Adjustment
	Total Core RRL Allocations	**723,323**	**83,218**	**119,550**	**926,091**	
Anticipated	Capital to Revenue			277	277	
Anticipated	NSD Adjustments		-989		-989	
		0	**-989**	**277**	**-712**	
Anticipated	IFRS			8,900	**8,900**	
Anticipated	Donated Asset Depreciation			115	**115**	
Anticipated	Impairment			1,333	**1,333**	
Anticipated	AME Provisions			-400	**-400**	
	Total Anticipated Non-Core RRL Allocations	**0**	**0**	**9,948**	**9,948**	
	Grand Total	**723,323**	**82,229**	**129,775**	**935,327**	

Appendix 3: Savings Position at 28 February 2022

Total Savings	Total Savings Target £'000	Forecast Achievement (Core) £'000	Forecast unmet savings (Covid-19) £'000	Identified & Achieved Recurring £'000	Identified & Achieved Non-Recurring £'000	Identified & Achieved to February £'000	Unachieved to March £'000
Health Board	21,837	8,181	13,656	5,779	3,839	9,618	0
					0		0
Total Savings	**21,837**	**8,181**	**13,656**	**5,779**	**3,839**	**9,618**	**0**

NHS Fife Potential Savings Summary	£000's	Risk level		Identified CY	Outstanding Balance		Identified FY	Outstanding Balance
Workforce Capacity and Utilisation Review	1,000	High		-607	393		-41	959
Pay Vacancy Factor (1%)	3,015	Medium		-3,015	0		-3,015	0
Repatriation of Services	500	Low		-500	0		-500	0
External Commissioning Cost Review	1,000	Medium		-1,000	0		-1,000	0
Medicine Utilisation	500	Medium		-640	-140		-595	-95
Contracts	1,500	Low		-284	1,216		0	1,500
Procurement - Non pay	500	Medium		0	500		0	500
Other	166	Low		-3,572	-3,406		-628	-462
	8,181			**-9,618**	**-1,437**		**-5,779**	**2,402**

Appendix 4: Service Agreements

	CY Budget £'000	YTD Budget £'000	YTD Actuals £'000	YTD Variance £'000
Health Board				
Ayrshire & Arran	99	91	88	3
Borders	45	42	52	-10
Dumfries & Galloway	25	23	52	-29
Forth Valley	3,227	2,958	3,365	-407
Grampian	365	334	259	75
Greater Glasgow & Clyde	1,680	1,540	1,534	6
Highland	137	126	187	-61
Lanarkshire	117	107	198	-91
Lothian	31,991	29,327	30,859	-1,532
Scottish Ambulance Service	103	94	92	2
Tayside	40,084	36,741	38,167	-1,426
Savings				0
	77,873	**71,383**	**74,853**	**-3,470**
UNPACS				
Health Boards	10,801	9,900	8,679	1,221
Private Sector	1,151	1,057	1,293	-236
	11,952	**10,957**	**9,972**	**985**
OATS	721	661	400	261
Grants	65	65	65	0
Total	**90,611**	**83,066**	**85,290**	**-2,224**

Appendix 5: Financial Flexibility & Allocations

	£'000	Flexibility Released to Feb-22 £'000
Financial Plan		
Junior Doctor Travel	17	14
Consultant Increments	232	213
Cost Pressures	3,656	2,035
Developments	2,054	1,240
Sub Total Financial Plan	**5,959**	**3,502**
Allocations		
Waiting List	1,300	0
AME: Impairment	73	0
AME: Provisions	126	0
Pay Award:AfC	1,664	1,522
Test & Protect	784	0
Covid General	629	0
Winter	661	0
Cancer Waiting Time	225	92
Distinction Award	3	3
Unscheduled Care Summer	180	0
Support to build recruitment capacity	27	0
Building Capacity for international recruitment	11	0
Young Patients Family Fund	38	29
Emergency Cancer Diagnostic Centre	196	0
Pregnancy Anaemia Management	28	0
Workforce Wellbeing	200	0
Discharge Without Delay Pathfinders	256	0
Interface Care Programme	480	0
Nurse Director Support	403	0
Fleet Decarbonisation	54	0
R&D	12	11
2020/21 Surplus	340	312
Chronic Pain	9	0
Additional CT & MRI Capacity	44	0
Mental Health Pharmacy recruitment	64	0
Additional Band 2-4	845	0
Capital to Revenue	355	0
International Recruitment	378	0
Diabetic Technologies	999	0
Audiology Equipmet	18	0
Funding Support	13,656	9,682
CSO Covid Research	60	0
Sub Total Allocations	**24,118**	**11,651**
Total	**30,077**	**15,153**

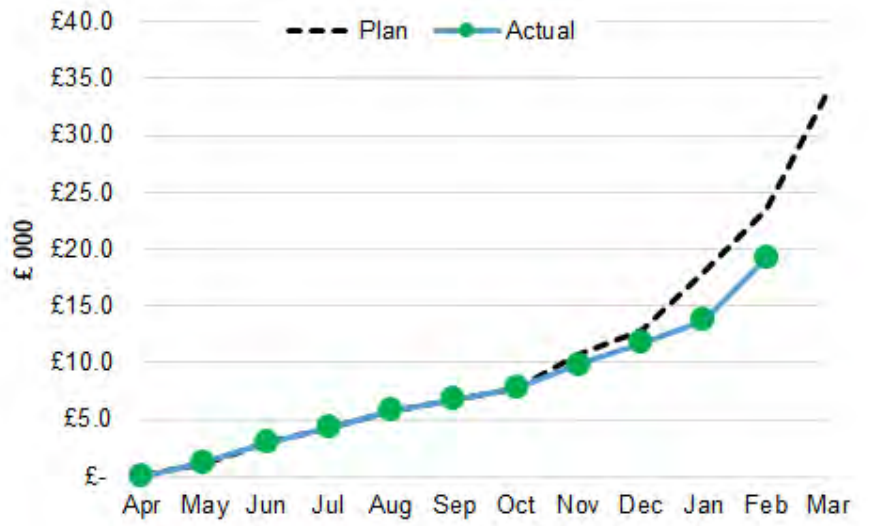
Appendix 6: Anticipated Funding from Health Delegated Earmarked Reserve

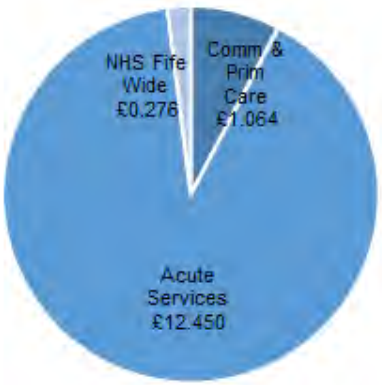
Health Delegated Earmarked Reserve	Total £000's	Health Delegated Budgets To M11 £000's	Anticipated £000's	Balance £000's
Vaccine	740	740		0
Care homes	526	82		444
Urgent Care Redesign	935	408		527
Flu	203	203	0	0
Primary Care Improvement Fund	2,524	1,011		1,513
Action 15	1,315	505		810
RT Funding	1,500			1,500
FSL	500	500		0
District Nurses	30			30
Fluenz	18			18
Core run rate	1,767	1,206	0	561
Core (covid offsets)	1,250	1,250		0
Total	**11,308**	**5,905**	**0**	**5,403**

Capital Expenditure

NHS Boards are required to work within the capital resource limits set by the Scottish Government Health & Social Care Directorates (SGHSCD)

Local Performance





Commentary

The overall anticipated capital budget for 2021/22 is £33.942m. The capital position for the period to January records spend of £19.233m. Therefore, 56.66% of the anticipated total capital allocation has been spent to month 11; with significant activity underway in the final month of the year which will inform a balanced capital position.

1. Annual Operational Plan

The capital plan for 2021/22 was approved by the FP&R Committee in July and was subsequently tabled at the NHS Fife Board. NHS Fife has assumed a programme of £33.942m detailed in the table below.

Capital Plan	£'000
Initial Capital Allocation	7,394
National Equipping Funding	1,537
Elective Orthopaedic Centre	15,907
Mental Health Review	22
Lochgelly Health Centre	348
Kincardine Health Centre	207
Energy Scheme Funding	1,457
Pre Capital Fund Grant	50
Covid Capital	1,878
QMH Theatre	1,000
CT Scanner	700
Louisa Jordan Equipment	22
Laundry Equipment	655
2nd Tranche NIB Equipment	1,176
National Eyecare Workstream	228
Capital to Revenue Transfer	- 277
SG Extra Funding Request	591
Decontamination Room	350
Colposcope	12
Extra National Eyecare Workstream	51
Audiology Equipment	97
Additional Equipment Funding	136
Decontamination Equipment	241
Additional Equipment Funding PH2	160
Total	**33,942**

There has been a reduction in the expected funding to be allocated for the Energy Grant this year. Originally, expenditure was planned to be £1.8m, however, this has now been reduced to £1.457m, and the remaining balance of £0.343m will be provided for next financial year.

Despite being a challenging year in terms of supply chain issues, availability of materials and price increases on materials the capital plan and achievement of the capital resource limit remains on target.

Capital Receipts

1.1 Work continues into the new financial year on asset sales re disposals:

- Lynebank Hospital Land (Plot 1) (North) – discussions are ongoing as to whether to remarket, there are also discussions ongoing around the potential possibility of HFS constructing a new sterilising unit for East Scotland on the site.
- Skeith Land – an offer has been accepted subject to conditions for planning and access - however the GP's have now put in an objection to the planning department. The Developers have provided other plans in order to move forward, however, the GP's are still objecting.

2. Expenditure / Major Scheme Progress

2.1 The summary expenditure position across all projects is set out in the dashboard summary above. The expenditure to date amounts to £19.233m, this equates to 56.66% of the total capital allocation, as illustrated in the spend profile graph above.

2.2 The main areas of spend to date include:

Statutory Compliance	£3.851m
Equipment	£3.241m
Digital	£0.343m
Elective Orthopaedic Centre	£10.658m
Health Centres	£0.424m
Clinical Prioritisation	£0.711m

3. Recommendation

3.1 Members are invited to approach the Director of Finance and Strategy for any points of clarity on the position reported and are asked to:

note the capital expenditure position to 28 Febuary 2022 of £19.233m and the year-end spend of the total anticipated capital resource allocation of £33.942m.

Appendix 1: Capital Expenditure Breakdown

Project	CRL Confirmed Funding £'000	Total Expenditure to Date £'000	Projected Expenditure 2021/22 £'000
COMMUNITY & PRIMARY CARE			
Clinical Prioritisation	218	158	218
Statutory Compliance	364	303	364
Capital Equipment	151	147	151
Condemned Equipment	23	23	23
National Infrastructure Equipment Funding	6	0	6
Kincardine Health Centre	207	173	207
Lochgelly Health Centre	348	250	348
Decontamination Room	350	0	350
Total Community & Primary Care	1,666	1,055	1,666
ACUTE SERVICES DIVISION			
Statutory Compliance	2,953	2,301	2,953
Capital Equipment	1,981	1,639	1,981
Clinical Prioritisation	763	292	763
Condemned Equipment	88	63	88
National Infrastructure Equipment Funding	3,407	1,288	3,407
Elective Orthopaedic Centre	15,907	10,658	15,907
Laundry Equipment	655	0	655
National Eyecare Workstream	279	0	279
Colposcope	12	0	12
QMH Theatre	1,000	242	1,000
Extra SG Funding Request	591	82	591
Audiology Equipment	97	0	97
Total Acute Services Division	27,734	16,565	27,734
NHS FIFE WIDE SCHEMES			
Equipment Balance	3	0	3
Information Technology	1,200	343	1,200
Clinical Prioritisation	0	0	0
Statutory Compliance	0	0	0
Condemned Equipment	1	0	1
Fire Safety	60	60	60
Scheme Development	0	0	0
Vehicles	142	0	142
Covid Capital	1,325	260	1,325
Mental Health Review	22	5	22
Total NHS Fife Wide Schemes	2,753	667	2,753
TOTAL CAPITAL ALLOCATION FOR 2021/22	**32,154**	**18,288**	**32,154**

ANTICIPATED ALLOCATIONS 2021/22			
Energy Funding Grant	1,457	945	1,457
Pre Capital Grant Funding	50	0	50
ECG Machines - Louisa Jordan Equipment	22	0	22
Capital to Revenue Transfer	-277	0	-277
Additional Equipment Funding	136	0	136
Decontamination Equipment	241	0	241
Additional Equipment Funding PH2	160	0	160
Anticipated Allocations for 2021/22	**1,788**	**945**	**1,789**

Total Anticipated Allocation for 2021/22	**33,942**	**19,233**	**33,942**

Appendix 2: Capital Plan - Changes to Planned Expenditure

Capital Expenditure Proposals 2021/22 Routine Expenditure	Pending Board Approval £'000	Cumulative Adjustment to January £'000	February Adjustment £'000	Total February £'000
Community & Primary Care				
Capital Equipment	0	151	0	151
Condemned Equipment	0	24	-1	23
Clinical Prioritisation	0	252	-34	218
Statutory Compliance	0	329	35	364
Lochgelly Health Centre	0	0	207	207
Kincardine Health Centre	0	0	348	348
National Infrastructure Equipment Funding	0	6	0	6
Decontamination Room	0	0	350	350
Total Community & Primary Care	**0**	**762**	**905**	**1,666**
Acute Services Division				
Capital Equipment	0	1,971	10	1,981
Condemned Equipment	0	88	0	88
Clinical Prioritisation	0	727	36	763
Statutory Compliance	0	2,945	8	2,953
National Infrastructure Equipment Funding	0	3,407	0	3,407
Elective Orthopaedic Centre	0	15,907	0	15,907
National Eyecare Workstream	0	228	51	279
Laundry Support	0	600	55	655
Colposcope	0	0	12	12
Audiology Equipment	0	0	97	97
Extra SG Funding Request	0	0	591	591
QMH Theatre	0	0	1,000	1,000
	0	**25,874**	**1,860**	**27,734**
Fife Wide				
Backlog Maintenance / Statutory Compliance	3,500	-3,476	-43	-18
Fife Wide Equipment	1,805	-1,792	-10	3
Digital & Information	1,000	200	0	1,200
Clinical Prioritisation	500	-480	-2	18
Condemned Equipment	90	-90	1	1
Fife Wide Asbestos Management	0	0	0	0
Fife Wide Fire Safety	0	60	0	60
General Reserve Equipment	94	-94	0	0
Pharmacy Equipment	205	-205	0	0
Fife Wide Vehicles	0	142	0	142
Covid Capital	0	1,325	0	1,325
Mental Health Review	0	0	22	22
Total Fife Wide	**7,194**	**-4,409**	**-31**	**2,753**
Total Capital Resource 2021/22	**7,194**	**22,226**	**2,733**	**32,153**

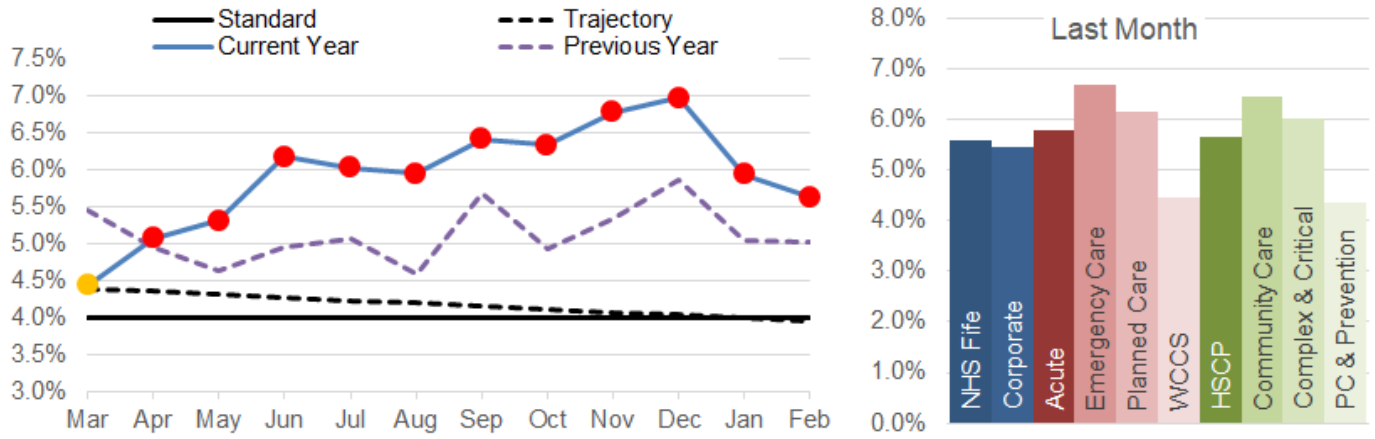
ANTICIPATED ALLOCATIONS 2021/22				
Energy Funding Grant	1,457	0	0	1,457
Pre Capital Grant Funding	50	0	0	50
ECG Machines - Louisa Jordan Equipment	22	0	0	22
Capital to Revenue Transfer	-277	0	0	-277
Additional Equipment Funding	136	0	0	136
Decontamination Equipment	241	0	0	241
Additional Equipment Funding PH2	160	0	0	160
Anticipated Allocations for 2021/22	**1,788**	**0**	**0**	**1,788**

Total Planned Expenditure for 2021/22	**8,982**	**22,226**	**2,733**	**33,942**

Sickness Absence

*To achieve a sickness absence rate of 4% or less (Improvement Target for 2021/22 = **3.89%**)*

Local Performance



National Benchmarking

Month	2020/21	2021/22										
	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb
NHS Fife	4.43%	5.07%	5.31%	6.17%	6.03%	5.95%	6.42%	6.34%	6.79%	6.98%	5.93%	5.63%
Scotland	4.56%	4.59%	5.04%	5.52%	5.62%	5.76%	6.12%	6.30%	6.37%	6.23%	5.37%	4.96%

KEY CHALLENGE(S) IN 2021/22

To secure an ongoing reduction in the current levels of sickness absence performance, as services remobilise, working towards the third-year trajectory for the Board of 3.89% in with NHS Circular PCS (AfC) 2019/2

IMPROVEMENT ACTIONS

22.1 Work towards improvement in long term sickness absence relating to mental health, using Occupational Health and other support services and interventions	**By Mar-23**

The additional OH Physician is providing specific support for staff affected by Mental Health and training is available for managers. This is in addition to the individual case work being progressed by local managers and HR staff, with input when necessary from the specialist OH Mental Health Nurse. The new OH Occupational Therapist is providing support to staff resuming work following diagnoses of long COVID, and this will continue into 2022/2023.

Additional staff support is being provided via a variety of services and initiatives, alongside the introduction of new eLearning Modules on resilience and wellbeing and access to the National PROMiS resources. This is complemented by a range of supporting materials, including a new “Benefits of Being Outdoors” poster and desktop campaign.

Additional monies to support staff during the winter months have been allocated and include improved access to meals out of hours, additional resources for Spiritual Care, Values Based Reflective practice, Psychology Staff support and Health Psychology, alongside bespoke wellbeing sessions for specific staff groups (e.g. H&S, ICU).

On line Fuel Poverty sessions took place in March, with additional on site sessions being arranged for April. Plans have been completed in terms of the use of the extra Scottish Government funding allocation for Staff Health and Wellbeing with a range of staff support activities during 2022/2023.

22.2 Continue existing managerial actions in support of achieving the trajectory for the Board and the national standard of 4% for sickness absence	**By Mar-23**

In addition to routine activities, a questionnaire is being circulated to managers in advance of the Promoting Attendance training sessions to identify areas for provision of support, both within and outwith the training sessions. The new Once for Scotland eLearning module is being promoted to complement our internal training and to assist managers and staff with their understanding of the policy.

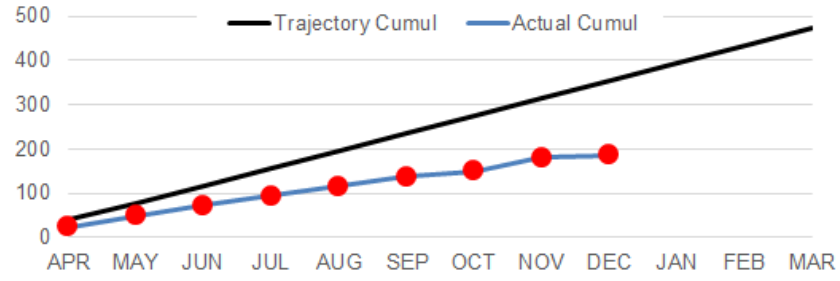
Feedback received following a programme to reinforce attendance management processes undertaken between May and July 2021 was discussed in partnership at the Attendance Management Workforce Review Group held in December, with a series of actions being progressed by key stakeholders. Promoting attendance at work is a regular agenda item at LPF and APF meetings ensuring regular discussion and suggestions/actions for consideration.

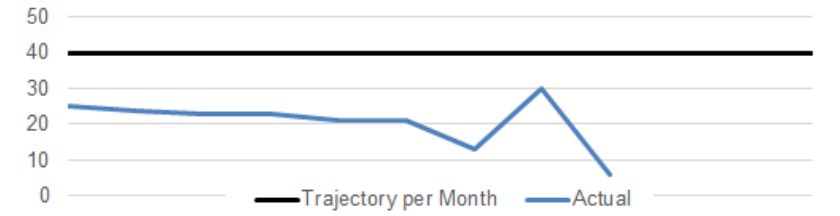
22.3 Consider refinements to COVID-19 absence reporting, including short-term manual data capture from SSTS and eESS in preparation for any change to self-isolation guidance and to support ongoing workforce resourcing actions, acknowledging that systems development is required to support MI reporting	**Complete Nov-21**

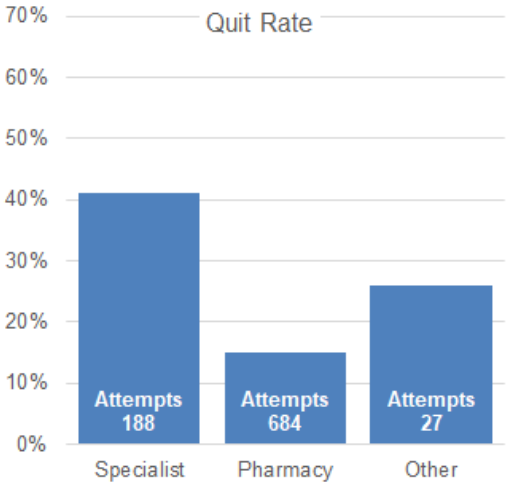
Smoking Cessation

In 2021/22, deliver a minimum of 473 post 12 weeks smoking quits in the 40% most deprived areas of Fife

Local Performance







National Benchmarking

		2021/22											
		APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
NHS Fife	Actual	25	24	23	23	21	21	13	30	6			
	Actual Cumul	25	49	72	95	116	137	150	180	186			
	Trajectory Cumul	40	79	118	158	197	236	276	315	354	394	434	473
	Achieved	62.5%	62.0%	61.0%	60.1%	58.9%	58.1%	54.3%	57.1%	52.5%			
Scotland	Achieved			92.4%			82.0%						

KEY CHALLENGE(S) IN 2021/22

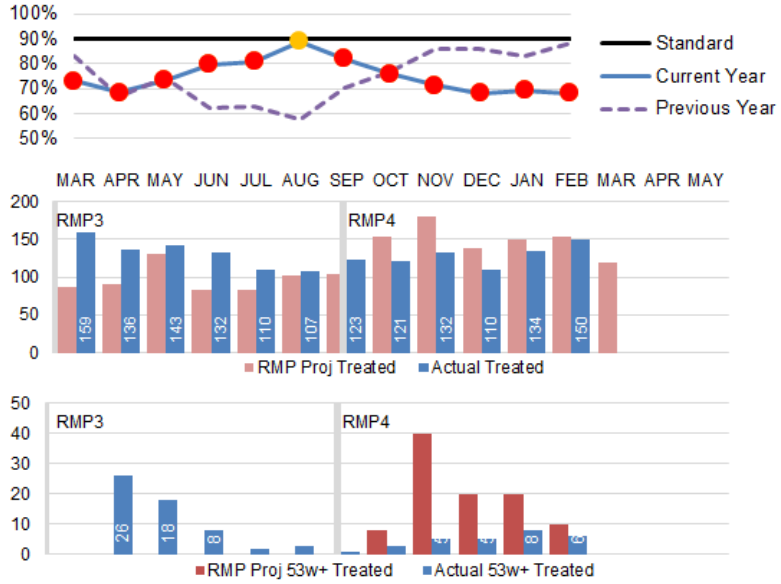
- Remobilising face to face delivery in a variety of settings due to venue availability and capacity
- Moving from remote delivery to face to face provision, patients having confidence in returning to a medical setting
- Potential for slower recovery for services as they may require to rebuild trust in the brand
- Re-establishment of outreach work

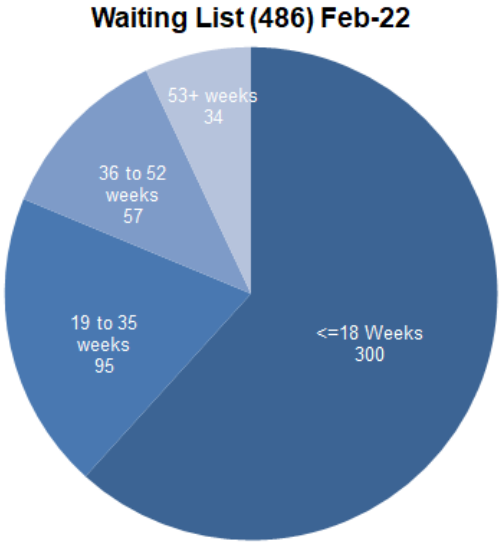
IMPROVEMENT ACTIONS	
20.2 Test Champix prescribing at point of contact within hospital respiratory clinic	**Complete Oct-21**
20.3 'Better Beginnings' class for pregnant women	**Complete Oct-21**
20.4 Enable staff access to medication whilst at work	**Closed Mar-22**
This action has been paused due to the pandemic, but may be revisited in FY 2022/23. Action closed at this stage.	
21.1 Assess use of Near Me to train staff	**Complete Jul-21**
21.2 Support Colorectal Urology Prehabilitation Test of Change Initiative	**Complete Sep-21**
22.1 Test face to face provision in two GP practices and one community venue	**Complete Mar-22**
Assess and engage with two GP practices and one community venue to re-establish face to face provision in the most deprived communities. Risk assessments, PPE, equipment and patient flow to be considered and included in plans. Early discussions with 2 GP practices were due to restart in the second week of January, while the remobilisation plan was scheduled to go to the remobilisation committee on 9th December. However, both activities were paused due to the impact of the COVID Omicron strain. Ongoing discussions with GP practices have taken place, and we have an agreed start date of week beginning 2nd April.	

CAMHS 18 weeks RTT

At least 90% of clients will wait no longer than 18 weeks from referral to treatment

Local Performance





National Benchmarking

Month	2020/21	2021/22										
	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB
NHS Fife	73.0%	68.4%	73.4%	79.5%	80.9%	88.8%	82.1%	76.0%	71.2%	68.2%	69.4%	68.0%
Scotland	67.5%	71.3%	71.8%	74.8%	75.9%	77.4%	82.1%	71.5%	70.5%	68.9%		

KEY CHALLENGE(S) IN 2021/22

- Implementation of additional resources to meet demand; development of workforce to meet National CAMHS Service Specification
- COVID-19: relaxation on referrals and delivery of 'models' to reflect social distancing

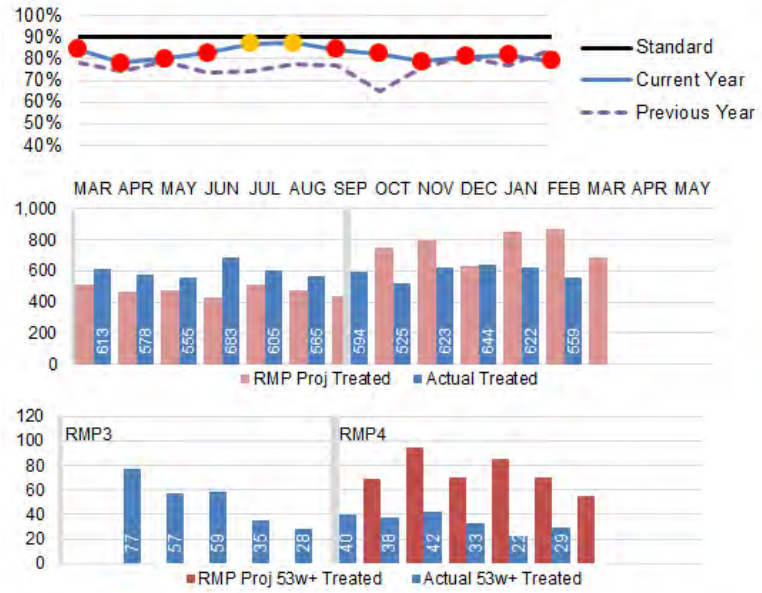
IMPROVEMENT ACTIONS

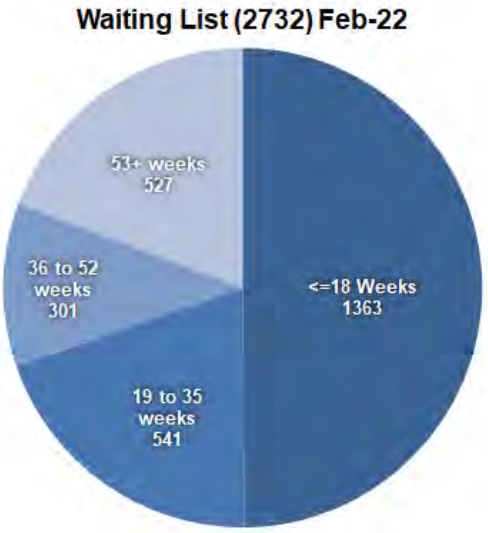
21.1 Re-design of Group Therapy Programme	**Complete Jul-21**
21.3 Build CAMHS Urgent Response Team (CURT)	**By Jun-22**
The CURT model is in place. Responsiveness to A&E and Paediatric inpatient unit has been extended with same day assessments available if young people are considered fit for assessment. Presentations to Emergency department due to self harm/suicidal ideation remain high with a 180% increase through 2022. Recruitment is underway to increase the existing CURT staffing capacity from 2.8 wte to 6.6 wte to address the increasing referral trend for urgent presentations. Review of activity and effectiveness of the model is ongoing utilising improvement methodology.	
22.1 Recruitment of Additional Workforce	**By Jun-22**
Recruitment is ongoing across multiple service areas to improve RTT, Longest waits and CAMHS service provision. From the 12 staff identified to address immediate capacity issues, 9 have been appointed with remaining posts re-advertised at lower banding to improve uptake. All new staff have worked through induction programme to ensure they are competent to take on caseloads and are incrementally increasing clinical activity towards full capacity. This is balanced against staff departures and retirements which have created 6 additional posts for recruitment. Phase 1 and Phase 2 recruitment as part of the SG Recovery & Renewal fund is underway. Currently Fife CAMHS has 21 wte posts either out to recruitment or in development with additional roles in admin (5.0 wte) and AHP (3.0 wte) working through the recruitment process.	
22.2 Workforce Development	**Complete Mar-22**
A revised development and training programme, which was originally postponed in January due to high Covid-19 absences, is now underway. Three Programmes have been developed to suit different levels of CAMHS experience. A Training needs analysis has been completed to ensure the right skills and competencies exist across the range of teams in CAMHS.	

Psychological Therapies 18 weeks RTT

At least 90% of clients will wait no longer than 18 weeks from referral to treatment

Local Performance





National Benchmarking

Month	2020/21	2021/22										
	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB
NHS Fife	84.3%	78.2%	80.0%	82.6%	86.9%	87.4%	84.5%	82.3%	78.8%	81.1%	81.8%	79.2%
Scotland	80.9%	81.3%	82.5%	84.3%	88.5%	87.0%	86.1%	85.5%	83.0%	85.1%		

KEY CHALLENGE(S) IN 2021/22

- Recruitment of staff required to achieve waiting times standard at a time of national workforce pressures
- Progressing vision for PTs within the timeframe required to sustain improved performance

IMPROVEMENT ACTIONS	
20.5 Trial of new group-based PT options	**Complete Sep-21**
22.1 Increase access via Guided self-help service	**Complete Sep-21**
22.2 Expansion of skill mix model to increase delivery of low intensity interventions	**Complete Jan-22**
22.3 Recruit new staff as per Psychological Therapies Recovery Plan	**By Jun-22**
There remain significant national issues with workforce availability for staff who can provide highly specialised PTs - required to address our WL backlog. The service has been successful in recruiting other grades of staff to increase delivery of PTs for people with less complex problems and free some capacity amongst staff qualified to work with the more complex presentations. The NHS Education for Scotland national recruitment campaign has been less successful than hoped but we do have some applicants for highly specialist posts, with interview dates for end of April. However, we shall not be able to recruit to all of the posts that were identified as required within the PT Recovery Plan.	
22.4 Waiting list management within General Medical Service in Clinical Health	**By May-22**
Staff are undertaking a focused piece of work to clear the backlog on the assessment waiting list. A key driver is the need to differentiate patients with functional neurological disorder from those with other needs in order to inform development of appropriate clinical pathways. The work will ensure that only those for whom psychological therapy is the best option remain on the waiting list. It will also inform next steps in development of clinical pathways.	
22.5 Programme of training to increase capacity for work with more complex patients	**Complete Mar-22**
The AMH psychology service have implemented a structured programme of training and supervision to increase the skills of the Clinical Associates in Applied Psychology. This will reduce the demand upon the Clinical Psychologists in the service who are able to work with people with more complex presentations.	

NHS Fife

Meeting:	**Finance, Performance and Resources Committee**
Meeting date:	**10 May 2022**
Title:	**Progress of Annual Delivery Plan (RMP4) 2021/22**
Responsible Executive:	**Margo McGurk, Director of Finance & Strategy** **Janette Owens, Director of Nursing**
Report Author:	**Susan Fraser, Associate Director of Planning & Performance**

1 Purpose

This is presented to the Committee for:

- Assurance

This report relates to the:

- Remobilisation Plan 4 2021/22 – Update to end of March 2022
- Review of National Response to Winter 2021/22
- Winter Report 2021/22 – Data to March 2022

This aligns to the following NHS Scotland quality ambition(s):

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

The fourth Joint Remobilisation Plan (RMP4) for Health and Care services delivered by NHS Fife and Fife Health and Social Care Partnership (HSCP) was submitted to Scottish Government on 30th September. This plan is considered as a review of the Remobilisation Plan 3, reflecting on progress and set out what is expected to be delivered over the remainder of 2020/21.

This paper reports on the actions of the Remobilisation Plan 4 and has been renamed as NHS Fife's Annual Delivery Plan (including the winter actions) 2021/22.

2.2 Background

The Scottish Government letter dated 20th July 2021 titled *Remobilisation Plans 2021/22: Mid-Year Update (RMP4)* commissioned the next iteration from NHS Boards of the Remobilisation Plan.

The feedback letter from Mr John Burns, Chief Operating Officer, Scottish Government was received on 19th November 2021 confirming that the RMP4 for the second half of 2021/22 can be taken through NHS Fife's governance process.

Progress against deliverables is to be reported to the Scottish Government on a quarterly basis. This paper focusses on status at end of March (to be submitted by 29th April).

This paper also covers the submission following the letter received 14th February from Scottish Government titled *Review of National Response to Winter 2021/22* which asked Boards for their winter lessons and reflections on collective planning and response arrangements.

2.3 Assessment

This assessment reports on three aspect of strategic planning and covers: update to the Remobilisation Plan 4, Review of national response to Winter 2021/22 and Winter Report (data).

Remobilisation Plan 4 2021/22 – Update to end of March 2022

The guidance document issued in July 2021 described a different approach and requirements for RMP4 since the submission of RMP3. We were required to provide a shorter strategic organisational overview with specific delivery action plans to be delivered by March 2022.

Action Status (31/3/2022)	
Unlikely to complete on time/meet target	12
At risk - requires action	20
On Track	61
Complete/ Target met	52

The summary status above shows that the majority of the action for 2021/22 are completed or on track to be completed by the target date. The key themes of actions that are unlikely to be completed are: delivery of elective care and diagnostics and improvements in cancer performance and early diagnosis.

The full delivery action plan of the Remobilisation Plan 4 can be found in Appendix 1 and is being monitored and documented quarterly. Any incomplete actions will be carried over into next year's Annual Delivery Plan 2022/23.

Review of National Response to Winter 2021/22

Following the request from Scottish Government, NHS Fife submitted the Review of the National Response to Winter 2021/22 on 18 March 2022 – the full response can be found in Appendix 2.

The pressure on the health and care system intensified over the winter period but has not subsided in terms of capacity and flow since 2020. NHS Fife and Fife Health and Social Care Partnership (HSCP) continues to prioritise the needs of our vulnerable and ill patients by providing timely and effective care, despite increases in demand on services or a mismatch between demand and supply of services.

Reflections of the health and care services over the winter period has been considered and the key actions taken by NHS Fife and Fife HSCP to lead and manage the health and care system are described in this section.

Emergency Command Structure
NHS Fife managed the emerging Covid-19 position through the Emergency Command structure that was already well embedded throughout the organisation and Fife Health and Social Care Partnership. The framework of the command structure of Gold, Silver and Bronze was implemented for operational teams, winter, capacity and flow and workforce.

Development of Escalation Framework
The development of the OPEL (Operational Pressure Escalation Levels) Tool at the end of 2021 enables the whole system to manage and respond to current challenges in capacity in a systematic and planned way. Each operational team now have an accurate overview of the pressures on their systems to be able to focus and plan to release or maintain capacity and flow in the system.

Informed Decision Making
A winter scorecard has been used on a weekly basis to discuss and plan in an integrated way with the operational teams. This scorecard follows the patients journey starting with Urgent Care, through Emergency Care and acute to community ward stays and onwards to social care capacity.

Impact on HAI standards
Constant pressures on the health and care system have impacted on the bed capacity in ward bays. The number of beds was reduced in ward bays to meet the HAI standards; however, additional beds were reintroduced in wards in acute and community settings. The demand for beds is such that these have remained open longer than expected.

Workforce
Workforce continues to be challenging across health and social care with a significant impact on the care and treatment that can be provided. We established a Workforce Resilience Silver Group last year as part of our command structure and the group has overseen workstreams on Resilience Planning, Resourcing, Education & Training and Employee Wellbeing.

Some of the key workstreams have involved the identification and deployment of a 'Workforce Resilience Layer' which has included non-frontline staff trained and redeployed for short term support in an operational support capacity.

Fife has experienced daily staffing challenges, so processes have been put in place to support the daily management of workforce, ensuring patient safety is maintained.

A number of initiatives have been introduced or enhanced to support staff wellbeing including wellbeing hubs, pastoral care, peer support and psychological support. These will continue to be in place to support our workforce.

Themes
Lessons learned have continued to be gathered and discussed by our staff throughout the winter period. Feedback from operational services were gathered and a detailed list of the responses received can be found in table below, which summarises the high-level themes. A further winter review workshop in April has been arranged with the wider clinical and

operational teams where the lessons learned will be discussed and proposed plans for 2022/23 will be described.

Theme	What went well	What did not go well?	What could be done differently?
Business Continuity/ Emergency Planning	Working of Local Resilience Partnership	Limitations on workforce and equipment	More robust BCPs and transport plans
Whole System Working	Agile and flexible teams Cross system working	Uptake of serial prescribing across all teams	Better deployment of Point of care testing (POCT)
Demand and Capacity	Pathway redesigned Staff Commitment Available information	Capacity challenges and delays Restricted GP access	Development of Front Door Model Improved discharge process
Escalation and Surge Plans	Command structure in place Development and Implementation of OPEL framework Agility of workforce	-	Earlier agreement of plans
Staffing Levels	Dedicated consultant cover Recruitment of temporary and redeployment of staff Wellbeing resources for staff	Staffing levels despite recruitment drive Patient care affected due the available staff	Ability to flex staff across the system Debrief for staff
Elective Activity	Maintenance of P1 and P2 activity Use of QMH	Stopping of electives, in particular orthopaedic	-
Infection Prevention and Control	Implementation of ARHAI Respiratory Pathway Care home huddles	Late publication of guidance	Time to implementation guidance Earlier MRSA screening
Test and Protect	Clear protocols for contact tracers Protocol to manage care home admissions	Managing the changes in isolation and testing requirements Timings of staff testing	Workforce model required going forward that can rapidly respond to demands
Communications	Regular engagement with all staff	Changing position with care home closures difficult to manage	Better national communications with public Revised visitors' policy

Winter Report 2021/22 – Data to March 2022

The Winter Report highlights the following key indicators for Winter – the full report can be found in Appendix 3:

A&E

The 95% Standard has not been met in the last 26 weeks. The Redesign of Urgent Care Program has had an impact on performance, and this affects all boards across Scotland. The board average has maintained within 5% of the Scotland average for the majority of the Winter Period.

Covid-19

The number of Covid-19 positive patients in Acute setting has risen increasingly since early March and are now at the highest levels seen throughout the Pandemic.

During the same period within Community settings Covid positive numbers have also risen increasing with the highest level seen causing many wards/bays to close during this period.

Occupancy
VHK occupancy was high late January then dipped in February till mid-March but has since been extremely high (98-99%).

The non-respiratory pathway has almost mirrored the overall occupancy and ending March with 98%.

Occupancy in Community Hospitals has maintained well above 100% for the whole of Winter and hitting 123% in January, and consistently 113% or above this year. Many wards throughout the period have had to close due to Covid which has contributed to pressure throughout. The occupancy this winter is trending higher than any other due to the number of surge beds opened to try and maintain flow within the acute hospital.

Delayed Discharges
The number of Delayed Discharge Bed Days in VHK was steady during February until the end of the month where numbers climbed and continued into March, these have since decreased again. There has been an average of 26 Delayed Discharge Bed Days lost over the last 2 months.

There has been an average of just above 446 bed days lost to delayed discharges within the community hospital throughout February and March. The standard delays have remained fairly static around the 230-240 mark, whereas code 9's have fluctuated a little more.

Health & Social Care Placements
The number of referrals to H&SCP for Health and Social Care Placement is on average 66 patients per week, with the number of discharges over this period over at an average of 69.3 per week.

The waiting list peaked at 57 for the week ending 23rd January and has gradually declined since thanks to the high levels of discharges achieved.

2.3.1 Quality/ Patient Care

Quality of patient care and safety are at the heart of the Remobilisation Plan. The Remobilisation Plan (RMP4) was endorsed by NHS Fife Board on 30 November 2021.

2.3.2 Workforce

Oversight to workforce implications during remobilisation have been considered and form part of the Strategic Planning and Resource Allocation process. The Remobilisation Plan (RMP4) was endorsed by NHS Fife Board on 30 November 2021.

2.3.3 Financial

Oversight to financial implications during remobilisation have been considered and form part of the Strategic Planning and Resource Allocation process. The Remobilisation Plan (RMP4) was endorsed by NHS Fife Board on 30 November 2021.

2.3.4 Risk Assessment/Management

A Risk Assessment is contained within the Remobilisation Plan.

2.3.5 Equality and Diversity, including health inequalities

Remobilisation Plan included the appropriate equality and diversity impact assessment as part of the restart process.

2.3.6 Other impact

N/A.

2.3.7 Communication, involvement, engagement and consultation

Appropriate communication, involvement, engagement and consultation within the organisation and with key external stakeholders is integral to the implementation of the Remobilisation Plan.

2.3.8 Route to the Meeting

This paper has been previously considered by the following groups as part of its development. The groups have either supported the content, or their feedback has informed the development of the content presented in this report.

- Executive Directors' Group by email, 22 April 2022
- Clinical Governance Committee, 29 April 2022

2.4 Recommendation

The Committee is asked to:

- **Note** progress of deliverables within Joint Remobilisation Plan 4 (RMP4)
- Take **assurance** from the lessons learned from Review of National Response to Winter 2021/22
- **Note** the performance in the Winter Report 2021/22 – Data to March 2022

3 List of appendices

- Appendix 1: Highlight Report of Actions from RMP4 Delivery Action Plan 2021/22
- Appendix 2: Review of National Response to Winter 2021/22
- Appendix 3: Winter Report 2021/22 – Data to March 2022

Report Contact
Susan Fraser
Associate Director of Planning & Performance

Appendix 1: Highlight Report of Actions from RMP4 Delivery Action Plan 2021/22

Complete Actions (those in **bold** since previous update)

Pandemic Response

- ✓ ICU capacity

Primary, Community and Social Care

- ✓ Development of a Specialist Respiratory team to support a wide range of respiratory conditions to work collaboratively with the wider Community Teams to support patients, both acutely and long term with COVID.
- ✓ Develop a new Fife laryngectomy service in collaboration with Acute Services.
- ✓ Working towards reinstatement of the diagnostic pathway for Children and Young People, subject to restrictions and guidance.
- ✓ **Phase 3 (return to majority of previous service provision) will be implemented when safety measures such as social distancing can be relaxed.**

Mental Health

- ✓ Resumption of activity in AMH Day Hospitals.
- ✓ Re-development of the Moodcafe website to facilitate information-giving and support self-help across the life span and for people with long term health conditions.
- ✓ **Increasing the delivery of group PTs.**

Cancer Performance and Early Diagnosis

- ✓ Continue implementation of 'Framework for Recovery of Cancer Surgery' and 'National Approach to Clinical Prioritisation'.

Planned Care, Electives and Diagnostics

- ✓ Introduce PIR (Patient Initiated Review) within Medical Paediatrics.
- ✓ Continue to increase the number of Nurse Endoscopist posts which is one of the priorities to creating a future sustainable workforce.
- ✓ Review the model of collection for issuing repeat prescriptions for patients on ADHD/sleep medication.
- ✓ Introduction of home spirometry.
- ✓ Developmental assessments for Global Developmental Delay to be re-established.
- ✓ **Near Me Phase 2 - Further develop communication and stakeholder engagement strategy.**

Workforce

- ✓ **Harness the benefits of the latest NHS Education and Public Health Scotland (PHS) developments on workforce modelling to support our service planning arrangements and delivery of workforce plans.**
- ✓ Potential long term COVID-19 health issues for staff to be addressed through incorporating national guidance from developing evidence into our policy, practice, and service delivery arrangements.
- ✓ **Consolidation of our Staffing Bank management arrangements.**
- ✓ Continue to ensure Workforce Mobilisation Hubs are robust and flexible to adapt to future challenges.
- ✓ Workforce Planning & Mobilisation Silver Group to continue into 2021/2022 and review workforce deployment mechanisms to address the changing workforce needs across the year.
- ✓ Adapt our onboarding and development delivery approach through the use of e-enabled fast-track induction and other training.
- ✓ **Staff personal/professional development needs that have been delayed or restricted due to COVID-19 response to be prioritised as restrictions are eased through Directorate development delivery plans.**
- ✓ **Provision of staff support and wellbeing initiatives which meet staff needs and contribute to workforce sustainability.**

Digital

- ✓ ServiceNow - Migration to joint South-East activity to modernise the IT Service Management suite offering improved automation and slicker processes for activities such as ‘Joiners, movers and leavers’ consistent SLA/OLA’s and much improved self-help solutions.
- ✓ ITIL Process Maturity Improvement - Assess and benchmark our maturity against the 5 lifecycles and 27 processes of ITIL.
- ✓ Digital Business Continuity and Disaster Recovery (BC/DR) Plan.
- ✓ Infrastructure and Network Connectivity - Initiate an architectural review of our infrastructure to support remobilisation including a review of licensing to ensure we have sufficient capacity to support the increase in digital usage.
- ✓ Paperlite - Subject to agreed funding, the ambition is to accelerate the Paperlite programme. Reducing paper to the patient and clinician.

Corporate Services

- ✓ **Deliver the NHS Fife Prevention and Control of Infection Annual Work Programme for 2021-2022. Provide a structured delivery programme with priorities for nursing staff, clinical support staff, clinicians and managers to minimise the spread of infection, support the reduction of HCAI and to meet the NHS Healthcare Improvement Scotland (NHS HIS) Standards (2015).**
- ✓ **Develop a framework for Innovation adoption, generation, development, monitoring and evaluation.**
- ✓ **Investment secured for Programme Management Office (PMO) and embedded as part of the strategic planning arrangements to ensure corporate focus on progressing the service redesign required to release both cash savings and productive opportunities over the medium-term.**

Unscheduled Care

- ✓ Seamless GP Admission Pathways
- ✓ Increased scheduling for patients accessing ED
- ✓ Increased capacity within ED Resus
- ✓ Safe and timely discharges – COVID STATUS
- ✓ Lack of physical capacity in Admissions Unit 1
- ✓ Effective HALO resource to support front and back-door flow
- ✓ Minimise delays across the in-patient bed base through the systematic use of the Moving on Policy.
- ✓ HSCP Escalation to support daily decision making at HSCP huddles aligned to joint escalation plan with Acute services.
- ✓ Review current clients who have packages of care and require a renewed assessment.
- ✓ Community ANPs will return to General Practice from the COVID Hub and Assessment Centre to support workload
- ✓ **Public Engagement to ensure people are enabled to access the right care at the right time**
- ✓ Pharmacy support to safely manage discharge and transfer medications within the SUMPP parameters
- ✓ **Public facing information - Public messaging on right place right care, and how / when to access ED distributed through a wide range of established communications platforms including; NHS Fife Website, NHS Fife Social Media Channels, Local Press and Media, Partner organisation communications channels – these will be issued on a regular basis to reflect demand on ED, urgent and primary care services.**
- ✓ NHS 24 – 4-hour pathways for minor illness triaged via FNH from 13/5/21
- ✓ Urgent Care Services and ED have revisited the OOH redirection policy and reviewed pathways between ED and OOH
- ✓ **Identify and establish resources to support new pathways.**
- ✓ An urgent need for Paediatric escalation planning which cannot wait until Autumn/Winter.
- ✓ Review of red pathway into acute paediatrics that ensures that all referrals have been assessed by another health care professional (GP, ED, Unscheduled Care) which will filter out the patients currently being seen with mild symptoms.
- ✓ Increase in HDU/ITU Paediatric Demand
- ✓ Protecting the most vulnerable babies
- ✓ **Delivery of the adult seasonal influenza vaccination programme.**

Actions at risk (those in **bold** since previous update)

Primary, Community and Social Care

- Review the arrangements to Primary Care 'Care Home Local Enhanced Service' during 2021-22 including strengthening good quality anticipatory care planning.
- **Podiatry Services to be made available in all community and hospital sites including domiciliary and care homes**
- Working towards a return to this routine therapeutic support as soon as restrictions allow e.g. securing of IPC compliant clear masks, vaccination of staff.
- Redesign by recruiting Advanced Nurse Practitioners who can support the Consultant Rheumatologists in the delivery of the service. This will reduce the reliance on agency medical locum staffing.
- **Review of GIRFEC practices and wellbeing pathway to increase effectiveness and impact**

Planned Care, Electives and Diagnostics

- ACRT and PIR - Continue rollout throughout 2021/22 to all appropriate services.
- Patient Self- Booking - Support Patient Self-Booking across acute and community services. Linked to the Digital Hub is also the emerging capability for pathways to be enhanced by Remote Health Pathways, with COVID discharge and Pre-operative Assessment being identified as high impact areas for consideration.
- **Digital Pathology - Support creation of a business case, which if approved will lead to the Introduction of digital pathology to support a more resilient and sustainable service by improving efficiency, patient safety and delivering value for money.**

Unscheduled / Elective Care

- Review of Business Continuity/Resilience
- Workforce planning - planning for surge capacity to include a robust Medical, Nursing & AHP model.
- Sustainable Workforce – ED & AU1
- Maximise discharges from inpatient wards within VHK before 12 noon and move discharge profile to earlier in the day. Improve weekend discharge profile for Emergency Care Directorate.
- Capacity available for pre-assessment and pre-admission for front door areas of the hospital.
- Develop appropriate alternatives to attendance at A&E, minimise the need for admission, and reduce length of stay and increase options and processes for timely and appropriate discharge
- Develop a Home First Strategy
- Reduce hand offs in discharge processes
- Promote interim care home moves for people waiting on PoC.
- **Additional coordinating role in social care to ensure transfer of patients from hospitals. Test the trusted assessor model.**
- Ensure timely access to UCAT and addiction services for patients within the Acute Services Division in crisis's

Actions unlikely to meet target (those in **bold** since previous update)

Public Health

- Improve the health of the Black and Minority Ethnic Community.
- Take forward the recommendations from the Independent Expert Reference Group on COVID-19 and Ethnicity on behalf of NHS Fife.

Unscheduled / Elective Care

- Reducing length of stay on CAMHS
- The development of an app to support the Moving on Policy and help with decision making of moving on patients. This will include care home videos, staff messages.
- Winter elective plan to minimise the impact on elective activity as far as possible.
- Optimise digital healthcare where possible.

Mental Health

- Community Wellbeing Hubs across Fife to support delivery of mental health interventions and integrated care

Pharmacy

- **Implementation and roll out of HEPMA.**

Planned Care, Electives and Diagnostics

- Secure additional Waiting Times funding to increase capacity and enable waiting list reduction.
- T&O to achieve 100% of pre covid activity with progression to 110% by March 2022 in line with national commitment.
- **Exploring Locum Consultant recruitment options.**
- Remobilisation of Elective pathway in a phased manner with the need to maintain adequate red and amber capacity.

Winter Lessons and Reflections 2021/22

18 March 2022

1 Introduction

Winter 2021/22 came with significant challenges due to the impact of COVID on the past 2 years as well as running efficient vaccination and test and protect programmes.

The pressure on the health and care system intensified over the winter period but has not subsided in terms of capacity and flow since 2020. NHS Fife and Fife Health and Social Care Partnership (HSPC) continues to prioritise the needs of our vulnerable and ill patients by providing timely and effective care, despite increases in demand on services or a mismatch between demand and supply of services.

Leadership is the key to the successful whole system collaboration in place over this time.

2 Winter 2021/22

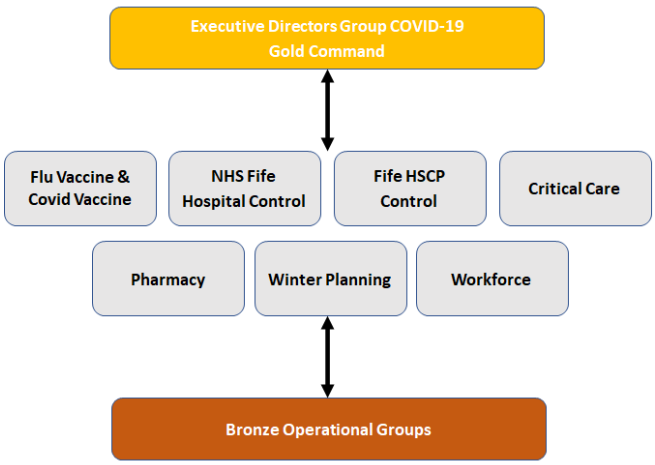
Reflections of the health and care services over the winter period has been considered and the key actions taken by NHS Fife and Fife HSPC to lead and manage the health and care system are described in this section.

2.1 Emergency Command Structure

As emergency planning measures were still in place, NHS Fife managed the emerging COVID position through the Emergency Command structure that was already well embedded throughout the organisation and Fife Health and Social Care Partnership.

The framework of the command structure of Gold, Silver and Bronze was implemented for operational teams, winter, capacity and flow and workforce. The reporting structure went to Gold Command that met at least twice a week and was made up of the Executive Directors' Group – the Chief Executive, Executive Directors and strategic senior managers.

The reporting and escalation structure provided clear lines of responsibility and decision making as shown below.



Chair: NHS Fife Chief Executive

- *Receive briefings from the Silver Command groups*
- *Approve operational acute health and social care service delivery priorities*
- *Approve NHS Fife Communications*

Chair: Executive Director

- *Receive briefings from the Bronze Command groups*
- *Escalate issues and challenges to Gold Command*

Chair: Senior Manager

- *Set up by each Silver Command group on an 'on demand' basis*
- *Aligned to specific workstreams*
- *Stood down when no longer required*
- *Reporting to Silver Command Groups*

2.2 Development of Escalation Framework

The development of the OPEL (Operational Pressure Escalation Levels) Tool at the end of 2021 enables the whole system to manage and respond to current challenges in capacity in a systematic and planned way. Initially development to manage early decision making and support to Acute's demand and capacity, it was then adapted to reflect the challenges in the HSPC. Each operational team now have an accurate overview of the pressures on their systems at least daily to be able to focus and plan to release or maintain capacity and flow in the system.

Testing has been a critical part of the implementation process. Multiple testing of the tool over daily cycles for the past 5 weeks has ensured the tool is reliable and sensitive to changes in pressure across the site to enable pro-active cross site and whole system actions to be undertaken to ensure a timeous de-escalation.

The OPEL tool has been demonstrated at the Executive Directors' Group and the Board and has been praised as being very positive and innovative. The operational and clinical teams have welcomed its introduction and is now part of their daily business. An example of the OPEL tool can be found in Appendix 1.

2.3 Informed Decision Making

Historically, during the winter period but over the last 3 years, a winter scorecard has been used on a weekly basis to discuss and plan in an integrated way with the operational teams. This scorecard follows the patients journey starting with Urgent Care, through Emergency Care and acute and community ward stays and onwards to social care capacity.

The scorecard is discussed at the Winter Capacity and Flow Bronze group with escalations, where appropriate, to Winter Silver Group. This provides the operation teams to discuss changes and monitor their impact on the whole system. An example of this can be found in Appendix 2.

The OPEL escalation framework works at an operational level, the Winter scorecard is used at a tactical level and at a strategic level, the Executive Directors' Group (Gold) received COVID report weekly and over the winter period, this was refined to a whole system monitoring report. The report provided an overview of COVID admissions and projections, planned and unplanned activity and delayed discharges. An example of this report can be found in Appendix 3.

2.4 Impact on HAI standards

The constant pressures on the health and care system have impacted on the bed capacity in ward bays. Previous work undertaken reduced the number of beds in ward bays to meet the HAI standards, however, there was such a strain on the system that additional beds were reintroduced in wards in acute and community settings. Although the situation is reviewed on a daily basis, the demand for beds is such that these additional beds have remained open longer than expected.

The current estate in Fife is such that in the older hospitals, the conditions are not optimal with investment into the older estate required to upgrade wards and improve ventilation.

2.5 Workforce

Workforce continues to be challenging across health and social care with a significant impact on the care and treatment that can be provided. Workforce continues to be challenging across health and social care with a significant impact on the care and treatment that can be provided. We established a Workforce Resilience Silver Group last year as part of our command structure which has coordinated a range of activity to support short, medium and longer term workforce supply and demand solutions and escalate workforce issues to our Gold group as required. The combination of operational, corporate, support and staff side representatives has allowed us to remain as responsive as possible during the changing context. The group has overseen workstreams on Resilience Planning, Resourcing, Education & Training and Employee Wellbeing.

Some of the key workstreams have involved the identification and deployment of a 'Workforce Resilience Layer' which has included non-frontline staff trained and redeployed for short term support in an operational support capacity; additional ward administration support; rapid recruitment to Healthcare Support Worker roles and bank utilisation and deployment of volunteers. Lessons learned have included reviewing how we improve workforce data, faster deployment of staff, better definition for support roles and enhancing communication methods and channels.

NHS Fife and Fife Health and Social Care Partnership have taken a number of actions to support workforce supply and these include:

- Accelerated recruitment to Nurse Staff Bank, including recruitment of medical, nursing and AHP students; returners (to support vaccination programme
- Early recruitment of nursing students who are graduating, employing them at Band 4 level as they await their registration from the NMC, in areas where they have secured permanent registered posts
- Accelerated recruitment processes supported by Workforce Directorate
- International recruitment: supported by the Centre for Workforce Supply and in collaboration with Yeovil Trust; 40 registered nurses and 3 radiographers will join our workforce over the coming months, with the first nursing recruits taking up posts in February 2022
- Participation in national recruitment campaign, although recognising that it is unlikely to attract a significant number of staff to work in Scotland

Fife has experienced staffing challenges on a daily basis so processes have been put in place to support the daily management of workforce, ensuring patient safety is maintained:

- Establishment of workforce hubs, monitoring staffing levels on shift by shift, on occasion hour by hour, basis
- Daily staffing huddles, led by senior nurses

- Development of 'Safe to Start Guidance' which forms part of the OPEL framework
- Development of Guiding Principles to support registered staff working in extremely challenging times
- Deployment of staff utilising Community Guidance in relation to Children's Services, Community Nursing and AHP
- Training modules adapted, which can be accessed online, rather than face to face sessions

Staff wellbeing continues to be vitally important and there has been a focus on staff wellbeing throughout the pandemic. A number of initiatives have been introduced including wellbeing hubs, pastoral care, peer support and psychological support and these will continue to be in place to support our workforce.

2.6 Winter Review themes

Lessons learned have continued to be gathered and discussed by our staff throughout the winter period. Feedback from operational services including Public Health were gathered and a detailed list of the responses received can be found in Appendix 4 – the table below summarises the high level themes with examples of positive and negative feedback and suggestions for next year. Lessons learned from the Vaccination Programme have not been included as they have been submitted separately.

A further winter review workshop in April has been arranged with the wider clinical and operational teams where the lessons learned will be discussed and proposed plans for 2022/23 will be described. As in previous years, this will bring together teams from across health and social care as well as partner agencies to gather multi agency feedback.

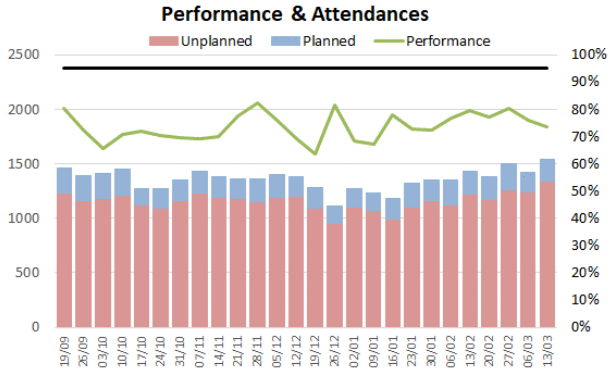
Theme	What went well	What did not go well?	What could be done differently?
Business Continuity/ Emergency Planning	Working of Local Resilience Partnership	Limitations on workforce and equipment	More robust BCPs and transport plans
Whole System Working	Agile and flexible teams Cross system working	Uptake of serial prescribing across all teams	Better deployment of Point of care testing (POCT)
Demand and Capacity	Pathway redesigned Staff Commitment Available information	Capacity challenges and delays Restricted GP access	Development of Front Door Model Improved discharge process

Theme	What went well	What did not go well?	What could be done differently?
Escalation and Surge Plans	Command structure in place Development of OPLE framework Agility of workforce	-	Earlier agreement of plans
Staffing Levels	Dedicated consultant cover Temporary and redeployment of staff Wellbeing resources for staff	Staffing levels despite recruitment drive Patient care affected due the available staff	Ability to flex staff across the system Debrief for staff
Elective Activity	Maintenance of P1 and P2 activity Use of QMH	Stopping of electives, in particular orthopaedic	-
Infection Prevention and Control	Implementation of ARHAI Respiratory Pathway Care home huddles	Late publication of guidance	Time to implementation guidance Earlier MRSA screening
Test and Protect	Clear protocols for contact tracers Protocol to manage care home admissions	Managing the changes in isolation and testing requirements Timings of staff testing	Workforce model required going forward that can rapidly respond to demands
Communications	Regular engagement with all staff	Changing position with care home closures difficult to manage	Better national communications with public Revised visitors' policy

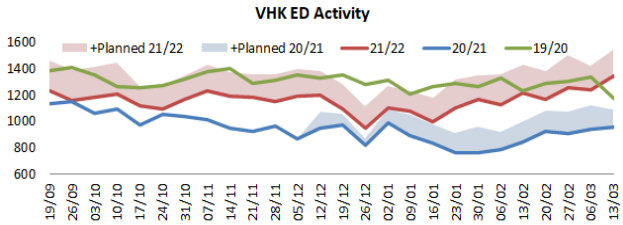
3 Analysis of Key Metrics

3.1 Emergency Department

Performance within Victoria Hospital against 4-hour standard averaged below 75% for the 26-week period to 13th March, achieving excess of 80% on four occasions. There was 1177 unplanned attendance on average per week up until festive period and have been rising since mid-January with last 8-week average over 1200. Week of 13th March exceeded 1300 unplanned attendances. Planned activity averaged just below 200 per week over the same time period.

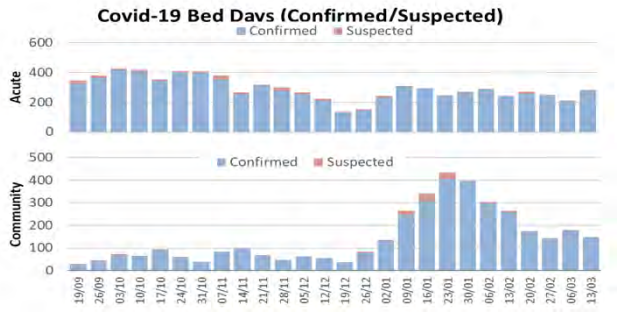


Unplanned attendances for this winter were below 2020 levels every week apart from the latest. However, when including planned activity, totals were similar up to mid-December and have been above since mid-January. Latest week was also higher than weekly average for winter 2020.



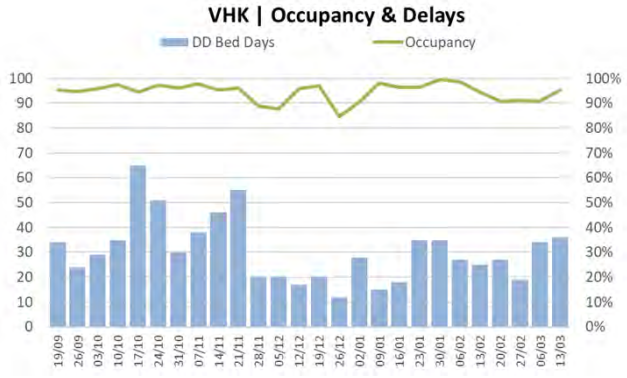
3.2 COVID-19 Hospital Activity

Bed days attributed to COVID-19 within Victoria Hospital peaked at 422 in early October. Steady decrease from then until Christmas period to below 150. This has risen since and has fluctuated between 250 and 300.



Bed days within Community and Mental Health Hospitals had been below 100 throughout winter until week ending 2nd January. Outbreaks within these settings led to an increase to 400 by mid-January leading to ward closures that placed significant pressure on the whole system.

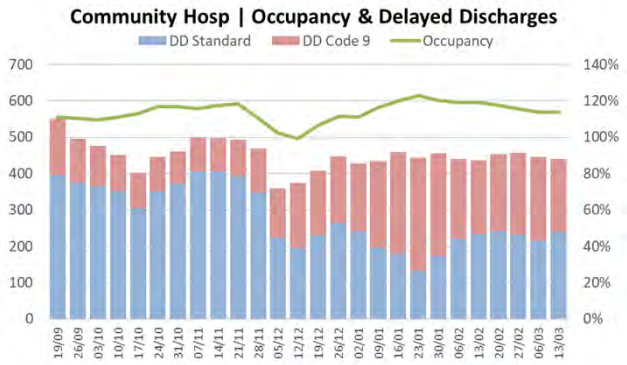
3.3 Acute Occupancy and Delays



Occupancy pressures have been extreme, driven by significant increases in admission demand leading to the requirement for the use of contingency inpatient capacity, over and above surge capacity to accommodate demand. This significantly disrupted the urgent elective programme, particularly Orthopaedics, with occupancy levels continuing to impact activity.

Delayed discharge bed days have come down because of the discharge profile to HSCP with enough flex in the system to accommodate additional flow during times of significant pressure.

Site pressures have been compounded by staffing challenges, with high absence rates eroding staff ratios and placing additional strain across teams. Pre-emptive service retraction, based on clinical priority, enabled staffing resource to be consolidated based on greatest need.



Occupancy across HSCP MoE wards is higher than what it has ever been due to number of beds open over and above the MoE normal covid bed base.

Bed days for standard delays has significantly dropped. We are seeing a sustained discharge profile to care at home and interim beds which has attributed to this reduction. Increase in Code 9 delays in early 2022 was due to ward closures due to COVID-19.

4 Financial Position

Winter monies made available to the Health Board and Integrated Joint Board in November 2021 have been used to support the delivery of key winter priorities. All the funding allocated has been utilised in full with additional costs underwritten by the Health Board and the Integrated Board. Monies received into Fife has been used by the board and the H&SCP to fund additional delayed discharge coordinators, medical locum cover, discharge vehicles and multiple reviews of packages of care, all monies spent with the focus being to take discharges out of Fife hospitals and support increasing demand.

In addition, further winter monies announced in October 2021 to support the board and the H&SCP with a focus to improved delayed discharges have enabled NHS Fife

to move forward with a successful International recruitment programme with the first members of staff recruiting from overseas joining NHS Fife in February 2022 with other new recruits expected in the coming months. A successful recruitment campaign has also enabled to board to recruit the minimum 68 new band 2-3 support staff roles to support delayed discharges. Several staff are already in post with others to join the board in the next couple of months. Monies allocated for staff wellbeing measures have also been spent in full providing much needed support to staff.

Despite significant ongoing recruitment challenges other winter monies have been utilised by the H&SCP to enhance service provision with a firm focus on improvement in delayed discharges.

5 Summary

NHS Fife and Fife HSPC have shown leadership and collaborative working over this period and the integrated actions described have demonstrated the benefits of whole system working with the patient at the centre. The challenges continue to be felt across the system and we will continue to work together across agencies.

Appendix 1: Example of OPEL reporting

NHS Fife Acute Services
Escalation Plan 2021/22

				Criteria Level of Decision Making	L1 (Green) Bronze	L2 (Yellow) Bronze	L3 (Amber) Bronze	L4 (Red) Silver	L5 (Purple) Gold	
	OPEL	**83**	**5**		**4**	**1**	**3**	**2**	**12**	
	Back Door	**26**	**5**		**1**	**0**	**2**	**1**	**3**	**ACTIONS**
1	Hospital Occupancy	2	3		90-97%	80-85%	86-89%	90-97%	>97% or more	>100% plus	1 Amber Action
2	Additional Bed Capacity		5		DIU or SSSU in use	0 wards open	Surge planned	Ward 6 open	Ward 6 / 9 over capacity	DIU or SSSU in use	2 Purple Action
3	Delayed Discharge / DToC		4		25-34	0-5	6 to 18	19-24	25-34	35 or more	3 Red Action
4	Boarding Patients		5		19 or more	0-4	5 to 9	10 to 14	15-18	19 or more	4 Purple Action
5	Total number of discharges at 13.00		3		66-80 planned	95 or more planned	81-94 planned	66-80 planned	51-65 planned	50 or less planned	5 Amber Action
6	Predicted Bed Balance		5		≤10	≥10 / in balance	≥5/in balance	In balance	≤5	≤10	6 Purple Action
7	Ward closures due to infection		1		0 Wards	0 Wards	1 - 2 bays closed	3 bays closed	1 ward closed	2 wards closed	7 Green Action
	Front Door	**49**	**5**		**0**	**1**	**1**	**1**	**8**	
8	Ambulances Waiting		2		1 ambulance holding & at risk of not off-loading in next 15 mins	0	1 ambulance holding & at risk of not off-loading in next 15 mins	2 ambulances holding & at risk of not off-loading in next 15 mins	3 ambulances holding & at risk of not off-loading in next 15 mins	4 or more ambulances holding & risk of not off-loading in the next 15 mins	8 Yellow Action
9	ED resus Capacity		4		Resus full with no availability for a standby	>2 resus bays available	2 resus bay available	1 resus bay available for standby	Resus full with no availability for a standby	Resus full + patients in overcapacity	9 Red Action
10	Total patients in ED / Majors capacity		5		No majors cubicle available, over capacity in majors area or >3 majors patients in waiting area	≥2 majors cubicles available and ≤30 pts in ED	1 majors cubicle available or >30 pts in ED	No majors cubicle availability & no majors patients in waiting room	No majors cubicle available, over capacity in majors area or up to 3 majors patients in waiting area	No majors cubicle available, over capacity in majors area or >3 majors patients in waiting area	10 Purple Action
11	Total Number of DTA (Unallocated)		5		7+ patients	No patients waiting	1-2 patients	3-4 patients	5-6 patients	7+ patients	11 Purple Action
12	Longest LoS - DTA		5		Any Patient >12hrs or 2+ DTA patients >8hrs or 7+ DTA patients >4hrs from admission	All patients <4hrs from DTA	Any DTA patient >4hrs from admission	2-3 DTA patients >4hrs from admission	1 patients >8hrs or 4-6 DTA patients >4hrs from admission	Any Patient >12hrs or 2+ DTA patients >8hrs or 7+ DTA patients >4hrs from admission	12 Purple Action
13	Total patients in AU1 (in patients)		5		32 (full)	≥25	26-27	28-29	30-31	32 (full)	13 Purple Action
14	AU1 (RV) Assessment space		5		Minus 1+ adjusted bed balance	4+	Plus 1 adjusted bed balance	In Balance to Minus 1 adjusted bed balance	Minus 2 adjusted bed balance	Minus 3+ adjusted bed balance	14 Purple Action
15	AU1 (N RV) assessment space available		5		Minus 5+ adjusted bed balance	6+	Plus 1 adjusted bed balance	In Balance to Minus 1 adjusted bed balance	Minus 2-4 adjusted bed balance	Minus 5+ adjusted bed balance	15 Purple Action
16	Total patients in AU2		5		22 (full)	≤15	≤17	≤19	≤21	22 (full)	16 Purple Action
17	AU2 assessment space available		5		Minus 3+ adjusted bed balance	2+	Plus 1 adjusted bed balance	In Balance to Minus 1 adjusted bed balance	Minus 2 adjusted bed balance	Minus 3+ adjusted bed balance	17 Purple Action
18	Staffing levels (RNs)		3		Amber	Green	Yellow	Amber	Red	Black	18 Amber Action
	Other Capacity	**8**	**2**		**3**	**0**	**0**	**0**	**1**	
19	Elective Cancellations		5		Cancellations at P2 Level	Full access to elective programme	Full access to elective programme - managed case-by-case	Decision taken not to appoint at P3 Level for ≥9 cases	Decision taken not to appoint at P3 Level for 10+ cases	Cancellations at P2 Level	19 Purple Action
20	Critical care Capacity		1		Full access to all pathways	Full access to all pathways	Full access to all pathways with 8 patients	10 level3 patients with bed availability in 4 hrs	11 level3 patients with bed availability tomorrow	No beds avaialble and none predicted > 24 hrs	20 Green Action
21	Business Continuity Event (defined as IT, PACS, utilities failure)		1		No critical issues identified	No critical issues identified	Reduced functional service - minimal impact/delay	Reduced functional service - moderate impact/delay	Reduced functional service - severe impact/delay	Reduced functional service - critical impact/delay	21 Green Action
22	Paediatric Capacity Escalation level		1		Level 1 - access to all pathways	Level 1 - access to all pathways	Level 1 - access to all pathways but no HDU Capacity	Level 2 - 2 SR available & 9 RV beds occupied	Level 3 - 2 SR available & 12 RV beds occupied	Level 4 - 0 SR available and 14 RV beds occupied	22 Green Action

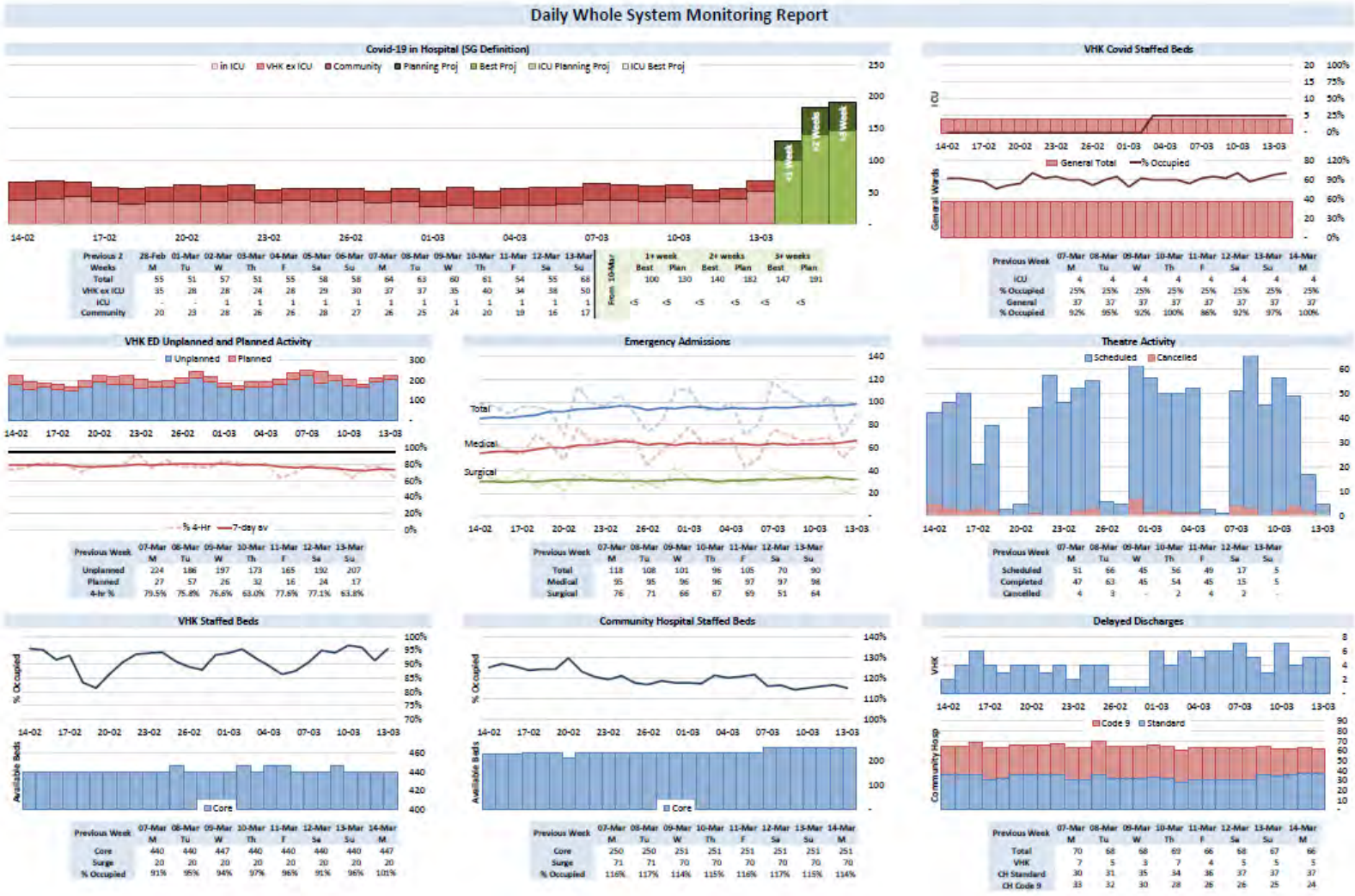
Fife HSCP
Escalation Plan 2021/22

				Criteria Level of Decision Making	L1 (Green) Bronze	L2 (Yellow) Bronze	L3 (Amber) Bronze	L4 (Red) Silver	L5 (Purple) Gold	
	OPEL	**65**	**4**		**7**	**8**	**1**	**6**	**3**	
	Flow	**41**	**4**		**4**	**4**	**1**	**4**	**2**	**ACTIONS**
1	Hospital Occupancy (H&SC MH Wards)	4	>95%		<85%	85-89%	90-95%	>95%	>100%	Facilitate daily capacity huddle
2	Patients clinically fit for next stage of care from VHK (with a confirmed pathway)	1	21-25		21-25	26-30	31-35	36-40	>40	ensure normal flow - 12 per day
3	VHK Patients to be assessed (Discharge Hub)	1	0 to 10		0 to 10	11 to 15	16 to 20	21-25	>25	ensure normal flow - 12 per day
4	Community Hospital Social Work waits (24K, 26C, 27A - official delay codes minus 51x / MH&LD)	1	<25		<25	25 to 29	30 to 34	35-40	>40	Continued Normal Service Provision
5	Official delay 51X codes	5	>25		0 to 10	11 to 15	16 to 20	21 to 25	>25	Escalate to Scottish Government
6	Community Hospital Social Care (25D, official delay codes minus 51x / MH&LD)	1	0-15		0-15	16-20	21-25	26-30	>30	normal business activity
7	Community SW / SC in Planning (5S, 5J)	2	21-25		0-20	21-25	26-30	31-35	>35	Verification meetings
8	Planned Community Hospital discharges	4	5 to 9		>15	12 to 14	10 to 11	5 to 9	<5	Emergency SW/SC meeting to expedite discharges
9	Down Stream Beds Available	2	32 to 34		>15	32 to 34	10 to 11	5 to 9	<5	early conversations re surge opening system wide
10	Hospital Occupancy Normal Bed Base (H&SC MoF Wards)	5	100% Normal Bed Base		91% or below Normal Bed base	94-95% Normal Bed Base	96-97% Normal Bed base	98-99% Normal Bed Base	100% Normal Bed Base	initiate business continuity plan
11	Surge Beds added (Medical & Nursing Pressure held)	4	21-50 beds open Planning for next tranche started		No Surge beds open and none in planning	Initial surge in planning	14-22 beds open Planning for next tranche started	21-50 beds open Planning for next tranche started	51-65 beds open	Assess all beds open and ongoing need based on numbers and length of stay
12	Ward closures due to infection	4	1 ward closed		No closures	2 bays closed - 2 in 1 ward or 1 in 2 wards closed	3 bays closed	1 ward closed	2 wards closed	Undertake PAG risk assess bed loss from system and implement any mitigation
13	H@H (figures are caseloads)	2	21 - 25		<20	21 – 25	26 – 30	31 -35	>35	Cross Cover H@H neighbouring team
14	ICT (Waiting list Community & VHK)	2	3-4 waits		2 or less	3-4 waits	5-6 waits	7-8 waits	9+waits	Cross Cover neighbouring ICT
15	Care Home Closures	3	30-39 closed		No closures	1-9 closed	30-39 closed	20-25 closed	>25 closed	Daily Meeting with Commissioning Team, Patient Flow Coordinator, Health Protection Team and Care Home Support and Assurance Team to review patients awaiting discharge to closed care homes and carry out individual risk assessments to facilitate patient flow where safe to do so.
	Wider System	**11**	**3**		**2**	**2**	**0**	**0**	**1**	
16	GP Appointment availability	2	Individual GP practices declaring they are unable to deliver F2F appointments within own Practice		All GP practices operating as normal	Individual GP practices declaring they are unable to deliver F2F appointments within own Practice	Buddy Practices declaring they are unable to provide F2F patient care	One Cluster declaring unable to provide F2F appointments, or three or more declaring they are close to being unable	Clusters unable to provide F2F appointments even with Covid Assessment Centre open	Buddying system involving two practices invoked when unable to deliver face to face appointments as a single practice
17	Community Pharmacy Service	1	No closures up to 4x Half-day or 2x Full-day closures		No closures up to 4x Half-day or 2x Full-day closures	Up to 8x Half-day or 4x Full-day closures	Up to 16x Half-day or 8x Full-day closures	Up to 40x Half-day or 20x Full-day closures	Up to 80x Half-day or 40x Full-day closures	normal business activity
18	Urgent Care Services Fife	1	Normal staffing levels		Normal staffing levels	Staffing levels ≥91%	Staffing 90-91% and or demand 110-120% of normal seasonal activity	80%-71% staff coverage and 110-120% seasonal activity	<70% staffing and / or demand beyond capacity	normal business activity
19	Public Dental Service	2	Staffing at 81-94% - reduced service still including routine but fewer appts and no risk		Staffing 95% and above full operation	Staffing at 81-94% - reduced service still including routine but fewer appts and no risk	Staffing at 80-51% - urgent care only	Staffing at 50-41% - emergency care only	Staffing at 40% or below - restricted and prioritised emergency care only	normal business activity with identified contingency in place
20	Hospital Occupancy (H&SC LD Wards)	5	No beds available and no out of area beds		Four or more local beds available	Three local beds available	Two local beds available	One local bed available	No beds available and no out of area beds	Check out of area admission possibly; Consider assessing independent health care facility via CAP application
	Workforce	**13**	**3**		**1**	**2**	**0**	**2**	**0**	
21	SW Hospital Discharge Team Staffing	2	Staffing 80-60%		normal staffing levels	Staffing 80-60%	Staffing 80-50% (supported by community team)	<50% staffing in team supported by busines continuity	<50% staffing and failure of business continuity plan	manage staffing within services
22	MHO Team Staffing	1	<30% absence		<30% absence	>30% staffing	90-50% staffing	<50% staffing and business continuity plan triggered	<50% staffing and statutory functions critically impacted	normal function
23	Wider HSCP Safe to Start position	2	>80% of services safe to start		All Areas Safe to Start	>80% of services safe to start	>60% of services safe to start	>40% of services safe to start	<20% of services safe to start	manage staffing within services
24	Business Continuity	4	Reduced functional service - severe impact/delay		No critical issues identified	Reduced functional service - minimal impact/delay	Reduced functional service - moderate impact/delay	Reduced functional service - severe impact/delay	Reduced functional service - critical impact/delay	50% of staff on deployable list mobilised
25	Workforce Hub (declared staffing position)	4	Red		Green	Yellow	Amber	Red	Purple	Discuss rec'd actions at workforce assurance/ esaplation huddle

Appendix 2: Whole System Scorecard

Area	Indicator	Trend	19-Sep	26-Sep	03-Oct	10-Oct	17-Oct	24-Oct	31-Oct	07-Nov	14-Nov	21-Nov	28-Nov	05-Dec	12-Dec	19-Dec	26-Dec	02-Jan	09-Jan	16-Jan	23-Jan	30-Jan	06-Feb	13-Feb	20-Feb	27-Feb	06-Mar	13-Mar
Urgent Care	Contacts		2312	2243	2339	2823	1993	2138	2218	2190	2257	2360	2223	2352	2312	2354	1920	3117	2897	2252	2341	2245	2174	2139	2229	2133	2134	2206
	Home Visits		101	124	120	152	107	125	134	104	98	108	116	118	107	83	98	247	179	124	124	131	108	120	121	112	114	121
	COVID Outcome		426	396	383	530	370	391	308	385	411	431	369	398	358	422	359	666	556	337	308	289	291	315	296	299	304	324
	NHS24 Outcome		326	338	344	414	323	351	376	365	359	351	369	398	399	342	308	522	440	367	383	396	359	362	397	358	342	368
VHK ED	All		1462	1392	1411	1450	1268	1267	1350	1434	1377	1357	1359	1398	1380	1283	1114	1267	1227	1177	1319	1348	1355	1433	1385	1504	1424	1543
	Planned		228	235	231	242	148	176	185	201	181	171	211	209	181	189	163	161	150	180	214	184	230	213	216	244	187	199
	Unplanned		1234	1157	1180	1208	1120	1091	1165	1233	1196	1186	1148	1189	1199	1094	951	1106	1077	997	1105	1164	1125	1220	1169	1260	1237	1344
	Performance		80.4%	72.5%	65.6%	70.8%	72.1%	70.4%	69.6%	69.3%	69.9%	77.4%	82.1%	75.9%	69.0%	63.7%	81.5%	68.4%	67.1%	78.0%	72.9%	72.4%	76.8%	79.3%	77.0%	80.5%	76.0%	73.5%
MIU	Total		484	414	419	377	361	339	347	353	375	374	370	305	352	295	197	204	199	320	367	325	382	347	317	403	383	436
	Unplanned		405	348	346	322	311	290	299	293	308	315	304	250	292	242	146	179	158	267	306	271	317	291	267	332	325	372
VHK	Admissions		696	730	729	709	705	703	683	714	702	689	705	767	716	750	649	715	639	667	730	737	693	677	707	730	743	770
	Emergency		589	640	636	628	624	650	611	626	621	601	619	674	628	658	586	687	611	616	657	653	617	597	641	657	651	686
	Medical		355	356	351	360	358	407	355	351	378	355	357	402	366	387	363	424	364	367	366	370	347	335	354	371	362	405
	Surgical		234	284	285	268	266	243	256	275	243	246	262	272	262	271	223	263	247	249	291	283	270	262	287	286	289	281
	Discharges		615	678	648	648	644	649	630	659	660	636	686	679	616	726	653	561	605	637	653	668	684	644	693	674	697	661
Theatre Activity	Scheduled		224	255	258	245	217	213	207	244	280	225	267	265	242	273	141	51	96	182	200	227	260	257	218	272	293	303
	Cancelled		14	16	16	15	14	16	15	16	15	11	11	13	15	19	4	1	11	7	7	20	19	7	15	7	12	15
	Hospital Cancelled		0	1	3	3	8	1	0	3	4	1	0	1	3	2	0	0	3	0	0	0	6	0	3	2	0	1
VHK Bed Utilisation	Occupancy		95%	95%	96%	98%	95%	97%	96%	98%	95%	96%	89%	88%	96%	97%	85%	91%	98%	96%	97%	99%	99%	95%	91%	91%	91%	95%
	COVID Bed Days		346	380	430	420	352	408	408	379	268	318	297	265	224	138	152	241	308	292	245	270	291	242	271	252	208	279
	DD Bed Days		34	24	29	35	65	51	30	38	46	55	20	20	17	20	12	28	15	18	35	35	27	25	27	19	34	36
Community Hospital	Admissions		54	51	52	52	53	42	52	59	59	50	65	52	40	59	57	55	46	71	34	55	73	53	56	50	50	52
	Discharges		55	52	55	46	45	36	68	53	48	48	78	53	41	55	57	51	33	60	37	57	69	55	51	60	45	57
	Occupancy		111%	110%	110%	111%	113%	117%	117%	116%	118%	118%	110%	102%	99%	107%	111%	111%	117%	120%	123%	120%	119%	119%	118%	116%	114%	114%
	COVID Bed Days		28	45	73	65	95	60	37	84	98	67	48	64	54	37	84	136	264	340	433	397	303	265	173	143	180	149
	DD Bed Days		551	496	476	452	401	445	462	499	498	493	469	359	376	408	448	428	434	459	443	456	440	436	454	458	446	440
	DD Standard		397	376	365	352	305	351	372	405	405	392	349	225	195	231	265	242	196	179	132	173	220	234	241	233	215	240
	DD Code 9		154	120	111	100	96	94	90	94	93	101	120	134	181	177	183	186	238	280	311	283	220	202	213	225	231	200

Appendix 3: Whole System Monitoring Report



Appendix 4: Themed responses

Business Continuity/Emergency Planning

What went well?

- Resilience in primary care in relation to Covid assessment.
- Local Resilience Partnership arrangements were rapidly put in place in response to Storm Arwen ‘red’ warning
- Local Resilience Partnership activated to consider social care pressures and concurrent risks and coordinated offers of assistance.

What did not go well?

- The Fife Equipment Loan Store has also had to deal with other external factors: Covid, Brexit which has led to a lack of supply of equipment.
- Consideration needs to be taken for the additional staffing and equipment needs for an increased number of community beds (Surge).
- Availability of 4 x 4
- Partner agencies were only able to offer limited support when additional social care was requested.

What should be done differently/changed?

- Could transport department take a role in providing 4 x 4 transport for all community services if required in severe weather?
- Strong contingency plans- Identified Winter surge capacity (winter wards that provide appropriate accommodation in line with national guidance) with HCWs recruited to staff these areas.

Whole System Working

What went well?

- Command structure (Bronze/Silver/Gold) in place for operational teams in Acute, HSCP and system wide. Clear actions and accountability relating to decisions
- Cross system working and flexibility in use of clinical space
- Launch of nMAB treatment for clinically vulnerable outpatient treatments

- Transition of Medical Admissions Controller GP function to Flow and Navigation Hub
- System wide working through huddles to manage flow through pathways for both care at home and care homes. Ensuring collaborative commissioning with providers to meet the needs of patients.
- Commitment of all teams to manage workforces across all sectors to work in an agile way has been very apparent – not only via deployment but also through prioritisation of work, responding to tight time scales and rapidly changing circumstances as well as being solutions focused. Staffing BRAG scoring and whole system approach to site safety including critical care bronze/silver daily reviews
- Increased integration and collaborative working between teams
- Multi-disciplinary approach to working under significant pressure to support hospital discharges and appropriate care placements. Regular multi-disciplinary meetings to ensure management oversight of service users' journey in as timely a way as is possible.
- Agile working from **all teams** clinical and support teams (domestics, facilities, portering and volunteers etc)
- Community Pharmacy remained open as a frontline clinical service to all patients. Use of Pharmacy First was significantly above previous years, allowing patients to access treatment quickly and flexibly.
- COVID POCT ability for clinical assessment and patient placement
- Staff rapid COVID testing for business-critical areas

What did not go well?

- While Board wide uptake of serial prescribing has been a success, there are a limited number of teams who have not engaged with this important service which is of benefit to workload management and clinical care.

What should be done differently/changed?

- Need to feed lessons learned from whole system working into workforce strategy and development as well as work on service re-design
- Consolidation of platforms for respiratory testing
- Improved route for COVID-19 reporting to deliver better TAT.
- Better deployment and management of the poct team.
- Increased availability of point of care testing (POCT) for **all** admissions (As NHS Fife is not 100% single room occupancy, this would support patient placement, and reduce number of hospital bay contacts from asymptomatic patients)

Demand and Capacity Planning

What went well?

- Use of Live Discharge tool for wards and hub whiteboard patient discharges
- Integrated HALO within front door
- Use of elective orthopaedic ward for screened trauma overflow
- Use of data intelligence and modelling to anticipate and plan acute service delivery
- Remodelling of ED resus area to allow for increased capacity whilst meeting IPCT requirements for COVID
- Commitment by all staff to provide the best service they possibly could during a period of working under extreme pressures with, at times limited resources available to them.
- Quick responses by most providers to ensure assessments were undertaken as quickly as possible and discharges arranged.
- Constant review of delayed discharges for up-to-date position.
- Use of interim/assessment/STAR bed placements to await the completion of care assessments/decision on pathway of care.
- Good dissemination of information about ward status.
- Daily care home huddle to address challenges and ensure optimal discharges
- Existing Pharmacy service core priorities provided an effective framework for targeting of resource. This supported the wider system appropriately and staff responded with flexibility and professionalism to the revised ask.
- Pathways for new COVID treatments were developed and deployed rapidly following exemplary multi-professional response. New pathways through Flow and Navigation Hub for Acute Admissions and nMAB Treatment.
- Rapid development of urgent COVID-19 pathways such as staff testing, discharge and surgery in spite of resource restrictions.
- Board-wide uptake of serial prescribing has improved across the last six months – this is important as a government priority supporting management of workload pressures in Community Pharmacies and General Practice.
- Public Health teams managed the pressures of Omicron through supportive practices established during earlier stages of the pandemic

What did not go well?

- Capacity challenges resulting in ambulance queues for ED
- Delays in transfers of care through Downstream Beds and Social Work pathways
- Use of planned care beds for emergency care patients with significant impact on patients requiring urgent surgery

- The daily request for sitrep reports to Senior Management and Scottish Government left staff feeling overwhelmed with providing data. This included for the first time the Social Work Hospital Discharge Team.
- Opportunity to reflect on transfers of care to support good relationship and safe optimal hand over. Interim beds – high numbers and length of stay due to lack of capacity in Care. More evidence to be gathered on this going forwards in respect of Service User outcomes.
- Restricted access to appointments at GP Practices
- Management of discharge pathways placed additional pressure on Microbiology and were too reactive.
- Challenges with adequate surge capacity (and staff for these areas) leading to increased number of patients in bays, which increases the risk of transmission of COVID-19
- An Increase in waiting times for support services (e.g. Fife Council Community OT Service) despite staff working to capacity.

What should be done differently/changed?

- Need to link Demand and Capacity Planning to transformation programme as demand outstripped the capacity available
- The Moving on Policy brought to the attention of the families/representatives as soon as possible rather than waiting until their family member has been delayed in hospital for a number of days without any decision made on care home choices/pathway agreed.
- Ensure families/representatives understand and are in agreement that staying in hospital is not an option or in the best interest of the patient while care home choices are made.
- Front door model is being developed – this will be in place for next winter, again, time needed to develop this model in light of what we know and what we need the model to achieve.
- Indicative guidance regarding policy would be helpful when Boards are required to rapidly stand-up new services or pathways. A proactive approach to planning for most likely scenarios would be beneficial, managed both locally and nationally – this would resolve concerns linked to reactive responses where there are time constraints.
- A review of use of resources such as surge wards and proactively planning for likely scenarios, allowing for proactive identification of staff and required processes etc. Review of data around organisation status may reveal patterns in demand levels across the system. More broadly, a proactive review of surge planning and assurance that all relevant areas, including clinical support teams, have visibility of them is important.
- Adequate Roll out time for New Processes i.e. training and system updates.
- System data reporting for specific services.
- Improved process and control on discharge across the hospital.

Escalation and Surge Plans

What went well?

- Development of OPEL escalation tools and live working for early warning and operational actions. Use of OPEL to have a shared language and understanding of operational pressures across Acute and HSCP
- Agility in retracting from services in Omicron wave
- Daily SLT meeting to provide a forum for escalation
- Authorisation for funding to increase GP resource.
- Continual assessment and redesign of the Urgent Care Service

What did not go well?

What should be done differently/changed?

- Earlier agreement of escalation plans before the start of Winter.

Staffing Levels

What went well?

- Unwavering passion and commitment from all teams across all services – inspiring!
- Dedicated consultant cover for additional capacity at VHK removing 'boarding' culture as per previous years
- Availability of up-to-date data through the workforce dashboard
- Staffing inpatient surge wards was achieved through the whole MDT approach which allowed sourcing of staff to cover the wards from Agency, Bank, extra hours OT/PT.
- Additional temporary staff through Health Improvement Scotland for Hospital at Home. This gave us the opportunity to secure permanent funding.
- Securing continuous permanent funding for OT/PT across ICASS and Nursing for Hospital at Home will have a significant positive impact for the future.
- Teams working across disciplines to support Care Homes have added huge value and support to struggling staff teams within care homes
- A lot of admin staff now have laptops and can work from home

- Team leads supported implementation of changes at pace and kept morale of staff high despite escalating numbers
- Based on previous year's activity we were able to forecast projections to put adequate staffing levels in place.
- Re-deployment staff from Partnership into Flow and Navigation Hub between January 2022 - April 2022.
- Recruitment to enhance Nursing and Admin Establishment.
- Availability of wellbeing resources for all staff.
- Re-deployment of 3 x Band 5 TUCP's to QMH to support Ward 8 at Queen Margaret Hospital Dunfermline.

What did not go well?

- Despite an ongoing recruitment drive, challenges remained with staffing (COVID related whether additional resources required for the vaccination programme, new streams of work such as the monoclonal antibody treatments as well as COVID related sickness/absenteeism)
- It is notable that staff across the service are feeling increasingly fatigued following pressure over the last two years.
- Plans for staff to rest over Christmas and New Year were not fully realised and we had to ask staff to work extra hours.
- Extended redeployment of staff to support Omicron response and impact of staff morale
- Temporary staff with a quick turnaround, as the availability of OT/PT staff is very difficult to access even through agency.
- Staff being redeployed to surge wards which meant teams were continuously working at critical function. This inevitably means there is a backlog of work to pick up when staff return e.g. CDM reviews
- Time taken to extend contracts for fixed term staff caused uncertainty and increased turnover
- Patient Conveyancing issues – due to staffing levels

What should be done differently/changed?

- Cultural changes in the way teams respond and commit to ensuring staffing as a whole system is safe and responsive to need i.e. flexing up capacity and staff movement
- To consider the positive impact that adequate staffing on wards will have on reducing length of stay and reducing level of dependency to decrease the demand on care services required on discharge
- Increased staffing resource to accommodate increased care of patients who are palliative or have complex health conditions and wishing to remain at home
- Debriefing for clinical teams to allow reflections over the last few months.
- There is a need to ensure staff have sufficient capacity to undertake the core parts of their jobs to a high standard and reviewing activities which do not add appropriate value.

- Funding for winter assurance should be released earlier to allow for recruitment processes to be followed ahead of winter, rather than reacting to it. A review of winter spends incurred across departments would allow for flexible use of resource across the organisation, focussing on key areas affected by winter.

Elective Activity

What went well?

- Maintenance of P1 and P2 surgery
- Use of QMH facilities to maintain activity

What did not go well?

- Cessation of all planned orthopaedic elective surgery in ward 10 due to demand for emergency patients.

Infection Prevention and Control

What went well?

- Adaptability with ARHAI guidance to improve flexibility of ward areas and minimise ward closures
- Good availability of PPE (supported by excellent collaboration with H&S, procurement and IPCT)
- Stepping up of HCT, Bronze, Silver meetings over winter months
- NHS Fife went live with the new ARHAI Scotland Winter 2021/22 Respiratory Infections in Health and Care Settings Infection Prevention and Control (IPC) Addendum, in line with the revised dates
- Local pathways and implementation of the above guidance supported by excellent leadership from Deputy COO, ADoN, clinical teams and IPCT.
- IPC training on new guidance and outbreak management available over the winter months
- Care home hub/care home safety huddle/care home oversight group (a multidisciplinary group to support best practice in care homes)- service found to be supportive.

What did not go well?

- Very late publication of the ARHAI Scotland Winter 2021/22 Respiratory pathway guidance (with revised launch/implementation dates as guidance was incomplete)

What should be done differently/changed?

- A full comprehensive National IPC winter guidance published with sufficient time for boards to develop and implement pathways locally
- Earlier MRSA screening for trauma patients anticipating ward 10 usage next year, but this won't be available as we will be in the FEOC by then.

Test and Protect

What went well?

- Agreed national protocols for Contact Tracing were implemented and there was clear focus on more vulnerable settings
- Local protocol developed to manage admissions into Care Homes with COVID19 outbreaks

What did not go well?

- Impact of changing isolation and testing requirements for staff and subsequent staffing pressures
- Lack of OH support over weekends to allow for use of Cameron for staff testing
- Lack of available resources due to care staff being unable to work due to contracting covid or waiting for test results – both of these being unavoidable.
- OH resources did not match demand for TAT of urgent staff testing.
- IT connectivity caused delays due to high demand for new interfaces and extended pathways developed to feed information back to T&P teams

What should be done differently/changed?

- A rapid response workforce for T&P needs to be retained to manage pressures given the likelihood of winter pressures next year. We recognise this may look different for winter 22/23 but there does need to be careful thought put to the retention of an agile emergency response for future COVID19 pressures and other infectious diseases.

Communications

What went well?

- Command structure in place (Bronze, Silver, Gold) which ensures optimal communication and clear lines of decision making.
- Staff engagement in recognising clinical need for redeployment
- Strong communications at a local, organisational and national level
- Regular communication to all staff regarding developments has been valuable.

What did not go well?

- Changing position with regards to care home closures due to Covid outbreaks – this led to delays in discharges taking place or alternative providers being sourced.

What should be done differently/changed?

- Improved national communications to the general public that the guidance is different in healthcare premises.
- Consider national policy for visitors- will requirements continue to be for LFD tests to be performed prior to visiting? Will these continue to be free? If not will boards have to provide the tests and an area for these to be performed?

Winter Planning

Monthly Report

Week Ending 31st January to 3rd April 2022

Contents

Introduction

The purpose of this report is to assure the Chief Executive, IJB and EDG that the Winter Plan is being delivered in accordance with the submission to Scottish Government and against agreed performance targets.

In 2021/22, the Winter Plan is integrated in the Remobilisation Plan and describes the actions that will be taken forward by NHS Fife and the Health and Social Care Partnership to optimise service resilience during the winter months and beyond in a COVID-19 sensitive environment. Executive leadership sits with the Director of Nursing and delivery lies with both the Directors of Acute Services in NHS Fife and the Health and Social Care Partnership.

A Silver Command has been established for winter planning which meets weekly and agrees actions, supported by the Winter Planning Bronze Command that monitors the dashboard weekly and escalates issues to Silver Command where appropriate. A bi-monthly report is provided to the board for assurance. The weekly reporting will cease at the end of March with the monthly report going to the NHS Fife Board in May 2022. Weekly reporting has commenced in October 2021 as part of the Winter Plan 2021/22.

The Winter Planning Performance Review Summary will be considered by the Finance, Performance and Resources and Clinical Governance Committees and for performance measures relating to the HSCP via Finance and Performance and Clinical and Care Governance Committees.

Section A: Executive Summary

This is the third bi-monthly report summarising performance against key indicators and actions for Winter 2021/22. The key points to note this month are as listed below.

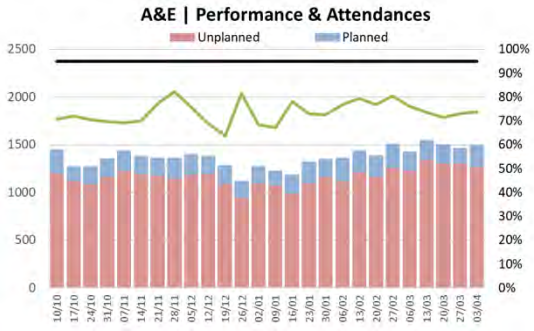
A&E

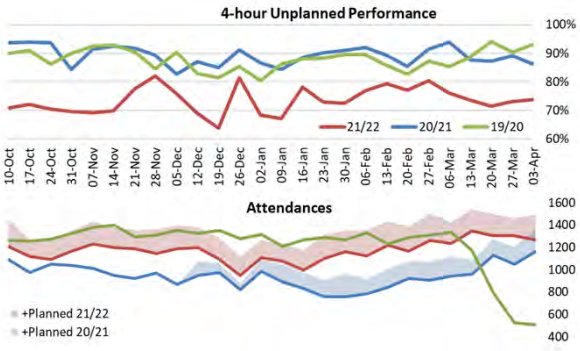
Narrative

The 95% Standard has not been met in the last 26 weeks. The board average has maintained above the Scotland average since w/e 6th February, and within 5% of the Scotland average throughout the Winter period with only week ending 19th December as the exception.

Planned attendances are not included within the numbers used to calculate the emergency access 4-hour target. The Redesign of Urgent Care (RUC) programme will transfer a portion of what previously would have been unplanned (minor) attendances into planned attendances. These patients would have been less likely to breach the 4-hour target, removing them has caused a negative effect on the performance.

Attendances including planned since the ed of January are now at the highest levels they have ever been and are trending much higher than pre pandemic levels now.



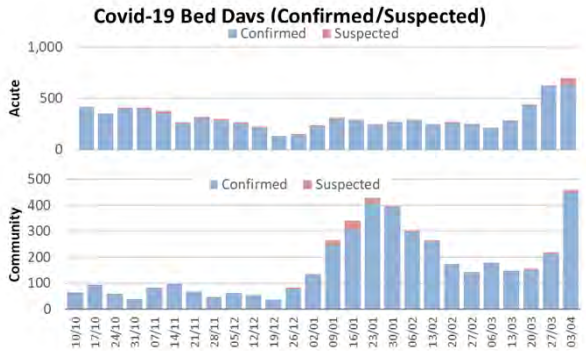


Covid-19 Bed Days

Narrative

The number of Covid-19 positive patients in Acute has risen increasingly since early March and are now at the highest levels seen throughout the Pandemic.

During the same period within a community setting the numbers have also risen increasing with the highest level seen causing many wards to close during this period.



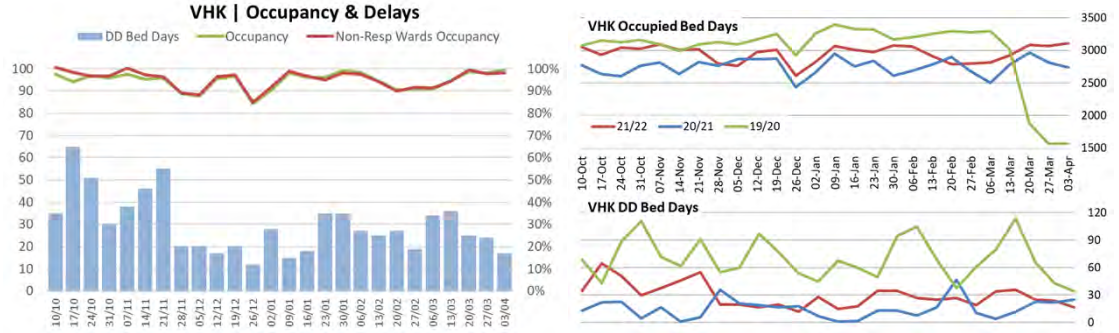
Acute Occupancy & Delays

Narrative

VHK occupancy was high late January then dipped in February till mid-March but has since been extremely high (98-99%), this coincides with the high covid numbers which will put a squeeze on beds available.

The non-respiratory pathway has almost mirrored the overall occupancy and ending March with 98%.

The number of Delayed Discharge Bed Days in VHK was steady during February until the end of the month where numbers climbed and continued into March, these have since decreased again. There has been an average of 26 Delayed Discharge Bed Days lost over the last 2 months.



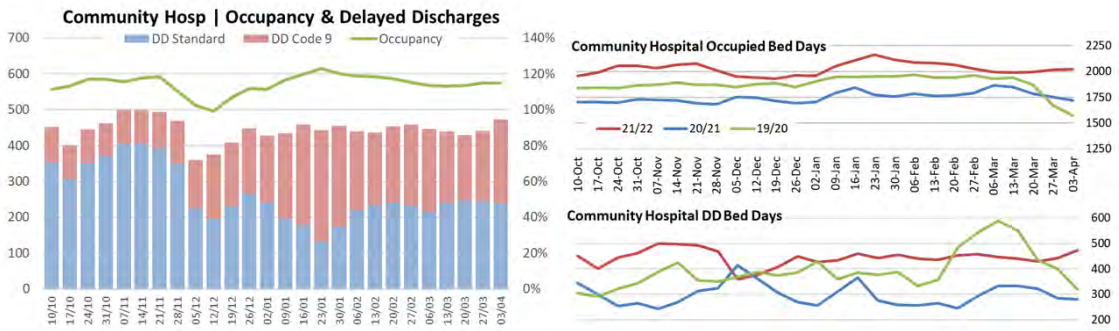
Community Occupancy & Delays

Narrative

Occupancy has maintained well above 100% for the whole of Winter and hitting 123% in January, and consistently 113% or above this year. Many wards throughout the period have had to close due to Covid which has contributed to pressure throughout.

The occupancy this winter is trending higher than any other due to the number of surge beds opened to try and maintain flow within the acute hospital.

There has been an average of just above 446 bed days lost to delayed discharges within the community hospital throughout February and March. The standard delays have remained fairly static around the 230-240 mark, whereas code 9's have fluctuated a little more.

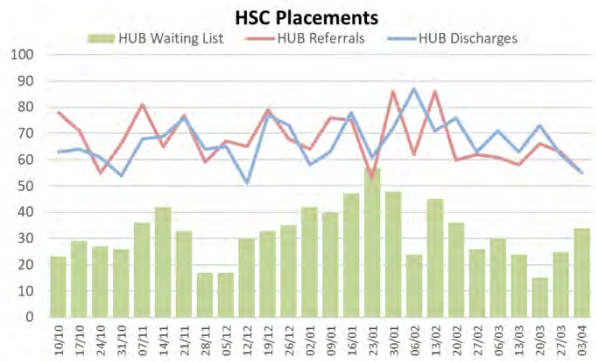


H&SCP Placements

Narrative

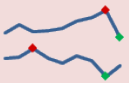
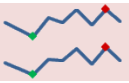
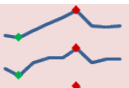
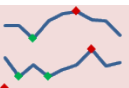
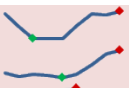
The number of referrals to H&SCP is on average 66 patients per week, with the number of discharges over this period over at an average of 69.3 per week.

The waiting list peaked at 57 week ending 23rd January and has gradually declined since thanks to the high discharges.



Section B: Performance Summary to Wk Ending 3rd April 2022

Weekly Unscheduled Care Monitoring Report

Area	Indicator	Trend	06-Feb	13-Feb	20-Feb	27-Feb	06-Mar	13-Mar	20-Mar	27-Mar	03-Apr
Urgent Care	Contacts		2174	2139	2229	2133	2134	2206	2150	2111	2296
	Home Visits		108	120	121	112	114	121	112	92	136
	COVID Outcome		291	315	296	299	304	324	336	357	277
	NHS24 Outcome		359	362	397	358	342	368	351	292	335
VHK ED	All		1355	1433	1385	1504	1424	1543	1501	1459	1493
	Planned		230	213	216	244	187	196	194	153	223
	Unplanned		1125	1220	1169	1260	1237	1347	1307	1306	1270
	Performance		76.8%	79.3%	77.0%	80.5%	76.0%	73.6%	71.5%	73.1%	73.9%
MIU	Total		382	347	317	403	383	436	371	440	385
	Unplanned		317	291	267	332	325	373	311	381	325
VHK	Admissions		696	687	709	731	745	769	722	718	724
	Emergency		617	595	639	651	651	684	639	650	647
	Medical		348	333	355	369	363	404	368	354	350
	Surgical		269	262	284	282	288	280	271	296	297
	Discharges		683	646	692	670	697	663	683	667	661
Theatre Activity	Scheduled		260	257	218	272	294	304	277	274	231
	Cancelled		19	7	15	7	12	15	25	14	16
	Hospital Cancelled		6	0	3	2	0	1	3	0	4
VHK Bed Utilisation	Occupancy		98%	95%	91%	91%	91%	95%	99%	98%	99%
	COVID Bed Days		291	242	271	252	208	279	441	621	698
	DD Bed Days		27	25	27	19	34	36	25	24	17
Community Hospital	Admissions		72	54	57	49	50	51	57	45	39
	Discharges		70	55	51	59	45	56	55	35	36
	Occupancy		119%	118%	117%	115%	114%	113%	113%	115%	115%
	COVID Bed Days		303	265	173	143	180	149	155	218	458
	DD Bed Days		440	436	454	458	446	440	429	442	472
	DD Standard		220	234	241	233	215	240	247	244	239
	DD Code 9		220	202	213	225	231	200	182	198	233

15MINUTE OF FIFE CAPITAL INVESTMENT GROUP MEETING

Wednesday 9 March 2022, 10.30am
Via MS Teams

Present: Margo McGurk, Director of Finance **(Chair)**
Neil McCormick, Director of Property and Asset Management
Dr Chris McKenna, Medical Director
Alistair Graham, Associate Director of Digital and Information
Maxine Michie, Deputy Director of Finance.
Ben Johnstone, Director of Capital Projects
Tracy Gardiner, Capital Accountant
Rose Robertson, Assistant Director of Finance

In Attendance:
Bryan Davies, representing Nicky Connor.
Andy MacKay, representing Claire Dobson.

1.0 WELCOME AND APOLOGIES

Apologies were received from Jannette Owens Director of Nursing, Wilma Brown, Employee Director, Nicky Connor, Director of HSCP, Paul Bishop, Head of Estates, Jim Rotheram, Head of Facilities and Claire Dobson, Director of Acute Services.

2.0 NOTES OF PREVIOUS MEETING

The note of the meeting held on 1 February 2022 was agreed as an accurate record.

3.0 ACTION LIST

The Action List was updated accordingly.

4.0 MINUTES OF OTHER COMMITTEES

4.1 Capital Equipment Management Group (RR)

It was highlighted that the National Infrastructure Equipping Team are seeking the Board's Capital Plan for 2022/23 and 2023/24. By collecting this data, the team plan to capture formulary capital spend and additional bids at the one time. Given the assumption that there will be slippage, the National Infrastructure Equipping Team plan to over commit on the capital budget to allow boards additional time to utilise the allocations.

It was noted that NHS Fife are currently in a good position for equipment replacement due to the additional covid funding received. NHS Fife have managed to replace a lot more equipment in the last 2 years, which in normal circumstances, would not yet

have been replaced. However, it was agreed that an assessment will be carried out to clarify if there will be significant items of equipment due to be replaced at one time that have not yet been identified to ensure a large influx of replacement occurs.

The minutes were noted.

Action: NM

4.2 Clinical Prioritisation Group (PB)

It was confirmed that the initial allocation of £1m has been committed to and spend is on track. At present only £2300 is outstanding which is planned to be utilised on works at QMH.

The minutes were noted.

5.0 MATTERS ARISING

N/A

6.0 GOVERNANCE

6.1 SPRA 2022/23 – 2023/24 – Capital Plan

MM advised that a paper on the SPRA 2022/23 Capital Plan was hoped to be circulated in advance of the meeting, however as there is an interdependency between the Capital and Revenue SPRA this has not yet been possible. The CRL for 2022/23 difference will be £2m this also included a capital to revenue resource transfer.

The SPRA 2022/23 Capital Plan will be presented at the next meeting for discussion and approval.

FCIG noted the update.

Action: MM

6.2 Orthopaedic Project Update (BJ)

BJ noted that work is progressing well, the project is maintaining programme and completion is scheduled for October 2022. The cashflow has been agreed with Scottish Government and the projected spend is on track. There is contingency spend remaining.

Workforce and revenue budgets have now been agreed.

BBC were onsite earlier in the month and began filming the progress of the build.

It was advised that there has been a strong interest in the consultant roles advertised. 14 candidates have applied many of which are of high calibre.

FCIG noted the update.

6.3 Kincardine & Lochgelly Project Update (NC/BJ)

BJ noted that the OBC's for both Kincardine and Lochgelly are progressing through the governance cycle. At the previous meeting of FCIG, it was asked that further information was detailed on the service revenue costs. These costs are now included in the OBC. For assurance, an additional meeting of the project board will be scheduled this month and the HSCP plan to do a presentation detailing the scope of services, the building area and highlight the revenue costs associated with the project in line with the service model to advise how everything links together

The year-end spend has been agreed and approved by Scottish Government.

The project team is currently progressing with the Stage 2 full business case activity, in line with the OBC governance process.

It was highlighted that the project is fully funded until 31 March 2022 for the business case, however from the 1 April 2022 costs will be incurred for design costs. It is expected that in May the Board will approve the OBC however between April and May costs will be accrued.

It was agreed this will be signalled to Alan Morrison to advise that NHS Fife will be operating at risk and a high-level figure of this cost will be advised.

FCIG noted the update.

Action: MMi

6.4 Mental Health Strategy (BJ)

BJ noted that work is underway to organise the optional appraisal with stakeholders.

CM noted that this project is making steady progress. It was highlighted that this project is very emotive within the community and needs to be carefully considered. There is a requirement to focus on how the facilities can become a therapeutic and holistic environment to ensure the service is supportive in the patients' recovery.

FCIG noted the update.

6.5 Review of Annual Workplan (MM)

It was agreed that the Capital Budget for 2022/23 will require to be formally approved in April 2022.

The 5-year plans will be brought forward in June and July 2022.

The workplan will be revised and brought back for further approval.

6.6 Review of Terms of Reference (MM)

FCIG approved the TORS, the next review date is March 2023.

PERFORMANCE

7.0 7.1 Capital Expenditure Report Update (TG)

TG noted that they are currently working on a £34m Capital programme. The capital report for end of December highlights a spend of £11/12m. In the next iteration FCIG will see that spend ramp up. At present there is no huge risk to the programme except for the Laundry Contract. JR confirmed that this has now been signed off by the Director of Finance and Chief Executive and will see this progress.

The capital spend remains on track.

FCIG noted the update.

8.0 ISSUES TO BE ESCALATED TO EDG

N/A

9.0 AOCB

It was agreed that individual capital proposals would be discussed at the next meeting.

10.0 DATE OF NEXT MEETING

9.30am, 20 April 2022 via MS teams.

NHS Fife

REPORT OF THE PHARMACY PRACTICES COMMITTEE HEARING HELD ON FRIDAY 18TH MARCH, 2022 AT 09.30 AM VIA MICROSOFT TEAMS

Present:

Appointed by NHS Fife

Mr Martin Black (Chair)
M Andrew Baillie, Lay Member
Mr Andrew Jack, Lay Member

Nominated by Fife Area Pharmaceutical Committee

Mr Raymond Kelly, Contractor Pharmacist nominated by the APC
Mrs Cara MacKenzie, Non-Contractor Pharmacist nominated by the APC

In Attendance:

Mrs Joyce Kelly, Primary Care Manager, Primary and Preventative Care, FHSCP
Mrs Karen Brewster, Note Taker

INTRODUCTION/BACKGROUND

APPLICATION FOR INCLUSION IN NHS FIFE'S PHARMACEUTICAL LIST

The hearing was called to consider an application submitted by Mrs Lisa Duncan to provide General Pharmaceutical Services from premises situated within Saline Community Centre, 13 Main Street, Saline, KY12 9TL

Under Regulation 5(10) of the NHS (Pharmaceutical Services) (Scotland) Regulations 2009, as amended ("The Regulations") the Pharmacy Practices Committee (PPC) were required to determine whether the granting of the application was necessary or desirable to secure the adequate provision of Pharmaceutical Services in the neighbourhood in which the Applicant's proposed premises were located.

a) The Regulations require that the Committee shall have regard to:-

- the Pharmaceutical Services already provided in the neighbourhood of the premises named in the application by persons whose names are included in NHS Fife's Pharmaceutical List;
- any representations received by the Board under paragraph 1 of the aforementioned Regulations;
- any information available to the Committee which, in its opinion, is relevant to the

consideration of the application;

- the Consultation Analysis Report submitted in accordance with regulation 5A;
- the Pharmaceutical Care Services Report; and
- the likely long term sustainability of the Pharmaceutical Services to be provided by the Applicant.

b) It was noted that copies of the following had been supplied to the members of the Committee, the Applicant and those who submitted a representation and had accepted the invitation to attend the hearing.

- Application Form A (1), Letter from Councillor Mino Manekshaw
- Representations received from ;-

I. Dears Pharmacy
II. Saline & Steelend Community Council
III. NHS Fife's Area Pharmaceutical Committee
IV. NHS Fife's Director of Pharmacy

- Consultation Analysis Report (CAR)
- A map of the area indicating the location of the proposed Pharmacy, existing Pharmacies and GP Surgeries and distances from these to the proposed site.
- An extract from the Fife Local Development Plan
- PPC Rules of Procedure

c) The Chair determined that the hearing should take the form of an oral hearing and the Applicant and those who submitted a representation were given the opportunity to attend the hearing. Those who accepted the invitation are listed below:-

i. Mrs Lisa Duncan, Applicant, accompanied by Peter Barilone
ii. Mr David Chisholm, Community Representative
iii. Mr Mahyar Nickkho-Amiry, Dears Pharmacy

d) The Committee noted that written notification of the application from Mrs Duncan was issued to the under-noted within 10 working days of the application being received in accordance with paragraph 1 of schedule 3 of the Regulations:-

i. NHS Fife's Area Pharmaceutical Committee
ii. NHS Fife's GP Sub Committee
iii. Pharmacies in High Valleyfield and Oakley
iv. Local Community Council

It was also noted that the Application had been provided to NHS Fife's Director of Pharmacy.

e) The Committee noted that written representations were received from the under noted within the required 30 days of written notice being sent to them:-

i. Dears Pharmacy
ii. Mr David Chisholm, Community Representative
iii. NHS Fife's Area Pharmaceutical Committee
iv. NHS Fife's Director of Pharmacy

No.

01/22 **CHAIR'S WELCOME AND INTRODUCTIONS**

The Chair welcomed everyone to the hearing, and round the table introductions were made.

02/22 **DECLARATION OF MEMBERS INTERESTS**

Prior to the commencement of the hearing, the Chair asked the members whether any of them had an interest to declare or were associated with a person who has any personal interest. The Chair then asked the Applicant and interested parties whether any person assisting them at the hearing was appearing in the capacity of Counsel, Solicitor or paid Advocate.

The Chair asked those present if they had any objections to the meeting being recorded for the purpose of the Minutes. All those present agreed they had no objections to the meeting being recorded.

There were no other declarations of interest, nor were any persons making representation attending in the capacity of Counsel, Solicitor or paid Advocate.

03/22 **FORMAT OF HEARING**

The Chair briefed those in attendance of the intended format of the hearing.

The Chair advised that the Applicant would be asked to make her submissions, followed by questions from the interested parties, then from members of the Committee.

The interested parties would then be asked, in turn, to make their submission, followed by questions from the Applicant, the other interested parties and then the Committee.

The interested parties would then be given the opportunity to sum up, followed by the Applicant.

04/22 **APPLICANT'S ORAL SUBMISSION**

Mrs Duncan thanked everyone for attending to discuss and consider her application to open a new Pharmacy from premises situated within Saline Community Centre, 13 Main Street, Saline, KY12 9TL.

Mrs Duncan (LD) spoke to her Presentation (Attached as Appendix 1)

05/22 **INTERESTED PARTIES QUESTION THE APPLICANT**

05/22.1 Mr Chisholm (DC) had no questions for Mrs Duncan (LD).

Mr Nickkho-Amiry (MN) questioned Mrs Duncan (LD)

MN asked LD if she agreed that residents would need to leave the neighbourhood daily to access most services that they require.

LD agreed that perhaps this may once have been the case, but less true now. She believed that with having the Primary School in Saline, people do not need to leave the neighbourhood to take their children to school and also that the way people shop has changed greatly. People now get their shopping online.

06/22 **COMMITTEE MEMBERS QUESTION THE APPLICANT**

06/22.1 Questions from Mr Andrew Baillie (AB) to the Applicant (LD)

AB reported that he had visited the premises and they were not particularly appealing. He asked LD how the Pharmacy would be set out and if there would be sufficient security in the Community Centre when the Pharmacy was closed.

LD confirmed there would be sufficient security. As part of the preparation when submitting the Application, LD had asked a shop fitter, who specialises in Pharmacy fit outs, to make sure the premises would be appropriate. He had done a preliminary plan for the Pharmacy and it would be fully alarmed and fully isolated. LD had also spent a lot of time with Estates in Fife Council looking at the plans. The Community Centre would still be fully accessible, whether the Pharmacy is closed or open and this has been fully discussed and agreed with Fife Council.

06/22.2 Questions from Mr Andrew Jack (AJ) to the Applicant (LD)

AJ asked LD what the Pharmacy First Service was and how it would be an advantage to the services that exist currently .

LD confirmed that Pharmacy First replaced the Minor Ailment Scheme, and allows Pharmacists to provide antibiotics, for conditions such as urinary tract infections, skin infections, which are normally provided under the remit of a Patient Group Direction. This service is managed by a Pharmacy Independent Prescriber, who is able to offer an extended service for minor conditions i.e. earache and back ache, which allows for a wider scope of prescribing.

AJ asked if a patient would have to visit their GP to currently access this Service.

LD confirmed they would not currently visit their GP, they would visit their Pharmacy where this service would be carried out by an Independent Prescriber.

AJ asked if Oakley Pharmacy currently employed an Independent Prescriber.

LD was not aware that they did.

Regarding viability, AJ stated that LD had mentioned in her presentation that the proposed Pharmacy would generate 3,000 prescriptions items per month.

LD confirmed that she had carried out a Freedom of Information request to find out how many items the area could potentially generate to ensure that she was submitting an Application to an area that would be viable. This showed that in this area there are more than 3,000 items generated per month. Presently these are split between different Pharmacies as there is not a Pharmacy in Saline, which proved to her that there is currently sufficient items being generated that would make a Pharmacy viable.

AJ asked LD if she believed that potentially more than 3,000 items would make a Pharmacy viable.

LD agreed it would.

AJ asked what she felt the impact would be on surrounding Pharmacies.

LD believed that currently the majority of items are dispensed at Oakley Pharmacy.

At this point MN clarified that Oakley Pharmacy does provide Pharmacy First and has a Pharmacy Independent Prescriber.

06/22.3 Questions from Mr Ray Kelly (RK) to the Applicant (LD)

RK asked LD to specify the boundaries of the proposed neighbourhood for clarity.

LD confirmed that when she first submitted the Application she had stated that the neighbourhood was the settlements in their entirety of Saline and Steelend. She reported that she had come to realise, during the delay due to Covid and having gone through more PPCs, that she had found it difficult to set her neighbourhood because she was trying to reflect the rural area that surrounds Saline that also considers itself as part of the Saline community. She believed that because of that her neighbourhood would be Saline and Steelend in its entirety but her catchment area would be Saline and Steelend, and the rural area which is to the North of Saline. LD believed that David Chisholm, with whom she had quite a few conversations regarding the neighbourhood, would be able to clarify this as she had tried to reflect her neighbourhood onto the area that the Saline Community Council delivered their newsletter to as they take in the rural farms and hamlets that surround Saline. She felt that it was difficult to define the neighbourhood, taking into consideration the rural areas, where they have their own population which also use the facilities within Saline.

RK asked if there is a sign as you are entering Steelend that says welcome to Steelend and is there a sign when you enter Saline that says welcome to Saline.

LD was unsure of a sign at the beginning of Steelend but believed there was one at the beginning of Saline.

RK reported that he had asked the question if there is a sign that says welcome to Saline and Steelend as he was trying to clarify if they are two different villages or classed as one village in terms of the Legal Test. RK asked if she accepted that from Lord Nimmo-Smith's point of view that Saline is a neighbourhood within its own right.

LD disagreed and said that in her opinion the neighbourhood would be Saline and

Steelend as they regard themselves as linked.

RK asked where residents of Saline go to for the Dentist..

LD believed they would go to Dunfermline and various different places. She understood the point he was making but stated that looking at the SMID data, it underlines the fact that Saline is deprived in terms of its access.

RK asked if LD felt it would be correct that people would go outwith the neighbourhood to access Dentists, Banks, Supermarket's etc.

LD agreed but believed this was reflected in the SIMD data, which shows that the three data zones are deprived in terms of access to services but she felt that things have changed in terms of the way people access these services i.e. online banking, online shopping, therefore she agreed that although to access some services you would need to be there in person, she felt things had changed in the way that people use neighbourhoods.

RK asked if online Pharmacy shopping exists.

LD confirmed it does exist but believed it was not likely to be used by a 75 year old lady that has mobility problems and doesn't have access to a computer. She did not believe it offered an all-round Pharmacy service.

RK asked where the 75 year old would currently access Pharmaceutical Services, and asked if they would get no service or would it be outwith the village.

LD confirmed that they currently access services outwith the village, or alternatively they do not access it at all, which has been demonstrated through the pandemic, where people cannot access services.

Regarding the increase in pupils attending the school in Saline, RK asked if 100% of them live in Saline and Steelend or if they come from the wider catchment area.

LD believed the increase in the amount of pupils at the Primary School is due to the new houses that have been built in Saline, and that they come from Saline, Steelend, the rural areas, Blairhall and Comrie.

In regards to LD's comment that people did not have to travel to the Primary School, RK asked if this would not strictly be the case as there are still some parents who have to travel to the Primary School.

LD agreed that what he was saying was fair but felt that for the 1200 residents of Saline and Steelend this makes a difference.

LD had stated in her presentation that 92% of the population had responded positively to the CAR. RK asked if 92% was from the neighbourhood or the catchment area.

LD confirmed this figure was from the 314 people that had responded to the Consultation.

RK asked, is that 92% of 314 people which is 25% of the total population.

LD confirmed it was.

RK asked if 2,000 is the minimum population she would need for a Pharmacy to be viable and if the 3,000 prescription items she referred to would make a new Pharmacy viable.

LD confirmed this was correct and reported that she had used the comparison figure of 1800, which previously was the figure used for Essential Small Pharmacies, which no longer exists.

RK stated that you need to have an Independent Prescriber to provide the Pharmacy First Plus Service and asked if LD agreed.

LD agreed this is the case.

RK asked what would happen to this service if LD went on holiday and whether or not she would only employ Locums who had the Independent Prescriber qualification.

LD's understanding of the Scheme was that the Pharmacy had to provide this service for 40 weeks of the year, which she confirmed she would be there for.

RK asked, if LD was granted the contract then decided two or three years down the line she wanted to sell it, would that only be to a resident of Saline and to someone who would provide the Pharmacy First Service.

LD did not envisage selling the Pharmacy in two years' time if she was awarded the contract.

06/22.4 Questions from Mrs Cara MacKenzie (CM) to the Applicant (LD)

CM asked LD if it would be her intention to work in the Pharmacy Monday to Friday and Saturday morning.

LD confirmed she would be working full time but it would be difficult to say what her defined hours would be. To start with, she intended to be there as much as she can.

In terms of Pharmacy First, CM wondered if LD had a niche at all that she was comfortable prescribing in and if she had done any assessment into the needs of the population.

LD reported that the qualification she had was in Substance Misuse, which she felt there was not much call for nowadays. She stated that she had not completed the common Clinical Conditions two day course but confirmed that she intended to do so. Once she gets to know the community better and has some collaboration with the GP Surgery, if there is a necessity for other types of clinics to deal with respiratory or hypertension then she felt that would be a fantastic route to follow.

CM asked if LD will be moving closer to the area if the contract is granted.

LD confirmed that she would be moving closer.

06/22.5 Questions from the Chair (Ch) to the Applicant (LD)

Ch asked LD what she felt the minuses would be of having a Pharmacy located within a Community Centre.

LD did not envisage any minuses. She believed it was in a great location as it is central and potentially allows the Community Centre to become a hub to the community. She felt at the moment she could only see positives and not negatives.

Regarding the FOI and 3,000 prescriptions being available in the area, Ch asked LD if she felt this would impact the 11,000 prescriptions that Oakley Pharmacy currently prescribed.

LD stated that an average Pharmacy could prescribe between 4,000 and 6.000 items per month, whereas Oakley dispenses between 11,000 and 12,000 so they have a huge amount of dispensing volume. In terms of the 3,000, the majority of the items are picked up by Oakley so it would have an impact on them but in terms of would it affect their viability, absolutely not.

Ch stated that in terms of Pharmacy First, the proposed Pharmacy planned to open on a Saturday, he asked LD if Oakley Pharmacy is open on a Saturday.

LD confirmed that Oakley Pharmacy is open on a Saturday.

Ch asked where the new houses are going to be based.

LD reported that there is a proposed site, which she believes is up the North Road, potentially for 150 houses, and believed this would warrant a new Pharmacy in Saline, although they would be free to go to any Pharmacy.

07/22 INTERESTED PARTIES' ORAL SUBMISSIONS

07/22.1 Mr David Chisholm (DC) referred to the documentation he submitted originally (Paper 2(ii)) and emphasised the following points.

The Community is very defensive and tries to prevent things but we are happy to work with Fife Council and other authorities and the private sector to help implement it. Within that vision improved Healthcare is very important. It is more than 30 years since there was a GP in the village. We have had conversations with Oakley Medical Practice to see if they would consider a satellite service to overcome the need to go down to Oakley but they do not have the resources and it is unlikely that it will ever return. However having a Pharmacy in the centre of the village, will give people the opportunity for face to face contact with a Health Professional without having to travel to Oakley. A young mum with a child that is unwell would not want to be putting them in a car and travelling outwith the village for healthcare. Just being able to ask someone for an opinion is reassuring. DC referred to the letter from Oakley Medical Practice, which confirmed that having a Pharmacy in Saline would reduce their workload.

Earlier this week my eight year old grandson was unwell with an ulcer on the back of his throat. My daughter asked family and friends for their opinion. They told her she would need to take him to a Health Professional. She then rang Oakley GP Surgery and

explained the circumstances to which she was told there were no GPs or Nurses available therefore there was no one to call her back which was very distressing. It ended up it wasn't too serious but it could have been. If she had been able to walk to the Pharmacy and get an opinion that would have been reassuring.

DC referred to one of the Panel asking about signage in the village. DC confirmed that both Saline and Steelend have signage at the start. Saline and Steelend is a Parish and the boundaries extend quite a long way North and take in the majority of the isolated properties and farms. People identify Saline with Steelend. DC believed that LD was right in saying a lot of people have food delivered to them. It is also the kind of place where people have a sense of neighbourliness, support and resilience. DC pointed out that through the Beast from the East people were caring and helped each other and that this has carried on through the pandemic. He felt that people are learning to live without using a car, which is part of their vision to reduce car usage and carbon emissions.

DC confirmed that Fife Council are going to carry out some essential roof repairs to the Community Centre and make the building more attractive.

DC stated that someone asked about the Dentist and confirmed that people do have to travel to Dunfermline or Oakley for a Dentist, however he believed that if the population were to grow there would always be a possibility that someone may build a Dental Practice in the village.

With regards to housing, DC advised that a site has been identified in Steelend which could accommodate another 40 or 50 affordable housing but most significantly there is a large stretch along the West Road which has been identified by developers for private housing and that has capacity for 200 to 300 new homes.

08/22 INTERESTED PARTIES QUESTION MR DAVID CHISHOLM

08/22.1 Questions from the Applicant (LD)

LD had no questions for DC.

08/22.2 Questions from Mr Nickkho-Amiry (MN) to Mr Chisholm (DC)

MN asked if DC agreed that people have to leave the defined neighbourhood in the course of their daily life to access most services.

DC agreed that people are inclined to leave the village less than they did previously. He advised that it was an ambition to take the shop into community ownership. At the moment it only has a limited stock of bread, milk and cigarettes etc, whereas people want healthy options such as fruit and vegetable which can be grown locally. This is all part of promoting the village as a healthy place to live. He also believed that peoples shopping patterns have changed and giving that fuel costs have risen, people will be less inclined to use their cars.

09/22 COMMITTEE MEMBERS QUESTION MR DAVID CHISHOLM

09/22.01 Questions from Mr Baillie (AB) to Mr Chisholm (DC)

AB had no questions for DC.

09/22.02 Questions from Mr Jack (AJ) to Mr Chisholm (DC)

AJ asked how DC's grandson's ulcer was resolved and if it involved travel.

DC was unsure what had been suggested through Facebook but it was not as serious as it looked. DC stated that if a prescription had been needed, they would have had to travel to Oakley.

09/22.03 Questions from Mr Kelly (RK) to Mr Chisholm (DC)

RK asked if the Parish would be more indicative of the catchment area or if it is Steelend only.

DC reported that the Parish is the largest in West Fife. To the South of Saline and Steelend is the Hamlets of the Kinneddar Park and Castle Burn and there are two roads that lead South, where the boundary is about half way down to Oakley, and to the North West, the North and to the East, it extends quite a long way to Busses Farm and beyond, probably about two miles into the village. On the Eastern boundary is Knockhill, then to the East of Saline and Steelend you have Upper Steelend and beyond that, a small Hamlett called Dunduff. DC stated that what he was trying to clarify is what people identify as a neighbourhood. He believed that perhaps someone living in that area is probably as close to Powmill, which is in Perth and Kinross.

RK asked DC to clarify that the Parish is the wider area.

DC confirmed it was.

RK referred to DC's statement that it had been more than 30 years since the village had a GP and that he had engaged recently with the GPs in Oakley but they had advised that they do not have the resources to provide that service again. RK asked if he thought it would be fair to say that the GPs did not think it would be viable to open a GP Surgery for that size of population.

DC believed they had a problem recruiting, but they had not discussed the economics behind it. He had suggested an ANP sitting in the Community Centre at designated times, which is not as good as a Pharmacy but felt it may have been a step in the right direction.

Referring to the issue of DC's grandson's ulcer, RK asked if DC would accept that another option would have been to telephone the Pharmacy in Oakley.

DC answered yes, but said it was a shock to see the child's ulcer at the back of his throat.

RK asked if DC was aware of the service that has been brought in on the back of Covid, where you can video call a Pharmacy, and they can give advice.

DC accepted that this was a possibility, but is wary of technology. He believed there is no substitute for human contact.

RK asked if DC was aware if any of the nearby Pharmacies deliver.

DC confirmed that Dear's Pharmacy deliver and since they have taken over from the

previous Pharmacy the opening hours are much better.

RK clarified that the Legal Test is the process for considering Pharmacy Applications only and therefore, should a decision to award a Contract to Saline be granted, it will be based only on the Legal Test and not the prospect of becoming a catalyst for other businesses and Fife Council.

DC agreed.

RK stated that if there is a chance that there will be Community ownership of the shop, this suggests that it will not be viable and asked for DC's comments.

DC believed the shop is a separate issue. He advised that he was in discussions with the sons of the shop owners to try and improve the offering. In his opinion, people are sometimes unwilling to accept change, but he felt this could be resolved separately. In terms of the Community Centre, they are looking at various options. The Community Council have spoken to the Scottish Land Fund, where they could proceed to stage two. They are relying on public support, but people are wondering where the money is coming from. He presumed a commercial anchor would be an important first step, in putting together a plan. Outright ownership is one option, but he felt that negotiating a management agreement with Fife Council may be more realistic.

RK asked DC if the plan was not wholly dependant on there being a Pharmacy.

DC confirmed it was not, although believed it would ensure that the building is open at all times.

09/22.04 Questions from Mrs MacKenzie (CM) to Mr Chisholm (DC)

CM had no questions for DC.

09/22.05 Questions from the Chair (CH) to Mr Chisholm (DC)

Ch was concerned that the Pharmacy may be used to create a spring board for other businesses within the Community Centre and asked for DC's comments.

DC felt a new Pharmacy would make it easier to come up with a business plan for the Community Centre, but the model in mind, which goes back a few years, when they were first approached, is based on a property in in Twecker, Glasgow, where they developed a Community Centre which in his opinion is an amazing place. DC had visited the Centre which has a Pharmacy and a Community Café, a toy shop etc and is a vibrant place. DC believed this would still be possible to achieve without a Pharmacy.

Ch referred to the negativity in the response to the CAR regarding Methadone and asked DC how he would see that impacting on people entering and leaving the Pharmacy and having to go through the Community Centre.

DC explained that people can enter through the foyer without going through the whole Centre where there is a plan to make it more attractive. There is also a consultation area in the proposed plan which will allow privacy for service users.

10/22.01 Mr Nickkho-Amiry (MN) spoke to his presentation (Attached as Appendix 2)

INTERESTED PARTIES QUESTION MR NICKKHO-AMIRY (MN)

10/22.02 Questions from the Applicant to Mr Nickkho-Amiry (MN)

LD had no questions for MN.

10/22.03 Questions from Mr Chisholm (DC) to Mr Nickkho-Amiry (MN)

DC asked if MN recognised any differences in the demography and character of Saline and Steelend.

MN agreed with some of the points, that there are a number of villages collectively that would pass as one neighbourhood.

DC asked how much experience MN had with social surveys and responses from communities being asked questions, as he felt MN had belittled the fact that 314 people had responded to the Consultation, which he believed was a terrific response.

MN stated that he did not disagree and clarified the fact that he was commenting on the percentage of people. MN felt that the number of people who you would have expected to reply, was not high enough.

DC asked if MN monitored the Community Facebook page as he would see the discussions that have taken place. He believed this was a sophisticated Community.

MN agreed, and went on to say that since he had taken over Dear's Pharmacy he had tried to meet with the Community Council on several occasions but due to Covid had been unsuccessful however he confirmed that he would be attending the next Community Councill meeting. MN reported that he believes in engaging with all the local communities that they serve through their Pharmacies.

DC asked if MN knew the price of an adult bus ticket between Saline and Oakley.

MN did not know.

DC confirmed the price is over three pounds and if you have children you will also be expected to pay for them. He believed the bus service was unreliable and expensive.

COMMITTEE MEMBERS QUESTION MR NICKKHO-AMIRY

10/22.04 Questions from Mr Baillie (AB) to Mr Nickkho-Amiry (MN)

In regards to MN's neighbourhood, AB asked MN to give him the Northern Ireland citation he had mentioned in his Presentation.

MN confirmed it was the Bangor Boots from Lord Justice Carswell.

AB asked what the English case was that he had mentioned in his Presentation.

MN confirmed that it was Lord Nimmo-Smith.

AB asked if the previous case had at all agreed with or contradicted Lord Nimmo-Smith's case.

MN reported that he was merely trying to explain the definition of a neighbourhood. To show that a neighbourhood is a neighbourhood for all purposes.

Although AB was unaware of any complaints about the Pharmacy in Oakley, he asked if MN was aware of any due to the pressures on the Pharmacy.

MN was unaware of any complaints and believed this was due to the fact they have invested heavily in staffing across all their Pharmacies. He stated that the Pharmacy had more than the average of support staff which helped and especially through the pandemic, whilst other retailers chose to reduce the number of staff they had increased their levels even further, hence making sure there were no interruptions to Pharmaceutical Services.

10/22.05 Question from Mr Jack (AJ) to Mr Nickkho-Amiry (MN)

AJ was interested in the Telewell App that MN had mentioned earlier. AJ was familiar with Near Me but not Telewell. He asked if there is a facility through Telewell, from a Pharmacy First point of view, that can be used.

MN confirmed that Near Me is also available in Pharmacies, where the Pharmacists can use the function to video call the patient. He advised that the App he uses in his Pharmacies is called Healthera which, as a business he pays for but makes it available for free to customers. This allows customers and their dependents to download the App, add their medication, how many they take in a day and the supply they have. The App then prompts them when to take their medication and also counts down for them so reminds them when to reorder. Once they order their medication they can then go onto the App and find out when the Pharmacy has delivered it to the Surgery and when it will be ready for collection, or if they wish to have it delivered, or they can use the 24 hour collection point. There is also an instant messaging function, where the patient can chat with the Pharmacist if they wish to do so or to purchase some medication after chatting with the Pharmacist.

10/22.06 Questions from Mr Kelly (RK) to Mr Nickkho-Amiry (MN)

RK asked MN to clarify if he thought that Oakley was a different neighbourhood or part of Saline.

MN was of the opinion that it depends on how each person sees it. From a personal point of view he sees Oakley, Saline, Steelend, Carnock, Gowkhall and Blairhall as one neighbourhood because it is all one rural area, it is not urbanised.

RK asked MN if he would accept that in Lord Nimmo-Smith's judgement, he makes comment about neighbourhood having a sense of place.

MN agreed.

RK asked how often MN delivered to Saline.

MN confirmed that deliveries were made every day.

RK asked if it was just once a day and if they have a cut off time.

MN explained they travel to the Surgery numerous times a day, then deliver on a daily basis. He confirmed there is not a cut off time but normally the majority of deliveries are done by 3pm, then they tend to reserve the time between 3pm and 6pm, for urgent deliveries. There are delivery drivers available at this time, essentially preparing for the following day. During the opening hours there is capacity to deliver every day.

RK asked MN if he could give him an example of anywhere in Scotland where a new Pharmacy Contract has been awarded and has resulted in the closure of an existing Pharmacy.

MN confirmed he could not.

RK pointed out that the Applicant had stated that Oakley Pharmacy's viability would not be impacted by losing 3,000 prescription items. He asked if he was correct in thinking that 3,000 prescription items would be a 25% decrease in their prescription volume.

MN confirmed that it absolutely would affect the viability and would have an impact on other services, such as staffing levels and service.

RK stated that MN had mentioned that during the pandemic, unlike other retailers, they had boosted their staffing levels. RK asked if he perceived himself just as being another retailer and how would he compare that with another Pharmacy.

MN clarified that they class themselves as an Independent Pharmacy Group, and during the pandemic they saw a lot of the large national Pharmacy chains cutting staffing because they saw massive reductions in their revenue, as they do a lot of other things that are not related to Pharmacy. MN believed they needed to make sure their staffing levels were maintained it was acknowledged that GP Practices closed their doors, so they took on more members of the Team and trained them up to support the Pharmacy. He stated that he always tries to look after local people and create jobs locally.

10/22.07 Questions from Mrs MacKenzie (CM) to Mr Nickkho-Amiry (MN)

CM asked MN to clarify, regarding Pharmacy First, if his two Pharmacists are Independent Prescribers.

MN confirmed that one of the Pharmacists has just passed at the start of this month and the other is due to pass in the next two months. They both work full time so every day that the Pharmacy is open, including Saturdays there will always be an Independent Prescriber available. He stated that they also have other Pharmacies and Independent Prescribers in the Group, therefore are able to maintain a service across all of them. MN reported that every Pharmacist in the Group will be an Independent Prescriber by 2024.

CM asked what measures are in place to maintain resilience to the Pharmacy if there is any adverse weather in the future.

MN stated that they are fortunate that the Pharmacies they have all employ staff locally. They also have a wide range of delivery vehicles which can pick up staff and

Pharmacists that live locally. He believed they are one large family who support one another.

CM referred to the App and asked MN how that works.

MN confirmed that the App has an instant messaging component which allows the patient to message a member of the team. If they can deal with the query they will, or if they feel they need to pass it to the Pharmacist they can do so, and if need be the Pharmacist can call the patient or use the video call on NHS Near Me.

CM asked MN to detail how he would provide counselling to patients if it was a new medication or something with specific counselling needs.

MN stated that when those patients receive a delivery, they make a note that they are requiring additional counselling, so when the delivery driver arrives at the house and has handed the medication over, the Pharmacist will follow up with a telephone call.

At this point Ch allowed DC to ask MN a question which he had tried to raise earlier.

DC stated that when he had met with MN a few weeks earlier, he had informed him that the GP Surgery had not supported the proposed Contract and asked if he had seen the letter that he had obtained on 7th March which confirms that they do support the Application.

MN confirmed that he had seen the letter and had also seen an email from the Surgery that had supported his Objection to this Application, which stated that there is no need for an additional Pharmacy. He felt the Surgery is basically eluding to the fact that they are saying, in principal, that if someone is willing to take on Pharmacy provision then they will support it but that is not their decision to make. That is the decision of the PPC.

DC clarified that he meant the written evidence from the Practice Manager.

MN confirmed he had seen the letter but reported that he had a copy of an email dated 2nd February from the Practice Manager who wrote the same letter to support his Objection to oppose the new Pharmacy Contract.

10/22.08 Questions from the Chair (Ch) to Mr Nickkho-Amiry (MN)

Ch asked, by definition of MN's neighbourhood, if he could clarify it.

MN confirmed that the defined neighbourhood should also include Blairhall, Oakley, Carnock and Gowkhall to the South.

Ch asked how many prescriptions Oakley Pharmacy delivers to Saline and Steelend.

MN reported that he would need to check, but he was aware they deliver a small proportion to that area.

Ch asked how many prescriptions the Pharmacy would deliver to Blairhall, Carnock.etc.

MN confirmed that collectively to the neighbourhood in the area that he had defined, they deliver approximately 1,300 prescriptions per month.

Ch asked how they could be assured that the Pharmacy App is appropriate for people who cannot access Pharmaceutical Services.

MN stated that the App is used by over 2,000 members of the community and is growing on a week by week basis. That 2,000 does not include the fact that there is also the ability to add dependents on the App. The App was brought in about three months before the pandemic and Healthera confirmed that the area they cover is one of the highest used in the UK. MN reported that they also had a 24 hour prescription collection point as part of their refit Which over 100 people had already signed up to.

11/22 INTERESTED PARTIES SUMMING UP

11/22.01 Mr David Chisholm (DC)

DC assured the Panel that Saline and Steelend constitute a place that people identify with. He believed that the neighbourhood of Saline and Steelend is quite a different place from Oakley. He felt this was important in regards to how people identify and receive their services.

11/22.02 Mr Nickkho-Amiry (MN)

MN believed the Applicant's case comes down to one question, is two miles too far to travel in a rural community, where there is very high car ownership, to access a Pharmacy when they travel for every other service outwith the village. He felt the answer was clearly no and that the existing Pharmacy provides an adequate service.

12/22 APPLICANT SUMMING UP

LD reiterated, the neighbourhood of the proposed Pharmacy is Saline and Steelend. She emphasized that there is a strong sense of identity in the community of Saline and Steelend and that she would not identify it as being in the same neighbourhood as Oakley. The catchment area is the rural area surrounding the neighbourhood stretching to the North around the A77 and South towards the A907. The closest Pharmacy is in Oakley, which is 2.4 miles from the proposed premises, which could prove difficult for people who do not have access to a car during the day and the fact that a round trip on public transport takes one hour and twenty minutes could also prove difficult. Access to the Pharmacy is of significant difficulty and therefore the current Pharmaceutical Service to the neighbourhood cannot be considered adequate. There is a high degree of support for the Pharmacy from the Community Council, local Councillors and from the GP Surgery in Oakley. LD reported that she would also like the Panel to note that it's the first time she has ever heard of 314 responses to the Consultation being described as insignificant. The population of the neighbourhood combined with the population living in the rural area, which surrounds the neighbourhood is in excess of 2,000. This population generates around 3,000 prescription items per month. There is no doubt that a Pharmacy at this location would be viable and therefore secure an NHS Pharmaceutical Service. She also reiterated that it is inconceivable that a Pharmacy in Saline would affect the viability of the Pharmacy in Oakley. She felt strongly that this Application passes the Legal Test. A Pharmacy in Saline is necessary and desirable in order to secure an NHS Pharmaceutical Service in the neighbourhood in which the proposed premises are located.

13/22 NOTIFICATION OF OUTCOME

13/22.01 The Chair asked all those present whether or not they felt they had had a fair hearing, they all confirmed that they had.

13/21.02 The Chair thanked the Applicant and the interested parties for their attendance and before asking them to leave advised them that the decision would be notified to them in accordance with the timescales laid down in paragraph 1, Schedule 3 of the Regulations.

THE APPLICANT, INTERESTED PARTIES AND PRIMARY CARE MANAGER WITHDREW FROM THE HEARING.

14/22 In accordance with the Legal Test, the Committee considered whether existing provision of Pharmaceutical Services in the neighbourhood was adequate. If it decides that such a provision is adequate, that is the end of the matter and the Application must fail.

In considering the Application the Committee took account of all relevant factors concerning neighbourhood, the CAR, the PCSR, the written and oral evidence and adequacy of existing Pharmaceutical Services in the neighbourhood in which the proposed premises would be located, in terms of regulation 5(10).

It also took account of all information available to it which was relevant to the Application

14/22.01 **The PPC were required and did take into account all relevant factors concerning the issue of:-**

a) Neighbourhood

b) Adequacy of existing Pharmaceutical Services in the neighbourhood and, in particular, whether the provision of Pharmaceutical Services at the premises named in the Application were necessary or desirable in order to secure adequate provision of Pharmaceutical Services in the neighbourhood in which the premises were located.

Proposed premises

The location for the proposed pharmacy is Saline Community Centre, 13 Main Street, Saline, KY12 9TL

14/22.02 **Neighbourhood**

Having considered the evidence presented to it by the Applicant, the interested parties, the Consultation Analysis Report and NHS Fife's Pharmaceutical Services Report the PPC had to decide firstly the question of the neighbourhood in which the premises to which the application related were located.

When seeking to define the neighbourhood the Committee considered a number of factors.

Mr Kelly was of the view that there had been three different neighbourhoods identified by the Applicant, the Community Council, and the Interested Party and that it was the role of the Committee to define their own understanding of the neighbourhood. It was felt that the Applicant had initially decided on Saline and Steelend but then today, added in the rural areas north of Saline. Mr Kelly felt that Saline and Steelend were two separate entities although the Applicant would not agree with this.

Mr Kelly proposed that the neighbourhood was solely the village of Saline: to Bluther Burn in the South, Saline Burn to the North, West along the B913 where West Road meets with the junction of West Park Gate, and East along the B914 to where it meets with the B913. He felt that phrases such as neighbourhoods, catchment areas and Parishes had all been used during proceedings which confused the matter. His recollection of Lord Nimmo-Smith's ruling was that the neighbourhood is the place where the proposed premises are located.

Mrs Mackenzie agreed with this interpretation and confirmed that she was satisfied that only Saline should be considered.

Mr Jack also accepted this and felt that it squared with the view of MN.

Mr Baillie disagreed with this decision as he had visited the site and had some local knowledge of the area. He spoke to a retired Post Woman during his site visit and she gave him some information on how the populations of both Saline and Steelend see themselves as one entity. Pupils from Steelend went to Saline School and newly weds would initially live in Steelend until they could afford to move back to Saline. His view was that the neighbourhood was Saline and Steelend and the hinterland. He noted that the cases quoted by MN referred to England and Northern Ireland, so they should be discounted and the Committee should make reference only to Lord Nimmo-Smith.

Mr Jack felt the neighbourhood would impact on viability of the proposed Pharmacy, thus the reason the Applicant had extended it past Saline. Although there may be around 3000 scripts per month from the neighbourhood, there was no guarantee that the Applicant would get them all.

Mr Black felt that if the neighbourhood was to be only Saline then it invalidated many of the responses to the CAR, as they came from people who lived out with Saline.

After a long discussion the Committee agreed that the neighbourhood was more than Saline, and accepted the Applicant's decision that it was both Saline and Steelend, bounded by Bluther Burn to the South, Saline Burn to the North, West along the B913 where West Road meets with the junction of West Park Gate, but in the East, along the B914 to the extremity of Steelend.

14/22.03 **Adequacy of Existing Provision of Pharmaceutical Services and Necessity or Desirability**

Having reached a conclusion as to the defined neighbourhood, the Committee was then required to consider the adequacy of Pharmaceutical Services within or to that neighbourhood and, if the Committee deemed them inadequate, whether the granting of the Application was necessary or desirable in order to secure adequate provision of Pharmaceutical Services in the defined neighbourhood.

In order to assist the Committee in reaching their decision, they took into account the following:-

Mr Baillie said it was a fact that there was no Pharmaceutical Service within the neighbourhood therefore was the service from Oakley reasonable? He felt that if he was a resident, he would not be convinced that this was the case. In his view the definition of Pharmaceutical Services was wider than being able to travel to a Pharmacy.

Mr Black stated that he had reservations about the viability of the application. He felt that this was being supported locally to aid the Community Council in taking over ownership of the Saline Community Centre as they would have a sitting tenant paying them rent. He was of the view that the current arrangements were adequate. Mr Jack agreed with these sentiments.

Mr Kelly noted that Mr Chisholm had mentioned 1500 people would be moving to new housing in the neighbourhood but the Committee could only consider the current situation. Mr Kelly felt that this would not make a material difference to the viability in any case.

Mrs MacKenzie confirmed that there were only 260 new homes planned which would not equate to 1500 residents. As Oakley Pharmacy already has two pharmacists, and three consulting rooms, it has the capacity to absorb this increase.

14/22.04 **Consultation Analysis Report**

It was noted that 92% of the 314 responses were positive, but that this number only equated to 25% of the population.

14/22.05 **NHS Fife's Pharmaceutical Services Report 2019-20**

It was noted that the FPSR did not identify any gaps in service in the Saline and Steelend area. The report had stated that services were well distributed across the Fife region and met the access needs of the vast majority of the population. Therefore the report concluded there was no unmet need for new community pharmacies across Fife.

14/22.06 **Pharmaceutical Services already provided in the neighbourhood of the premises named in the application by persons whose names are included in a pharmaceutical list**

Mr Kelly suggested that the question the Committee had to answer, was whether or not NHS Fife currently has sufficient capacity to provide a Pharmaceutical Service to that part of Fife. The median number of scripts monthly per Pharmacy to make it viable is 4300. Both the APC and the then Director of Pharmacy and Medicines noted that there was no gap identified in the Pharmaceutical Services Report for this area therefore no insufficiency of service has been identified. The Pharmacy in Oakley was busy with approximately 12000 scripts per month, but there were two full time Pharmacists in the store, and these numbers were not unmanageable.

Mrs MacKenzie felt that if she was a resident of Saline she would be content that her needs were being met in terms of Pharmaceutical Services, perhaps not so a few years ago but definitely now, as the new owners of Oakley Pharmacy provide an excellent service.

Mr Jack agreed that Oakley Pharmacy appears to have the capability but queried whether adequacy of access was the same as access at a distance. Whilst Oakley Pharmacy provided electronic solutions for prescription ordering etc, not all people were IT savvy. In his view, the true test was how many people were not getting their needs met via inadequacy.

14/22.07 **Information available to the Board which, in its opinion, is relevant to consideration of the application**

The Committee noted the APC and the Director of Pharmacies' views that, in line with the PCSR, a new Pharmacy Contract was not required in this area.

14/22.08 **The likely long-term sustainability of the Pharmaceutical Services to be provided by the Applicant**

Consideration was given to the Applicant's statement that the Pharmacy could generate around 3,000 prescription items per month, which is currently split between pharmacies outwith Saline and Steelend. The Applicant was of the view that these items could potentially transfer to the Pharmacy in Saline, however the Committee was of the view that there was no guarantee this would happen.

15/22 **IN ACCORDANCE WITH THE STATUTORY PROCEDURE THE PHARMACIST CONTRACTOR MEMBERS OF THE COMMITTEE AND THE NOTETAKERS WITHDREW FROM THE MEETING DURING THE DECISION MAKING PROCESS**

16/22 **COMMITTEE VOTE AND DECISION**

Mr Baillie felt the provision to the neighbourhood was marginally inadequate as there was no direct connection between Oakley, and Saline and Steelend. He felt it unwise to rely on one pharmacy especially in light of all the services community pharmacy now provides. He remarked that if this application was approved, he was not convinced that it would take away 25% of Dears' bottom line. He confirmed that he would support granting the application.

Mr Jack noted that the proposed pharmacy might not get all the custom from the current residents and as the new housing was yet to be built, that could not be considered. The legal test focuses on adequate provision from either within our out with the neighbourhood and he felt that the service from Oakley was more than adequate. Mr Jack therefore voted against the application.

Mr Black, as Chair had the casting vote. He felt that applicants should be able to take the risk of opening new premises but that did not fall within what the Committee could decide. He was of the view that existing service were adequate therefore voted against the application

For the reasons set out above it was the view of the Committee that the provision of Pharmaceutical Service to the neighbourhood was adequate therefore the Application was rejected.

Hearing Closed.

SALINE PPC

Introduction:

Thank you for giving me the opportunity to speak today.

My name is Lisa Duncan. I qualified as a pharmacist in 2001 and have worked as a community pharmacist since then. My first job was with Munro Pharmacy working as a relief pharmacist in Glasgow. After a few months I moved to ASDA Pharmacy as pharmacy manager and stayed with the company for nearly 20 years.

I worked in 3 different ASDA stores. Initially Linwood, then Cumbernauld then a final move to Parkhead in the east end of Glasgow where I worked for 15 years. As you probably know the east end of Glasgow is an area of high deprivation and this really allowed me to see the difference that pharmaceutical services can make to a community and the day to day lives of the people living within it.

Towards the end of my time with ASDA I spent a 2 year secondment working 2 days a week as prescribing support pharmacist in local surgeries. As well as improving my clinical knowledge this allowed me to complete my Independent Prescribing qualification and I am registered with the GPHC as an independent pharmacist prescriber.

Since December 2019 I have worked as a locum pharmacist, covering a variety of multiple and independent pharmacies.

Having been mainly based in the Glasgow area you may wonder what my connection to Saline is and if this is merely an opportunistic application. In fact I have a lifelong connection with Saline. My father was born there, and I spent a significant part of my childhood and early adult life visiting relatives in the area. Indeed, I have pictures of my great grandparents sitting outside their house in Drumhead.

Saline and Steelend are a tight knit community, and one common complaint over the years has been the difficulties that this community face when trying to access services. This is reflected in the Scottish Index of Multiple Deprivation scores for ACCESS which show that in this respect this is a deprived area.

I have made this application because I know the difference that an easily accessible pharmacy makes to a community. The onset of Covid with the ensuing perceived decrease in access to the GP service has underlined the necessity of a pharmacy in Saline. If this application is approved I will be an owner/operator working full time in the pharmacy. I believe my experience working in community pharmacy coupled with my qualification as an independent prescriber will allow me to support this community and greatly improve access to pharmaceutical services. As far as I am aware this would be the only pharmacy in the wider area providing the pharmacy first plus service.

Before I go through the Legal Test in detail, I'd like to start by making a bold claim: As applications go, this one is very straightforward

I don't think there can be much dispute that however you define this neighbourhood - either as Saline, Saline plus Steelend, or the wider rural area surrounding these two villages, **there is no existing pharmacy in the neighbourhood.**

There can also be no dispute that the nearest pharmacy to the neighbourhood is way beyond what could reasonably be called 'walking distance'.

There can be no dispute that whilst there is a public transport to the closest pharmacy it is erratic and the timings of the buses make planning a journey quite difficult with a round trip taking well over an hour. This isn't like an urban area where you can jump on a bus that passes every 15 minutes in either direction.

Car ownership data is unremarkable but that isn't hugely important. Because behind dry statistics there are all sorts of exceptions: the elderly who don't drive, parents with kids whilst their partner is at work with the car; parents with a kid sick in bed, etc... Covid has really hammered home the value to a community of a pharmacy that is embedded within it.

So I don't think there can be any dispute that this population has an **inadequate** pharmaceutical service.

There's only one factor which **may** justify the refusal of this application, and that would be if the PPC determined that there was an insufficient population for a pharmacy to be viable.

So I believe it is a simple question today for the PPC - 'Is the population of Saline/Steelend **and the surrounding rural area** of **sufficient size** to sustain a community pharmacy which would give the residents **an adequate NHS pharmaceutical service.**

I believe the answer to the question is a resounding '*Yes*'.

I'd like to go on now to talk about THE LEGAL TEST, starting with

NEIGHBOURHOOD

The neighbourhood in which the proposed premises are located would be the two adjoining settlements of Saline and Steelend.

In the words of Lord Nimmo Smith this is a '*neighbourhood for all purposes*'.

I just want to quickly clarify what that actually means. It does not mean - as is so often incorrectly claimed - that a neighbourhood must have some pre-defined list of facilities or shops or services before it can be considered a neighbourhood.

What Lord Nimmo Smith actually meant was that it doesn't matter what the context or the 'purpose' is for defining a neighbourhood. The boundaries of a neighbourhood do not change in different contexts. A neighbourhood stays the same regardless of the context, unlike the **catchment area** which will be different for different things.

For example, a corner shop in the neighbourhood called Ingliston might have a catchment area equivalent to its neighbourhood – ie Ingliston.

If I built a supermarket in Ingliston, it would also be in the neighbourhood called 'Ingliston' but its catchment area might be a wider area including Kirkliston and Queensferry.

There's also an airport in Ingliston - Edinburgh Airport. It is also in the neighbourhood called 'Ingliston', but it's catchment area is the whole of central Scotland.

So the neighbourhood is the same for all purposes - but the catchment area is different depending on the context or 'purpose'. The catchment area of a corner shop is not the same as the catchment area of an airport.

A neighbourhood need not have **any** existing facilities to still be defined as a neighbourhood and in fact, when this phrase was first used, it was applied to a retail park in Inverness that had no residents!

In the context of an application to open a pharmacy, the catchment area is still critically important. The neighbourhood tells you **where** the pharmacy is located, but the catchment area tells you about the size and demographic of the population a pharmacy might be expected to serve. In a rural area this is a particularly important distinction.

The important thing here is that the phrase 'neighbourhood for all purposes' has nothing to do with the range of facilities that are or are not present in a particular neighbourhood. A neighbourhood can have next to no facilities and still be a neighbourhood.

As it happens the facilities in Saline and Steelend are extremely limited. There's a school, a village shop and a mobile Post Office, and not much else. Is this a reason why there is no need for a pharmacy? Absolutely not. In fact, if there's anything the pandemic has taught us it's what services a

community **really needs** in extremis. The two things that were deemed absolutely essential during lockdown? A food shop and a pharmacy.

I'd like to talk now about EXISTING SERVICES

There is no pharmacy in the neighbourhood. The nearest pharmacy to the neighbourhood is at Oakley which is 2.4 miles from the proposed premises.

With regard to the ADEQUACY of existing services,

in order to determine whether or not the existing service provided to Saline and Steelend is adequate can I first refer to the CAR.

Obviously this was done way back in 2019 in the days before COVID, but the results are still valid. If anything the experience of the pandemic is likely to have consolidated the support for a pharmacy.

Can I first point out that the level of engagement with the CAR was exceptionally high with 314 responses. This is a significant percentage of the population in the neighbourhood and the surrounding rural hamlets and adds weight to the opinions expressed by the local population in the report.

The CAR speaks for itself and I'm sure you have all read it but I'd like to highlight some important findings:

The most important one is that an overwhelming 92% of the population (who expressed an opinion) believe that there is a deficiency in the existing provision of pharmaceutical service and the most common reason was **difficulty accessing the existing pharmacy.**

Is this surprising? Remember - the village is 2.4 miles from the pharmacy at Oakley. As I said in my opening remarks, I really don't think there is a coherent argument that existing service are adequate.

And what about Q10? A massive 94% of those who expressed an opinion support a pharmacy in Saline and Steelend.

If I can just highlight some of the key themes from the CAR:

There is a high level of support for a pharmacy

Travel to a pharmacy requires access to transport - it is too far to walk

Public transport is limited and can be costly

I don't think there can be any doubt about it - the CAR is convincing evidence that a pharmacy in Saline and Steelend is necessary to address the inadequacy of the existing service.

I'd now like to look at the demographics of the neighbourhood **and equally importantly** the surrounding rural catchment area both of which the proposed pharmacy would provide pharmaceutical services to.

The population of the **neighbourhood** is approximately 1,200.

However, when you include the rural population in the surrounding area the population which we would reasonably expect to provide services to is 2,004. This is important when considering *viability.*

This is also a growing population as evidenced by the school roll:

In 2018 it was 111, and it has now increased to 168 (that's a 51% increase) and at the next intake in August it will rise to 172 (that's a 55% increase).

The demographics are quite mixed, and the population in general could be described as 'average'. But average people still need pharmacies

Looking at the neighbourhood in more detail, Saline North is in a lower SIMD, Saline south is medium SIMD, and the old mining village of Steelend is in a higher SIMD.

(This also translates into car ownership data - the parts of the neighbourhood and surrounding catchment area with the highest SIMD scores also have stark differences in car ownership. - see SNS)

What the SIMD data shows is that the area of 'deprivation' which is common to everyone is **access.**

Car ownership statistics are generally unremarkable, but as I just said there are clusters of postcodes where car ownership is markedly low. And again, this probably mirrors those people **most in need of a pharmaceutical service.**

Why? Because the people most in need of an accessible pharmaceutical service are the people least likely to have access to a car - the elderly, the more deprived, and young mothers.

So what's the bus service like?

The simple answer is 'not good' - and this is reflected in the comments in the CAR.

There is a bus every hour from Saline to Oakley.

But it's not as simple as that. You don't only need to get to Oakley - you need to get back. And that means a journey of one hour and 20 minutes. (Have bus timetable to reference)

Do I believe that no-one should ever need to use a bus to get to a pharmacy? No, I do not. But I do think that there are cases where a bus service is not an adequate replacement for a service in a neighbourhood -

and this is such a case. Expecting people to make a 1 hr 20 round trip to visit a pharmacy is **unreasonable.**

I'd just like to make a very important point. There is of course a primary school, and a General Store. These are two **key** services which allow many residents to go about their normal daily life within their own neighbourhood. Mums don't need to travel to take the kids to school. The elderly don't need to travel to buy provisions.

Of course there's one important service missing. If you think back to the early days of the pandemic and the first lockdown - what were the two **essential services** that remained open? It was food shops and **pharmacies.**

This is important because it could be reasonably argued that if residents need to travel to an adjacent neighbourhood to take the kids to school, or to buy food, then their **normal daily life** would be such that accessing a pharmacy in the same neighbourhood as the school and/or the shops would be a reasonable expectation. Such a service might be 'adequate'.

But that's not the case here. Without a pharmacy in the neighbourhood then any trip to a pharmacy must be a **specific** trip to the pharmacy. And that isn't reasonable. It's **inadequate.**

I also don't believe that a delivery service is an adequate substitute. A delivery service is sometimes useful e.g. if a mum has a sick kid at home or a pensioner is housebound **but it can never replace a proper face to face pharmaceutical service.** If that was the case we'd just get Amazon to run Pharmacy in Scotland.

So far, we have established that:

There is no pharmacy in the neighbourhood.

The closest pharmacy is too far to walk to, and a trip by public transport takes an hour and twenty minutes. Access is **inadequate.**

Car ownership is average, which means that a significant number of people will not have access to a car during the day and these will likely be those who are most likely to require pharmaceutical services.

Services in the neighbourhood are inadequate.

Finally id ;like to discuss VIABILITY

Of course it is not enough to show that a neighbourhood has an inadequate service. I must also show that the proposed pharmacy is

commercially viable and also that it will not affect the viability of any pharmacy in an adjacent neighbourhood.

The latter question is easy to answer: Oakley Pharmacy currently dispenses between 10 and 12 thousand items per month. This is an enormous number of scripts. It is inconceivable that a pharmacy in Saline could affect the viability of this pharmacy.

The former question is the important one: Is a pharmacy in Saline & Steelend viable?

Well, the simplest way of predicting if a pharmacy can be viable is to look at the population it will serve, and as I stated earlier this is over 2,000 people. As a rule of thumb, that's the number a contractor would be confident with. It's always difficult to predict how much income any particular population might generate for a pharmacy - a young, mobile, wealthy population will generate much less income than an older, deprived population. But 2000 is the figure of an 'average' population that will generate sufficient income for a pharmacy to survive.

But I have evidence that **this** population is **not average** in this respect. I did a Freedom of Information request to see how many scripts are generated by the residents of the Post Codes within the 3 relevant Data Zones. This shows that the catchment area generates almost 3000 items per month

This is way over what would be considered viable. (For comparison, the number of scripts per month which used to be the cut off point for

'Essential Small Pharmacies' was 1,800. Below that number a pharmacy received an extra subsidy.

Further, I expect the population of the neighbourhood to grow. The figures I obtained are 2015-2018 but since then there have been at least 120 new homes built. That would give (using SNS average for persons/house) an additional population of 258.

This is reflected in the increase in the school roll by around 55% over the past 5 years, as mentioned earlier.

So to summarise, there can be **absolutely** no doubt that a pharmacy in Saline and Steelend is viable. I know that decisions made by PPCs in other applications are not transferable, but I think it's important to point out that the PPC has granted numerous applications in neighbourhoods smaller than Saline.

Before my final summary, I'd like to highlight the support I've received for this application. From the outset I have had the unwavering support of Saline and Steelend community council, and particularly David Chisholm who have welcomed this application as an opportunity to support and improve their community. Likewise I give heartfelt thanks to Councillor Mino Manekshaw for his support, encouragement and advice. I would like to thank both parties for the letters of support that they have kindly submitted to the PPC.

Finally then I would like to summarise as follows:

The neighbourhood of the proposed pharmacy is the two adjacent settlements of Saline and Steelend.

The **catchment area** is the rural hinterland surrounding the neighbourhood, stretching north towards the A977 and south towards the A907.

The closest pharmacy is in Oakley - which is 2.4 miles from the proposed premises.

On the basis that many people do not have access to a car during the day, and a round trip by public transport takes one hour and twenty minutes, **access** to this pharmacy is of sufficient difficulty that the pharmaceutical service provided to this neighbourhood cannot be considered **adequate.**

The population of the neighbourhood combined with the population living in the rural area surrounding the neighbourhood is in excess of 2000. Our research suggests this population generates over 3000 prescription items per month. **There can be no question that a pharmacy at this location would be viable** and therefore **secure** an NHS Pharmaceutical service in the neighbourhood.

It is my strong belief that this application **passes the Legal Test.** A pharmacy in Saline/Steelend is **necessary and desirable** in order to secure an NHS Pharmaceutical Service in the neighbourhood in which the proposed premises are located.

It has always been my dream to own my own pharmacy and to build a business which provides an exemplary service to its patients, and I ask this PPC to grant the application so that I can make that happen.

DEARS PHARMACY

SUBMISSION TO PCC OPPOSING APPLICATION FROM LISA DUNCAN TO OPEN A PHARMACY IN SALINE, FIFE

Thank you for the opportunity to address the Committee today.

As the Committee is aware it is for the Applicant to satisfy the legal test. In other words, they need to prove to you that the pharmaceutical services available to the relevant neighborhood are not adequate.

What is an "adequate" service?

Simply put it means that it is proper and sufficient to meet the needs of patients.

Our submission to you is that the Applicant has failed to prove their case for a number of reasons. If you agree with me on any one of these points then the application must be refused and I respectfully suggest that you may well agree with all of the points we make today.

NEIGHBOURHOOD

The first task for this Committee will be to define the relevant neighbourhood.

The Applicant simply says it is the villages of Saline and Steelend.

We disagree with this but the reality is that the exact definition of neighbourhood is unlikely to be determinative in this case as you can – and indeed must – consider pharmaceutical services that are provided in the neighbourhood by pharmacies located outwith the neighbourhood.

Looking at the Applicant's definition –

- End to end the villages of Saline and Steelend cover approximately 1.5 miles east to west.
- So the Applicant believes that people who live 1.5 miles away from each other would consider themselves "neighbours" and be living in the same neighbourhood
- We agree with this. In a rural area it is common for neighborhoods to cover many square miles and for people to access services and facilities in nearby villages as part of their daily lives.
- What the Applicant does not – and cannot explain – is why they are happy for the neighbourhood to extend over 1.5 miles east to west, but only 100 metres or so north / south. This makes no sense. It is artificial and irrational

- Our pharmacy in Oakley is less than 2 miles from Saline. This is not dissimilar from the east to west length of Saline.

- Our pharmacy is used by people who come from Saline and Steelend because it forms part of their neighbourhood.

- Remote and rural villages rely on each other for services. This interdependency creates neighborhoods which are much larger than they would be in places such as towns or cities.

- The Applicant seems to believe that people are only happy to travel over 1 mile if they are travelling east to west, but for some reason are unable to do so when travelling from north to south. Again – this makes no sense.

- In our submission the neighbourhood definition must recognize the rural nature and interdependency of the various villages. It should include not only Saline and Steelend but also Blairhill, Oakley, Carnock and Gowkhall to the south.

- In its fullest extend this represents a distance of less than 3 miles (Saline to Gowkhall) – which for a rural area is a small distance to travel. – AND – even the Applicant seems happy to accept that patients could travel 1.5 miles with ease across Saline and Steelend.

We therefore submit that the neighbourhood should be extended AT THE VERY LEAST to include the villages of Blairhill, Oakley, Carnock and Gowkhall to the south

As the Committee will be aware, the leading case in neighbourhood definition comes from a Northern Irish case known as the Boots Bangor decision and this has been approved by the courts in Scotland.

In that case Lord Justice Carswell said;

> *"I think it is impossible to lay down any general rule as to the extent of the area indicated by the word 'vicinity'. In country districts people are said to be neighbours, that is to live in the same neighbourhood, who live many miles apart. The same cannot be said of dwellers in a city, where a single square may constitute a neighbourhood. Physical features may determine the boundary or boundaries of a neighbourhood as, for example, a river, a railway or a range of hills. In an urban area lacking such physical features the lay out of the streets and the nature, character and use of the buildings need to be looked at, as well as the size and distribution of the population, whether residing or working in the area."*
>
> *I would perhaps qualify that in the way in which I expressed it in Donnelly v Regency Hotel*
>
> *"I think that it is of importance to look both at the physical features of an area and any natural boundaries,* ***and also at the established dwelling patterns and any geographical allegiances of those who live, work, or shop there. A vicinity accordingly seems to me to connote more than***

the area plotted on a map: its determination has to take into account the habits and movements of people in the area~ and the directions in which those habits take them in the course of their daily lives."

The Applicant simply wants to draw the lines on a map without considering the movements and habits of people. That is wrong. People who live in Saline and Steelend can and do travel outside the village in the course of their daily lives to access even basic services.

As Lord Nimmo Smith said in the December 1999 Scottish case of Boots v National Appeal Panel

> *"the word "neighbourhood" in regulation 5(10) of the 1995 Regulations means an area which is relatively near to the premises in question, which need not have any residents, and which can be regarded as a neighbourhood for all purposes."*

The neighbourhood proposed by the Applicant is clearly not a neighbourhood for "all purposes".

However,

As I said at the beginning – it is unlikely that the exact definition of the neighbourhood will be determinative by itself in this case as you will of course consider services provided by pharmacies located outwith the neighbourhood when determining if the neighbourhood has adequate pharmaceutical services.

Our pharmacy is the closest to Saline and is located in Oakley a little over 2 miles from Saline.

Are there really access difficulties that would render pharmaceutical services inadequate?

We note that the Applicant has failed to provide you with any, or any significant, evidence about difficulty accessing our pharmacy. That is because there is no such difficulty.

I would accept that few patients are likely to walk from Saline to Oakley. Indeed, patients in rural areas understand and accept the need to have access to other means of transport than their own feet.

DRIVING to our pharmacy from Saline takes less than 10 minutes – Google puts it at 7 minutes.

89% of households have access to a car.

Some of those households may have people who need a car to travel to work and it is therefore not surprising that there is a very high % that have access to 2 or more cars – 41% - so even households who need a car for work still have access to another.

Source https://www.scotlandscensus.gov.uk/search-the-census#/explore/snapshot

For those who do not want to use a car or do not have one then the 6A **BUS SERVICE** also takes 7 minutes and goes from the middle of Saline to within a few metres of our pharmacy. The 6A runs from early morning (about 5am) to late at night (after 8pm) and is approximately every hour.

It is worth noting that many rural areas would not have a pharmacy within 7 minutes bus journey. In fact, many people living in towns would take longer than 7 minutes to get to a pharmacy using a bus, or driving, or on foot.

DEMOGRAPHIC STATISTICS

https://www.scotlandscensus.gov.uk/search-the-census#/explore/snapshot

We have focused on the stats for Saline as adding Steelend does little to change the picture and the % stay the same.

Saline, Fife

Population 1,097 adding in Steelend makes it circa 1,200.

Only 466 households

89% with a car

96% describe their health as being between VERY GOOD (51.5%) to GOOD (32.2%) or FAIR (11.8%)

BAD or VERY BAD health is only 3.7% and 0.8% respectively.

LESS THAT ONE PERCENT WITH VERY BAD HEALTH !!

Clearly the Applicant hope to provide services to many more than 1,097 people as their pharmacy would be unviable otherwise.

They need people to be able to easily travel from surrounding villages and access their pharmacy – yet here – today – they are arguing that it is in some way difficult to make a 7 minute journey to our pharmacy.

THEY CANNOT HAVE IT BOTH WAYS

Either our pharmacy is easily accessible for local those living in nearby villages or the Applicant believes that they will only be serving 1,000 patients.

In terms of the age profile for Saline;

60-69 years 171

70-79 years 134

80+ years 47

Now most 60 to 69 year olds are still perfectly able to get about with relative ease. This ability decreases with age until one gets to a point where one is relying on carers and relatives to help out with day to day chores.

Once you understand that the 80 plus age group (47 people) probably would not access the pharmacy in person very much anyway and the 60-69 age group is very able to get around and travel 7 minutes to our pharmacy – you are left wondering who exactly the pharmacy thinks does not have adequate access to a pharmacy. It may well be that the answer is NOBODY.

THERE IS SIMPLY NO EVIDENCE THAT PATIENTS ARE SUFFERING FROM ANY SORT OF INADEQUACY IN SERVICE PROVISION.

In fact, we submit that the service they receive within a 7 minute journey of their homes is exemplary given the changes we have implemented to the pharmacy since we took over in 2019.

We acquired pharmacy November 2019

Previous open hours were M-F closing 1 hour lunch and no Saturday open

When we took over we changed this to 8.30 to 6pm M-F and Sat 9-1pm

2 pharmacists daily in branch

2 trained pharmacy technicians

12 support staff

Delivery service available every day 6 days a week

One pharmacist IP and our other pharmacist training near completion of their independent prescribing qualification to deliver pharmacy first plus service

Active involvement with local surgery in their practice meetings

Surgery doesn't support the application

Acquired land at back of pharmacy and extension and full refit near completion

24/7 prescription locker as part of refit

3 consultation rooms as part of refit

2000 plus patients using repeat prescription app called Healthera

Full delivery of all NHS services including serial prescriptions, smoking cessation, gluten free, public health, emergency contraception

Introduction of needle exchange service as health board identified as gap

Branch is Palliative care pharmacy for area

A full range of private services including travel clinic, children vaccinations, diagnostic services, private pharmacy services

Full trained ear health clinic including microsuction

Trained phlebotomists and offering this as a service

Car park being done as part of us purchasing land to improve access in area

We **are not** here saying that we are better than everyone else BUT

We are saying that this represents much more than a bare level of adequacy. It goes well beyond that.

It is hard to understand how the Applicant can claim that having all of this available within a 7 minute journey of a patients home is not adequate.

The Community Consultation Exercise

I fully appreciate that people who live in a rural area would normally like to have additional services in their village. That is unsurprising. However, it does not mean that the current service in inadequate.

Starting with the KEY THEMES section of the report on page 14, we wish to point out that whilst there was a "high level of support for a new community pharmacy" this was only amongst those who responded to the survey.

The Methodology on page 3 tells us that a wide variety of organisations were consulted with along with an advert and that the consultation ran for 90 days.

In that time 314 responses were received. The population of the neighbourhood defined by the Applicant is circa 1,200 but the consultation went over a much wider area and lasted for 90 days.

314 responses include those from outside the neighbourhood defined by the Applicant. Overall it is a relatively low response rate. Approximately 25% of the population and not everyone supported the proposal.

Only 273 of those who responded said that there was a "gap" in the existing provision. However, that is not the correct legal test.

Analysis of the perceived gaps shows that many of the perceived gaps have in fact been filled. For example;

1. It is unclear what people meant by "easy" transport for those without a car. Bearing in mind that 89% do have at least 1 car it is a very small number of people AND there is an hourly bus service to our pharmacy.
2. The need to travel outwith the village is a fact, but it is not an inadequacy.
3. 30 people said that public transport was "limited" and "can be expensive". Public transport is always limited. As for expensive, the following groups receive free bus travel
    a. Under 22 (from January 2022)
    b. Over 60's
    c. Disabled persons

    The only people who would need to pay for bus travel are those aged between 22 and 60 who do not have a car. The number of these is unknown but is likely to be less than 100 and probably less than 50.

Other consultation comments are no longer relevant as our pharmacy;

- does not close for lunch (8 people mentioned) and
- does open on Saturdays (17 people mentioned),
- does not have "restricted" hours (3 people mentioned)
- is not too busy to provide advice or consultations (1 person) and
- does deliver to Saline (1 person).

Some people who said "YES" to their being gaps then commented that Oakley pharmacy provides "sufficient service".

Removing these comments that are clearly wrong leaves very little perceived gap even from the small % who support the application.

It is the same when you look at the other questions that patients answered. Comments about opening hours and access are often simply incorrect.

The reason the comments are incorrect is because of the extensive changes that we have made to the pharmacy in Oakley since we took over. Feedback from patients in Saline has been very positive and if this consultation was done now the results would be completely different.

The survey results are simply unreliable as they are from May to July 2019 – **NEARLY THREE YEARS AGO AND BEFORE WE TOOK OVER THE OAKLEY PHARMACY**

The vast majority of residents either did not feel any need to take part in the survey or did not think there was any gap in services.

LETTER AND SUPPORT FROM SALINE AND STEELEND COMMUNITY COUNCIL – EMAIL OF NOVEMBER 2019 (FROM PAPERS)

We of course completely understand the desire of any local organization to have more services in their village.

This is especially true in this application was the Applicant would be making payments (rent) to the Community Council. The Community Council acknowledges this and they say;

> *Additionally, there is an aspiration to take the community centre into community ownership and develop it as a local hub for health and wellbeing.*
>
> *Discussions with Fife Council have been underway for several years.* ***Having a commercial tenant in the building will greatly enhance the plan's financial viability.***

And.

> *The decision that the committee will take is about much more than whether a pharmacy can open. It is about supporting a small village to take a further step towards securing a sustainable future.*

With the greatest respect, the Committtee is not tasked with financially supporting the community centre, by transferring patients from other pharmacies that are working hard for the community already. Nor should the Committee support one village, or one pharmacist over another. Such an approach is clearly wrong.

The Community Action Plan

The Community Council says that over half the households in the Parish contributed to the Community Action Plan. This plan has been presented to this Committee by the Applicant as evidence to support their case.

We have read this plan in detail. We have also read the update prepared in 2020 – which is **after** the consulation exercise for this application.

There is not a single mention of a need for additional health services in either document apart from the comment in the 2020 document to "support plans for a local pharmacy" – ie after the community had been asked to by the Applicant and after the financial benefit to the community council had been recognised.

The original document made no mention of any desire for a pharmacy.

Instead the documents correctly point out that there are no real services in Saline and that "a wider range of shops and services can be accessed in Oakley, three miles away, including the health centre, dentist, library and optician" – (even here they do not mention pharmacy!)

In fact, when people were asked what local services and what was needed they said; (See page 11 of attachment and page 7 of plan document.)

- No pub or cafe to meet friends
- I would like the shop to expand its stock,
- We do not have a shop at Steelend
- Frequent power cuts and absence of broadband
- No mains gas in Kinnedar Park.

The community's own plan – that over 50% of household contributed to – identifies no inadequacy in pharmaceutical services and that was before all the improvements we made in Oakley Pharmacy.

IN SUMMARY

We submit that;

- The Applicant's neighbourhood is far too small. It does not consider judicial guidance and the few residents who commented on this would have been unaware of the large amount of legal case law on the subject.
- Residents leave Saline in the course of their daily lives and access Oakley with relative ease.
- Oakley does form part of the relevant neighbourhood in this case.
- However, the exact definition is unlikely to matter as the panel will consider pharmacy services provided to the neighbourhood by pharmacies located outside of it.
- Our pharmacy serves Saline and Steelend. We provide services which are much better than simply being "adequate"
- Our services are available within a 7 minute journey to well over 90% of the population of Saline and Steelend.
- There is no inadequacy in pharmaceutical services and the application should be refused.