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Scottish Borders
Health and Social Care
PARTNERSHIP

An Extraordinary meeting of the Scottish Borders Health & Social Care Integration Joint Board will be held on Wednesday 17 August 2022 at 9am via Microsoft Teams

AGENDA

Time	No		Lead	Paper
9.00	**1**	**ANNOUNCEMENTS & APOLOGIES**	**Chair**	Verbal
9.02	**2**	**DECLARATIONS OF INTEREST** *Members should declare any financial and non financial interests they have in the items of business for consideration, identifying the relevant agenda item and the nature of their interest*.	**Chair**	Verbal
9.05	**3**	**MINUTES OF PREVIOUS MEETING** 15.06.22	**Chair**	Attached
9.08	**4**	**MATTERS ARISING** Action Tracker	**Chair**	Attached
9.10	**5**	**FOR DECISION**		
	5.1	Resourcing of Primary Care Improvement Plan and of the Primary Care Mental Health and Wellbeing Fund from 2023/24 onwards	**Chief Officer**	Appendix-2022-21
	5.2	National Care Service consultation response - Potential to pilot as local test of change for the NCS (letter to SBC and NHS Borders)	**Chief Officer**	Appendix-2022-22
9.55	**6**	**DATE AND TIME OF NEXT MEETING**	**Chair**	Verbal

Wednesday 21 September 2022
10am to 12pm
Microsoft Teams

10.00	**7**	**DEVELOPMENT SESSION**	**Chief Officer**	Presentation
	7.1	Care Village		

Minutes of a meeting of the **Scottish Borders Health & Social Care Integration Joint Board held** on **Wednesday 15 June 2022** at **10am** via Microsoft Teams

Present:

(v) Cllr D Parker (Chair)
(v) Cllr R Tatler
(v) Cllr T Weatherston
(v) Cllr E Thornton-Nicol
(v) Mrs L O'Leary, Non Executive
(v) Mrs H Campbell, Non Executive
(v) Mrs K Hamilton, Non Executive
(v) Mr T Taylor, Non Executive
Mr C Myers, Chief Officer
Mrs J Smith, Borders Care Voice
Dr K Buchan GP
Ms L Gallacher, Borders Carers Centre
Ms V MacPherson, Partnership Representative NHS
Mr D Bell, Staff Side SBC
Mr N Istephan, Chief Executive Eildon Housing
Mr S Easingwood, Chief Social Work and Public Protection Officer
Dr L McCallum, Medical Director

In Attendance:

Miss I Bishop, Board Secretary
Mrs J Stacey, Internal Auditor
Mrs N Meadows, Chief Executive, SBC
Mr A Bone, Director of Finance, NHS Borders
Mrs H Robertson, Chief Financial Officer Designate
Mrs C Oliver, Head of Communications & Engagement, NHS Borders
Ms S Flower, Chief Nurse Health & Social Care Partnership
Ms S Bell, Communications Officer, SBC
Mrs C Wilson, General Manager P&CS
Mrs C Cochrane, Director of Psychological Services and Head of Psychology Speciality
Mrs J Smyth, Director of Planning & Performance, NHS Borders
Mr S Burt, General Manager, Mental Health & Learning Disability Services
Mrs S Henderson, Planning & Development Officer, Learning Disabilities Service
Mrs M Walker, BAVs
Mr A McKenzie, Lead Pharmacist, Community Pharmacy
Ms H Jacks, Planning & Performance Officer, NHS Borders
Mr A McGilvray, Southern Reporter
Mr D Knox, BBC
Mrs Morag Muir, Locum Consultant in Dental Public Health

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1. APOLOGIES AND ANNOUNCEMENTS

1.1 The Chair advised that she would Chair the meeting in her capacity as Vice Chair of the IJB until approval of Item 5.1 on the agenda was agreed, when she would then assume the full role of Chair of the IJB.

1.2 Apologies had been received from Cllr Jane Cox, Mr John McLaren, Non Executive, Ms Juliana Amaral, BAVs, Mrs Sarah Horan, Director of Nursing, Midwifery & AHPs, NHS, Ms Linda Jackson, LGBTQ+ and Mr Ralph Roberts, Chief Executive NHS Borders.

1.3 The Chair welcomed Mrs Hazel Robertson to the meeting who would be taking up the position of Chief Financial Officer on 1 August 2022. A paper referring to the appointment had been added to the agenda at Any Other Business so that the IJB could formally make the appointment as per regulations.

1.4 The Chair to welcomed a range of attendees including: Mrs Morag Walker who was deputising for Juliana Amaral as part of the Borders Third Sector Interface and BAVS (Berwickshire Association of Voluntary Services); Mr Simon Burt, General Manager MH&LD services, Mrs Susan Henderson, Planning & Development Officer, Learning Disabilities Service; Mrs Cathy Wilson, General Manager, Primary & Community Services; Mrs Morag Muir, Locum Consultant in Dental Public Health; Mr Adrian Mackenzie, Lead Pharmacist, Community Pharmacy; and Mrs Caroline Cochrane, Director of Psychological Services and Head of Psychology Speciality

1.5 The Chair confirmed the meeting was quorate.

2. DECLARATIONS OF INTEREST

2.1 The Chair sought any verbal declarations of interest pertaining to items on the agenda.

2.2 Mrs Harriet Campbell declared that as the Chair of the Parent Council at Kelso High School she had an interest in the Item regarding CAMHS and the renew programme.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the verbal declaration made.

3. MINUTES OF THE PREVIOUS MEETING

3.1 The minutes of the previous meeting of the Health & Social Care Integration Joint Board held on 2 March 2022 were approved.

4. MATTERS ARISING

4.1 **Action 2020-2:** As Renew appeared as part of the PCIP substantive item on the meeting agenda the action was marked as complete on the Action Tracker.

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4.2 Mrs Harriet Campbell enquired if monitoring dates for the directions issued by the IJB would appear on the IJB action tracker. Mr Chris Myers assured the Board that monitoring dates would be planned through the Audit Committee.

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the action tracker.

5. MEMBERSHIP

5.1 Miss Iris Bishop presented the membership paper to the Board.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the current membership of the IJB.

5.2 Cllr Tom Weatherston proposed Cllr David Parker be nominated as Vice Chair of the IJB. The proposal was seconded by Cllr Elaine Thornton-Nicol.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** confirmed the Chair, Mrs Lucy O'Leary and Vice Chair, Cllr David Parker of the IJB.

5.3 Cllr Tom Weatherston proposed Cllr Jane Cox be nominated as Chair of the IJB Audit Committee. The proposal was seconded by Cllr David Parker.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** confirmed the membership of the IJB Audit Committee: Cllr Jane Cox, Cllr Tom Weatherston, Mrs Karen Hamilton, Mrs Lucy O'Leary.

5.4 Mrs Karen Hamilton asked that the current IJB membership and tenure periods be provided to the IJB. Miss Iris Bishop advised she would action the request.

5.5 Mrs Jill Stacey commented that the Audit Committee Terms of Reference required further updating to include the role of the Audit Committee in monitoring the commissioning plan and directions policies.

6. CODE OF CONDUCT

6.1 Miss Iris Bishop presented the revised Code of Conduct to the Board.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** adopted the new model code of conduct.

7. DIRECTION - COMMISSIONING OF DAY SERVICES FOR ADULTS WITH LEARNING DISABILITIES

7.1 Mr Simon Burt provided an overview of the content of the paper and highlighted several elements which included: range of services provided; some individuals directly commission services; 5 buildings were in scope; impact of COVID-19; day services; increase in higher levels of needs; 90% of services were commissioned to the

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independent sector; and suggested commissioning of 5 year contracts with 2 year add on provision.

7.2 Mrs Lynn Gallacher commented that it would have been helpful to have engaged the carers workstream in the proposals and she supported the 5 year contract for commissioning proposal.

7.3 Mrs Harriet Campbell enquired if people were being missed, given numbers had been reducing pre COVID-19 and with the direction of travel to move out of buildings, people might not realise services were available to them.

7.4 Mrs Jenny Smith enquired about savings targets being met if a building was required and if there was unmet demand how that would be identified and proposals flexed to address it.

7.5 Ms Susan Henderson confirmed that carers, families and stakeholders had been engaged with at the outset of the project with much consultation done through independent organisations. The model had been built on the basis of the evidence gleaned from the consultation and engagement process. There were currently 2 families involved in the specification work and 2 families involved in the tender evaluation process.

7.6 Mr Burt advised the Board that engagement with carers had focused on the carers of those with learning disabilities to ensure their opinions were heard. In terms of unmet need he advised that the remobilisation of day services had remained an issue and there were gaps for those who required day time support. However, he anticipated the new model would fill those gaps with the new commissioned services once COVID-19 restrictions were fully lifted. With regard to demand, numbers were reducing and he suggested this was due to the broader range of choices available to individuals through self directed support and direct payments.

7.7 Mr Chris Myers commented that there had recently been some negative press suggesting the IJB would be closing learning disability day services and he emphasised that was not the case and the proposal was about commissioning a new service model.

7.8 Cllr Tom Weatherston supported the direction of travel and enquired about the continuity for individuals involved in areas of change.

7.9 Mrs Gallacher suggested it was time for a review of local area coordination, given there were some mixed messages being provided locally.

7.10 Mr Burt confirmed that transition planning would take place to ensure continuity of change would be provided and he would also ensure the carers workstream were involved in the on-going review. He also welcomed the suggestion of a review of local area coordination.

7.11 Mr Myers suggested the Strategic Planning Group be tasked with the local coordination review. He further clarified that as the Learning Disability services was an integrated

service the direction would be issued to both Scottish Borders Council (SBC) and NHS Borders to ensure NHS Borders supported the direction of travel being taken.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** agreed to issue a Direction to Scottish Borders Council and NHS Borders to re-commission the Learning Disability Day support services from the market.

DIRECTION: To re-commission a new model of Learning Disability Day Services by going to the open market in line with the relevant papers agreed at the Integration Joint Board on 15 June 2022.

8. DIRECTION - HEALTH BOARD DEVELOPMENT OF THE ORAL HEALTH PLAN

8.1 Mrs Morag Muir provided a brief overview of the content of the paper.

8.2 The Chair sought clarification that the direction was to move on to produce the plan and in addition to make sure oral health was sewn into the strategic commissioning plans.

8.3 The Chair enquired if links to oral health and more general health was something that was being teased out in the plan as it developed.

8.4 Mrs Muir commented that there were many links between oral health and general health such as diet, smoking and alcohol. She further advised that oral health was being recognised as a key part of overall health care.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** ratified the report for publication and wider dissemination.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** agreed to include oral health in their strategic commissioning plan.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** agreed to commission the Health Board/Public Health Directorate to develop a strategic plan for oral health and dental services.

DIRECTION: To provide planning and performance, communications and public engagement support for the development of the Oral Health Plan, which will be based upon the 2020 Oral Health Needs Assessment. This includes support for:

- The production of an Oral Health Plan based on the priorities identified by the Oral Health Needs Assessment
  - Planning and Project Management support (NHS Borders)
  - Re-establishment of the Dental Services and Oral Health Strategy Group
  - Consultation and engagement with stakeholders, staff and partners on the draft plan (NHS Borders)
  - Communications support (NHS Borders)

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It is expected that the plan will be referred to in the broader revised IJB Strategic Commissioning Plan once complete.

9. DIRECTION - PHARMACY SUPPORT TO SOCIAL CARE SERVICE USERS

9.1 Mr Adrian McKenzie provided a brief overview of the content of the paper.

9.2 Dr Lynn McCallum highlighted the significant spend on 5 individuals and that the way to release funds was to close beds. The quantification of bed day savings had not been worked through. She further supported the project and was cognisant of the potential positive impact on both patients and carers.

9.3 Mrs Karen Hamilton highlighted the challenges in recruiting social care staff and enquired if there was a confidence to recruit and have sufficient resource in terms of pharmacy staff to take the project forward.

9.4 Mr McKenzie commented that recruitment would remain a challenge.

9.5 Mr Andrew Bone commented that the benefits in the paper in terms of opportunities to alleviate pressure on the bed base and assist with system flow were to be welcomed. He suggested realistically there would be zero cash release savings as savings would be about opportunity costs and using resources differently. He suggested the project was about pump priming a change in working arrangements and there was funding within the IJB reserves that had been carried forward in relation to Multi-Disciplinary Teams that could be utilised to deliver the project for an initial period. He suggested it was important to be clear on how the benefits would be monitored and delivery demonstrated for any future investment.

9.6 Mrs Jenny Smith supported the project and was interested in the secondary aim of supporting the workforce with learning around medication. She commented that any efforts and offers around medication training, guidance and leadership for the third and independent sector workforce would be welcomed.

9.7 Mr Chris Myers commented that the direction contained a regular review and annual review by the Audit Committee and suggested the review process would assist in identifying the cash release versus productivity gains throughout the project. He also commented that the direction was to be issued to both SBC and NHS Borders. SBC had been included in the direction in the context of appropriate engagement with the social care sector.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** agreed to issue the Direction.

DIRECTION: To work in partnership to develop an integrated polypharmacy support service for all adult social care service users, provided by all providers.

It is expected that an integrated impact assessment will be undertaken prior to commencing work on this initiative, to inform the development of the programme.

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It is expected that any associated savings as a result of this commission are identified and flagged to the Integration Joint Board Chief Financial Officer. The Integration Joint Board will determine at a later stage how the productivity gains from this development should be used, and whether they be recycled and used to increase capacity in the system, or used to contribute to a further reduction in the delegated services budget. Decisions about the recurrence of this initiative will be made following 2 reviews of the initiative by the Integration Joint Board Audit Committee and a review by the Integration Joint Board.

10. 2021-22 ANNUAL PERFORMANCE REPORT & 2022-23 COMMISSIONING PLAN

10.1 Mrs Chris Myers presented the draft report and highlighted several elements which included: a focus on the commissioning role of the IJB; focus on national health and wellbeing outcomes; strategic implementation plan actions; 2022/23 outline of areas requiring improvement in performance; hospital at home; development of common geriatric model; and areas not expected to achieve full deliver this year against the ambitions.

10.2 Dr Lynn McCallum enquired if the lower admission rate quoted was due to the fact that people were bedded in the overcrowded ED awaiting admission. She questioned in regard to care at home that the report suggested that occupied bed days had increased and spend on acute care had decreased. In terms of quantitative date the indicator figure at 19 appeared misleading given there were more delayed discharges in the system than in previous years.

10.3 Mr Myers commented that point 19 related to the year 2020/21 and he suggested he would follow up on the other points raised outwith the meeting. He commented that the validated figures within the report were for the year 2020/21 as the figures for 2021/22 were not yet nationally validated.

10.4 Mrs Lynn Gallacher commented that in regard to carers support it was clear their satisfaction levels had consistently reduced since 2018. She urged the IJB to acknowledge that it related to the closure of buildings and day care centres, respite opportunities and the inability of carers to access care packages. She suggested it was not just a financial issues but also a workforce and capacity issue and she welcomed the needs assessment that was being undertaken.

10.5 Dr McCallum commented in regard to the acceptability of the data that it portrayed an inaccurate picture of less pressure and spend in the health care system and she asked that the report reflect the current position, target performance and pressures being faced by the health service. She accepted that the validated data was out of date but urged that the current position be included.

10.6 The Chair suggested the Chief Officer message should acknowledge that the data included in the report did not reflect that current reality for health and care services.

10.7 Mr Myers welcomed the comments and suggested amendments be made to the report and that it be circulated to the IJB for approval via email.

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The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the Annual Performance Report for 2021-22.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the commissioning plan for 2022-23.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** agreed to receive a revised version of the report for approval via email.

11. DIRECTION – 2022-23 FINANCIAL PLAN

11.1 Mr Andrew Bone provided an overview of the content of the report and highlighted several elements which included: increase on baseline for overall resource; context around Scheme of Integration around how budgets were set and monitored for the IJB; level of savings required at £7.1m across all of the functions including those in the set aside for large hospital function as well; milestones outlined of the recovery plan for the partnership does not include set aside function; level of reserves; and potential repayment of financial gap in future years.

11.2 Mrs Lynn Gallacher requested sight of the detail of the £2.4m Carers Act Funding received by SBC within the budget. Mr Bone commented that he believed the funding was directed at SBC and had been ring fenced separately and was therefore not within the reserve or the budget as it would be administered through SBC.

11.3 Mrs Harriet Campbell noted that the Direction mentioned the “delivery plan” and she enquired what that plan was. Mr Chris Myers confirmed that it was the “commissioning plan” and he would amend the direction accordingly.

11.4 Cllr David Parker commented that the Carers Act Funding was not part of the IJB funding and was held separately by SBC. He committed to providing a note on the specifics of the carers act funding and detail of where it was held and what it was used for, outwith the meeting.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** approved the 2022/23 budget in line with resources agreed with the partners.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** endorsed the approach to development of an HSCP Recovery plan to address savings targets and the status of work towards this plan.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the risks described in the paper.

DIRECTION: The Scottish Borders Health and Social Care Integration Joint Board commissions NHS Borders and the Scottish Borders Council to deliver services within the budgets and under the framework outlined in Item 5.7 of the 15 June 2022 Integration Joint Board.

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NHS Borders and the Scottish Borders Council are expected to work in partnership with Scottish Borders Health and Social Care Integration Joint Board Chief Financial Officer and Chief Officer to facilitate the development of an HSCP Recovery plan to address savings targets, and to share progress against the Recovery plan with the Integration Joint Board.

In addition NHS Borders and the Scottish Borders Council are expected to work to develop an integrated transformation projects and a wider programme in line with the detail noted in the Delivery Plan outlined in the 2022/23 Annual Report (Item 5.6 of the 15 June 2022 Integration Joint Board), and the new developing Strategic Commissioning Plan.

It is expected that all new transformation plans will be brought to the Integration Joint Board via its Strategic Planning Group to ensure that they are appropriately consulted upon and align to the aims of integration and outcomes that are being sought by the Integration Joint Board.

12. MONITORING OF THE HEALTH & SOCIAL CARE PARTNERSHIP BUDGET

12.1 Mr Andrew Bone provided an overview of the content of the report. The overall position reported for the IJB was an underspend of £913k operationally across the budgets (predominantly social care functions). He emphasised that the IJB would be in a break even position at the year end.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the report.

13. STRATEGIC RISK REGISTER UPDATE

13.1 Mr Chris Myers provided an overview of the content of the report and assured the IJB that risks were identified, managed and monitored.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the progress made to reframe the IJB Strategic Risk Register to reflect the remit of the IJB.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted that the previous risks contained in the IJB Strategic Risk Register have been archived as they focus on partnership risks.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted that a further risk update will be provided in September and December 2022.

14. PRIMARY CARE IMPROVEMENT PLAN UPDATE

14.1 Mrs Cathy Wilson provided a presentation to the IJB on the work that had been carried out over the previous year.

14.2 Mr Andrew Bone noted the singular financial gap and advised the IJB that to date a resolution to that gap had not been identified. There was on-going dialogue with the Scottish Government in regard to additional funding. He commented that NHS Borders had a significant financial deficit and any further investment or delivery from within existing resources would increase the deficit further. There had been a shortfall in the

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funding made available to the PCIP and he urged the IJB not to sign up to additional levels of commitment unless additional funding was made available by the Scottish Government.

14.3 Cllr David Parker supported the proposal not to sign up to additional funding at that stage.

14.4 Mr Chris Myers commented that the IJB had to be financially sustainable and work towards breakeven. He suggested a process was required to be worked through to understand what the financial gap was in the context of additional allocations that may or may not come from the Scottish Government. He further suggested the IJB work with NHS Borders to look at how to ensure all the workstreams were as cost effective as possible and to review skill mix and look at where the opportunities were for transformation.

14.5 Mr Myers suggested a further paper be brought back to the IJB following that process to ensure the IJB were clear on any impact on delivery of the contract.

14.6 Dr Kevin Buchan commented that the contract had not run as had been expected and continued to be difficult to put down in practice. He advised that the Scottish Government had made a payment to practices and individual contractors and those that had not met the targets had not received a second payment due to a lack of funding which had left practices with a financial gap. It was a picture that was endemic across Scotland as the initiative had been underfunded centrally. In the Borders the initiative had been progressed aggressively and the infrastructure of CTAC remained an issue to resolve. He commented that there was a lot of disquiet in the GP cohort in Scotland on how to move forward and the SGPC were considering walking away from the contract.

14.7 Mrs Wilson commented that the main concern with CTAC was that it was underfunded and a risk for GPs. Work had been progressed on the TUPE of staff from practices, but the main issue for GPs remained the lack of recurring funding and potential risk to them. A lot of trust and goodwill had been built up during the PCIP initiative which was now being undermined.

14.8 Mr Myers suggest a paper be worked up and brought to the next meeting to look at the issues in more detail in terms of what the IJB should be doing to reduce the risk.

14.9 Cllr Elaine Thornton-Nicol noted that it appeared to be a level of crisis and rather than wait for a paper for the next meeting she suggested an extraordinary meeting be called to discuss the paper.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the report, the risks, and actions being undertaken to reduce the risks.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** sought the development of a direction immediately to NHS Borders to undertake further work to build the IJB's level of assurance that all opportunities to understand and reduce the cost pressure had been

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explored, so that an update can be brought back to an extraordinary meeting of the IJB to inform its approach to financial planning for 2023/24.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted that a further update would be provided to the IJB in September.

15. MENTAL HEALTH AND WELLBEING IN PRIMARY CARE SERVICES

15.1 Mr Simon Burt advised that the Scottish Government had committed recovery renewal funding to Health Boards and partnerships for mental health and wellbeing services within primary care over a period of 4 years. The funding was targeted specifically at certain areas such as CAMHS. Proposals were to be drawn up and submitted to the Scottish Government for review with successful proposals securing funding.

15.2 Mrs Caroline Cochrane provided an in-depth presentation into the local Renew programme and highlighted several key elements which included: good collaboration between mental health and primary care; see and treat model; average of 300 referrals per month; a range of evidence based interventions are offered; centralised service for those of 18+ age group; digital service commenced during the pandemic; and feedback from service users was very positive.

15.3 Dr Kevin Buchan commented that the Renew programme had been a great success with GPs and clients having a positive experience with the service and he welcomed it as a step away from GPs prescribing anti-depressants. Dr Buchan advised the IJB of the current gap in child mental health needs and the distress that it caused to children, families and GPs.

15.4 Mrs Harriet Campbell welcomed the initiative and urged the inclusion of SBC education in it.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted for reference this 4-year programme.

16. STRATEGIC PLANNING GROUP MINUTES: 02.02.22

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the minutes.

17. ANY OTHER BUSINESS

17.1 The Chair advised that there was one item of any other business in regard to the appointment of the Chief Financial Officer and a late paper had been issued (Appendix-2022-20).

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** formally approved the appointment of Hazel Robertson as Chief Financial Officer of the Health & Social Care Integration Joint Board with effect from 1 August 2022.

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17.2 The Chair recorded the thanks of the IJB to Mr David Robertson and Mr Andrew Bone who had covered the position of Chief Financial Officer to the IJB previously.

18. DATE AND TIME OF NEXT MEETING

18.1 The Chair confirmed that the next meeting of the Scottish Borders Health & Social Care Integration Joint Board would be held on Wednesday 21 September 2022, from 10am to 12noon, via Microsoft Teams, however an extraordinary meeting would be called in August 2022.

The meeting concluded at 12.15.

Signature: ……
Chair

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SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD

ACTION TRACKER

Meeting held 19 August 2020

Agenda Item: Primary Care Improvement Plan: Update

Action Number	Reference in Minutes	Action	Action by:	Timescale	Progress	RAG Status
2020 - 2	7	Evaluation report of new Primary Care Mental Health Service, funded through PCIP.	Rob McCulloch-Graham Kevin Buchan	~~August 2021~~ ~~April 2022~~ September 2022	**In Progress:** **Update 22.09.21:** Mr Rob McCulloch-Graham confirmed that the "Renew" service was being evaluated and regular reports were received by the PCIP Executive. He confirmed that a full evaluation would be shared with the IJB at a later date (2022). **Update 23.02.22:** Paper on "Renew" scheduled for the IJB meeting on 20 April 2022. **Update 15.06.22:** Will be reviewed at IJB Audit Committee on 12.09.22 (as full agenda for Audit Committee on 20.06.22) **Complete:** Appeared as part of the PCIP Update paper on the 15.06.22 IJB meeting.	G

Meeting held 15 December 2021

Agenda Item: Day Services Petition and Future Provision

Action Number	Reference in Minutes	Action	Action by:	Timescale	Progress	RAG Status
2021 - 6	10	The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** sought a timeline for the work to be taken forward.	Stuart Easingwood	April 2022	**In Progress:** Work to define the Carers Needs Assessment has commenced with the IJB Carers Workstream. The needs assessment and planning will be incorporated into the updated IJB Strategic Commissioning Plan, however an update on day services will be provided in advance of the conclusion to the development of the full Strategic Commissioning Plan. **Update 15.06.22:** Needs assessment questionnaire went out to unpaid carers on 06.06.22	G

Meeting held 15 June 2022

Agenda Item: 2021-22 ANNUAL PERFORMANCE REPORT & 2022-23 COMMISSIONING PLAN

Action Number	Reference in Minutes	Action	Action by:	Timescale	Progress	RAG Status
2022 - 1	10	The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** agreed to receive a revised version of the report for approval via email.	Chris Myers	August 2022	Complete: Revised version emailed to the IJB for final comments by close of play Friday 26 August 2022.	G

Agenda Item: PRIMARY CARE IMPROVEMENT PLAN UPDATE

Action Number	Reference in Minutes	Action	Action by:	Timescale	Progress	RAG Status
2022 - 2	14	The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** sought the development of a direction immediately to NHS Borders to undertake further work to build the IJB's level of assurance that all opportunities to understand and reduce the cost pressure had been explored, so that an update can be brought back to an extraordinary meeting of the IJB to inform its approach to financial planning for 2023/24.	Iris Bishop	August 2022	**Complete:** EO IJB meeting scheduled for 17 August 2022.	G

KEY:	
Grayscale = complete:	
R	Overdue / timescale TBA
A	Over 2 weeks to timescale
G	Within 2 weeks to timescale

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Scottish Borders Health & Social Care Integration Joint Board

Scottish Borders Health and Social Care PARTNERSHIP

Meeting Date: 17 August 2022

Report By:	Chris Myers, Chief Officer Hazel Robertson, Chief Financial Officer Cathy Wilson, General Manager, Primary and Community Services
Contact:	Cathy Wilson, General Manager, Primary and Community Services Caroline Cochrane, Director of Psychology
Contact:	Via Microsoft Teams

RESOURCING OF PRIMARY CARE IMPROVEMENT PLAN AND OF THE PRIMARY CARE MENTAL HEALTH AND WELLBEING FUND FROM 2023/24 ONWARDS

Purpose of Report:	To appraise Integration Joint Board members on the current position relating to the financial and operational delivery of both the Primary Care Improvement Plan and the Mental Health and Wellbeing in Primary Care Services fund, and to advise on the actions undertaken and current status of these workstreams.
Recommendations:	The Health and Social Care Integration Joint Board is asked to: a) Note the progress made since the last Integration Joint Board b) Note the risks to non-delivery of the GMS Contract, GP sustainability, workforce, and mental health and wellbeing services c) Note that the local financial position has been escalated to the Scottish Government Primary Care Directorate, and that the Scottish Government have subsequently issued a national allocation letter and the process to be followed d) Note that the funding for the Mental Health and Wellbeing in Primary Care Services plan reviewed at the Integration Joint Board in June 2022 has not been released and the plan has not been signed off by Scottish Government e) Note that discussions will occur with the Scottish Government about use of the Mental Health and Wellbeing in Primary Care fund to inform a future paper for the Integration Joint Board
Personnel:	Circa 70 WTE new posts will be established across a number of clinical and support services. Each workstream is established at a level which enables provision for a 50 week service throughout the year through sufficient additional resource to cover annual leave and sickness absence. However there are now significant system-wide workforce pressures which have led to challenges recruiting and retaining staff across a number of these workstreams, which impact both on

	Primary Care and on other parts of the Health and Social Care system. In addition, there are risks associated to delays in recruitment and a delay to the TUPE of staff from General Practice to NHS Borders.
Carers:	Impacts on carers have been considered as part of the Healthcare Inequalities Impact Assessments that have been undertaken. There have been no stated impacts.
Equalities:	A Healthcare Inequalities Impact Assessment for the whole PCIP programme has been undertaken. For each new workstreams, service specific Healthcare Inequalities Impact Assessments have been undertaken (e.g. Vaccination Transformation) to ensure that the services appropriately ensure that the new services are not discriminating in their approach, that they widen access to opportunities, and support the people with protected characteristics.
Financial:	For 2022/23, we have received confirmation of an allocation of £3.648m for the Primary Care Improvement Fund. .This is an improvement on our working assumption of £3.2m. Reserves brought forward from 2021/22 must be used first. Funding from the allocation will be released in two tranches - 70% in August) with 30% following in autumn 2022 subject to supporting data and evidence (in particular Primary Care Improvement Plans.. Confirmation has been given that future allocations will be at least £170m for Scotland (Borders NRAC share £3.655m) and that Scottish Government will supply additional funds for Agenda for Change uplifts, and to ensure fulfilment of the terms of the MOU2. Any further investment will be subject to assessment at each budget round. There is financial risk to the Partnership and its PCIP as a result of two stage process. Should these workstreams not be delivered, the Integration Joint Board and NHS Borders will be required to compensate GPs to deliver activity that will no longer be contractually obliged, at rates yet to be negotiated by the BMA and Scottish Government. Scottish Government issued an updated Memorandum of Understanding (MOU 2) to Health Boards in July 2021. The revised MoU for the period 2021-2023 recognises what has been achieved but also reflects on the fact that there is still a way to go to fully deliver the GP Contract Offer commitments as originally intended. This revised MoU 2 acknowledges both the early lessons learned as well as the impact of the Covid-19 Pandemic and that the delivery of the GP Contract offer requires to be considered in the

	context of Scottish Government remobilisation and change plans. The MoU 2 officially runs until March 2023. In November 2021, the Scottish Government recognised that partial implementation of the Pharmacotherapy and Community Treatment and Care (CTAC) service, on a national level would require additional support for general practices. As such, it was agreed to allocate a sustainability payment to all practices covering 2021-22 and 2022-23. The first payment has been made and the second will be paid out later in the year.
Legal:	The delivery of the Primary Care Improvement Plan is part of the national GP GMS Contract (2018) through a Memorandum of Understanding, and subsequent Memorandum of Understanding 2 between the British Medical Association (Scotland), the Scottish Government, Health Board and Integration Authorities.
Risk Implications:	• Risk of non-delivery against GMS Contract • Associated sustainability risk for Primary Care • Impacts on Children's Mental Health and Wellbeing in Primary Care services, in the context of recovery from Covid-19 • Financial risk • Recruitment issues
Direction required:	No

1. Introduction

In the Integration Joint Board on 28 July 2021, progress against the Primary Care Improvement Plan was reviewed. This showed good progress with the implementation of the Primary Care Improvement Plan and excellent tripartite arrangements between the Integration Joint Board, General Practitioners and NHS Borders. However it was also noted that there was a financial risk to the delivery of the plan, but that this would be bridged through the use of non-recurrent spend pending a further allocation from Scottish Government for 2022-23.

In the Primary Care Improvement Plan update at the Integration Joint Board on 15 June 2022, it was noted that further good progress had been made locally in delivering against the Memorandum of Understanding 2, however there remained a number of risks; predominantly around the implementation of the Community Treatment and Care Service, and Pharmacotherapy Services, with a forecast financial deficit of £2.5m from 2023/24 onwards.

The risk associated to Pharmacotherapy delivery was reviewed by the Integration Joint Board Audit Committee on 20 June 2022, where it was noted that actions were in place to improve the operational position, but that there were also financial constraints to delivery. The main risk relating to the Community Treatment and Care Service is due to financial constraints.

The Primary Care Improvement Plan was noted to be at a stage where further recruitment or TUPE of staff from General Practices to the Health Board to support the delivery of the plan against the Memorandum of Understanding 2 would lead to a recurrent overspend. In addition, the non-recurrent reserve for the Primary Care Improvement Plan has been fully committed. As a result, in line with the Integration Joint Board's statutory finance requirements, further financial resource is required in order to ensure the continued development of the plan in line with the Memorandum of Understanding 2.

Development of Primary Care Multi-Disciplinary Teams is a contractual issue as it is a pre-requisite to the delivery of the GMS Contract. The development of these services were agreed to between General Practice, the Scottish Government, Integration Joint Boards and NHS Boards. Adequate levels of resourcing are clearly a pre-requisite to the delivery of the GMS Contract, in resourcing the development of Primary Care Multi-Disciplinary Teams to develop and support General Practitioners in their role as Expert Medical Generalists.

Broadly speaking, the roles of the Integration Joint Board and NHS Borders are to commission and deliver the Primary Care Improvement Plan respectively in line with local needs under the national framework, which is resourced by the Scottish Government (see Appendix 1). Whilst not responsible for funding the contract, should the priority workstreams not be delivered, Integration Authorities and Health Boards are required to compensate General Practitioners to deliver activity that will no longer be contractually obliged, at rates yet to be negotiated by the BMA and Scottish Government.

As a result of the financial situation and risks to operational delivery, the Integration Joint Board requested that further work be undertaken to review the situation and allow for further appraisal at the allow for more detailed understanding of the situation, to outline whether these risks could be reduced, and to better understand the financial and delivery risks that remained. The Integration Joint Board also agreed to hold an extraordinary

meeting to further review the situation and agree the next steps, so as to reduce the likelihood of any delays in relation to progress against delivery of the Primary Care Improvement Plan.

This paper summarises the extensive work that has been undertaken by the Primary Care Improvement Plan Executive and notes the further actions undertaken to reduce the risks to the delivery of the plan.

2. Background

The 2018 GMS contract arose out of necessity. Nationally, general practices were faced with unprecedented level of challenge in terms of sustainability – national recruitment issues and increasing demand for appointments resulted in practices struggling to deliver the service at the level they aspired to achieve.

In recognition of the severity of the situation, it was hoped that by creating a system where tasks are directly realigned to a more appropriate professionals would help relieve GP pressures.

National funding was to provide new staff employed by Health Boards that would be dedicated in improved patient-centred care. A new multidisciplinary primary care system could allow other health care professions to develop and grow in community based care. For GPs, it would go beyond just the easing of workload pressures. It would allow GPs to focus on being an expert medical generalist role at the heart of the community multidisciplinary team. This would aim to improve patients' quality of care, increase GP job satisfaction, and ensure more seamless delivery of health and social care services.

Since 2018, workstreams were created to deliver new services, including Vaccinations, Community Treatment and Care (CTAC), Pharmacotherapy, Musculoskeletal, Mental Health, Pharmacotherapy and Community Link Workers. Within the funding envelope available, the PCIP Executive Committee pushed with the implementation of key workstreams to deliver services to practices – scrutinising every spend and overseeing progress, ensuring that decision made were having a meaningful impact on GP workload and benefiting patients in an equitable manner.

Work continued to develop these workstreams throughout the Covid-19 pandemic in the recognition of the very pressing requirement to meet the increased needs of our population and General Practice throughout the pandemic.

In 2022 the Scottish Borders' Primary Care Improvement Plan (PCIP) remains committed to delivering the 2018 GMS contract through its collaborative process between NHS Borders, Integration Joint Board (IJB) and GP Sub Committee (e.g PCIP Executive Committee).

A second Memorandum of Understanding (MoU2) would later ask that Integration Joint Boards and Health Boards prioritise three services for delivery: Vaccinations, CTAC and Pharmacotherapy. Prior to this revised edition, the Scottish Government's Primary Care Improvement Funding (PCIF) allocation for the Scottish Borders had already been committed to funding other workstreams first. The PCIP Executive Committee had judged that based on work demand analysis, services such as Mental Health, Musculoskeletal and Urgent Care would provide immediate relief to local GP workloads. It is important to note that the MoU2 also states that Integration Joint Boards and Health Boards should not

defund established workstreams to address shortfalls for the three priority services. This raised the risk of securing funding for full delivery of the contract.

3. Actions undertaken

3.1. Request for funding from the Scottish Government

As the Memorandum of Understanding noted that the Scottish Government is responsible for "providing financial resources in support of the new Scottish GMS contract and primary care transformation (including the transfer of services) in line with the Scottish Government spending review process," the Integration Joint Board Chief Officer wrote to the Scottish Government to escalate the situation relating to the potential non-delivery of the Memorandum of Understanding 2 within the current resource, and to request additional funding.

In response, the Scottish Government has confirmed that £170m nationally would be made available for 2022-23 plans. This represents an increase of £15m from £155m and equates to around £319k for the Scottish Borders, which does not cover the forecast gap. The Scottish Government have now outlined the funding arrangement for future years in an allocation letter which sets out the level of funding and how funding will be issued, in two tranches (see allocation letter in Appendix 3).

For 2022/23, we have received confirmation of an allocation of £3.648m for the Primary Care Improvement Fund. This is an improvement on our working assumption of £3.2m. Reserves brought forward from 2021/22 must be used first. Funding from the allocation will be released in two tranches - 70% in August with 30% following in autumn 2022 subject to supporting data and evidence.

Tranche 1

Given the overall financial pressures across health and social care, and taking into account the Resource Spending Review, it is prudent and sensible to use existing reserves that have been built up over time. Integration Authorities should draw down existing reserve balances in the first instance, and therefore 2022-23 allocations will reflect reserves held.

The initial tranche in August 2022 will take account of Integration Authority reserve balances at October 2021 as well as baselined pharmacy funding. Note that baselined pharmacy funding of £7.8m has been allocated separately and must also be treated as part of the Primary Care Improvement Fund.

Tranche 2

Any locally held reserves should be invested in the implementation of PCIPs in 2022- 23 before new funding is requested. Further funding will be made available later this year, subject to reporting confirming latest spend and forecasts required by Friday 4 November 2022, providing a breakdown of spending by category (staff and non-staff costs) and detailing what benefits have been created. Second tranche allocations will follow in Autumn 2022, subject to supporting data and evidence (in particular Primary Care Improvement Plans) regarding additional PCIF funding required in 2022-23. The approach to second tranche allocations will also be informed by updated financial data on the reserve positions as at 31 March 2022, which Scottish Government officials have

separately requested from Integration Authorities. Second tranche allocations will be accompanied by any further guidance, as required.

Future funding

Confirmation has been given that future allocations will be at least £170m for Scotland (Scottish Borders NRAC share £3.655m) and that the Scottish Government will supply additional funds for Agenda for Change uplifts, and to ensure fulfilment of the terms of the MoU2. Any further investment will be subject to assessment and benefits case at each budget round.

This commitment aligns to the Memorandum of Understanding 2 commitment which noted that “the Memorandum of Understanding parties are committed to determining the full cost of delivering MoU services and refining the evidence base for this purpose.”

However there does remain an element of financial risk as further investment will only be determined following the agreement to these cases via a review of benefits by the Scottish Government.

From 2022-23, new investment in the Primary Care Improvement Fund can be used for a wider range of costs (such as premises, training, digital, fixed-term contracts and redesign and change management) as long as they support delivery of the MoU MDT and are agreed with the GP Sub-Committee.

Evaluation guidance will be reviewed and used for the release of tranche 2 funding. Scottish Government will work with Public Health Scotland and local evaluators to understand the current evaluation landscape, the work already underway at local level and any gaps that might exist. This work will inform further development of the monitoring and evaluation of PCIPs at the national level, in turn allowing us to better target investment in future years.

In light of the allocation letter and guidance contained therein we will further review the planned spend during 2022/23 and beyond.

3.2. Review of Mental Health and Wellbeing Funding in Primary Care

The Memorandum of Understanding 2 noted that: "With Mental Health, there is a need to consider how PCIF (Primary Care Improvement Fund) funded posts interface with Action 15 funded posts as well as new policy commitments for mental health. The Primary Care Mental Health Development group in Scottish Government is taking this consideration forward. Separate to this MoU and the arrangements in place to fund it, the commitment of additional Mental Health Link Workers is currently being considered in the context of the locally led model proposed by the Mental Health in Primary Care Short Life Working Group."

In line with this, an additional £271,503 of Action 15 funding was allocated on an annual basis to supplement investment to facilitate the implementation of the Primary Care Mental Health Workstream, from the commencement of the service (Renew).

In addition, Mental Health and Wellbeing Funding in Primary Care funding has also been committed by the Scottish Government, and in February 2022 it was noted that the following allocation would be made to the Scottish Borders Health and Social Care

Integration Joint Board and Partnership. In the Integration Joint Board in 15 June 2022, the plans to implement the Mental Health and Wellbeing in Primary Care investment locally were noted. The level of indicative allocation from the Scottish Government for this policy commitment is noted below:

Financial year	Indicative allocation
2021-22	£67,009
2022-23	£204,537
2023-24	£406,437
2024-25	£823,677

Table 1 Mental Health and Wellbeing in Primary Care Services indicative allocation

In line with the Memorandum of Understanding 2, the Scottish Borders Health and Social Care Integration Joint Board and NHS Borders should also consider the use of this funding to support the delivery of the Primary Care Mental Health service from within the Primary Care Improvement Plan. This should also be undertaken in the context of the terms set out by the Mental Health and Wellbeing in Primary Care Fund.

Funding for this policy commitment from the Scottish Government was noted as indicative and that it would be subject to the approval of national future budgets in the Scottish Parliament.

Resource for this is assumed to come from the remaining funding from the national Health and Social Care portfolio after a number of costed commitments including Social Care, the National Care Service and reducing drug related deaths, which total £1,306-£1,578m of the total £1,922m commitment to Health and Social Care over the course of this Parliament.

This leaves between £344m-616m for investment across the other national priority areas over the course of this parliament, representing a total of 2.0-3.6% growth in total over the other national priority areas in the health and social care budget over the four year parliamentary period. It is important to note that due to the national context relating to inflation, there are a number of other significant pressures including pay and cost inflation that need to be funded within available budgets.

As a result, and within the context of the Resource Spending Review, whilst the allocation for 2021-22 has been received, we are unclear about the confirmed levels of funding from this financial year onwards.

Scottish Government have confirmed in the Primary Care Improvement Plan allocation letter that partnerships are requested to use this additional funding for Mental Health and Wellbeing to build on the existing investment from the Primary Care Improvement Fund and other funding streams to create additional capacity. Partnerships are asked to use this year to consider whether there are any practical challenges in allocating and reporting on Mental Health Workers across different funding streams (Primary Care Improvement Fund, Mental Health and Wellbeing Funding in Primary Care and other funding streams) and whether there would be benefits/opportunities to aligning reporting.

The Integration Joint Board should not commit to commission this workstream until clarity on the Mental Health and Wellbeing Funding in Primary Care fund is available and the submitted plan is signed off by the Scottish Government.

In addition, confirmation is required jointly from the Scottish Government Mental Health and Primary Care Directorates on how the Mental Health and Wellbeing in Primary Care fund should be allocated in the context of the Scottish Borders to ensure that we are able to reduce the risk to implementation of both the Mental Health and Wellbeing and Primary Care Improvement Plan workstreams. Once we have received this confirmation and funding, then a paper will be submitted to the Integration Joint Board for consideration.

3.3. Local review of potential to further maximise local impacts of spend on the Primary Care Improvement Plan

Following the IJB meeting in June 2022, members were updated on the funding constraints. A forecast financial deficit of £2.511m from 2023/24 was presented; primarily risking the successful delivery of both Community Treatment and Care and Pharmacotherapy services.

In preparation of the Extraordinary IJB meeting called for August 2022 to further examine the financial risk, a detailed review into each workstream was undertaken. This review led to an in-depth look into workforce projections with clinical leads re-applying skill mix analysis of each key role within service structures in an attempt at reducing cost without compromising patient care and to validate value for money. This work was supported by the Health and Social Care Partnership Chief Nurse and also by the NHS Borders Director of Nursing, Midwifery & Allied Health Professionals. The revised financial shortfall now stands at £2.372m.

Further detail on progress is included in Appendix 2 – Primary Care Improvement Plan 2022 Annual Programme Report.

4. Conclusions

Whilst excellent progress has been made locally on the development and implementation of the Primary Care Improvement Plan and the Mental Health and Wellbeing in Primary Care workstream in partnership with General Practice and with NHS Borders; we need to further review the plan to ensure there is sufficient funding and evidence of impact, to deliver the plan further on a recurrent basis.

Much work has been undertaken since the last Integration Joint Board which has reduced the forecast overspend for the Primary Care Improvement Plan by £139k.

For this financial year, now that the Scottish Government have provided assurance of at least £170m funding will be available nationally on an annual basis, there remains an element of risk as the funding will be released in tranches.

For 2023-24 onwards there is risk to delivery of the GMS Contract as funding will only be confirmed following approval by the Scottish Government on a case by case basis, however this risk has reduced significantly since the last allocation and confirmation of funding from the Scottish Government.

In light of the allocation letter and guidance contained therein we will further review the planned spend during 2022/23 and beyond.

Confirmation is required jointly from the Scottish Government Mental Health and Primary Care Directorates on how the Mental Health and Wellbeing in Primary Care fund should be

allocated in the context of the Scottish Borders to ensure that we are able to reduce the risk to implementation of both the Mental Health and Wellbeing and Primary Care Improvement Plan workstreams. Once we have received this confirmation and funding, then a paper will be submitted to the Integration Joint Board for consideration.

5. Recommendations

The Health and Social Care Integration Joint Board is asked to:

a) Note the progress made since the last Integration Joint Board
b) Note the risks to non-delivery of the GMS Contract, GP sustainability, workforce, and mental health and wellbeing services
c) Note that the local financial position has been escalated to the Scottish Government Primary Care Directorate, and that the Scottish Government have subsequently issued a national allocation letter and the process to be followed
d) Note that the funding for the Mental Health and Wellbeing in Primary Care Services plan reviewed at the Integration Joint Board in June 2022 has not been released and the plan has not been signed off by Scottish Government
e) Note that discussions will occur with the Scottish Government about use of the Mental Health and Wellbeing in Primary Care fund to inform a future paper for the Integration Joint Board

Appendix 1:
Responsibilities of parties to the Memorandum of Understanding

The responsibilities of Integration Authorities are:

- Planning, design and commissioning of the primary care functions (including general medical services) delegated to them under the 2014 Act based on an assessment of local population needs, in line with the HSCP Strategic Plan.
- The development of a HSCP Primary Care Improvement Plan, in partnership with GPs and collaborating with other key stakeholders including NHS Boards that is supported by an appropriate and effective MDT model at both practice and Cluster level, and that reflects local population health care needs.
- Collaboration with NHS Boards on the local arrangements for delivery of the new Scottish GMS contract.
- Section 2c of the National Health Service (Scotland) Act 1978 places a duty on NHS Boards to secure primary medical services to meet the reasonable needs of their NHS Board area. To achieve this, NHS Boards can enter into GMS contracts. HSCPs will give clear direction to NHS Boards under sections 26 and 28 of the 2014 Act in relation to the NHS Board's function to secure primary medical services for their area and directions will have specific reference to both the available workforce and financial resources.
- Ensuring that patient needs identified in care plans are met

NHS Territorial Boards responsibilities:

- Contracting for the provision of primary medical services for their respective NHS Board areas
- Ensure that primary medical services meet the reasonable needs of their Board area as required under Section 2C of the NHS (Scotland) Act 1978.
- Delivering primary medical services as directed by HSCP as service commissioners.
- Arrangements for local delivery of the new Scottish GMS contract via HSCPs
- As employers, NHS Boards will be responsible for the pay, benefits, terms and conditions for those employees engaged in the delivery of the priority areas set out in Section G.

Scottish General Practice Committee responsibilities:

- Negotiating, with the Scottish Government, the terms of the GMS contract in Scotland as the negotiating committee of the BMA in Scotland.
- Conducting the poll (and any future poll) of its members on the terms of the GMS contract in Scotland.
- Representing the national view of the GP profession.
- Explaining the new Scottish GMS contract to the profession (including communication with Local Medical Committees (LMC) and GP practices).
- Ensuring that GP practices are supported encouraged and enabled to deliver any obligations placed on them as part of the GMS contract; and, through LMCs and clusters, to contribute effectively to the development of the HSCP Primary Care Improvement Plan.

Scottish Government responsibilities:

- Setting the legislative framework underpinning the commissioning of primary medical services by HSCPs and delivery by NHS Boards.

- In collaboration with NHS Boards and with HSCPs, shaping the strategic direction and the development of commissioning guidance in respect of primary care that is in line with the aims and objectives set out in National Clinical Strategy and the Health and Social Care Delivery Plan.
- Providing financial resources in support of the new Scottish GMS contract and primary care transformation (including the transfer of services) in line with the Scottish Government spending review process.
- Making arrangements with stakeholders to meet the future GP workforce requirements both in terms of numbers and education and training.
- Agreeing the metrics and milestones against which progress will be measured; with regular progress reporting as part of the existing statutory arrangements for reporting performance against Strategic Plans.

Appendix 2: Primary Care Improvement Plan – Annual Programme Report

Local progress on delivery of the Primary Care Improvement Plan

Appendix 3

2022/23 PCIP Annual funding letter 11 August 2022

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PCIP Borders
Primary Care Improvement Plan

2022

Primary Care Improvement Plan

Annual Programme Report

PCIP Executive Committee Report

“

PCIP doesn’t stand in isolation but continues to evolve and support development of other strands of work which will hopefully improve patient experience and breakdown unneeded barriers.

- Dr. Kevin Buchan, GP Sub Chair

”

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Foreword

It has been a long journey since 2018.

Then, Scottish Borders set out an ambitious and progressive Primary Care Improvement Plan (PCIP) to implement and deliver the new General Medical Services (GMS) contract.

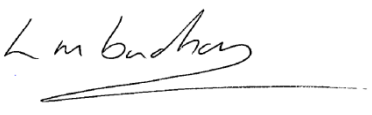
Now, through dedicated tripartite collaboration and partnership approach, the careful planning and implementation of our PCIP has successfully made use of its PCIP funding to provide significant workforce resources to practices. Recognising the limitations of funding, the process has been agile, innovative and responded to patient needs. A huge amount of pragmatism has underpinned the decision making process, recognising both the need to deliver the contract but also responding to evolving needs such as the significant rise in mental health issues and the urgent need for vaccinations.

We continually strive towards introducing new ways of working that will require further innovation and the establishment of new models of multidisciplinary care across General Practice. We remain motivated by the positive impact this work has had on practice workload and in supporting the healthcare needs within our communities.

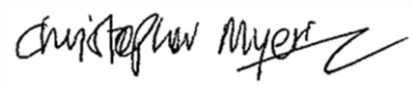
Sufficient funding remains our biggest challenge to date as we await national direction regarding future funding allocation to enable us to fully implement the GMS contract. We continue to work hard on squeezing out the maximum gains from our funding through continual oversight at PCIP Executive Committee. Scottish Borders has to the best of their ability, implemented either fully or partially on the majority of workstreams and is well placed to progress further phases, as national direction and resource is given.

In the meantime, we will continue to work with our valued patients, GPs and other health, social care and voluntary sector providers to ensure that the programme progresses well through the next steps for development of strong and sustainable community based services.

Cathy Wilson
PCIP Executive Chair/General Manager
Primary and Community Services



Dr Kevin Buchan
GP Sub Chair
GP Executive



Chris Myers
Chief Officer
Integration Joint Board/Health and Social Care Partnership

Our PCIP journey is much more than building new pathways and bridges in primary care services. It is about seizing the opportunity to bring about sustainable transformation in the bedrock of all healthcare services in the Scottish Borders.

Cathy Wilson – PCIP Executive Chair

PCIP Timeline

In 2018, a new GP contract was introduced. A new primary care model was to be rolled out to make it easier for people to access care from a wide range of healthcare professionals.

Funding was to be provided for the streamlining of services and for new staff who would be employed by NHS Health Boards to help maximise the time GPs can spend for caring for those who require their expertise.

It was hoped that this transition would take place over the course of 3 years – this would be locally agreed through Primary Care Improvement Plans (PCIPs) .

2018

PCIP is part of the GP Contract. It is defined through an agreed national Memorandum of Understanding (MoU) between the Scottish Government (SG), the Scottish General Practitioners Committee of the British Medical Association (SGPC), Integration Authorities (IAs) and NHS Boards.

This MoU mandated the delivery of specific priorities aimed at supporting people to access more easily the most appropriate healthcare to meet their needs to in turn release GP Clinical time to allow GPs to focus on their role as Expert Medical Generalists.

SGfunding to support the implementation of the MoU has been allocated to IAs through the Primary Care Improvement Fund (PCIF), and locally agreed PCIPs would set out in more detail how implementation of the 6 priority service areas will be achieved.

PCIP Executive April 2019

The PCIP Executive Committee (created in April 2019) is the body which overseas and directs the development and implementation of the PCIP progrogramme in the Borders. Its membership is at senior level and represents the 3 partner organisations – a tripartite agreement between GPs, NHS Borders and the Integration Joint Board (IJB).

A revised version of the Borders PCIP Plan 2018-2021 would be published later in the year.

COVID-19 Pandemic

The PCIP Executive notes the impact of COVID on service delivery. GP Executives of the GP Sub Committee would work closely with NHS Borders to mitigate risks and focus on the recovery and remobilasation progress.

Journey

December 2021
Joint letter SG/SGPC

In December 2021, the Government issued a letter announcing implementation change order of workstreams recognising which streams would be of more benefits to GP workloads, also the extended deadline for workstreams and also highlighting the contractual burden on Health Boards for non-delivery of these workstreams.

July 2021
MoU2

SG issued an updated Memorandum of Understanding (MoU2) to Health Boards in July 2021. The revised MoU for the period 2021-2023 recognised what had been achieved on a national level but also reflects gaps in delivering the GP Contract Offer commitments as originally intended by April 2021.

This revised MoU2 acknowledges both the early lessons learned as well as the impact of the Covid-19 Pandemic and that the delivery of the GP Contract offer requires to be considered in the context of Scottish Government remobilisation and change plans.

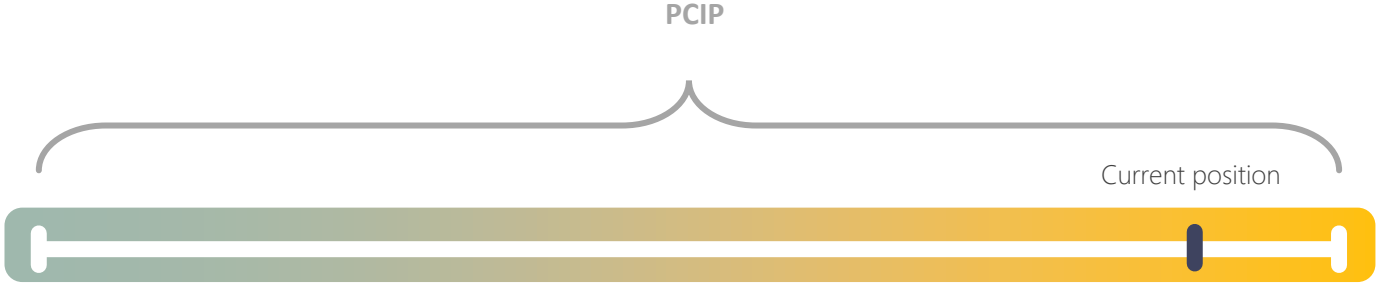
SG advised that all 6 MoU service areas should remain in scope, however following the SG/SGPC letter of December 2020, they agree that the following services should be reprioritized to the following three services:

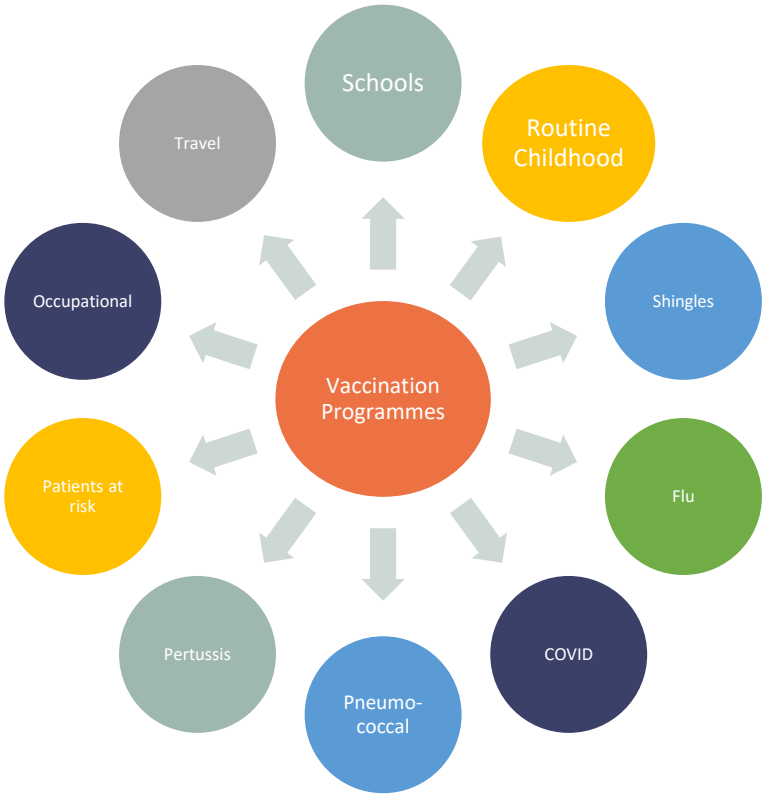
- Vaccination Transformation Programme (VTP)
- Pharmacotherapy
- Community Treatment and Care Services (CTAC)

It is important to note that prior to the MoU2 announcement, other PCIP Borders workstreams were well underway and PCIF commitments attached.

November 2021
GP Sustainability Payment

In recognition that nationally several HBs were struggling with the March 2022 deadline, a GP sustainability payment was offered to help cover costs- giving an additional year for implementation of both CTAC and Pharmacotherapy.





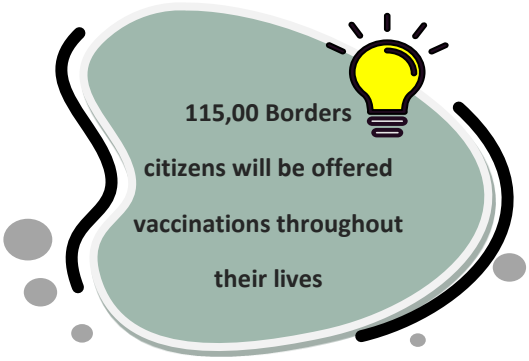
WHAT WE SET OUT TO DELIVER

As per the outcomes of the 2017 GMS contract negotiations, NHS boards and local partners are required to plan, manage and deliver vaccinations rather than the longstanding arrangement of contracting delivery through general practice.

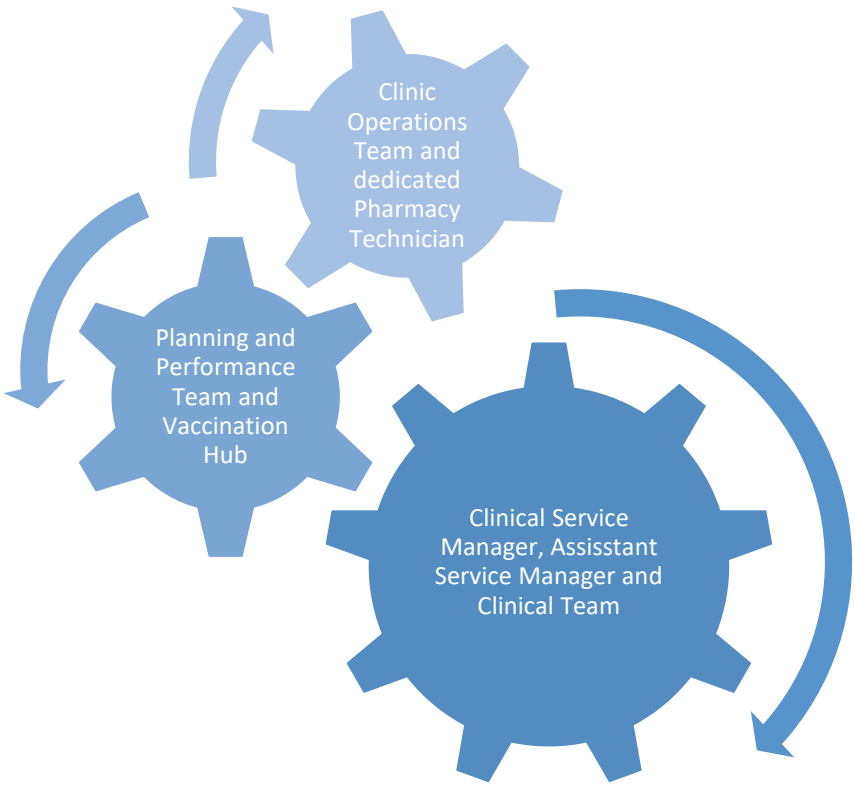
While the UK Joint Committee on Vaccination and Immunisation (JCVI) and Public Health Scotland (PHS) will continue to guide national policy and vaccination programmes, delivery must be managed and implemented by NHS health boards and their local partners to suit their local population, geography and workforce.

Between September 2021 and April 2022, NHS Borders Vaccination Transformation Programme created a dedicated Vaccination Service with responsibility for vaccinations and immunisation, and successfully transitioned all outstanding programmes from GPs to the health board by the required deadline.

NHS Borders Vaccination Service leads the delivery of programmes in partnership with public health, school immunisation, community nursing, occupational health, maternity services, child health, general practice, acute services and the wider Scottish Borders Health and Social Care Partnership.



Vaccination clinics take place on an ongoing basis in health centres, schools, hospitals and community venues across the Borders. Provision is also in place for patients who are housebound or live in residential care.



The service is led by a dedicated Clinical Service Manager, supported by an Assistant Service Manager and the following teams:

- Clinical team including senior charge nurse, nurses and healthcare support workers.
- Planning and performance team to manage planning, uptake monitoring, change and improvement.
- Vaccination Hub for patient contacts, admin and staffing, including a coordinator, supervisors, admin officers and call handlers.
- Clinic operations team to manage clinic set up, logistics, kit and vaccine transport.
- A dedicated pharmacy technician to manage vaccine provision.

DELIVERY APPROACH

The Vaccination Transformation Programme delivered patient journeys, operating processes, policies, workforce, communications, resources, systems and reporting from scratch to support a new service.

A dedicated “Vaccination Hub” was developed following its introduction during the 2020 flu programme, evolving to provide a single centre of expertise for:

- Call handling and patient appointment booking line (inbound and outbound)
- Clinic administration (registering patients, arriving patients, liaising with clinical staff)
- Staffing support (recruitment, rostering and training support)
- Dedicated administration and operational support
- Clinical operational support (e.g. clinic kit boxes, printing documentation, ad hoc transport requests)
- Caseload and patient list management (e.g. housebound patients, care homes)
- Records management (devolved management, record amendments, issues and data quality)

Covid-19 and other non-PCIP vaccinations

The Vaccination Programme was integral in the successful delivery of Covid-19 Vaccinations. It is important to note that this vaccine along with other non-PCIP vaccines introduced after the PCIP specification was agreed are funded with a separate additional funding stream.

The Vaccination Transformation Programme capitalised on innovations and new technologies to create a streamlined, resilient, people-centred service introducing:

- A new cloud based telephone system, increasing call capacity, improved patient routing, call queues, options for patient call back, and the capability for call handlers to answer calls remotely.
- Vaccination Management Tool, a national web-based application to support the recording of vaccinations at point of care.
- IPads to support the recording of vaccinations ‘on the move’ and in varied clinic settings.
- National Vaccination Scheduling System to support the appointing of patient en mass by cohort, and a web-based portal allowing patients to book and reschedule appointments online.
- National Clinical Data Store and COVID status app, allowing patients to view their own vaccination status online and automatically pushing data into GP systems.
- Reporting dashboards – sharing concise, visual summaries of uptake, performance and planned appointments.
- Dedicated vaccinations webpage for patients http://www.nhsborders.scot.nhs.uk/vaccinations
- Dedicate vaccinations intranet for NHS staff and partners.

CLINICAL STAFFING BREAKDOWN (July 2022)

	Permanent		Fixed Term		As & When	
	In Post	Vacant	In Post	Vacant	In Post	Vacant
VTP (Babies, Pre-School, Travel & Selective)	1.99	4.91	0.00	0.00	0.00	0.00
Adult Vaccinations (Shingles, Pneumo, Flu & CV-19)	2.10		1.95	8.08	0.47	0.00
School Immunisations	3.80	0.00	0.00	1.70	0.00	0.00
Total:	7.89	4.91	1.95	9.78	0.47	0.00

VACCINATION ACTIVITY & UPTAKE- As of July 2022, the Vaccination Service has given over 370,000 vaccinations, including over 295,000 COVID vaccinations (since December 2020), and 75,000 vaccinations across routine childhood, pneumococcal, shingles, flu, selective and travel programme.

Programme	Vaccinations given	Uptake range
Routine childhood (baby/pre-school)	8,500	94 – 97%
Pneumococcal	5,000	43% (including mop up)
Shingles	2,500	46% mop up aged 70 31% mop up aged 71 - 79
Selective referrals	100	-
Travel	100	-
Flu	59,000	55 - 93% (all programmes)
COVID	295,000	86 – 99%

Public Feedback:
Covid-19 Vaccinations

"Felt safe at all times for my first Covid-19 vaccine."

"My 13 year old daughter really wanted her Covid vaccine but has a needle phobia following an earlier healthcare experience. Our vaccinator (Lucy Anna) was absolutely amazing with her, reassuring her all the way.

"My daughter was shaking and yet her kind explanation and distraction made all the difference. She feels she would be less afraid in the future following this experience! Thank you so much to the whole team today..."

"Despite it being a miserable cold wet day I would like to commend all staff employed, they were cheery, helpful and very professional and everything went according to plan."

Public Feedback:
Travel Vaccinations

"This is good news indeed. Completely understand travel is not a priority so this is great news people will no longer have to travel to Edinburgh or be subjected to additional costs."

"This is fantastic news as we was going to have to travel to Edinburgh, pay for vaccines and the travel costs...Thank you"

What we set out to deliver

The GMS Contract (2018) and the supporting Memorandum of Understanding 2 outlined a commitment to the development of HSCP led pharmacotherapy services to support GP workload. Acute prescribing makes up a significant part of day-to-day workload in primary care services and this programme provides solutions to support rapid sustainable improvement.

The programme aims to deliver improvements that:

- enable staff involved in prescribing to work together effectively, and
- enable pharmacotherapy and practice staff to fully utilise their skills sets.

Service Delivery

The original service plan in 2018 for Pharmacotherapy was for 28wte staff completing work in Level 1 – 3. NHS Board allocated staff funded prior to PCIP were later removed early on in the plan, reducing the workforce to 21wte with further funding cuts leading to a current workforce of 18wte.

In March 2022, faced with concerns around the delivery of Levels 1, 2 and 3, a survey was sent to all GP practices to better understand which areas could make a significant difference at reducing GP workload. The results indicated that GP Practices prioritised Level 1 work. A technician led service was organized mainly focusing on supporting Level 1 prescribing, hospital discharge letters, clinic letters and repeat prescribing (increasing serial prescribing).

Core and Additional Pharmacotherapy Services		
	Pharmacists	**Pharmacy Technicians**
Level 1 (core)	Authorising/actioning all acute prescribing requests • Authorising/actioning all repeat prescribing requests • Authorising/actioning hospital Immediate Discharge Letters • Medicines reconciliation • Medicine safety reviews/recalls • Monitoring high risk medicines • Non-clinical medication review Acute and repeat prescribing requests includes/authorising/actioning: • hospital outpatient requests • non-medicine prescriptions • installment requests • serial prescriptions • Pharmaceutical queries • Medicine shortages • Review of use of 'specials' and 'off-licence' requests.	• Monitoring clinics • Medication compliance reviews (patient's own home) • Medication management advice and reviews (care homes) • Formulary adherence • Prescribing indicators and audits
Level 2 (additional advcanced)	• Medication review (more than 5 medcines) • Resolving high risk medicine problems	• Non-clinical medication review • Medicines shortages • Pharmaceutical queries

Level 3 (additional specialist)	• Polypharmacy reviews: pharmacy contribution to complex care • Specialist clinics (e.g. chronic pain, heart failure)	• Medicnes reconciliation • Telephone triage

Workforce

Based on our 2018 original plan we would have had 1wte member of pharmacy team per 5000 patients, with the reduction in funding this is now 6800 patients (which equates to 1 wte to 9200 patients in practice)

- 17.69wte pharmacy team
- Skill mix: Pharmacist / Pharmacy Technician was 0.9/1
- 0.7 wte Service Co-coordinator role

What has been achieved by March 2022?

Workload

Data collection processes (read code activity) have been developed to quantify the tasks being carried out by the pharmacy team.

We have learned that practice workload for Level 1 tasks is subject to wide variation (complexity of work assigned to team, level of experience, skill mix and different practice demographics), this is being addressed by standardisation of practice work using the Universal Prescribing Policy (UPP) agreed at the PCPG.

Data is captured electronically on a monthly basis (work completed by the team) and is dependent on the ability to run the search in practice. This process is not able to demonstrate demand and Capacity data due to work coming into the practice from an external source (IDLs and clinic letters) and others in the practice completing similar work to the team.

Service Delivery

A wide variance in the work that each practice would like the team to complete, the skill set of the team and how work is completed in practice has led to significant challenges in delivering an equitable service. The agreement to implement the UPP will standardise the processes across practices. The demand for acute prescriptions is greater than the capacity of the team resource, thus limiting work like discharge letters.

Acute Requests

Quantifying the number of acute requests managed by the team is challenging, the only way to gain this information from EMIS is to run a monthly report in each practice using the read code (8B3H) alongside each staff member's name. There are caveats in that not all prescriptions generated by the team will be acute requests (request that have been declines etc.). See table 1

below which sows the acute requests completed by the Team during these months mentioned.

Month	Jan 22	April 22
Number of Prescriptions Generated	2573	2573

The wide variance of acute requests across practices has demonstrated that there needs to be a significant quality improvement initiative to reduce that variation and standardise practice. The Pharmacy team are part of the HIS Acute Prescription Pilot that is being developed to assist in the movement of acutes to repeats in practices. Practices have been set a target to reduce the number of acute prescriptions to less than 10%.

Immediate Discharge Letters (IDL) and Out Patient Dispensing (OPD) recommendations using READ codes, we are able to quantify the number of IDLs and OPD requests processed by the pharmacy team (like the acute requests above) however, it is not possible to identify what percentage of the total number this is (demand data).

We are confident that the majority of practices have the bulk of IDLs and OPD requests with medicine related actions, processed by the team. The total number of IDLs and OPD requests actioned per month is shown in the table below.

Month	Jan 22	Feb 22	March 22	April 22	May 22
IDl/OPD Requests	569/980	580/762	529/924	545/1000	334/861

Serial Prescriptions

Managing the medicines to treat chronic disease is part of the service delivery plan and serial prescribing is key to this. Work is continuing over 2022/23 to maximize the number of repeat medications that are managed via the serial prescribing route, currently we average at 3.5% over the board.

Workforce Development

Over the past 48 months, we have been developping our service and are continually reviewing skill mix. Recognising the lack of technician workforce at a national level, we have 5 trainee pharmacy technicians in post; 2 who will qualify at the end of the year, 1 who will qualify early 2023 and 2 who will qualify spring 2024. Further trainee technicians have been funded by Scottish Government as they recognise that across all sectors of pharmacy, there is a need to increase the numbers of qualified technicians.

GP Impact

We have Pharmacy resource split equitably across all 23 practices. The practices feel strongly that once the service has embedded and the time freed up is utilised by the GPs, then it is incredibly difficult to take back that workload. The service needs to be resilient and able to flex sufficiently to manage during sickness, vacancies and maternity leave.

Community Pharmacy

The links between practice teams and community pharmacy teams are very important. Community pharmacy provides supports to general practice in a number of areas (Pharmacy First and Pharmacy First plus) as well as working alongside the team to provide Serial prescribing.

What gaps do we still have to deliver on the MOU?

Within NHS Borders the attention is focused on delivering the Level 1 tasks only and how we deliver this given the current budget constraints around staffing. This means that delivery of MoU2 is not attainable due to Level 2 and 3 not being delivered by the Pharmacy Team.

Key Risks:

Service resilience was mentioned above and this has been challenging. Even without COVID causing increased absences, maintaining service with vacancies is not possible. The PCIP Executice has asked that we provide a 50 week AL service for the Technicians only as there is not enough resource in the Pharmacist Team to allow for this – current funding does not provide absence cover. The use of the UPP in all practices will need to be explored.

Remote working from hubs is another way to improve resilience. This streamlining of staff to a central area can reduce inefficiencies in travel as well as resolve issues with space within practices. Progress with this plan has been influenced heavily by the availability of work stations and available areas to work in.

Staff training and ongoing support for staff development in line with the national direction led by NES to ensure that staff have the necessary skills and competence to carry out these new roles safely and effectively does impact on service delivery to some extent and requires negotiation with practices. Practice pharmacist specific frameworks have been developed by NES (both at foundation and advanced practice level) but the team find the workload at present does not afford them the opportunity to engage with these frameworks and future staffing models need to take this into account (staff given between 10% and 20% of their time to complete training and admin). Frustration is felt by the team that there is no time to undertake these frameworks.

Leadership As teams grow in size more time is required to lead the changes required within practices and support the less experienced staff.

Travel Time

All Pharmacy staff have the Borders General Hospital (BGH) as their work base, as such, travel time is calculated from the BGH to their actual GP workplace. Due to limited staff living in the outer perimeters of the Scottish Borders, this increases the travel time and distance for others (e.g. GP practices in the East). Due to current HR policy, travel time must be inclusive of a staff working hours. This is resulting in a significant loss of clinical time for teams. (e.g. loss of 8 hours per week for GP Practice in East). Many practices who received full days before are now receiving single sessions causing staff to travel more between practices (or remote in if this is an option) and cover more practices having a detrimental effect on their efficiency and equity.

What do we still need to enable this?

Understanding the workload challenges and practice systems has led to the realisation both locally and nationally that there needs to be a significant piece of quality improvement work embedded into practices to get them "pharmacotherapy ready" where the Level 1 tasks can be devolved to the pharmacy team. The required resource as well as skill mix to deliver a pharmacotherapy service is being modelled nationally based on experience to date from various boards.

Our original modelling of a total resource of 1 wte per 5000 patients has been shown over the past 2 years to be inadequate and this finding is supported across Scotland. A national view is awaited regarding this and whilst recognising that current funding and workforce availability is insufficient.

PCIP Vaccination

Delivered March 2022

Community PCIP Care & Treatment

PCIP Pharmacotherapy

Due by April 2023

MoU 2 Priorities

PCIP Community Mental Health

PCIP Urgent Care

PCIP Musculoskeletal

Community PCIP Links Worker Service

Additional Professional Roles

PCIP Premises

PCIP Communications

Enablers

What we set out to deliver

The Primary and Community Services (P&CS) Team within NHS Borders Health Board are responsible for delivering a robust, efficient and sustainable CTAC service which will enable people to live safely and confidently in their own homes and communities, supporting them and their families and carers to effectively manage their own conditions whenever possible. The CTAC service aims to provide person centred care through integrated models that are safe, efficient & effective – underpinned by a culture of learning, kindness and respect.

The CTAC delivery model will maximise capacity and delivery of CTAC services across NHS Borders to enable services to be run efficiently and for patients to access services in a location which is most convenient for them.

The CTAC project will also put in place the required infrastructure and workforce so that in future, an enhanced CTAC service can be offered to assist with shifting the balance of care from acute settings to the community.

NHS Borders currently operate 10 Treatment Rooms in a number of different Health Centres and Community hospitals. In 2021 a pilot of phlebotomy services in Haylodge Health centre took place. This allowed the project team to test centralised booking and consider premises and human resource issues. The learning from the pilot led to a more ambitious plan where all CTAC work would be delivered in all GP practices rather than an incremental plan. This work looked to build and improve upon the current treatment rooms in NHS Borders and to provide equity of service. With this in mind a service specification was agreed. The planned CTAC activity is summarised in the following table;

Engagement activity

Work has been undertaken to engage with GP practices and current treatment room staff about the planned changes to treatment room provision. This has involved open drop in sessions with the project team, held monthly, and one to one practice meetings.

For the internal organisational change process a workforce steering group has been establish which has staff, partnership and HR representation.

Workforce plan development

Initial estimates of a workforce model were based on limited data (from two practices) which was extrapolated for the whole service area. This gave the following staffing estimates.

CTAC Staff	In post	Additional	Total Required
Band 3 (Clinical)	**5.37**	**8.53**	**13.9**

Band 4 (Clinical)		**9.8**	**9.8**
Band 5 (Clinical)	**6.88**	**4.02**	**10.9**
Band 6 (Clinical Team Leader)	**2.3**	**0.7**	**3**
Band 7 (ASM)	**1**	**0**	**1**
Uplift	**0**	**0**	**0**
Total	**15.55**	**23.05**	**38.6**

Following the pilot a GP practices completed a survey giving detail of staffing numbers currently employed in GP practices and undertaking CTAC activity. This gave revised estimates of the personnel needed.

CTAC Staff	Current HB Establishment	GP Practice WTE CTAC	Recruitment needed	Total Requirement	Total including uplift
Band 3 (Clinical)	**5.2**	**12.91**		**18.11**	**21.73**
Band 4 (Clinical)	**0**			**0**	
Band 5 (Clinical Charge Nurse)	**9.26**	**10**		**19.26**	**23.11**
Band 6 (Clinical Senior Charge Nurse)	**2.42**		**2.58**	**5**	**6**
Bans 7 (Clinical Nursing Team Lead)	**0**		**1**	**1**	**1**
Band 7 (ASM)	**0**		**1**	**1**	**1**
Band 8a (Clinical Nursing Manager	**0**		**1**	**1**	**1**
Total					**53.84**

The project team was also engaged with the national HIS CTAC network and within this forum, other Health Boards were reporting the use of ratios when determining staffing. With reference to this

national work, a decision was made to base the staffing model on ratios. This was to ensure equity of provision across all practices. When this model was tested this gave a similar number of staff but with a greater skill mix. Skill mix was possible due to the economies of scale in managing staff across clusters rather than individual practices.

Further work to consider skill mix has reduced time of Band 6 Charge Nurse spent on non-clinical tasks by the introduction of administration to support with tasks such as scheduling, rosters, SSTS updates, sickness monitoring etc.

This gives a workforce based on 1:5000 HCSW, 1:10,000 Staff Nurse and 1:30,000 Charge Nurse. A final workforce proposal is detailed below;

CTAC Staff	Total including Headroom Adj	Current HB Establishment^	Gap (Recruitment/ TUPE)	Additional cost
Band 3 (Healthcare Support Worker)	28.56	5.2	23.36	748,804
Band 4 (Associate Practitioner)	0	0	0	0
Band 5 (Staff Nurse)	14.32	9.26	5.06	212,813
Band 6 (Charge Nurse)	4.93	2.42	2.51	130,927
Band 7 (Senior Charge Nurse)	2	0	2	126,036
Band 7 (ASM)	1	1	0	63,018
Band 8a (Clinical Nurse Manager)	1	1	1	0
Band 3 (Administrator)	1.2	0	1.2	64,110
Total	**55.93**	**17.88**	**37.5**	**1,345,708 plus 100,000 for equipment**

Due to the need to train Band 4 Associate Practitioners, there will be an incremental increase in workforce costs as described here:

CTAC Staff	Total including Headroom Adj	Additional cost from 2024/5
Band 3 (Healthcare Support Worker)	19.04	
Band 4 (Associate Practitioner)	9.52	26,731
Band 5 (Staff Nurse)	15.6	
Band 6 (Charge Nurse)	4.93	
Band 7 (Senior Charge Nurse)	2	
Band 7 (ASM)	1	
Band 8a (Clinical Nurse Manager)	1	
Band 3 (Administrator)	1.2	
Total	**55.93**	**Plus possible further equipment costs.**

Table showing planned activity in new service (column 1&2 and future possible activity column 3)

Core CTAC treatments *(as per GMS contract list)*	**Current Treatment Room Provision beyond Core CTAC** *(as currently provided in limited number of existing HB Treatment Rooms)*	**Enhanced service** *(secondary care – for further discussion/resource transfer after Core and Additional services established – likely 2023 onwards)*
Ear Care	Assisting minor surgery	Assisting for coil services
ECG	Catheterisation	Cognitive screening
INR checks (phlebotomy or near patient testing)	Continence Assessment	Diagnostic tests e.g. Short synacthen
Minor Injuries*	Complex wound Management (including leg care and Dopplers)	Eating disorder monitoring measurements
Monitoring chronic conditions (BP-including 24 hour monitoring / active stand / Weight / Height / Urinalysis / Diabetic Foot Screening)	Medicine Administration	Phlebotomy (secondary care)
Phlebotomy (primary care)	Phlebotomy (secondary care)	Post bariatric surgery measurements
Suture removal	Resus trolley and equipment maintenance	PSA monitoring
Wound Dressings	24 hour heart rate monitoring removal	Ring pessaries
	24 hour urine collection	Spirometry
	Glucose tolerance testing (? If not done by Midwives)	Visual acuity
	MRSA Screening	

Appointments per cluster

Norm times for the service were established through work undertaken by Meridian and appointments range from 10 mins to 40 mins. Clinic templates are still to be fully developed.

Key Risks:

Risk	Details	Mitigations
Finance – delivery of CTAC	CTAC recurring expenditure is set against non-recurring, insufficient budgets which is hindering project planning and potentially setting up an unsustainable service delivery model. The draft PCIP implementation tracker submitting in late November has a forecasted gap next financial year of £2.512m against the PCIF allocation this year of £3.296m.	Finance Business Partner has oversight of CTAC related budgets and requirements. We continue to submit our reported forecast gap on a regular and frequent basis

	Of this, £1.603m relates to CTAC net of £121k of recurring funding already directed. No indicative SG PCIF allocation has yet been made for 2022/23 and therefore the overall affordability of the proposal remains uncertain. Costs for equipment and supplies have been estimated at £200k over and above the £1.5m of additional staffing resource identified and are included in above net position.	(last was 29/04/22) – financial risk escalated to PCIP Executive, NHS Board and IJB. The project team will be kept informed about developments regarding funding from Scottish Government and discussions with PCIP Executive as they arise.
Finance – Non delivery of CTAC	There is no indication of financial risk of non-delivery however in 2022 an interim payment was made to GP practices due to non-delivery of CTAC and pharmacology work streams of PCIP. Further payments may be required by boards not able to deliver by new dates.	Early support for workforce model and recruitment at risk to permanent posts. Scottish government have indicated that 2nd sustainability payment will be paid by the end of the year.
Recruitment	Recruitment processes can take up to 12 weeks. Delivery of CTAC service is dependent on staffing being available to run clinics and provide treatments. Temporary posts – current experience shows that recruitment to Fixed Term Posts reduces successful recruitment in RN and HCSW posts. Some types of staff e.g. Band 4 associate practitioners may not be available due to a lack of suitably trained personnel.	Request to start recruitment campaign as soon as possible and to recruit to permanent posts. In house sponsorship of HCSW to undertake Band 4 Associate Practitioner training.
TUPE of staff, organisational change and wider staff engagement	In order for the Health Board to take on the delivery of CTAC services, a number of staff currently employed by GP Practices will need to be offered the opportunity to TUPE across to Health Board employment when the tasks they carry out are transferred. Staff will have pay and conditions protection unless consultation with individuals allows for agreement on contract variation. Also staff can only TUPE into long-term contracts so recurrent funding would need to be available for this to happen. Delays in CTAC delivery have caused practices to employ recently hired staff on short-term contracts who will not be eligible for TUPE. Practices may also be holding vacancies for these posts currently knowing that CTAC delivery has to be imminent. A recent survey and meetings with GP practices has indicated only a small amount of staff with transfer. The transfer of staff under TUPE regulations is complex and requires a significant amount of HR legal advice and consultation. In this project, it is particularly complex given	HR Manager/Business Partner and Partnership representative are supporting organisational change. Monthly engagement sessions have been set up to give all stakeholders the opportunity to raise questions with the project team. In line with the Boards Organisational Change policy, a dedicated Workforce Steering Group has been established and new job descriptions for Bands 3 , 5 and 6 have been developed and confirmed via the job evaluation process.

	there are potentially 23 different employers to engage with as part of the transfer. The TUPE of staff also poses a significant financial risk to the Health Board due to the lack of recurring funding for CTAC. Under the TUPE regulations, staff will have pay protection when moving across to being Health Board employees. Initial investigations by HR colleagues has shown some GP Practice staff are currently paid higher hourly rates than NHS employed staff doing the same role. This has the potential to put an additional financial pressure on the Health Board until such times as the Agenda for Change bands progress to meet the same rates of pay. In order to be able to transfer staff to Health Board employment, all existing staff employed within the Health Board to delivery Treatment Room services need to be moved across to standardised CTAC role descriptions. This process will involve consultation with 30 staff (bands 3 – 6), with HR and Partnership support. Staff joining the organisation will need support with induction and gaining/ evidencing skills and competencies for the role.	
Data assumptions	Data used to create the original CTAC staffing and financial planning model was based on 2019 activity and broad assumptions have been applied rather than a full analysis of demand/capacity across all GP practices. The assumptions will have an impact on the reliability of the model. A ratio approach has now been used and tested against existing workforce used to deliver CTAC tasks.	Model based on ratios has been tested against the number of staff currently delivering activity. This has confirmed the reliability of a ratio approach. National work has been referenced regarding ratios.
Project delay risk	Project timelines have slipped considerably and delivery by the new 2023 deadline is at risk. Without a clear agreement for financial funding by 16th September 2022, delivery of CTAC with timescales will not be feasible. Agreement of the workforce model and finance is imperative to achieving this deadline. Various other factors may delay project delivery including IM&T delays, dependency on other corporate functions e.g. HR, issues with premises. Failure to deliver CTAC by April 2023 will result in fines which need to be paid by NHSB / PCIF which will greatly increase the financial pressures	Key project posts and clinical lead for CTAC in place by September. PCIP Executive and the CTAC delivery Team are poised with all the preparatory work done to deliver within the given timescales of April 2023, however as of June 2023, all work has been essentially paused due to lack of PCIF funding clarity to support any further progress.

DID YOU KNOW ?

PCIP Programme has a communicationworkstream dedicated to promoting PCIP services

Platforms

- Web: lastest news; featured adverts; service webpages
- Social media: Facebook, Twitter and YouTube
- Public members
- Local and national press: print press, radio and TV

Key Activities

- Web content
- Media releases
- Public members weekly update & bi-monthly meetings
- Social media posts including content such as assets, media releases and animations
- Press interviews including preparing briefing notes, facilitating and accompanying journalists
- Meetings: Covid-19 delivery group; Covid-19 programme board; CTAC steering group; P&CS silver command

PCIP Borders
Primary Care Improvement Plan

The Renew service was established in NHS Borders in October 2020 utilising funding from PCIP and Action 15 with the aim of offering a "see and treat" model for mild to moderate anxiety and depression using evidence based psychological therapies in primary care. The aim was to reduce GP Mental Health workload as well as increase the capacity and access to psychological therapies. This report outlines the service's development, performance, current state, and development issues going forward.

Background

Historically psychological therapy and mental health services for adults in NHS Borders have been accessed via the Community Mental Health Team (CMHT) in secondary care. This has led to long waits, rejected referrals and GP's needing to support people with mild to moderate mental health difficulties.

Changes to GP contracts and the PCIP have created the opportunity to revisit this and resulted in the development of an innovative collaboration between with GP's, Mental Health, and Psychology Services to establish a centralised primary care mental health service where assessment and treatment is offered under one service.

This in itself is innovative, as traditionally models of mental health support in primary care are aimed at distress management with onward referral to other services e.g., psychology should this be needed.

Psychology Services in NHS Borders have been under resourced pre 2018 and had the smallest workforce per 100,000 for a mainland Board. Resource has been largely focused on secondary care services, but in adult mental health this resulted in very long waiting times and the inability to widen access to psychological therapies or meaningfully address these capacity issues or cater for people who needed evidence based psychological treatment for mild to moderate mental health issues, but who did not meet the criteria for secondary care services.

Through audit and discussions with GP's, it became clear that many patients were seeing GPs on a regular basis who fell into the category of mild to moderate mental health issues with the only option GP's could consider being medication or wellbeing services which did not necessarily meet the treatment need.

Following discussions with GP's it was agreed that to fill this gap and reduce the workload on GP's, that offering a "see and treat" model of psychological intervention in situ, may be a solution.

Initial Pilot

It was agreed to pilot this approach in one GP Practice. This took place between October and December 2019 where referrals for mild to moderate anxiety and depression were assessed and treatment started "under one roof" as opposed to an initial period of distress reduction and then onward referral to psychology waiting lists. This approach proved popular and reduced GP return mental health referrals considerably.

Scaling Up

It was agreed to investigate scaling up the model in 2 GP Clusters in 2020. However, this did not come to pass due to Covid as well as logistical issues. It was agreed that Psychology Services would support primary care by offering psychological first aid training and enhancing the Wellbeing service during this time.

Following the first lockdown, in July 2020, an options appraisal to reconsider scaling up the primary care mental health service for adults took place. Of the options considered, the preferred option was for a centralised service offering a range of evidence based psychological interventions delivered digitally using a combination of PCIP and Action 15 funding.

A SLA was agreed and the Renew Service started in October 2020 with a much reduced staff complement while recruitment continued for CAAPs (Clinical Associates in Applied Psychology), Mental Health Practitioners and Assistant Psychologists. The service was at full staffing complement by April 2021.

Interventions offered include computerised CBT, internet enabled CBT (IESO), anxiety and low mood courses, guided self-help (121) and one to one psychological therapy. It was agreed that a comprehensive assessment would be undertaken a quickly as possible so that people could be directed to /choose the best treatment for them.

As mentioned earlier, the service was offered without a physical base, with all practitioners (except the admin team) operating from home using Near Me and telephone to offer interventions.

Summary and Recommendations

In general, given its origins and the conditions it has operated under Renew has been a successful service. It is still relatively new and from a clinical perspective there is work to be done to ensure the model, flow and treatment options fit the demand. The centralised model has worked well, especially with courses as previously there had been resistance to face to face courses or groups due to the rural nature of the Borders and people knowing each other – with the centralised model this ensures a wider group and mix of people attending the groups. Given the Scottish

Government's investment in primary care services, it is important to review and take learning from the Renew experience to help us in this wider development and ensure that we build on our successes, while continuing to allow Renew to develop and mature. The following recommendations are proposed: - Review Renew KPI's to ensure they are deliverable (especially KPI 4) - Review SLA in the light of future primary care developments. Future service developments should not negatively impact on the delivery of psychological therapies and pathways. - Continue to monitor flow and reduce treatment backlogs and ensure model, flow and treatments fit demand - Consider how to meet gaps that have come to light between Renew and the CMHT e.g., trauma treatment - Enhance the digital therapeutic offering (e.g. cCBT) by establishing a digital team - Establish a more permanent administrative base, and scope out clinical options for Near Me Hubs - Establish a website that will provide referrers and those referred with service details and links - Review the pathway for GSH via Wellbeing - Review and improve the pathway for ongoing referrals to other psychology services - Collaborate closely with proposed primary care developments to ensure that pathways are improved and developments work seamlessly.

Workforce and footprint:

First contact Physiotherapy services were implemented in the Borders in 2019 with only 2.2 WTE B7 Physiotherapists.

The service has grown to 100% of budget allocation with a staff compliment of 9.2 WTE FCP's in service from February 2022, working at a 1:20 000 population ratio.

8.7 WTE Clinically and 0.5 WTE Management. FCP services are delivered in 100% of the 23 GP practices in the Borders in a hybrid model.

- Vision:
  - First contact Physiotherapy (FCP) in the Borders will provide a trusted and direct triage service, in the GP practice, for patients presenting with musculoskeletal pathologies.
- Mission:
  - To be the Gold standard of FCP in Scotland. To inspire hope and contribute to health and well-being by providing the best first contact MSK care to every patient through integrated clinical practice, education and research.
- Slogan:
  - "Together we are the difference"

Priorities of FCP in PCIP:

1. Multidisciplinary teams:

The team is well integrated in all 23 of the 23 GP practices within the Borders. The FCP work-stream changed the delivery model in a staggered approach form 1 January 2022 to 1 July 2022 to move away from a silo working model imbedded in the GP practices to a hybrid- central diary system, in order to answer to the GMS MOU key priorities of:

- Safe
- Person centred
- Equitable
- Accessible
- Outcome focused
- Effective
- Sustainable

- Affordable
- Value for money

2. Pathways:

The team has been working continuously on developing various pathways across the MDT for better patient care, early access and “right time-right care-right practitioner”.

FCP pathways established is with

- MSK teams
- Orthopaedics
- Community link workers incl. Mental health
- OT/Speech and Language therapist
- Podiatry
- Third party vendors e.g. Live Borders

3. Expert Generalist role

FCP continuously work towards our four pillars of practice to enhance our skill, clinical outcomes for patients and our leadership within the developing roles and delivery of care in PCIP and the Physiotherapy profession.

4. Enablers:
    1. Workforce: 8.7 Clinical WTE delivering FCP services in 23 GP practices to a 1:20 000 ratio.
        i. GP requirement is currently 223.57 hours per week (11178.5 pa – 50 weeks)
        ii. 8.7 WTE FCP = 326.25 FCP hours per week
            1. (70% clinical time /30% time to work towards our professional four pillars of practice.
            2. 228.375 clinical hours -11 418.75 pa over 50 weeks
        iii. Capacity is created by virtual triage across the Borders to absorb leave/ long term illness, but still lack enough resources to deliver on a full 50 week cover.
    2. Education and training:
        i. 91.6% (11 /12) FCP are cortisone injection therapy trained, the last FCP will undergo training end of 2022

ii. 110% (12) FCP staff members are IRMER trained and refer for special investigations including MRI scans
iii. 0% of the FCP are Non-medical prescribers as the current need is low.

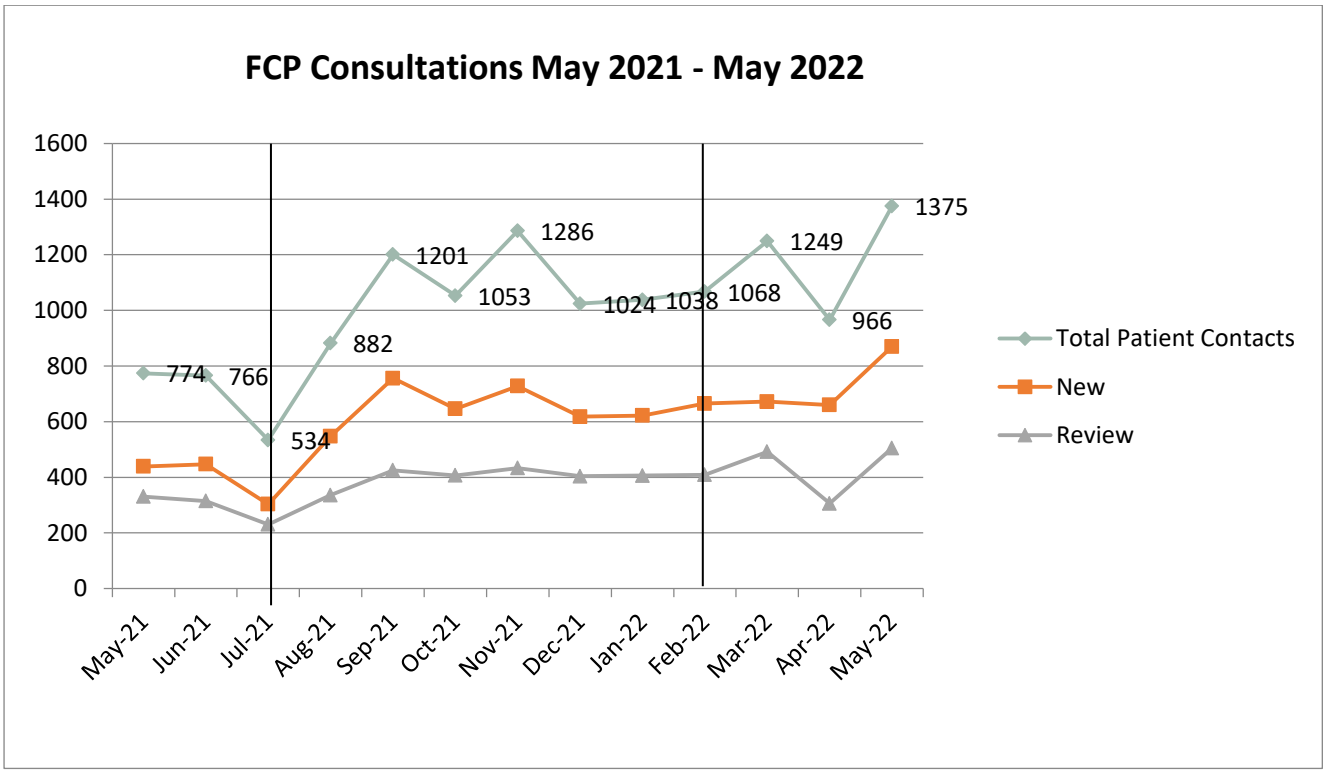
3. The APP lead represents The Borders at the National APP Primary Care Network.

5. Premises:
    1. Hybrid delivery model for FCP in Borders to help with accommodation in certain practices where space is a limitation
    2. Blended working format between Face-Face / Telephone triage and Near Me consultations.

6. Digital:
    a. Developing systems that facilitate seamless working of extended Board-employed Multidisciplinary teams linked to the GP Practice is fundamental.

What did we deliver?

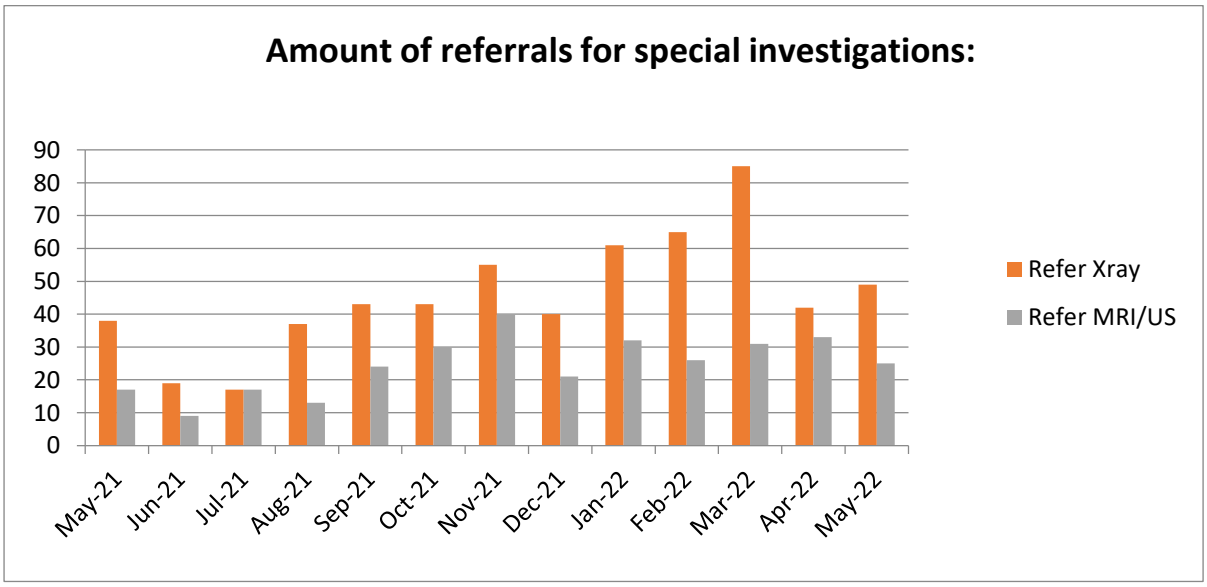
1) Impact on GP workload:



3.8 WTE FCP until July 2021, increased to 5.5 WTE in July 2021. Returning members of staff from maternity leave and new recruitment increased workforce to 7.8 WTE in September 2021 and reaching 100% capacity by February 2022 with 8.7 WTE clinical FCP.

- 1016.52 average consultations per month with a 50% average of self-management and no further referral/intervention required.
- 13216 total consultations for the year
- 0.9% patients referred back to GP practice for medication or fit note prescription.

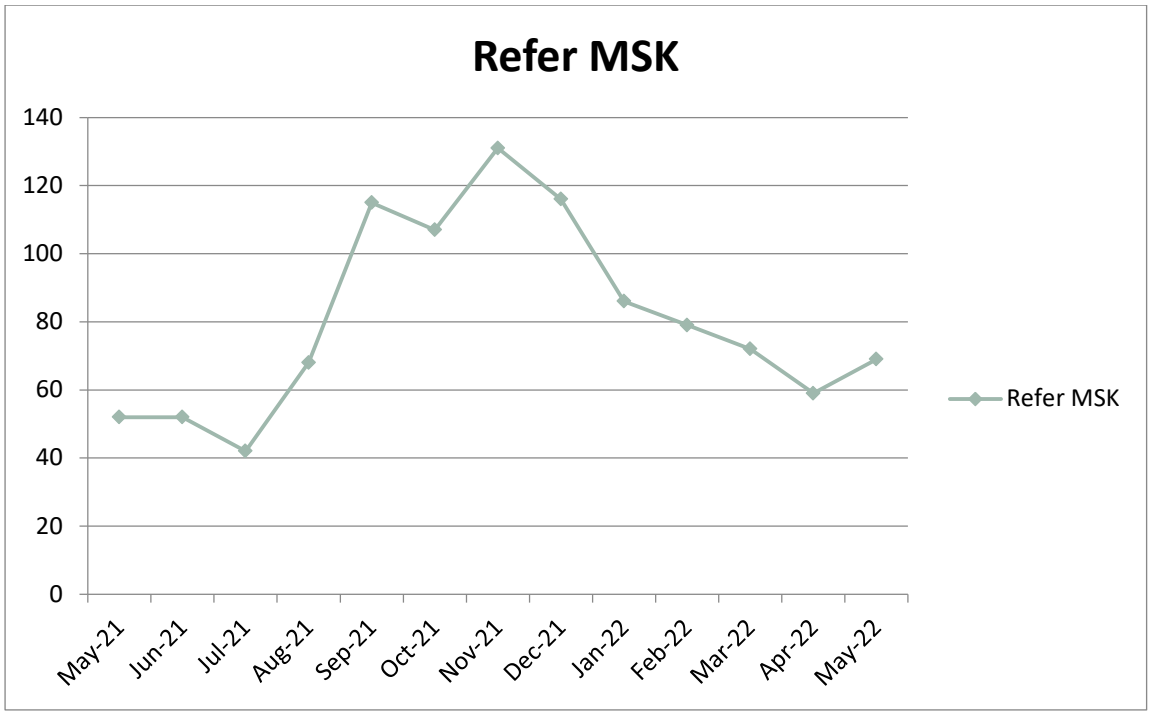
2) X-ray and MRI referrals:
    - 3.7% average referral rate for x-ray views
    - 2.1% average referral rate for MRI views



3). Wider system benefits:

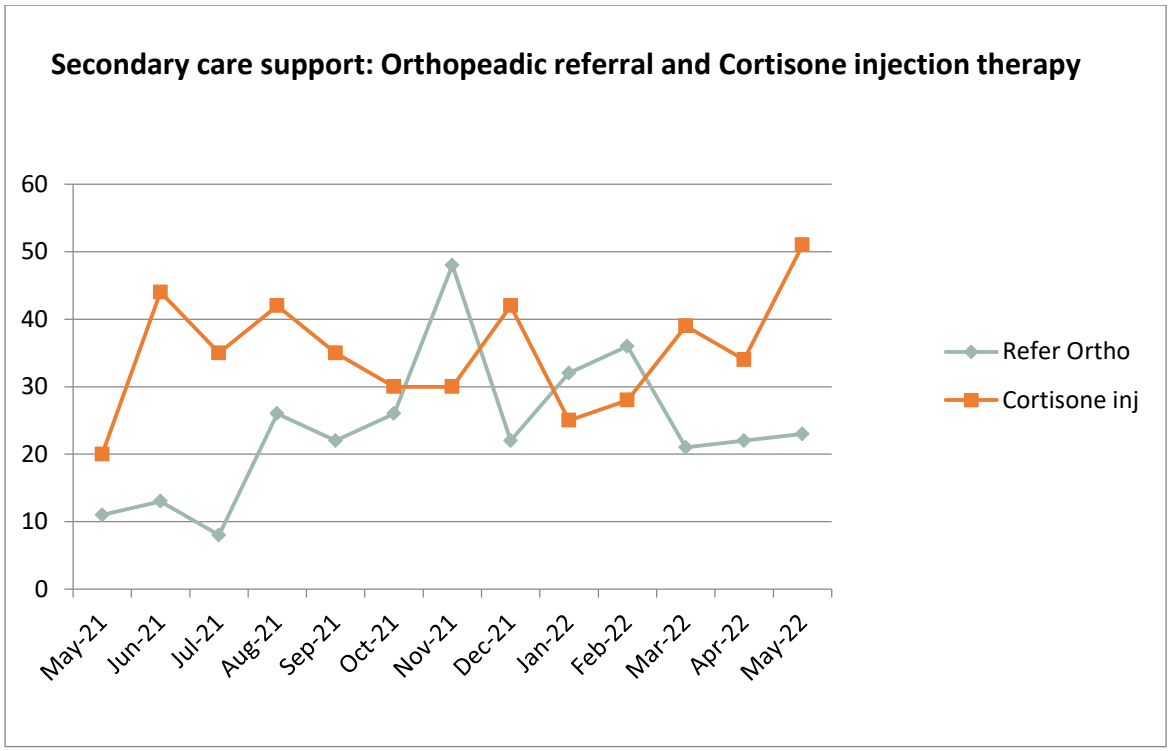
MSK activity:

- 8% average MSK (Musculoskeletal Physiotherapy department) referral rate.



Orthopaedic activity:

- Cortisone injection therapy in primary care setting:
    - Average of 3.7% of FCP activity is administering Cortisone injection therapy
    - 455 CSI injections administered for the year
- Orthopaedic referral rate:
    - 5.6% referrals to orthopaedic secondary services.
        - Clinical pathway development was done with focus on the patient journey,
        - Education and in service training to clinically up-skill FCPs on diagnosis and referral patterns.



4). IT and technological considerations:

- Use Emis Web for more virtual cross cover- by combining all FCP diaries.
- 4- 13 hours per week virtual FCP consultation hours to address the need for cross cover.
- Creation of a platform for automated service audits and activity data.
- Creation of 1WTE administrative post for service delivery and support.
- Improved Quality of care and peer review auditing to support, mentor and educate the FCP team.

Gaps in the delivery of FCP services?

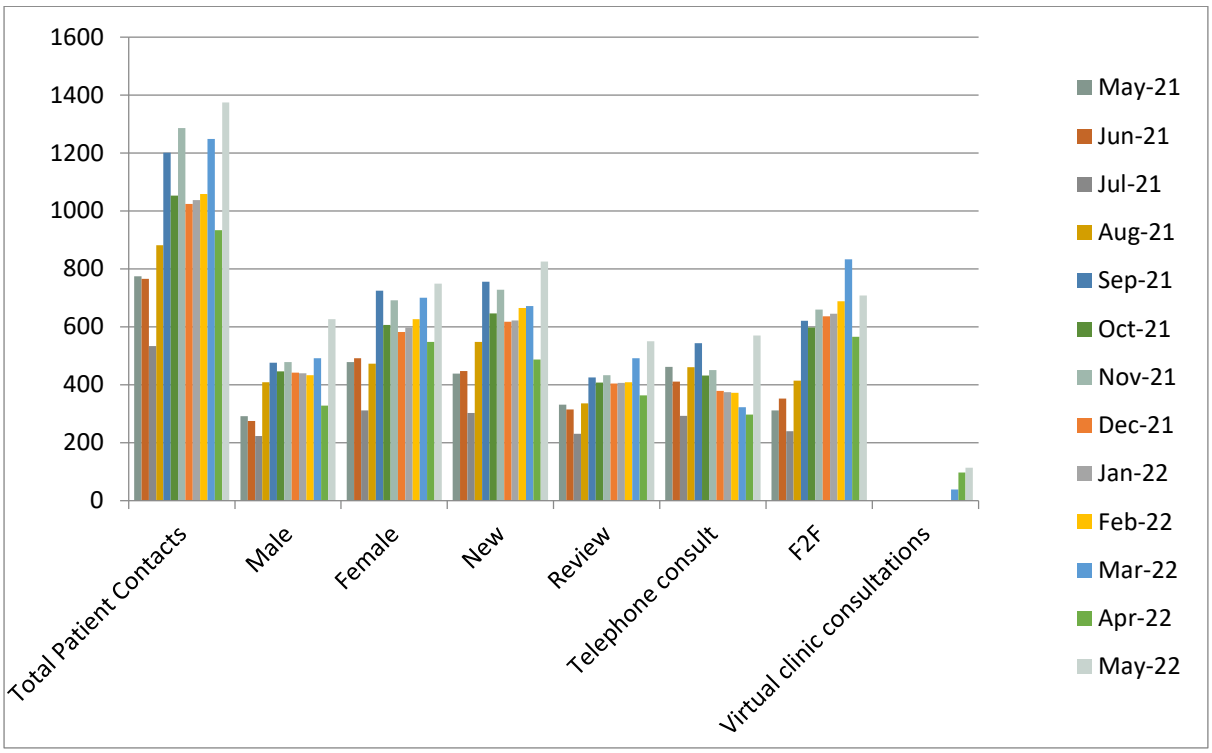
1) HR: To be in line with National service delivery of 1:12 000 population ratio over a 50 week service the Borders are in need of 372.61 additional FCP hours per week.

- FCPs to increase with 14 WTE to successfully answer to the demand.
- 2 x 0.5 WTE B3 administrative support currently employed – gaps remain:
  - Single point of contact -to ease patient queries
  - Automated booking messaging system for appointments and reminders

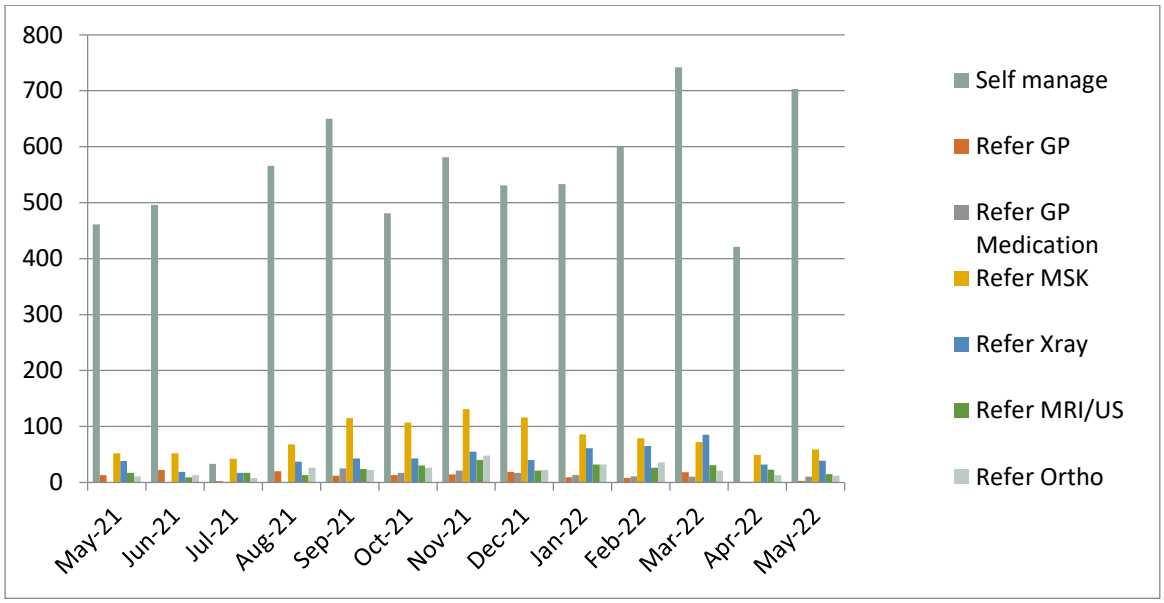
2) IT systems:

a. The current IT provisioning in the Borders does not communicate successfully with IT used in GP practices. To be able to render a virtual model FCPs are using one IT system that is removed from the GP IT system and duplication of clinical notes exist.
b. Delayed times in reports for investigations due to the different IT systems and FCP need to employ a third system to search for reports.

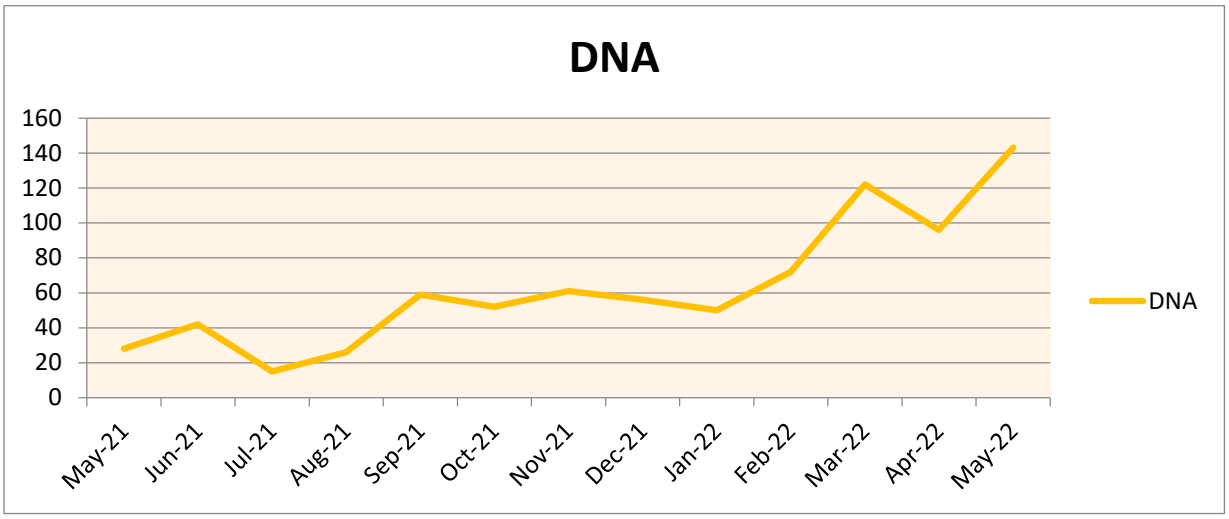
How do we deliver a virtual hybrid model?



Cost saving of FCP:



Risk of the new hybrid system and central booking model:



The lack of a central office with central telephone line limits patients being able to contact the service and cancel or change their appointments, each GP practice has to email patient correspondence to the central hub and communications may be delayed and a rise in "Did Not Attend" (DNA) (3.4 % 2021 to 9.7% in 2022) with each practice moving over to the hub system has been noticed.

To address DNAs, we are currently exploring setting up a central PCIP Booking Hub enabled by IT solutions for VTP, FCP and ultimately CTAC.

"Together we are the difference!"

What we set out to deliver

''By 2021, in collaboration with NHS Boards there will be a sustainable advance practitioner provision in all HSCP areas, based on appropriate local service design. These practitioners will be available to assess and treat urgent or unscheduled care presentations and home visits within an agreed local model or system of care''. MOU 2018

As there was a shortage of trained ANPs nationally and within the rural Borders demographic, NHS Borders undertook to recruit a cohort of untrained ANPs and the initial focus of the Scottish Borders Primary Care Improvement Plan 2018-2021was the development and establishment of an Advanced Nurse Practitioner model.

Prior to PCIP roll out there was no workforce supply of trained primary care ANPs and in 2019 a successful pilot of five trainees Advanced Nurse Practitioners (ANP) was carried out across South and West GP Clusters. Currently there are now 12 ANP/trainee ANPs in post within all four clusters of NHS Borders and a further three have been successfully recruited and are due to commence in post by Aug 2022.

The ANP service is highly valued and supports the PCIP to meet the urgent care pathway to provide a service to GP practices for `urgent care`, delivering on the day presentations: face to face consultations, telephone consultations and home visits. This releasing the GP to take on a more holistic view of patient care and clinical expert role, and improving patient access to care and treatment. The ANP are autonomous practitioners and manage the comprehensive clinical care of their patients, including prescribing and onward referral. Independent prescribing is an integral component of advanced practice which allows easier and quicker access to medications for patients and increases patient choice in accessing medication, and there is a growing body of evidence to support the positive impact of independent prescribing by ANPs.

What has been delivered by Aug 2022?

- 10 Trainee ANPs in post and 1 now fully qualified.
- 1 Lead ANP in post – 50% clinical as ANP, 50% non-clinical as Lead.
- 7 are qualified independent prescribers and the remaining 5 will qualify in Aug 2022.
- All 12 have completed their IRMER Training and can forward refer for radiology investigations. A local radiology referral protocol and training has now been developed.
- Currently there is scope for over 800 practice based appointments per week (capacity varies depending on type of consultation and qualification level of TANP– appointment times vary from 10minutes (telephone consultation) to 30 minutes (home visit).
- Ongoing training of ANPs and successful local education programme in place.
- The ANPs provide specific high quality and comprehensive assessments and interventions to those with acute presentations and illnesses.
- ANPS are the first point of contact for patients. Patients do not require to be seen by a GP first.
- Legislative changes in July now allow ANPs to issue `fit notes` - training is underway to support the delivery of this.

Service User Experience

Patients have embraced the role of advanced practitioners in primary care and they have reported high levels of satisfaction with the care they receive. They have commented on their surprise at the autonomous ability of advanced practitioners to include assessment, diagnosis and treatment. Many patients request to see the ANP again. This allows for continuity of care.

Positive feedback on the referral of patients to secondary care has also been received.

Challenges and Key Risks:

There is a national shortage of primary care ANPs and recruitment of qualified advanced practitioners has been extremely challenging, particularly due to the rural geographical area of the Borders. This has also required a local training pathway to be developed for trainee ANP and significant support, clinical supervision time and educational input from GPs, acute medical/surgical colleagues and lead ANP, work that was not initially anticipated. We need to continue to train further ANP to address the national and local shortage.

What gaps do we still have to deliver?

- Covid-19 and a national shortage of primary care ANPs have challenged the recruitment process of staff resulting in the ANP resource not being rolled out fully to all GP clusters yet.
- Rural posts have been particularly difficult to recruit to, exacerbated by increasingly rising fuel costs.
- Advanced practitioners are currently unable to request some diagnostic imaging.
- Further data collection required on patient activity/service delivery.
- Continue working with local radiological leads to update the primary care ANP radiology referral criteria. The goal is to promote and broaden access rights to enable ANPs to request those diagnostic tests which are essential to improve patient care by reducing any potential delays in diagnosis.

The Community Link Worker (CLW) Service in Scottish Borders was set-up in March 2020.

The CLW posts & delivery of the CLW service sits within the Borders Local Area Co-ordination (LAC) Team as part of the Scottish Borders Health & Social Care Partnership. The LAC team is a well-established team operating with a locality focus across the entire Scottish Borders providing a service to adults who are isolated in their community due to impact of learning disability, mental ill-health, physical disability or older age.

This meant the lead times for becoming operational delivery of the CLW service were vastly reduced with the CLW service being available to all GP practices in Borders since inception in March 2020. Similarly, we were able to build on the established local knowledge and connections that the team already had.

The vast majority of the time the CLW programme has been operational has been during the pandemic. The team adapted and navigated the associated restrictions on service & communities delivering online provision via phone and Near Me/MS Teams. We were open to and responded to referrals throughout.

Staffing/financial commitment from PCIP:
PCIP fund - 2 FTE Local Area Co-ordinators (SBC Grade 8) & 2.5 FTE Community Link Workers (SBC Grade 5).

Financial commitment from PCIP (includes £4,000 per annual for staff travel)
2020/2021 - £150,439*
2021/2022 - £155,401**
2022/2023 - £158,349***
*Full year costs plus 3% pay increase
** Full year costs plus 2% pay increase & incremental uplift
*** Full year costs plus 2% pay increase

LAC Mental Health service contributes to 4.72 FTE plus admin support and operational management via existing management structure

Community Link Workers undertake the majority of the direct contact with clients. LAC's will also have direct contact/input with individuals & carry a caseload however there is also a community development/community capacity building element in the LAC role. This is a key element in working

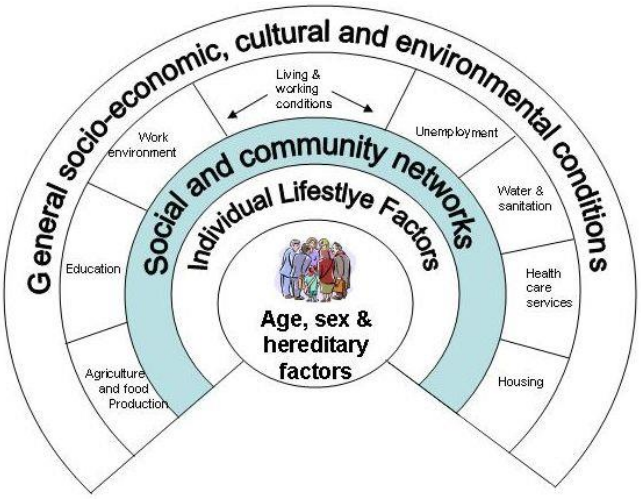
with community partners, third sector etc. to develop inclusive communities & in addressing gaps/unmet need in communities.

The approach

"We need to stop pulling people of out the river and go further upstream to see why they are falling in"

- Desmond Tutu

- Asset-based - focuses on harnessing the willingness and resources within the individual, family and community.
- Emphasis on developing capacity rather than the need for services (individual & community level).
- Focus is local communities, universal services and individual & community assets.
- Fundamental focus on community as sources of mutual support & creative solutions
- Addresses the broader determinants of health and seeks to tackle health inequalities.
- Work with individuals to promote recovery, self-management and personal resilience.
- Focus on facilitating supportive social connections/networks and natural supports as well as utilising social capital.
- Empowering individuals to exercise their rights as citizens of their local community.



Social prescribing recognises that people's health is determined primarily by a range of social, economic and environmental factors, and seeks to address people's needs in a holistic way. It also aims to support individuals to take greater control of their own health.

So how does it actually work in practice?

We will work with you to help you to:

- Think about what matters to you
- Increase your social connections

- Make links to community opportunities and services that may be of interest and beneficial to you.
- Identify opportunities to use your skills in the community.
- Build confidence and resilience to manage your health condition
- Improve your physical and mental health.
- Become a more active member of your local community.
- Recognise role of informal carers in persons' life. Signpost carers to sources of support.

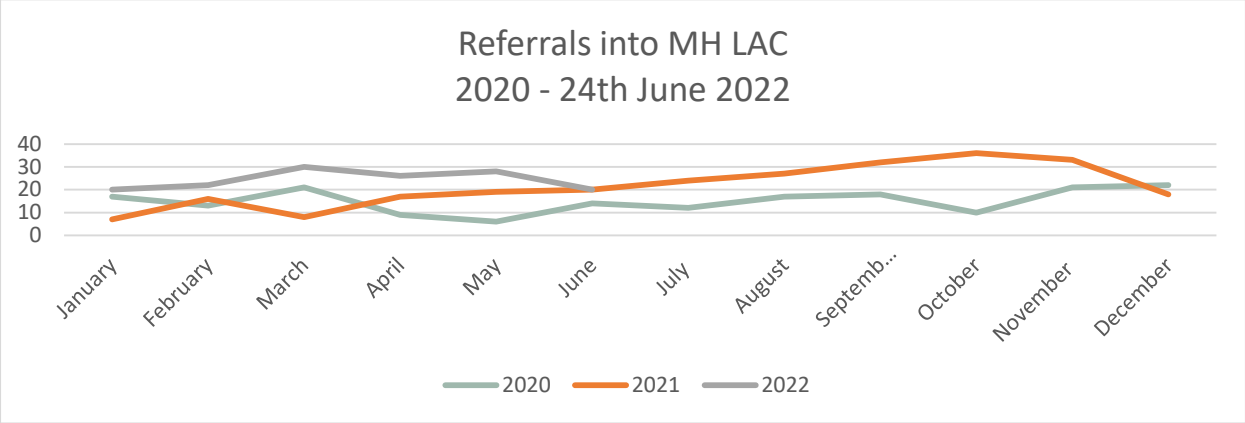
Our role in working with local communities:

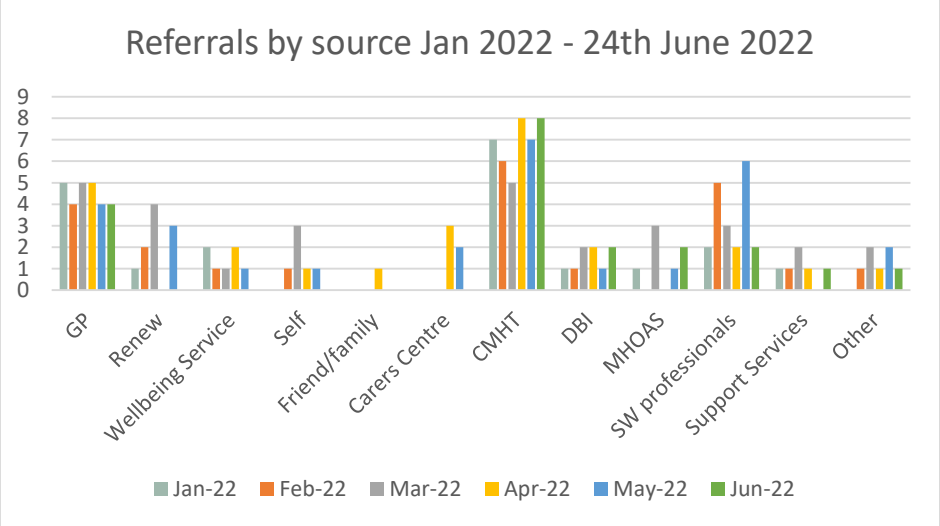
- Challenging stigma & discrimination.
- Enabling people to live as independently as possible in their own community.
- Raising awareness of what supports good mental health
- Working together to support the involvement of people.

How we do it:

- Build strong partnerships with a range of organisations and groups across the local communities.
- Create new opportunities with partners if none currently exist.

What have we delivered?





Referrals are received from a wide range of sources. We also actively support & promote self-referrals/supported self-referrals.

We have a single referral route and point of access across the service, fundamental to making the service as accessible as possible. There is strong collaborative working across the team, for example many referrals for older adults and adults with a physical disability are passed to CLW programme as referral has been made for support to address low mood.

Established collaborative working with Wellbeing Service & 'Renew' as partners also operating in Primary Care resulting improved patient journey in getting the right input at the right time as well as information sharing on community resources etc.

Currently exploring use of the social prescribing STRATA application. Benefits would include safe and secure referrals into the service to reduce data security issues with current referral process for GPs.

Individual outcomes measures – new workflow in team recording system to report on impact of the service direct from individuals.

Continued engagement with locality model (strategic & operational level) and associated work-streams (Pathway Zero, What Matters Hubs etc.)

Linked with national CLW network.

What gaps do we still need to deliver?

Impact of the pandemic was significant in terms of severely restricting plans to promote the CLW service. Consequently recognition of need to increase referral into the service direct from GPs/practitioners working within GP practices. Test of change currently being undertaken with a number of practices to increase awareness of the service and crucially referrals into the service this includes making the service accessible examples of work includes asking for patient details and contact to be passed to the service for proactive contact to me made. We are working around challenges practices have raised which include availability of accommodation and IT issues but some of the challenges that some GP practices are dealing with has impacted on the progress of the test of change.

Below info on referrals directly via GP's

2020 - 30 referrals from GPs directly into CLW (from 11 practices).
Plus 8 referrals into other parts of the LAC service (older adults, adults with a physical disability and adults with a learning disability)
2021 - 24 referrals from GPs directly into CLW (from 11 practices).
Plus 15 referrals into other parts of the LAC service (older adults, adults with a physical disability and adults with a learning disability)

What do we need to enable us to do this?

Continuing the conversations and ongoing learning to respond to areas being raised through the test of change to improve closer working with GPs and ultimately increase use of the service. For GP colleagues as key stakeholders to see the benefits of the service.

Continued recognition that we are still addressing the impact of the pandemic on the delivery of the CLW programme in terms of the restrictions on promoting the service, limited access to GP practices to deliver presentations/share information etc. for a prolonged period.

Next Steps

The restriction of the model for CSLW and LAC which is focussed on community engagement will not deliver the service that GPs expect or desire. We know that this model works much more broadly in other areas as such, PCIP Executives are currently reviewing how this work stream can be delivered to meet the expectations of GPs to provide value for money and workload shift for PCIP spend.

Case Study

Cuppa and Catch up

Cheviot have held an online weekly 'Cuppa and Catch Up' group for some time via Teams – clients come along with a cuppa and have a chat/laugh. As the weeks progressed, the group appeared to be connecting well with one another and Government guidance then allowed for increased numbers from different households to meet.

The LAC suggested we meet in person for a walk – the idea went down well and clients met up in Kelso for a walk along the riverside. As Government guidance relaxed further to allow shops/services etc to open, this has since progressed to a walk followed by a cuppa in a local café.

Friendships have developed within this group and – for some – it is the first time they have felt able to interact and feel relaxed in a small group situation for many years.

"After that bad group experience I had over 30 years ago I never imagined I'd be able to feel comfortable with more than one or two people at any one time. It's really helping my confidence and I feel I might be able to go on to do other similar things"

Accomodation constraints have been a central theme regarding implementation of the PCIP work streams. When NHS Borders published the first PCIP plan in 2018, a number of changes were outlines in which primary care services will be delivered. In particular, it identified new workforce roles that would require accomodation in primary care premises in future.

Buchan + Associates were commissioned by Hub South East on behalf of NHS Borders to conduct a review of primary care services and premises – taking account of the implementation of PCIP and new housing developments with the objective of identifying investment priorities within primary care premises.

The approach undertaken included the following key stages:

- **Data Gathering** – national, local, Board level and practice level information
- **Establishing Trends** – demographic, housing, impact of new models of care within PCIP, increased use of Information Technology and smarter working; best practice examples.
- **Future Capacity Planning** – identification of the capacity required by practice and highlighting potential solutions
- **Prioritised Investments** – identifying the investments both short-term minor modifications and long term investment required

The review was published in October 2021 and outlined significant immediate pressures faced by the majority of practices when seeking to find space for the new workforce within primary care.

Key Challenges:

Investment and dedicated resources are now required to commence implementation of the recommendations identified in the Buchan report.

Funding allocation for PCIP Premises is described under the Finance section of this document.

PRIMARY CARE IMPROVEMENT FUND OVERVIEW

Current Position

Each month, a PCIP budget monitoring report is made to the PCIP Executive. This report outlines:

- Latest known information with regard to expected / actual PCIF allocation;
- Conditions over its use;
- How the recurring PCIF allocation has been directed / allocated across PCIP workstreams by PCIP Executive;
- Expenditure against the workstream budgets created in support of this direction;
- Forecast expenditure by workstream to 31 March;
- How non-recurring slippage / allocation are expected to be utilised during the financial year;
- Proposed revisions to the PCIP and their financial impact; and
- Risks to delivery and overall affordability.

Currently, the actual and forecast position regarding the recurring PCIF allocation and its directed use is summarised in Table 1 below:

Table 1a: Latest PCIP Recurring Forecast v Budget

	PCIP 3-Year Recurring Investment £'000	Actual Expenditure to 31 May 2022 £'000	Forecast Expenditure to 31 March 2023 £'000	Surplus / Slippage / (Deficit) at 31 March 2023 £'000
VTP	16	0	16	0
Pharmacotherapy	879	158	971	(92)
CTAC	121	0	45	76
Urgent Care	883	125	823	60
FCP	528	95	575	(47)
Mental Health	669	109	636	33
Community Link Workers	150	25	150	0
Central Costs	49	7	40	9
Total Expenditure	**3,296**	**518**	**3,257**	**39**
Funded by:				
2.13% of £155m	(3,296)			
Drawn Down Share			(3,257)	(39)
Total Funding Requirement	**(3,296)**		**(3,257)**	**(39)**

No confirmation of the level of PCIF allocation for 2022/23 has yet been received from the Scottish Government. For the purposes of monitoring however, the level of PCIF allocation this year has been assumed to be £3.296m, the same as 2021/22, representing the Scottish Borders NRAC share of a national resource envelope which has grown to £155m over the last 3 years.

Informal national intelligence suggests that the national funding pot may increase to £170m which if true, will proportionately increase the Scottish Borders' share by a further £0.300m. Formal confirmation of this has yet to be made however and in essence, even if correct, will only fund expected cost pressures arising from pay inflation and incremental drift across PCIP workstream pay budgets.

Whilst the forecast position reports a small level of underspend / slippage currently of £0.126m, there are a number of key points to note:

- Most significantly, PCIP Executive can and has only directed resources which are available via expected PCIF allocation. On that basis, the full £3.296m share of the 2021/22 national envelope has been directed. Notably however, this has meant that only £0.016m and £0.121m has been available for direction to Vaccine Transformation Programme (VTP) and Community Treatment and Care Services (CTAC) respectively. This leaves a significant funding shortfall in the region of £2.372m directly against these workstreams combined, based on the current workforce models being developed;
- There are forecast variances across a number of workstreams. Where forecast underspends prevail (e.g. Urgent Care) these are largely attributable to forecast slippage in recruitment to all posts within the workstream workforce model. Where cost pressures are forecast (e.g. Pharmacotherapy), these are attributable to the workforce model being largely fully established and the impact of pay inflation and incremental drift over the years since their establishment (due to the status of PCIF allocation being 'earmarked recurring' only, the level of PCIF is not indexed by the Scottish Government currently and therefore increases in pay cost are not funded via increased allocation accordingly).

In addition to the recurring allocation in Table 1a above, PCIP Executive also has authority and oversight over historic PCIF allocations that have not been utilised before now and which have been carried forward via the Health and Social Care Partnership IJB's earmarked general reserve. At the end of 2021/22, this amounted to £1.523m which is available to be used non-recurrently. The majority of this has been directed also by PCIF Executive in the following table:

Table 1b: Non-Recurring Funding Available 2022/23

	Resource Directed £
ANP Training	82
CTCS Programme Management	54
CTCS Admin Support	15
CTCS General Allocation	545
PCIP Project Management	72
PCIP Comms / Engagement	25
VTP	200
System Acquisition & Installation	276
Provision for 22/23 pay inflation and drift	254
Total Commitments	**1,523**

With the exception of £0.254m, all non-recurring resource has been fully directed. Expenditure to date this financial year against non-recurring funding this has been minimal (£0.012m).

3-Year PCIP Forecast Expenditure by Workstream

Actual and Forecast costs of the Scottish Borders PCIP, based on current / proposed delivery models for the period 2021/22 to 2023/24 are detailed in Table 2 below:

Table 2: PCIP Expenditure by Workstream

	PCIP Expenditure by Workstream		
	Actual 2021/22 £'000	Forecast 2022/23 £'000	Forecast 2023/24 £'000
Vaccination Transformation Programme	0	751	761
Pharmacotherapy	1,007	985	1,003
Community Treatment and Care Services	47	1,758	1,785
Urgent Care	722	962	1,039
First Contact Practitioners	440	509	518
Mental Health Renew	650	752	767
Community Link Work / Local Area Co-ordination	114	158	160
Central Costs	12	12	12
Total	**2,992**	**5,888**	**6,045**

The forecast position in each of 2022/23 and 2023/24 include assumed pay inflation of 2% per annum which may change / increase when agreed. Further incremental drift will also be a factor although the impact of this is not known at the current time.

The differences between Table 2 and Table 1a relate to the Table 2 reporting the full-year cost of each workstream's delivery model being fully established. As reported above, the total current cost of VTP and CTAC, based on current proposals, is included as is the impact of pay inflation and incremental drift in the current year. Work is ongoing to further develop and refine the delivery models of these workstreams and going forward, forecast cost will undoubtedly change accordingly.

Whilst 2022/23 is likely to be lower in reality due to ongoing slippage, it provides an indication of what the likely cost implications are for PCIP on a recurring basis and the overall resource envelope required in order to ensure that the currently proposed delivery model is affordable.

Available Resources

Against this forecast level of required expenditure, the current and expected PCIF funding allocations for 2021/22 and 2022/23 are detailed in Table 3 below:

Table 3: Current Funding Envelope

	PCIP Identified Funding	
	Actual 2021/22 £'000	Forecast from 2022/23 £'000
Primary Care Improvement Funding Allocation	3,296	3,621
Total	**3,296**	**3,621**

In addition to PCIF funding, there is also a contribution of 2.7 WTE Action 15-funded CAAP posts within MH RENEW and NHS Borders baselined-funded School Immunisation posts that will form part of Vaccine Transformation Programme.

Should the national PCIF resource envelope increase from £155m to £170m in line with anecdotal intelligence, this will result in an increased PCIF allocation of around £3.621m to the Scottish Borders Partnership. This is significantly and critically well short of the c. £6m of recurring investment that the current proposed workstream model of PCIP requires to be affordable and sustainable going forward.

Options for bridging the gap therefore require to be identified. These are explored in more detail in section 5 below.

Current Workforce Model

A summary of the current workforce model funded by PCIF is detailed below in Table 4:

Table 4: PCIP Workforce

	PCIP WTE by Workstream			
	March 2021/22	Current 2022/23	Per PCIP 2023/24	
Vaccination Transformation Programme	-	-	-	*
Pharmacotherapy	21.00	21.12	21.00	
Community Treatment and Care Services	1.03	2.11	1.03	*^
Urgent Care	16.00	12.87	16.00	
First Contact Practitioners	10.20	10.79	10.20	
Mental Health Renew	14.30	14.24	14.30	
Community Link Work / Local Area Co-ordination	4.50	4.50	4.50	
Central Costs	-	1.00	-	
Total	**67.03**	**66.63**	**67.03**	

**** still in development***
^ programme management & support

Bridging the Gap

To be financially sustainable going forward, the affordability gap between forecast expenditure and current / forecast PCIP resource envelope must be significantly reduced. In summary, there are two main ways that this can happen:

1. Reduce the level of expenditure required by the current plan through improved cost-effectiveness, rationalisation or cessation of services currently in place or proposed;
2. Seek to increase the level of resources available to support the delivery of the Primary Care Improvement Plan.

In all likelihood, both approaches are required and Figure 1 below outlines some of the suggested ways that this might happen:

Figure 1: Required Affordability Objectives and Approach

Primary Care Improvement Plan	
Expenditure	**Resource Envelope**
Options to Reduce	Options to Increase
Efficiency Review of Models of Delivery Identify Alternative Models of Delivery Review Model v MOU2 Review / Challenge MOU2 Rationalise or Cease Workstreams	Seek Increased PCIF Allocation Direct Other Allocations to PCIP Partner Cost Pressures Targeted Re-Investment of Planned Efficiencies

In addition, albeit non-recurrently, the non-recurring PCIF balance brought forward summarised in Table 1b above can also support the affordability gap in 2022/23 although with other commitments already having been made against a proportion of this funding, its impact is insufficient even temporarily.

Options to Reduce Funding Requirement

Given the current forecast recurring affordability gap, the Partnership must consider ways in which the projected forecast cost of delivering the PCIP can be mitigated. Potential options are detailed below:

Efficiency Reviews*	Each workstream's model of delivery has should be reviewed with a view to ensuring that the optimally economic model is in place to deliver required outcomes at the lowest possible cost.
Alternative Models*	Alternative, less expensive models of delivery should be considered. It may be possible to deliver required outcomes more cost effectively.
Review against MOU2*	The Memorandum of Understand should be reviewed and current targeted outcomes evaluated against it. Only specifically required outcomes should be targeted and delivery models reviewed and where required, rationalised accordingly.

Challenge MOU2**	There should be ongoing dialogue with the Scottish Government as to whether previously directed PCIF resource can be moved from lower priority workstreams towards higher priority workstreams in order to reduce overall resource requirement.
Rationalisation / Cessation*	Given the ongoing affordability gap, there should be an assessment of whether some workstreams now in place can be rationalised or even ceased. This will also require engagement with the Scottish Government.

PCIP Executive additional comments regarding listed options above:

*** PCIP Executives believe PCIF spend to date delivers exceptional value for money. As an added layer of scrutiny, both the Health and Social Care Partnership Chief Nurse and Director of Nursing, Midwifery and Allied Health Professionals have reviewed and validated workforce models. As such, we do not believe that further skill mix can deliver against the specification for services.**

**** Current PCIF national resource envelope and allocation to Scottish Borders HSCP is insufficient to deliver all provision within MoU2 (by default the GMS 2018 contract). It is important to note that the MoU2 also states that Health Boards should not defund established workstreams to address shortfalls for the three priority services.**

Options to Increase Resource Envelope

Similarly, options for increasing the level of resource available to fund PCIP require identification and consideration. These include:

Increased Allocation	Scottish Government should continue to be lobbied for a further increase in the overall national PCIP resource envelope. It should also be highlighted that NRAC proportionately as an allocation base does not meet the resource requirement in the Borders.
Other Allocations	Some partnerships have supplemented PCIF with other SG allocations in order to increase funding of PCIPs. To date, this has not happened within the Scottish Borders although a small proportion of core baseline funding supplements MH Renew. Advice from Scottish Government also suggests that partnerships should consider how Recovery and Renewal, Action 15 investment and PCIF is combined to deliver the Mental Health model set out in the planning guidance for example.

Increased Partner Investment	It may be possible that partners can increase baseline funding to support PCIP and supplement PCIF allocations.
Planned Efficiencies	THE H&SCP IJB may wish to direct the delivery of further planned efficiencies in order to create financial capacity to re-invest any efficiency savings in a targeted manner to PCIP, although there is already a substantial challenge here.

Primary Care Infrastructure - GP Premises Improvement

In addition to the core PCIF allocation, Partnerships have received a series of small further allocation from the Scottish Government specifically to be directed towards the improvement of GP Premises. Allocations were made in each of the last 3 financial years with accompanying conditions that they be prioritised for use through a combination of improvement grants, physical property estate works or digitisation of physical records in order to create clinical or administrative space.

No confirmation of any allocation has yet been received this financial year (2022/23). Over the last 3 years however, the allocations received are detailed in Table 5 below:

Table 5: Premises Funding Allocations

	PCIP Premises Funding Allocation £'000
2019/20	105
2020/21	107
2021/22	106
Total	**318**
2022/23	tbc

In total therefore, £0.318m has been received to date. In February 2021, a report was approved by GP Premises Group, which following a process of evaluation of proposals, directed £0.214m towards premises improvement. This fully consumed the £0.212m of funding allocations received during 2019/20 and 2020/21.

Taking account of the subsequent £0.106m allocation received in 2021/22, no commitment has been made against the remaining balance of £0.104m to date therefore.

Actual expenditure at the end of 2021/22 is detailed in Table 6 below.

Table 6: Premises Expenditure by Workstream

	PCIP Premises Expenditure by Workstream		
	Directed by GP Executive £'000	Actual Expenditure £'000	Remaining Balance £'000
Improvement Grants	53	46	7
Premises Works to Increase Space	47	11	36
Digitisation of GP Practice Records	114	0	114
Sub-Total	**214**	**57**	**157**
2021/22 Balance Remaining Undirected	**104**	**0**	
Total	**318**	**57**	

A particular issue has arisen in respect of digitisation of practice records. In early 2021, bids were submitted by 5 practices at a total cost of £0.114m in respect of digitisation of records. At that point in time, the amount directed was based on a quoted unit cost per record of £2.28 by Microtech, the preferred supplier, in October 2020. Since then however, the supplier has revised the unit cost to £3.85 per unit, an increase of 69% which has cast the overall financial affordability and cost-effectiveness of the proposals into question, particularly given the competing premises priorities highlighted in the recent Buchan Associates review of the Primary Care Property Estate. Alternative suppliers have been approached but to date, an equally-effective and affordable solution has yet to be identified. As a result therefore, PCIP / GP Executive groups require to reconsider priorities across the estate and (a) identify how the 2021/22 allocation can be used to best address them (including any further allocation that may be received in 2022/23) and (b) reconsider whether previously agreed proposals should continue to be progressed given competing priorities, slippage in work to date and overall affordability concerns of the previously agreed plan.

It is acknowledged that in recent years, health board-owned practices have required a range of miscellaneous premises work or furniture for which only limited resource has been available. Following discussions with the Director of Finance, the creation of a small resource envelope that can be accessed to fund such going forward within the 2023/24 Financial Plan is intended and a process for submitting and prioritising requirements to accompany it will be developed in due course.

We are making excellent progress on our journey to develop Primary Care Multi-disciplinary teams through our Primary Care Improvement Plan.

The close and mature partnership between General Practice, the Integration Joint Board and NHS Borders has been pivotal in helping achieve this.

In addition to the core aim of supporting the implementation of the GMS Contract, these services provide significant benefits in improving access for the public and experience, providing more seamless care, supporting the sustainability of primary care, and providing career progression for staff. This has been all the more important in the context of the recent pressures associated to Covid-19, General Practice workforce challenges and the increased levels of demand for General Practice.

I would like to thank everybody involved for their significant efforts on this journey of major transformation.

- Chris Myers – Chief Officer of Integration Joint Board

Acknowledgements

PCIP transformation work would not be possible without the dedicated support and involvement of the various workstreams highlighted in this report. Although it is not possible to name everyone individually, PCIP Executive Committee would like to thank everyone who has contributed to the drafting, testing, implementation and refining of Scottish Borders' Primary Care Improvement Plan.

Workstream Leads

Workstream	Lead
Vaccination Transformation Programme	Nicola Macdonald – Clinical Service Manager
Community Treatment and Care Services	Kathy Steward – Clinical Nurse Manager
Pharmacotherapy	Mairi Struthers
Community Mental Health "Renew"	Dr Caroline Cochrane – Director of Psychological Services and Head of Psychology Speciality
Urgent Care Services	Lisa Hume – Lead Advanced Nurse Practitioner
Musculoskeletal Services "First Contact Physio"	Wilna-Mari Van Staden – Clinical Lead Advanced Physiotherapy Practitioner
Community Link Works	Claire Veitch – Team manager Local Area Co-ordination Service
Premises	Stephanie Errington – Head of Planning & Performance Callum Cowan – Primary and Community Services Premises Lead
Communications	Clare Oliver – Communications Manager
Finance	Paul Mcmenamin–Deputy Director of Finance / Finance Business Partner (IJB)

PCIP Executive Committee

GP Executives	Dr Kevin Buchan Dr Rachel Mollart Dr Kirsty Robinson Dr Robert Manson
NHS Borders	Cathy Wilson – General Manager Dr Tim Young – Associate Medical Director Paul Mcmenamin–Deputy Director of Finance
Integration Joint Board	Chris Myers – Chief Officer Hazel Robertson – Chief Finance Officer

Document Edited by:

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August 2022

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Integration Authority Chief Officers
NHS Board Chief Executives
Integration Authority Chief Finance Officers
NHS Board Director of Finance

11 August 2022

Dear Colleagues

PRIMARY CARE IMPROVEMENT FUND: ANNUAL FUNDING LETTER 2022-23

I am writing to confirm the 2022-23 funding allocations for the Primary Care Improvement Fund (PCIF) element of the wider Primary Care Fund (PCF). As in previous years, funding will be allocated on an NRAC basis via Health Boards to Integration Authorities (IA's).

Background

The Scottish Government remains committed to the aims and principles which underpinned the 2018 GP Contract Offer. This letter relates to the PCIF component of the PCF, setting out our expectations as we continue to improve primary care. This should be read in conjunction with the Memorandum of Understanding 2 (MoU2) on GMS Contract Implementation for Primary Care Improvement[1] and the Amendment Regulations[2].

Primary Care Improvement Fund (PCIF)

Available Resources

Having assessed Primary Care Improvement and spending Plans, I can confirm that £170 million will be available for Integration Authorities in 2022-23 under the auspices of the Primary Care Improvement Fund (PCIF). In-year delivery and expenditure will be monitored by my team to account for both slippage and funding pressures.

[1] Memorandum of Understanding (MoU) 2: GMS Contract Implementation for Primary Care Improvement – Agreement between Scottish Government, British Medical Association (BMA), Integration Authorities (IAs) and NHS Boards

[2] The National Health Service (General Medical Services Contracts and Primary Medical Services Section 17C Agreements) (Scotland) Amendment Regulations 2022 (legislation.gov.uk)

Given the overall financial pressures across health and social care, and taking into account the Resource Spending Review, it is prudent and sensible to use existing reserves that have been built up over time. On this basis, we have agreed with the Cabinet Secretary for Health and Social Care that Integration Authorities should draw down existing reserve balances in the first instance, and therefore 2022-23 allocations will reflect reserves held. Please note, therefore, that the £170 million envelope takes account of the funds already held by Integration Authorities by means of these existing PCIF reserves.

Methodology for Tranche One Allocation

We will be making two in-year allocations on a 70:30 basis. The initial tranche of £119 million in August 2022 will take account of IA reserve balances at October 2021 as well as baselined pharmacy funding. Note that baselined pharmacy funding of £7.8m has been allocated separately and must also be treated as part of the Primary Care Improvement Fund.

Annex A shows the initial allocation of the fund, by Health Board and by IA. The funding must be delegated in its entirety to IAs.

Methodology for Tranche Two Allocation

Any locally held reserves should be invested in the implementation of PCIPs in 2022-23 before new funding is requested. Further funding will be made available to IAs later this year, subject to reporting confirming latest spend and forecasts required by Friday 4 November 2022.

Robust assessments of future resourcing requirements to support implementation of the PCIPs helps to inform central financial planning and policy development, enabling the Scottish Government to target funds as efficiently and effectively as possible, ensuring best value for the public purse. Reporting using national templates should detail how this initial 70% (comprising new funding plus utilisation of any local reserves) has been spent, providing a breakdown of spending by category (staff and non-staff costs) and detailing what benefits have been created.

Second tranche allocations will follow in Autumn 2022, subject to supporting data and evidence (in particular Primary Care Improvement Plans) regarding additional PCIF funding required in 2022-23. The approach to second tranche allocations will also be informed by updated financial data on the reserve positions as at 31 March 2022, which Scottish Government officials have separately requested from IAs. Second tranche allocations will be accompanied by any further guidance, as required.

Scope of PCIF

For 2022-23, PCIF should continue to be used to deliver the priority services set out in the Memorandum of Understanding:

- Pharmacotherapy
- Vaccination Transformation Programme
- Community Treatment and Care Services
- Community Links Workers
- Additional Professional Roles
- Urgent Care services

There should be a particular focus on Pharmacotherapy, CTAC and Urgent Care given existing or planned regulations for these services. Please also note the following changes in the scope of the fund:

- The Memorandum of Understanding 2 noted Pharmacotherapy, CTAC and the Vaccination Transformation Programme should be prioritised. The Vaccination Transformation Programme is now substantially delivered with GP practices only continuing to deliver vaccinations on a transitional or remote basis. We anticipate that Health Boards will have completed the remaining elements of the programme by the end of this financial year allowing Primary Care Improvement Plans to intensify their focus on other transformational activity. Where possible, Partnerships are advised to consider synergies between PCIF-funded VTP activity and wider Board governance and funding.

- With the introduction of the Mental Health and Wellbeing in Primary Care Services programme, partnerships are requested to use this additional funding to build on the existing investment from PCIF and other funding streams to create additional capacity. Partnerships are asked to use this year to consider whether there are any practical challenges in allocating and reporting on Mental Health Workers across different funding streams (PCIF, MHWPCS and other funding streams) and whether there would be benefits/opportunities to aligning reporting. We would ask partnerships to feedback as appropriate and we will write out with further guidance at financial year-end working alongside Mental Health and Wellbeing policy colleagues.

- We note that current investment projections from PCIP trackers assume the majority of the PCIF will be spent on MoU MDT staff. From 2022-23, new investment in the Primary Care Improvement Fund can be used for a wider range of costs (such as premises, training, digital, fixed-term contracts and redesign and change management) as long as they support delivery of the MoU MDT and are agreed with the GP Sub-Committee.

Future PCIF Funding

As previously noted, robust financial planning is critical to support effective and efficient use of resources and to enable continued investment in PCIF. To this end, the Scottish Government, in collaboration with other MoU Parties, will be reviewing and updating the PCIP trackers and financial reporting templates this year to ensure

they remain fit for purpose. Using this information, we will review the PCIF position mid-year, during the process of allocating tranche 2 of the funding.

Scottish Government will also work with Public Health Scotland and local evaluators to understand the current evaluation landscape, the work already underway at local level and any gaps that might exist. This work will inform further development of the monitoring and evaluation of PCIPs at the national level, in turn allowing us to better target investment in future years. **However, the Cabinet Secretary has agreed that £170 million will be the minimum budgeted position for future years. In future years, where Partnerships have used the full £170m minimum budgeted position, Scottish Government will ensure additional funding is available to apply agenda for change uplifts to staff recruited through the PCIF and ensure fulfilment of the terms of the MOU2 dated 30 July 2021. Any further investment will be subject to joint assessment and benefits case at each annual budget round.**

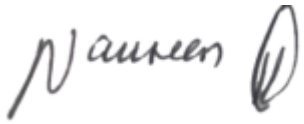
To help inform our ongoing review of the current monitoring and evaluation landscape, we also request sharing of Primary Care Improvement Plans this year. These can be sent to: PCImplementation@gov.scot

GP Sustainability Payment – 2022-23

The second tranche of the GP Sustainability Payments will be paid out later in the year.

I look forward to working with you as we continue to drive forward on delivering primary care reform.

Yours faithfully



Naureen Ahmad
Deputy Director - Primary Care Directorate

ANNEX A

PRIMARY CARE IMPROVEMENT FUND: ALLOCATION BY BOARD AND INTEGRATION AUTHORITY

Allocation By Territorial Health Board

NHS Board Name	NRAC Share 2022-23	PCIF NRAC Share 2022-23 (£)	PCIF tranche 1 2022-23 (£)	less PCIF baselined funds (£)	less PCIF IA reserves (£)	PCIF initial allocation 2022-23 (£)
Ayrshire & Arran	7.32%	12,440,274	8,708,191	-569,300	-4,050,213	4,088,679
Borders	2.15%	3,647,718	2,553,403	-161,300	-79,201	2,312,902
Dumfries & Galloway	2.97%	5,043,683	3,530,578	-229,100	0	3,301,478
Fife	6.86%	11,663,366	8,164,356	-521,800	-3,453,067	4,189,489
Forth Valley	5.46%	9,286,259	6,500,382	-415,000	0	6,085,382
Grampian	9.81%	16,672,511	11,670,758	-755,400	-10,567,097	348,261
Greater Glasgow & Clyde	22.18%	37,705,607	26,393,925	-1,718,200	-11,434,501	13,241,224
Highland	6.58%	11,188,302	7,831,812	-494,100	-2,785,450	5,239,790
Lanarkshire	12.28%	20,878,060	14,614,642	-947,700	-5,216,468	8,450,474
Lothian	14.97%	25,449,756	17,814,829	-1,132,000	-5,578,785	11,104,045
Orkney	0.49%	838,060	586,642	-75,000	-886,857	0
Shetland	0.48%	809,431	566,602	-76,200	-125,574	364,828
Tayside	7.80%	13,258,304	9,280,813	-601,900	-8,946,318	522,576
Western Isles	0.66%	1,118,667	783,067	-103,000	-318,806	361,261
Total		**170,000,000**	**119,000,000**	**-7,800,000**	**-53,442,336**	**59,610,387**

**Pharmacists in GP practice funding was baselined in 2018-19, this has been removed from the 2022-23 allocation in the above table.*

Allocation by Integration Authority

NHS Board Name	IA Name	IA NRAC Share 2022-23 (£)	PCIF NRAC Share 2022-23 (£)	PCIF tranche 1 2022-23 (£)	less PCIF baselined funds (£)	less PCIF local reserves (£)	PCIF initial allocation 2022-23 (£)
Ayrshire & Arran	East Ayrshire	2.37%	4,032,636	2,822,846	-186,694	-1,777,911	858,240
	North Ayrshire	2.70%	4,587,529	3,211,270	-209,033	-1,302,178	1,700,059
	South Ayrshire	2.25%	3,820,108	2,674,076	-173,573	-970,124	1,530,379
Borders	Scottish Borders	2.15%	3,647,718	2,553,403	-161,300	-79,201	2,312,902
Dumfries & Galloway	Dumfries and Galloway	2.97%	5,043,683	3,530,578	-229,100	0	3,301,478
Fife	Fife	6.86%	11,663,366	8,164,356	-521,800	-3,453,067	4,189,489
Forth Valley	Clackmannanshire and Stirling	2.57%	4,367,222	3,057,055	-195,164	0	2,861,891
	Falkirk	2.89%	4,919,037	3,443,326	-219,836	0	3,223,490
Grampian	Aberdeen City	3.81%	6,480,253	4,536,177	-298,317	-4,232,528	5,333
	Aberdeenshire	4.27%	7,251,701	5,076,191	-324,766	-4,714,534	36,891
	Moray	1.73%	2,940,557	2,058,390	-132,317	-1,620,035	306,037
Greater Glasgow & Clyde	East Dunbartonshire	1.85%	3,150,460	2,205,322	-140,141	-837,807	1,227,374
	East Renfrewshire	1.58%	2,685,569	1,879,898	-120,632	-1,233,315	525,951
	Glasgow City	11.99%	20,381,275	14,266,893	-928,315	-3,438,308	9,900,270
	Inverclyde	1.62%	2,747,032	1,922,922	-126,472	-1,223,070	573,380
	Renfrewshire	3.37%	5,721,487	4,005,041	-261,903	-3,161,668	581,470
	West Dunbartonshire	1.78%	3,019,783	2,113,848	-140,737	-1,540,333	432,778
Highland	Argyll and Bute	1.88%	3,199,436	2,239,605	-141,683	-2,785,450	0
	Highland	4.70%	7,988,867	5,592,207	-352,417	0	5,239,790
Lanarkshire	Lanarkshire combined	12.28%	20,878,060	14,614,642	-947,700	-5,216,468	8,450,474
Lothian	East Lothian	1.87%	3,173,726	2,221,608	-140,067	-75,922	2,005,619
	Edinburgh	8.35%	14,191,963	9,934,374	-634,173	-3,921,067	5,379,134
	Midlothian	1.63%	2,765,128	1,935,589	-120,660	-486,844	1,328,086
	West Lothian	3.13%	5,318,940	3,723,258	-237,100	-1,094,952	2,391,206
Orkney	Orkney Islands	0.49%	838,060	586,642	-75,000	-886,857	0
Shetland	Shetland Islands	0.48%	809,431	566,602	-76,200	-125,574	364,828
Tayside	Angus	2.16%	3,674,043	2,571,830	-165,208	-2,700,440	0
	Dundee City	2.86%	4,858,691	3,401,084	-226,196	-3,671,050	0
	Perth and Kinross	2.78%	4,725,571	3,307,899	-210,496	-2,574,828	522,576
Western Isles	Western Isles	0.66%	1,118,667	783,067	-103,000	-318,806	361,261
Total			**170,000,000**	**119,000,000**	**-7,800,000**	**-53,442,336**	**59,610,387**

Scottish Borders Health & Social Care Integration Joint Board

Meeting Date: 17 August 2022

Report By:	Chris Myers, Chief Officer Hazel Robertson, Chief Financial Officer
Contact:	Chris Myers, Chief Officer Hazel Robertson, Chief Financial Officer
Contact:	Via Microsoft Teams
INTEGRATION JOINT BOARD NATIONAL CARE SERVICE RESPONSE	
Purpose of Report:	To seek comments, and seek agreement on the Scottish Health and Social Care Integration Joint Board's response to the Scottish Parliament Health, Social Care and Sport Committee's 'Call for Views' and 'Your Priorities' consultations on the National Care Service. In addition Integration Joint Board members are asked to endorse joint working with partners in the Scottish Borders Council and NHS Borders to strategically manage the situation and to put the Scottish Borders forward as a local pathfinder to support the development of the Bill.
Recommendations:	The Scottish Borders Health and Social Care Integration Joint Board is asked to: a) Consider the response developed b) Provide any further comments c) Approve a finalised response for submission to the Scottish Parliament's 'Call for Views' and 'Your Priorities' consultations d) Agree to the principle of progressing discussions with the Scottish Borders Council, NHS Borders and Scottish Government to explore the potential for a local pathfinder to support the development of the Bill
Personnel:	The proposed National Care Service will affect all staff working in Health and Social Care. At this stage the impacts on staff are unclear, as the Bill represents primary legislation which has not been finalised. As it stands, the staff most likely to be most directly affected would be Adult Social Work and Social Care Commissioning staff, along with a number of local authority staff who provide support to these Social Care commissioning and Adult Social Work Services. In addition, the Bill proposes that there would be a process of local determination of whether the internal provision of Social Care continues to be provided by Local Authorities, or by the new proposed Local Care Boards.

	The impacts will be further considered at the next Integration Joint Board Joint Staff Forum.
Carers:	Impacts on carers have been considered as part of the national Equalities Impact Assessment that has been undertaken. The NCS aims to establish a statutory right to breaks from caring for all unpaid carers, adult and young carers. Possible barriers to this being achieved have been noted as: • Carers not coming forward and not engaging with local support • Carers not having the time to engage or prioritise themselves • Availability and range of breaks and services, particularly for those with intense or specialist needs and those living in rural areas • Resources/cost • Availability of local support capacity to identify individual's needs and provide advice • Availability of replacement care services, if required As part of the consultation for this response, due to the timescales for the Call for Views, we have not been able to fully engage with the Carers workstream at this stage, however, invited all members of the Integration Joint Board to respond to our consultation which informed this response, including the Integration Joint Board's unpaid carers representative. The impacts will be further considered at the next Integration Joint Board Carers Workstream.
Equalities:	The national Equalities Impact Assessment is available from the following link: https://www.gov.scot/publications/national-care-service-equality-impact-assessment/
Financial:	The Financial Memorandum is available at https://www.parliament.scot/bills-and-laws/bills/national-care-service-scotland-bill/introduced The responses pertaining to the Financial Memorandum questions are enclosed. These have been developed by the Integration Joint Board's Chief Financial Officer, following consideration of the financial consequences as they are currently outlined at a national level.
Legal:	Statements on legislative competence are outlined at: https://www.parliament.scot/bills-and-laws/bills/national-care-service-scotland-bill/introduced

	There is a three stage legislative process within the Scottish Parliament. At this current stage, the Bill is in stage 1. This Bill is an enabling Bill (primary legislation). At a later date it is expected that further clarity will be
Risk Implications:	It is important to note that the proposed reforms will mean that Integration Joint Boards as they are currently comprised would no longer exist. However the reform proposes further powers for the new local Care Boards that build on the current Integration Joint Board functions. Work has commenced with the risk team supporting the Integration Joint Board to create a new strategic risk on the risk register. As part of this risk management approach, mitigations are already being considered. There have been good discussions between the Chief Officer, and the Integration Joint Board's strategic partners in the Scottish Borders Council and NHS Borders to discuss the way forward. A collaborative approach to strategically manage the situation has been proposed, and potentially to put the Scottish Borders forward as a pathfinder to help inform the development of the Bill. Further detail is enclosed in section 2.
Direction required:	No

1. Introduction

On 8 July, the Scottish Parliament's Health, Social Care and Sport Committee informed Integration Joint Board Chief Officers that their 'Call for Views' and 'Your Priorities' Digital consultations on the National Care Service had opened. The deadline for submissions is Friday 2 September.

The 'Call for Views' includes general questions about the Bill, questions about the Financial Memorandum and the option to provide more detailed comments on individual sections of the Bill. It is primarily aimed at groups and organisations who are looking to input their views on the Bill.

The 'Your Priorities' consultation offers an opportunity to ask questions or to highlight specific hopes or concerns about the Bill. Respondents can also rate specific provisions in the Bill and make brief comments about them.

2. Local process

The Bill and accompanying documentation has been reviewed by the Chief Officer and the Financial Memorandum has been reviewed by the Chief Financial Officer.

A local online questionnaire was developed and shared with Integration Joint Board and Strategic Planning Group members to support the development of the responses to these consultations. A response was then developed based on these responses, and discussed with the Chair of the Integration Joint Board. This response is enclosed in Appendix 1.

Unfortunately due to the short timescales involved in the consultation process, it has not been possible to more broadly consult on this locally at this stage. However discussion will happen with key stakeholder groups over the coming months and years as we work to strategically manage the impacts of the National Care Service.

The proposed National Care Service and additional proposed investment comes with a number of major opportunities and benefits which would assist with the implementation of integration agenda and improvements in outcomes. However it is also important to note that due to the major structural changes proposed, there are a number of risks.

As a result, the Chief Officer has asked the risk team that support the Integration Joint Board to log the risks associated with the development of the new National Care Service, which will support the risk management approach.

In summary, the key risks which may make the outcomes being sought by the Integration Joint Board harder to achieve are listed below:

- There is a risk relating to workforce recruitment and retention through this period of change
- There is a risk relating to partner engagement through this period
- There is a risk that the workload associated to the strategic management of the new National Care Service, which may divert resource away from the core business of the Integration Joint Board
- There is a risk that some of the current integrated arrangements between the Integration Joint Board and its partners in the Scottish Borders Council and NHS Borders are affected

- There is a risk that the transfer of some services from Local Authority and NHS Board to the new Care Board impact on the delivery of services affected due to key interdependencies with other Local Authority and NHS Board services

3. Local considerations

3.1. Closer joint working

As part of the regular series of meetings between the leadership of the Integration Joint Board, Scottish Borders Council and NHS Borders, a discussion has occurred on the high-level considerations of each organisation in how the development of the National Care Service is strategically managed locally.

It was clear that all three organisations are keen to put what is best for the people of the Scottish Borders first, and are keen to work together closely, constructively and collaboratively in order to facilitate this, in recognising that by working together we are likely to reduce risks throughout the process and secure a better outcome for the communities of the Scottish Borders.

3.2. Pathfinder to inform the development of the National Care Service

In a meeting with Chief Officers on 18 July, the Minister for Mental Health and Social Care, Kevin Stewart MSP asked whether areas would like to put themselves forward as a test of change to consider and apply the principles of the National Care Service Bill, to help inform the ongoing development of the National Care Service.

When considering the opportunities that this could bring in relation to our local context in covering a large remote and rural area with a relatively small population, with strong local communities, and the co-terminosity and desire to collaborate between the Integration Joint Board, Scottish Borders Council and NHS Borders as the three statutory partners involved in Health and Social Care; a pathfinder would present an opportunity to further the integration agenda and help to inform the future direction of travel for the National Care Service.

As part of this, Health and Social Care Integration Joint Board members are asked:

1. To support a request to the Scottish Government to indicate that the Integration Joint Board would like to put itself forward to the Scottish Government as a local pathfinder area to test the adoption of the principles of the National Care Service Bill.

To facilitate this approach, this would require closer joint working with the Scottish Borders Council and NHS Borders.

Should this be supported, as part of this we would commit to adopt a pragmatic approach which works in line with our respective responsibilities to deliver best value by promoting the efficient, economic and effective use of staff and other resources, and where appropriate participation in shared service arrangements (i.e. on a formally agreed and resourced basis rather than a ‘grace and favour’ basis).

In addition, we would commit to ensure that effective arrangements are in place to provide assurance on risk management, governance and internal control. It is important to note

that as this would need to reflect the arrangements of the Bill and the principles of the proposed National Care Service as closely as possible within the existing legal framework, that there may need to be further changes required to the Scheme of Integration to facilitate this.

Through closer collaboration both with our local statutory health and social care partners, and with the Scottish Government, this approach will reduce the risks to the Integration Joint Board.

4. Recommendations

The Scottish Borders Health and Social Care Integration Joint Board is asked to:

a) Consider the response developed
b) Provide any further comments
c) Agree to a finalised response for submission to the Scottish Parliament's 'Call for Views' and 'Your Priorities' consultations
d) Agree to the principle of progressing discussions with the Scottish Borders Council, NHS Borders and Scottish Government to explore the potential for a local pathfinder to support the development of the Bill

4. Appendix 1

Proposed Scottish Borders Health and Social Care Integration Joint Board response to the National Care Service 'Call for Views' consultation

1. **The Policy Memorandum accompanying the Bill describes its purpose as being "to improve the quality and consistency of social work and social care services in Scotland". Will the Bill, as introduced, be successful in achieving this purpose? If not, why not?**

We are supportive of the aspirations of the Bill, and believe that broadly speaking, the Bill could be successful in achieving this stated aim. However it is hard to determine this due to the lack of detail made available in the Bill. We need more clarity on the potential operational form of Care Boards to help answer a number of these consultation questions appropriately.

Within our broader submission we offer a number of suggestions on how to improve the Bill to better achieve its existing aim, to reduce risks, improve outcomes and value for money.

In addition we would suggest that the purpose of the Bill should be "to improve the quality and consistency of health, social work and social care services in Scotland." We would also suggest that there is more focus on the needs of people and our communities, who need to be put at the centre of the Bill, in line with the recommendations of the Feeley review.

We welcome the focus on improving quality and consistency of social work and social care services, and the opportunity to further develop the integration of health and social care for our local population. However we would note an element of caution around the unintended balancing impacts of the transfer of services to new Care Boards from Local Authorities and NHS Boards, in relation to the potential fragmentation of service and impacts on our statutory delivery partners.

However, the Bill is very focused on the structural and organisational issues for Social Work and Social Care. Along with the structural changes proposed, it is important to not lose sight of the need to continue to focus on workforce training, recruitment and retention, the ongoing integration of health and social care services, consistency of service provision, and overall funding for frontline Social Work and Social Care service delivery.

2. **Is the Bill the best way to improve the quality and consistency of social work and social care services? If not, what alternative approach should be taken?**

Much of the Bill will certainly make a big difference in improving the quality and consistency of social work and social care services, including the investment into frontline services and the development of a National Social Work Agency.

There are other ways in which the aims could be achieved, that could also be explored:

- Use of the model used by Education services, which is nationally overseen from a consistency and quality perspective, and locally delivered
- Use of the Lead agency model

- Unitary public
- Further statutory guidance / performance management could be issued to support Integration Joint Boards to achieve their aims locally in line with existing legislation

3. Are there any specific aspects of the Bill which you disagree with or that you would like to see amended?

We recognise that there will need to be investment in developing the local Care Board infrastructure, but due to the scale of the extra investment proposed into the administrative infrastructure of Care Boards (£142-376m per annum); it is our view that these costs should be reviewed with an aim to invest more into social care and social work service delivery, or into other associated pressures. This is all the more important in the context of the current challenging fiscal environment.

The secondary legislation will clearly be helpful in clarifying the full intent and direction of travel, however early clarity will be needed in primary legislation on the role of the new Care Boards in the planning and commissioning of their functions, and in the operational delivery and management of their functions. In line with this, we would hope to receive clarity on the scope of these Care Boards, including whether Health services are included as in or out of scope from a commissioning and a delivery perspective.

4. **Is there anything additional you would like to see included in the Bill and is anything missing?**

Explicit provisions allowing and encouraging local communities to establish a single, truly integrated health and social care commissioning and delivery body, with real engagement of that community and the ability to plan and deliver care across the system.

There is a particular opportunity to undertake this approach within the Scottish Borders and this is of particular relevance to remote, rural, island and areas with co-terminous Integration Joint Boards, Local Authorities and Health Boards.

This approach would provide a real opportunity to unify service delivery in a consistent way with a single expanded and co-terminous integrated authority and support improvements in local outcomes within this context.

This could be facilitated using a participatory framework approach, with the options of a single Care Board or Single Health and Care Board.

5. **The Scottish Government proposes that the details of many aspects of the proposed National Care Service will be outlined in future secondary legislation rather than being included in the Bill itself. Do you have any comments on this approach? Are there any aspects of the Bill where you would like to have seen more detail in the Bill itself?**

Whilst recognising that secondary legislation will ensure that national co-production can take place, the approach undertaken leaves a lot of uncertainty about the future model, and so makes it difficult to strategically manage the situation and its impacts at a local

level. It is important to recognise the impacts that this uncertainty has on staff and partners working across Social Care, Social Work and Health, and so further clarity would be welcomed.

6. **The Bill proposes to give Scottish Ministers powers to transfer a broad range of social care, social work and community health functions to the National Care Service using future secondary legislation. Do you have any views about the services that may or may not be included in the National Care Service, either now or in the future?**

Should a Care Board structure be established then the core delegated services listed in the Public Bodies Act should be part of this. Should the review of children's and justice services recommend that these services are also in scope, then these should also be delegated.

It is important to note that the delivery of social work and of social care is sensitive to a range of local factors and is (and should be) inextricably part of a whole system of local care, including but not limited to housing, communities, education, economic development and secondary care. As a result, it is important that there is a significant level of consultation and consideration of balancing impacts of any transfer of services.

7. **Do you have any general comments on financial implications of the Bill and the proposed creation of a National Care Service for the long-term funding of social care, social work and community healthcare?**

At this stage there is insufficient detail about the Bill to allow for a robust financial assessment. Comments on financial implications will be detailed in full as part of the Health and Social Care Scotland response to the Consultation on behalf of all Integration Authorities.

The administrative costs of the National Care Service and Care Boards are very high and lead to less financial resource for service delivery. Whilst recognising that there is a pre-requisite to cover the overhead costs of these new organisations, it is suggested that these costs are reviewed in the context of the delivery models being considered to maximise value for money.

8. The Bill is accompanied by the following impact assessments:

- Equality impact assessment
- Business and regulatory impact assessment
- Child rights and wellbeing impact assessment
- Data protection impact assessment
- Fairer Scotland duty assessment
- Island communities impact assessment

9. Do you have any comments on the contents and conclusions of these impact assessments or about the potential impact of the Bill on specific groups or sectors?

In addition to the island communities impact assessment, we would suggest that a remote and rural impact assessment is also undertaken.

There are risks in separating social care and social work services from local authorities, as these services are interdependent on the broader local authority portfolio of services including (but not exclusively) housing, communities, transport, sport, business and the local economy and education. In addition, there are risks related to the separation of primary and secondary care, and also between primary care, community health social care and social work services.

10. Financial memorandum questions

- **Did you take part in any consultation exercise preceding the Bill and, if so, did you comment on the financial assumptions made?**
  Scottish Borders Integration Joint Board members have commented as part of the previous National Care Service consultation. However members have not had the opportunity to comment on the financial assumptions made in the National Care Service Financial Memorandum until this stage.

- **If applicable, do you believe your comments on the financial assumptions have been accurately reflected in the financial memorandum (FM)?**
  Not applicable.

- **Did you have sufficient time to contribute to the consultation exercise?**
  Timescales have been very tight and have not permitted full local engagement.

- **If the Bill has any financial implications for you or your organisation, do you believe that they have been accurately reflected in the FM? If not, please provide details.**

  Provisions for the administration costs of Local Care Boards are required and welcomed, but do appear to be high when considering the potential transfer of staff from Local Authorities. For the Scottish Borders, based on NRAC share this would represent between £3-8m per annum. However at this stage as we are not clear on the level of structures required within Care Boards, it may be that these are required. We also provide comment on other areas of uncertainty relating to the financial assumptions in the sections below.

- **Do you consider that the estimated costs and savings set out in the FM are reasonable and accurate?**
  We do not believe this is a case for a range of reasons. These will be detailed in full as part of the Health and Social Care Scotland response to the Consultation on behalf of all Integration Authorities.

  Using 3% as an overall inflation figure may not be adequate to reflect increased demand due to increase inflationary costs and needs, particularly when considering pay inflation which is likely to be substantial. It would be helpful for Integration Joint Board Chief Financial Officers to receive more information on the modelling assumptions.

Given the learning from the NHS Agenda for Change process, it is unclear on how realistic the timescale is to move to national terms and conditions and the associated funding impact.

- **If applicable, are you content that your organisation can meet any financial costs that it might incur as a result of the Bill? If not, how do you think these costs should be met?**
  The inflationary and VAT issues have been noted and it these are likely to cause a significant cost pressure. A reduction in the core administration costs may help to assist with this. In addition, the development of shared services may need to be promoted with Health Boards and Local Authorities. However at this stage there is insufficient detail to be able to cost this appropriately due to the uncertainty of the primary legislation.

- **Does the FM accurately reflect the margins of uncertainty associated with the Bill's estimated costs and with the timescales over which they would be expected to arise?**
  There is uncertainty in the areas below which need to be explored by the national policy and finance teams in further detail:
  - Impacts of the change to VAT status of Care Boards
  - The impacts of inflation
  - The financial impacts of any changes to Terms and Conditions, and the associated timescales. These need to be considered appropriately in the context of the negotiations required.
  - The pensions position
  - Data and digital costs

11. **There is also the option to give your views on specific provisions in the Bill. There is no obligation to complete this section of the call for views and respondents can choose to restrict their comments to certain sections of the Bill. In providing comments on specific sections of the Bill, please consider:**
    - **Whether you agree with provisions being proposed?**
    - **Whether there is anything important missing from these sections of the Bill?**
    - **Whether there is anything you would disagree with or there are amendments you would wish to propose to these sections of the Bill?**
    - **Whether an alternative approach would be preferable?**

    There seems little in the bill around Primary Care and the role of GPs, Community Pharmacists, Dentists, and Optometrists in the Care Service.

    It is important to consider that the impacts of the Bill will be experienced differently in different parts of Scotland. As a result, as previously noted, flexibility in delivery models according to local circumstances needs to be considered as circumstances across large remote and rural areas like the Scottish Borders will be different to urban populations.

Proposed Scottish Borders Health and Social Care Integration Joint Board response to the National Care Service 'Your Priorities' consultation

Do you have any specific questions on the Bill?

- How will the seamless delivery of health and social care services be delivered in the Bill
- How will the playing field be levelled in terms of the resources and infrastructure available to Care Boards, which have different baselines
- How can the Bill be developed on the basis of the principles set out by the Christie Commission and the Feeley Review
- How can the Bill put the person at the heart of the Bill

Do you have any specific hopes for the Bill?

- That it achieves the best outcome for our local population in the Scottish Borders. As part of this our aspiration would be to see an integrated Care Board that covers the Scottish Borders area and that provides seamless services to our population, with continued flexibility to have localism of planning and delivery with our local population, the third sector, independent sector, primary care and statutory partners.
- That it will achieve its core and stated aim of providing care to individuals without duplication of assessment or complex bureaucracy in a fair and equitable way, and supports an improvement of outcomes
- That it will encompass level standards and quality for all providers including the Independent and Third Sectors
- That integration of health and social care services continues to be promoted under the Act when legislated
- That staff are supported through the process, with a national steer on messaging during what is an uncertain time
- That unpaid carers are able to receive the support they need
- That it provides flexibility in terms of delivery models
- That there is the opportunity for the Scottish Borders Integration Joint Board to work in partnership with the Scottish Borders Council and NHS Borders to work as a test of change locally
- That the Bill will build on the best of the existing IJB systems
- That the Bill includes explicit provisions allowing and encouraging local communities to establish a single, truly integrated health and social care commissioning and delivery body, with real engagement of that community and the ability to plan and deliver care across the system.

Do you have any specific concerns about the Bill?

- That as currently written it would appear that the Bill will lead to a fragmentation of a Unified Health system across Primary & Secondary (or Acute and Community health, or Health and Social Care). This would appear to be a backwards step and risk leaving whole system health and social care planning split between multiple bodies.

- That the Bill focuses on the structural / accountability issues for Social Care and Social Work. While this may need to be addressed the key issues that will lead to improvements in Social Care on the ground will not in themselves be addressed by structural change (i.e. workforce gaps, consistency of service provision, overall funding for frontline Social Care)
- That the focus on structural and legislative change may lead to a lack of focus and resources for the key issues that will deliver real improvement in social care servicer and users experience – the focus needs to be on ‘the people’
- High costs of the administrative functions of the National Care Service and Care Board structures, and low estimates of other key costs (as noted in our response to the Financial Memorandum section)

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