# Scottish Borders Primary Care Improvement Plan

# (Revised)

# 2018-21

Final Version 22nd Oct 2019

# CONTENTS

## 1. INTRODUCTION

The Scottish Borders Primary Care Improvement Plan (PCIP) was originally developed in 2018 in line with the National Memorandum of Understanding between the Scottish Government, BMA, Integration Authorities and NHS Boards linked to the introduction of the 2018 GMS Contract in Scotland.

While some progress was made initially across the PCIP workstreams within the plan, at the end of 2018/ 19 it was acknowledged that this had not been at the pace we would have wished and it was agreed to re-invigorate the process and subsequently to revisit and update the PCIP. This document reflects that and should be considered in conjunction with the original plan (attached separately as **Appendix 1**) which describes the local and wider context in detail.

## 2. BACKGROUND

Scottish Borders covers a rural area of 1831 square miles with a practice population of circa 118,484 and a population density of 25 persons per square kilometre, compared to 65 persons per square kilometre for Scotland. There is no one large centre of population, rather a number of small towns ranging in size from 2,000 to approximately 16,000 and many smaller villages and hamlets in rural settings. NHS Borders is co-terminous with one Local Authority and there is one Health & Social Care Partnership. There are 23 GP practices in Borders with 4 GP clusters.

## 3. GOVERNANCE

As part of the PCIP revitalisation process, it was evident that a more robust governance framework was required; a GP Executive was therefore introduced in April 2019 with membership from GP Sub Committee, NHS Borders and Borders Health & Social Care Partnership at senior level. The GP Executive is chaired by the Chair of GP Sub Committee and has the remit to oversee and steer the development and implementation of the PCIP. In doing so, the GP Executive ensures that the six priority areas for change within the PCIP are progressed and monitored in a meaningful way, according to an agreed timetable and with a level of scrutiny; thereby safeguarding the principles of the GP Contract and making sure that there will be equitable access to the new models of care across Scottish Borders.

In addition, NHS Borders identified an Executive Lead to help drive forward progress; this post began in June 2019. A Project Manager for the overall programme was also appointed and started at the end of August. Both are members of the GP Executive.

The GP Executive meets monthly and has previously reported at the Primary Care Strategy Group, however that group is under review and may not continue in its current format. The GP Executive provides regular reports to GP Sub Committee and IJB as well as to NHS Borders Executive Team and NHS Borders Board as appropriate. A governance diagram is at **Annex A** and membership list at **Annex B**

Since its inception, the GP Executive has introduced a number of steps to ensure more robust planning, reporting and governance arrangements:

- The GP Executive receives standardised highlight reports from each of the workstreams each month. Scrutiny of progress takes place in line with the overarching programme plan. Any proposed changes to the workplans and workforce plans must be agreed by the GP Executive.
- The GP Executive includes a designated Business Partner who has comprehensively reviewed the budget and commitments to date and has presented a confirmed financial outlook; this has been formally agreed by the GP Executive and allows robust forward planning. Finance reports are taken at each meeting where all proposed financial commitments must be approved.
- A delivery map has been developed; this is a dynamic working document which plots where the new posts are being sited and services are being delivered across practices as an aid to ensuring equitable provision across Borders.
- A Communications Plan is in development and will incorporate processes to raise the profile and awareness of the PCIP locally.

Clinical Governance

A consistent approach to the delivery of service and development of an appropriately skilled workforce is essential to ensure safe and appropriate patient care. Provision has been made within the PCIP for Band 8a roles in each workstream to manage this and to provide a clinical professional line for the individual disciplines. In addition, resource has been allocated to allow time for GPs to mentor and support the new staff appointed through PCIP, most particularly the Advanced Nurse Practitioners and Pharmacists.

Health Inequalities Impact Assessment(s) will be undertaken across the PCIP.

## 4. KEY PRIORITIES (PCIP WORKSTREAMS)

The key priorities have been developed in line with the MoU and are managed through individual workstreams. The additional posts appointed and planned within each workstream are detailed in **Section 7**.

**The Vaccination Transformation Programme (VTP)**

The Vaccination Transformation Programme (VTP) was announced at national level in March 2017 prior to the introduction of the PCIP to review and transform vaccine delivery in light of the increasing complexity of vaccination programmes in recent years, and to reflect the changing roles of those, principally GPs, historically tasked with delivering vaccinations. This was to be incorporated within the PCIP and in Borders the plan was developed as overleaf:

| | Previously Completed | Year 1 | Year 2 | Year 3 |
|---|---|---|---|---|
| Plan /Outcomes | School programme (including flu vaccines) | Pertussis/ whooping cough vaccine seasonal flu vaccination being provided by NHSB midwifery team | Continuation of 0-5 years programme work - pre-school childhood population<br><br>Travel | Shingles (start)<br><br>Seasonal Flu Adults 65 years and over<br><br>Pneumococcal vaccines adults aged 65 years<br><br>Flu Vaccines ('At risk adults' aged 18-64 years) |
| Progress | | **HPS Data**<br>**Pertussis –**<br>**Quarter 1 2018**<br>NHSB deliveries =138 with vaccination rate of 64.49%<br>**Quarter 1 2019**<br>NHSB deliveries =136<br>With vaccination rate of 67.65%<br>**increase in % vaccination rate by +3%**<br><br>Reduction in healthcare appointments for pregnant women as all vaccinations are now part of midwifery led care. Practice Nurse appointment time therefore freed up. | <u>Pre-school childhood programme</u><br>Data gathering completed, this details the % vaccination uptake across all GP Practices and Clusters for the Scheduled routine vaccinations (Primary and Booster vaccinations) and Seasonal flu vaccinations for 2,3 and 4 year olds<br><br>Draft Protocol developed to support local delivery model<br><br>Model initially identified has raised some challenges and an alternative model has been proposed to Scottish Government (detailed separately below*)<br><br><u>Travel Health & Advice</u> - liaison with GP practices ongoing; likely to become Year 3 Outcome. | Data gather completed, this details the % vaccination uptake across all GP Practices and Clusters for the 65 years and over population and the 'At risk' adults aged 18-64<br><br>Proposed alternative delivery model has been identified (see separate detail) |

*<u>Alternative model for under 5 non-flu and flu vaccinations, adult vaccinations and adult flu vaccinations</u>

The VTP workstream initially identified a model of delivery for all under 5 non-flu vaccinations to be taken over by NHS Borders with plans to subsequently incorporate child flu and adult flu vaccination programmes. This model has raised some challenges in terms of the high cost attached to both the additional NHS Borders

workforce required and the change to the current IT and data sharing infrastructure necessary to enable non-practice staff to provide the service. A further significant issue is the lack of suitable and accessible accommodation from which to provide the service equitably across the area. Within the original model consideration had been given to the vaccination service being provided from a central point in each locality or cluster given that it has proved impossible to find space in every health centre. However this has also proved extremely difficult; even if it were possible, the public transport infrastructure is limited and there is a concern that the more vulnerable or poorer members of the community would either choose not / be unable to travel out of their home setting for their vaccinations or would not be able to afford to do so.

The potential need to use centrally located accommodation in geographical areas rather than within each health centre or community also presents the risk of a reduced vaccination uptake and an associated increased risk to "herd immunity" with potential widening of health inequalities.

The current scheduled routine programme of vaccinations for under 5yrs, for under 5yrs flu and adult vaccinations has been delivered successfully by GP practices for many years and from accommodation within practice premises. The alternative and preferred approach put forward would see NHS Borders taking over the element of practice nurse time required to deliver this vaccination programme, thereby becoming health board salaried hours. This would allow the practices to divert the element of their budget currently attached to these hours to support additional capacity within the practice e.g. by developing further professional roles / advanced practitioners etc. The use of existing accommodation and IT infrastructure would continue thereby removing the problem highlighted previously around changes to IT, sourcing space elsewhere and the need for patients to travel for vaccinations. This would maximise the potential to sustain our current good vaccination rates and minimise the risk of a reduction in them and to herd immunity. The approach proposed has been tested successfully in one GP practice.

The VTP workstream had identified a modus operandi and governance structure for the original proposed delivery model which would be transferrable to this new proposal and would ensure a standardised approach to the vaccination programme across the area.

This proposal is being developed in more detail and will be considered further by Scottish Government. The PCIP will be amended based on the response received.

## Pharmacotherapy

| | Year 1 | Year 2 | Year 3 |
|---|---|---|---|
| Plan /Outcomes | Develop a unified repeat prescribing system<br><br>Ensure a sustainable process for hospital discharge letters<br><br>Establish a process for medicines reconciliation | Embed the repeat prescribing system<br><br>Create a process for Level 2 pharmacotherapy services | Roll out the medication review & high risk medicines process<br><br>Develop support for Level 2 pharmacotherapy services |
| Progress | The Unified Prescribing Policy (UPP) has been circulated and agreed as a working document with the GP Sub Committee.<br><br>Process for Discharge Letters and Medicines Reconciliation has been progressed; full service provision across all practices will be possible once more technicians are in post | UPP awareness raising across practices.<br><br>Pharmacotherapy reviews are being rolled out across all practices as recruitment progresses. Reporting information on activity and outcome will be available by November 2019.<br><br>Recruitment and development of additional technicians to allow roll out of support for IDLs. | Recruitment and development of additional technicians |

Recruitment to Technician posts has proven difficult, however a new 2 year training cycle has been developed with three students currently enrolled. The first three students will be in Primary Care training posts from 2020/21.

## Community Treatment & Care Services

| | Year 1 | Year 2 | Year 3 |
|---|---|---|---|
| Plan /Outcomes | Data gathering and development of a model of service delivery for Treatment Rooms | Application and testing of model with first phase NHS Borders treatment rooms.<br><br>Roll out to remaining NHS Borders Treatment Rooms.<br><br>Develop plan for roll out to GP Treatment Rooms.<br><br>Identify and plan interface with Urgent Care Workstream and | Confirmation and of Treatment Room model and plan for roll out to GP Treatment Rooms.<br><br>Implementation of the roll out plan for Treatment Rooms.<br><br>Confirm plan for transfer of VTP services to treatment rooms in Year 4<br><br>Identify interface with wider MDT development and new |

| | | | |
|---|---|---|---|
| | | establishment of ANP cohort. | community services model – plan to be in place Year 4 |
| Progress | Model and SOP identified | Model implemented in 4 NHS Borders Treatment Rooms as first phase and evaluation ongoing.<br><br>Roll out to remaining 6 NHS Borders Treatment Rooms will be complete by end of third quarter. | |

**Urgent Care**

The main focus will be on the development and establishment of an Advanced Nurse Practitioner model.

| | Year 1 | Year 2 | Year 3 |
|---|---|---|---|
| Plan/ Outcomes | SAS pilot in South Cluster<br><br>NHS Borders ANP strategy developed<br><br>Begin recruitment of nurses to ANP roles | Develop local training pathway<br><br>Demonstrate ANP roles working in two cluster areas ( West & South) | Recruit remaining practitioners for coverage of all areas.<br><br>Review of paramedic practitioner role. Outcome to inform wider development of service. |
| Progress | 4 ANPs recruited for deployment into South and West Clusters.<br><br>Governance and Communication protocols complete.<br><br>Paramedic Practitioners Pilot in South Cluster established. | ANPs established in South and West Clusters<br><br>Activity data collection processes for South & West clusters - review and confirm.<br><br>Further 11 posts approved for recruitment by end of 2019/20.<br><br>Local training pathway under development. | |

## Additional Professional Roles

### First Contact Physiotherapists

Patients with musculoskeletal problems can be directed to First Contact Physiotherapists (FCP) rather than a GP within a practice. FCPs can autonomously assess, diagnose and address the immediate clinical needs of this patient cohort; initiating further investigations and making onward referrals where clinically appropriate.

| | Year 1 | Year 2 | Year 3 |
|---|---|---|---|
| Plan /Outcomes | Initial phase of FCP service established in East and part of Central cluster | Roll out of model | Final phase roll out to remaining practices |
| Progress | 3.4 wte (5 staff) FCPs appointed to all of east and part of central (Gala HC & Melrose/Newtown St Boswells) clusters.<br><br>Framework for service developed. | Second phase of recruitment approved for a further 4 posts in 2019/20<br><br>Evaluation of service to take place before final recruitment phase is approved | |

### Community Mental Health Workers

Community Mental Health Professionals will provide a "see and treat" mental health model for individuals experiencing conditions such as low mood, anxiety, and depression. The new team will offer triage, assessment and a range of different types of psychological therapies, using telephone, face-to-face and remote access.

| | Year 1 | Year 2 | Year 3 |
|---|---|---|---|
| Plan /Outcomes | Identify a service delivery model | First Implementer site to be established at one GP practice.<br><br>Referral pathway confirmed.<br><br>Evaluation of first implementer site and confirmation of plan.<br><br>Recruitment to further posts identified and roll out to remainder of Cluster | Roll out of model to all practices |
| Progress | Model developed | First Implementer site identified in South Cluster. | |

| | | | |
|---|---|---|---|
| | | PCMHT (3 staff) consisting of Psychologists, CAAPs(Clinical Associate in Applied Psychology) now based in the first implementer practice; CPN recruitment underway.<br><br>Referral pathway will be signed off Nov 2019.<br><br>Recruitment underway for next phase of posts required. | |

## Community Link Workers

The Community Link Workers (CLWs) will work closely with the Local Area Coordinators to enable the most appropriate support to be provided for individual clients. CLW support will be provided for as long as necessary to enable the individual to achieve the outcomes they have identified, it is not time limited. Where the initial assessment determines that the service is not appropriate, signposting to other relevant services will be undertaken and information supplied to the referring agency.

| | Year 1 | Year 2 | Year 3 |
|---|---|---|---|
| Plan /Outcomes | Development of the service model | Recruitment to additional posts<br><br>Development of referral pathway for GP practices.<br><br>Roll out of model across all GP practices | Evaluation and further development of service model |
| Progress | Building on the existing service delivery model with the Local Area Coordinators and CLW hours, the new model of service has been identified and will incorporate additional posts.<br><br>Staffing model identified. | First phase of recruitment complete.<br><br>Recruitment to second phase underway. | |

## 5. CHALLENGES AND RISKS

Across all of the workstreams a number of common challenges have been identified:

I. Accommodation: space within existing health centre premises is already at a premium and making available appropriate clinical space for use by the additional staff appointed through the PCIP is proving difficult. This has the potential to inhibit or even prevent the establishment of the new services in some areas and carries the risk of inequitable access across Borders. This issue is being addressed through the work on Premises (see Section 6)

II. IM&T: access to the relevant IT systems is not available at every health centre site for the new services being introduced and the different needs of the new services for appropriate recording and collection of data has added to the complexity of issues highlighted to date. This brings the risk of not being able to appropriately and safely deliver and record clinical activity. Work is underway with IM&T to address these issues (see Section 6)

III. Recruitment: A range of new posts are being created across various disciplines and at various levels within the workstreams. Recruitment at senior levels of skill and therefore at higher Bandings can prove difficult as there are not necessarily the numbers of suitably qualified professionals available nationally; this has particularly applied to ANPs and to FCPs, though not solely. Conversely, Pharmacotherapy have had difficulty with the lack of available Technicians. While service leads have tried to review skill mix and develop training programmes to develop staff into roles where recruitment has been problematic, this takes time. Core senior level posts are crucial in terms of clinical leadership, professional supervision clinical governance and also in delivery of specific clinical practice. Inability to recruit to posts will cause delays in delivering the proposed new PCIP services.

IV. GP Involvement in delivery: involvement in the development and delivery of the PCIP to date has fallen mainly to a small cohort of GPs. It has proved challenging to attract additional GPs willing to undertake a more formal role in delivering the contract with the associated risk to ensuring wider engagement and ownership as implementation progresses.

## 6. ENABLERS AND INFRASTRUCTURE

### Premises

The Memorandum of Understanding has identified the requirement for two main priorities linked to premises to be progressed as part of the PCIP:

*"The National Code of Practice for GP Premises sets out how the Scottish Government will support a shift, over 25 years, to a new model for GP premises in which GPs will no longer be expected to provide their own*

*premises. The measures outlined in the Code represent a significant transfer in the risk of owning premises away from individual GPs to the Scottish Government.*

*Premises and location of the workforce will be a key consideration in delivering the multi-disciplinary arrangements envisaged in the HSCP Primary Care Improvement Plan".*

NHS Borders has historically owned the majority of local health centre premises and in the recent past has taken over two sites previously practice-owned through reprovisioning via new builds. There remains only 1 practice (O'Connell Street in Hawick) who own their main premises, another 2 own branch surgery premises and 1 leases branch surgery premises from a third party landlord.

The issues around access to appropriate accommodation at health centre sites for the new services being introduced through PCIP has been highlighted in Section 5. While some staff have been found accommodation at a number of locations, it is currently not possible in some buildings and is causing great disruption at others. The problem will only increase as more services are established.

A Primary Care Premises Group was established some years ago within Primary & Community Services and while it has a wider role around Primary Care Premises Modernisation for that Clinical Board, it has been agreed to re-vitalise the group in order to progress the two PCIP areas of work identified above as part of its remit. The GP Executive will oversee and monitor this element of the Group's workplan and the Group's membership will be widened to include GP Executive representation. Discussions are now also underway with colleagues from the Capital Management Team to ensure links with their space utilisation programme in order to address and plan accommodation requirements for new PCIP services – this will sit within the Primary Care Premises Group workplan.

**IT Infrastructure and Data Collection**

As highlighted in the previous Section, the requirement to access specific IT systems is crucial in the development and delivery of the new services identified across all of the workstreams. IT colleagues have been involved in a number of workstream discussions to date but there requires a more co-ordinated approach to the issue to allow them to manage their responses appropriately and to develop workable solutions – some solutions may be applicable over a number of services whilst others may need to be tailored to individual service need. Similarly, appropriate data sharing and collection processes need to be developed and managed across the new services and in liaison with GP colleagues.

The Head of IM&T is now working to establish a designated primary care function within the IT service. This new team will work alongside the workstream leads and GP Executive to address these points.

**NHS 24**

Colleagues from NHS 24 have been in discussion with the GP Executive regarding a proposal to trial, evaluate and establish a Triage Programme in Scottish Borders whereby NH24 will manage the triage of calls and signpost / redirect certain referrals received through GP practices to more appropriate services in order to

free up GP clinical time for more complex cases. Importantly it will also enable patients to be seen without delay and to receive the right care from the right person at the right time. Work is now taking place to develop this proposal in more detail.

## 7. WORKFORCE

The revitalisation of the PCIP governance process and consequent review and confirmation of the overall programme has allowed the development of a more robust workforce plan. All of the workstreams have identified workforce requirements in line with their workplans. These workplans and any changes proposed as implementation progresses must be approved by GP Executive.

All staff within the workforce plan are employed either by NHS Borders or by Scottish Borders Council. GP Executive have confirmed their commitment to establish all new posts at 52 week level to ensure continuity of service provision to our patients; accordingly the associated costs have been built into the financial plan. Line managers of the relevant services will be operationally responsible for ensuring that this level of service is delivered equitably across practices.

The tables overleaf shows the current workforce plan in terms of headcount and whole time equivalents (wte). It must be noted however that this is a fluid picture and can change as service models are evaluated and progressed and as highlighted previously, recruitment difficulties may impact on the skill mix and timetable.

## Headcount

| Financial Year | Service 2: Pharmacotherapy | | Services 1 and 3: Vaccinations / Community Treatment and Care Services | | | Service 4: Urgent Care (advanced practitioners) | | | Service 5: Additional professional roles | | | Service 6: Community link workers |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Pharmacist | Pharmacy Technician | Nursing | Healthcare Assistants | Other [a] | ANPs | Advanced Paramedics | Other [a] | Mental Health workers | MSK Physios | Other [a] | |
| TOTAL headcount staff in post as at 31 March 2018 | 10 | 7 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| INCREASE in staff headcount (1 April 2018 - 31 March 2019) | 5 | 2 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 5 | 0 | 0 |
| PLANNED INCREASE in staff headcount (1 April 2019 - 31 March 2020) [b] | 9 | 8 | 3 | 0 | 1 | 15 | 0 | 1 | 8 | 5 | 1 | 3 |
| PLANNED INCREASE in staff headcount (1 April 2020 - 31 March 2021) [b] | 1 | 3 | 23 | n/a | 0 | 8 | n/a | 0 | 0 | n/a | 0 | 0 |
| PLANNED INCREASE staff headcount (1 April 2021 - 31 March 2022) [b] | n/a | n/a | n/a | n/a | n/a | n/a | n/a | 0 | 0 | n/a | 0 | 0 |
| TOTAL headcount staff in post by 31 March 2022 | 25 | 20 | 26 | 0 | 1 | 23 | 1 | 1 | 8 | 10 | 1 | 3 |

## Whole Time Equivalents

| Financial Year | Service 2: Pharmacotherapy | | Services 1 and 3: Vaccinations / Community Treatment and Care Services | | | Service 4: Urgent Care (advanced practitioners) | | | Service 5: Additional professional roles | | | Service 6: Community link workers |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Pharmacist | Pharmacy Technician | Nursing | Healthcare Assistants | Other [a] | ANPs | Advanced Paramedics | Other [a] | Mental Health workers | MSK Physios | Other [a] | |
| TOTAL staff WTE in post as at 31 March 2018 | 5.2 | 3.8 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | |
| INCREASE in staff WTE (1 April 2018 - 31 March 2019) | 5.3 | 1.6 | 0.0 | 0.0 | 0.0 | 0.0 | 1.0 | 0.0 | 0.0 | 3.8 | 0.5 | |
| PLANNED INCREASE in staff WTE (1 April 2019 - 31 March 2020) [b] | 7.8 | 7.0 | 1.5 | 0.0 | 1.0 | 15.0 | 0.0 | 0.5 | 8.0 | 4.2 | 0.0 | 2.5 |
| PLANNED INCREASE in staff WTE (1 April 2020 - 31 March 2021) [b] | 1.0 | 3.0 | 2.3 | n/a | n/a | 8.0 | n/a | 0.0 | 0.0 | n/a | 0.0 | 0.0 |
| PLANNED INCREASE staff WTE (1 April 2021 - 31 March 2022) [b] | n/a | n/a | n/a | n/a | n/a | n/a | n/a | 0.0 | 0.0 | n/a | 0.0 | 0.0 |
| TOTAL staff WTE in post by 31 March 2022 | 19.3 | 15.4 | 3.8 | 0.0 | 1.0 | 23.0 | 1.0 | 0.5 | 8.0 | 8.0 | 0.5 | 2.5 |

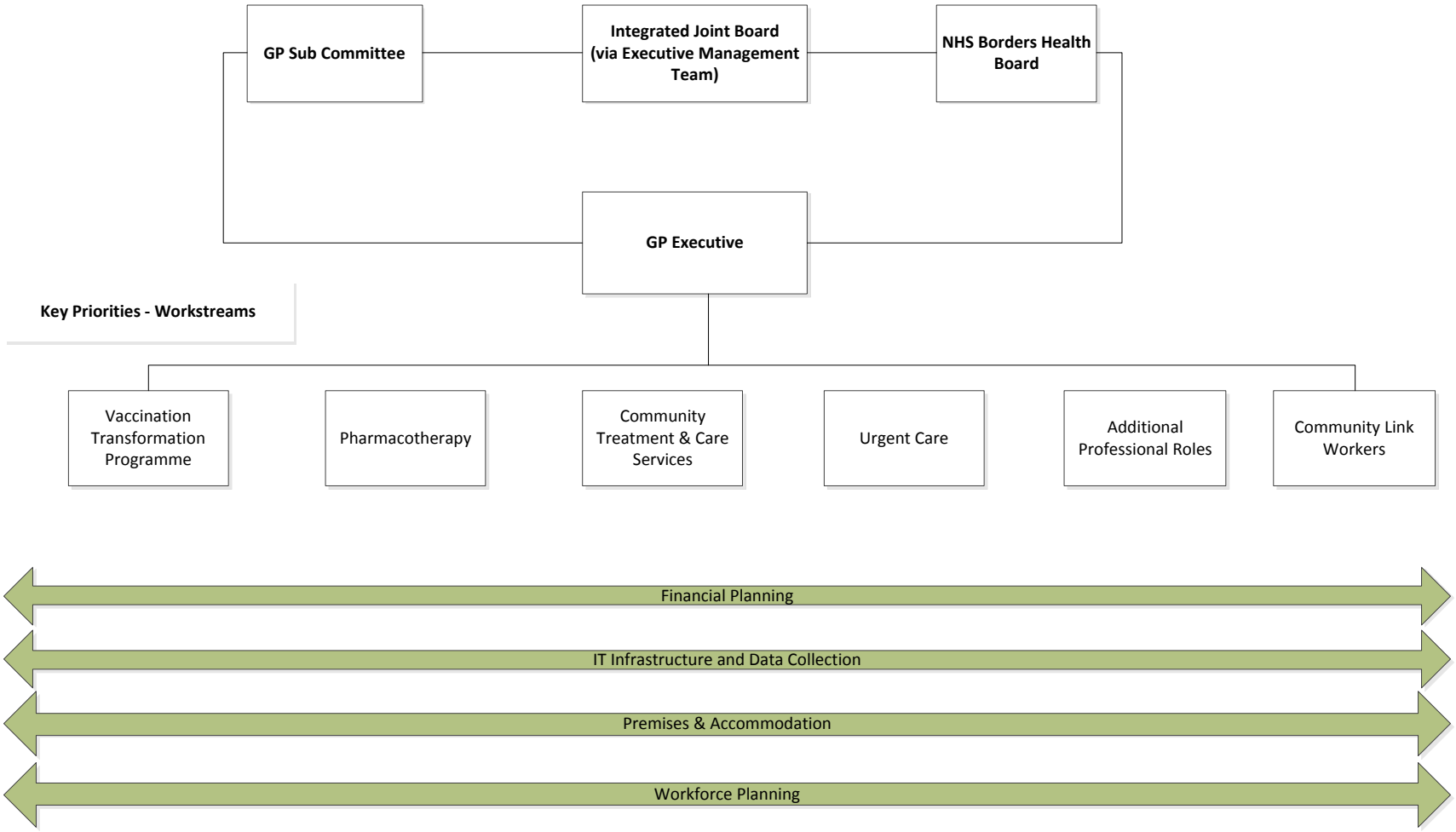
## 8. FINANCIAL PLANNING

Within the new governance framework, the GP Executive's Business Partner has undertaken a comprehensive review of the budget and commitments to date and has presented a confirmed financial outlook; this has been formally agreed by the GP Executive and allows robust forward planning. The information from this will inform the regular submissions made to Scottish Government in line with the required Local Implementation Tracker. The financial tables from the October 2019 submission is attached at **Annex C** and gives actual spend together with estimated planned costs for the years 2018 – 2022.

## 9. SUMMARY

This revised Primary Care Improvement Plan is set in the context of the recognised need to increase pace and progress across the programme and the consequent introduction of a revitalised local governance framework. The document reflects not only the good progress made over the last six months but also the more robust planning now in place for the remainder of year two and into years three and four. It is a dynamic working document and will be updated as the new services are progressed and implemented.

## Annex A Governance Structure



**Annex B GP Executive Membership**

Dr Kevin Buchan, Chair GP Sub Committee

Rob McCullochGraham, Chief Officer, Health & Social Care Partnership

Dr Kirsty Robinson, GP Sub Committee

Dr Tim Young, GP Sub Committee

Dr Rachel Mollart, GP Sub Committee

Vivienne Buchan, Business Partner, IJB

Sandra Pratt, Associate Director, Strategic Change, NHS Borders

Erica Reid, Acting GM, Primary & Community Services

Nicola Lowdon, Associate Medical Director, Primary & Community Services

Zena Trendell, Contracts Manager, Primary & Community Services

Mags Baird, Project Manager, PCIP

**ANNEX C**

**Table 1: Spending profile 2018 - 2022 (£s)**

| Financial Year | Service 1: Vaccinations Transfer Programme (£s) | | Service 2: Pharmacotherapy (£s) | | Service 3: Community Treatment and Care Services (£s) | | Service 4: Urgent care (£s) | | Service 5: Additional Professional roles (£s) | | Service 6: Community link workers (£s) | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Staff cost | Other costs (staff training, equipment, infrastructure etc.) | Staff cost | Other costs (staff training, equipment, infrastructure etc.) | Staff cost | Other costs (staff training, equipment, infrastructure etc.) | Staff cost | Other costs (staff training, equipment, infrastructure etc.) | Staff cost | Other costs (staff training, equipment, infrastructure etc.) | Staff cost | Other costs (staff training, equipment, infrastructure etc.) |
| 2018-19 actual spend | 0 | 0 | 340489 | 0 | 0 | 0 | 11044 | 0 | 0 | 0 | 0 | 0 |
| 2019-20 planned spend | 124980 | 29750 | 959075 | 0 | 15533 | 29750 | 250000 | 37250 | 644706 | 33750 | 45089 | 8000 |
| 2020-21 planned spend | 95490 | 0 | 974910 | 0 | 0 | 29750 | 1162766 | 33750 | 778855 | 33750 | 142439 | 8000 |
| 2021-22 planned spend | 95490 | 0 | 1004157 | 0 | 0 | 29750 | 1197649 | 29750 | 802219 | 29750 | 147401 | 8000 |
| Total planned spend | 315960 | 29750 | 3278631 | 0 | 15533 | 89250 | 2621459 | 100750 | 2225780 | 97250 | 334929 | 24000 |

**Table 2: Source of funding 2018 - 2022 (£s)**

| Financial Year | Total Planned Expenditure (from Table 1) | Of which, funded from: | | |
|---|---|---|---|---|
| | | Unutilised PCIF held in IA reserves | Current year PCIF budget | Unutilised tranche 2 funding held by SG |
| 2018-19 | 351533 | | 962647 | |
| 2019-20 | 2177883 | 440867 | 1157757 | 240404 |
| 2020-21 | 3259710 | | 2314561 | |
| 2021-22 | 3344166 | | 3261426 | |
| Total | 9133292 | 440867 | 7696391 | 240404 |