PCIP Borders
Primary Care Improvement Plan

Scottish Borders Primary Care Improvement Plan

(Revised)

2018-21

Working v5.0 Amended 12th November 2020

Scottish Borders Health and Social Care PARTNERSHIP

NHS Borders

VERSION CONTROL

VERSION REVISED TO:	DATE CHANGED	CHANGES MADE
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Working v2.0	15 / 11/19	Following approval of financial report at GP Executive 14/11/19, Workforce and Finance tables updated; page numbers amended.
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Working v 4.0	9 / 1 / 2020	Workforce and Finance tables updated
Working v5.0	12/11/2020	General update to all sections

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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.

In December 2019, Scottish Government asked to be informed of projected shortfalls in resource needed to fully deliver PCIP i.e. resource required in addition to the original committed allocation (which was £3.2m for Borders). Accordingly Scottish Borders identified £1.9m to be the local shortfall which largely consisted of the resource required to deliver CTAC and VTP (£1.5m). No additional resource has been received to date.

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 kilometer 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.

Change of title

During Covid 19, the four members of GP Sub Committee known as the GP Executive of the GP Sub Committee worked closely with NHS Borders and continue to do so as recovery and remobilisation progress. In July 2020, to avoid confusion over titles, it was agreed to rename the GP Executive Committee as the PCIP Executive Committee; as such this title is used from this point forward in this document.

The PCIP Executive Committee meets monthly and 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 PCIP Executive Committee has introduced a number of steps to ensure more robust planning, reporting and governance arrangements:

- The PCIP Executive Committee receives standardised highlight reports from each of the workstreams monthly. Scrutiny of progress takes place in line with the overarching programme plan and specifications laid down within the national contract. Any proposed changes to the workplans and workforce plans must be agreed by the PCIP Executive.
- The PCIP Executive Committee includes a designated Business Finance Partner who on a routine basis comprehensively reviews the budget and commitments in the plan and presents a confirmed financial outlook; this is formally agreed by the PCIP Executive Committee and allows robust forward planning. Finance reports are taken at each meeting where all proposed financial commitments must be approved.
- Post files have been established and specific financial coding has been attached to the PCIP posts so that the resources can be tracked and monitored.
- 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.
- NHS Borders agreed that all PCIP vacancies will be processed in an expeditious manner as they are resourced through ring-fenced PCIP funding which is not subject to any general savings requirements and must not be used to address any wider funding pressures. All PCIP vacancies are logged within NHS Borders processes so that they are noted as part of workforce records.

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. Each workstream also has a named GP Lead from the PCIP Executive Committee who works in liaison with the Band 8a postholder. 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.

An Health Inequalities Impact Assessment has been undertaken across the PCIP.

Operational Governance

Working in GP practices may be a very different experience for the new PCIP post holders; having these new staff and services sited in general practice will also be a new experience for the service managers and practice staff. In order to enable consistency of approach and understanding for all of the new posts and services being established through PCIP, three "Handbooks" have been developed; one for the new postholder, one for the GP practice and one for the service manager and /or workstream lead. The Handbooks set out what to expect of each other, what to do on the first day on site, general staff governance and what to do in different circumstances e.g. when a staff member needs to take sickness absence or a complaint is received etc.

To ensure equity of service provision across practices, equity of access to services for patients and equity of workload for staff members, the PCIP Executive Committee has put in place agreed specifications, definitions of role and workplans for all PCIP services. Using the principles of the clinical productivity programme supported by NHS Borders, clear expectations of clinical vs non-clinical activity proportions within workplans have been agreed for all posts

Ongoing Monitoring and Oversight of PCIP

The PCIP Executive Committee was established to oversee the PCIP Programme until its conclusion on 31st March 2021. However with reference to the points set out in this paper it is apparent that ongoing oversight and monitoring will be essential as the new posts and services move into mainstream delivery in order to protect the major investment in primary care delivered through PCIP and to safeguard the core aims and principles set out in the MoU as part of the national GP contract.

The risks of not establishing a robust oversight, governance and monitoring structure post 2020/21 have been summarised as:

- As vacancies arise and service managers change the understanding of what the posts were established to deliver may be lost and the posts (and associated resources) could then be used in other areas of service provision not linked to primary care or PCIP.
- Equity of provision across GP practices is a core element of the MoU and as services and organisational priorities change over time this focus may be lost which would be detrimental to patients and to GP practices.
- The Vaccination Transformation Programme will not develop.
- The Community Treatment and Care Service will only partially develop and lose focus.
- New career structures in clinical services and potential for professional growth will be limited.
- The progress in shifting the balance of care will be curtailed.
- The core values and principles of PCIP will be eroded.

These risks would lead to the default in delivery of the GP Contract in Borders.

It has therefore been recommended to GP Sub Committee, NHS Borders and IJB that consideration is given to the establishment of an ongoing oversight and monitoring function to support the PCIP services after the end of the PCIP Programme in March 2021.

It will be important that any such function is made up of senior-level representation from GP Practice, NHS Borders and H&SCP with delegated decision-making authority to ensure the continuation of the PCIP programme and framework.

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 outlined below.

However, at the outset of Covid 19, Scottish Government paused VTP for 12 months therefore the revised local model has not progressed. In line with the requirement to deliver flu vaccinations in 2020, the GP Executive has worked with NHS Borders to put in place local arrangements this year.

	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 Travel	Shingles (start) Seasonal Flu Adults 65 years and over Pneumococcal vaccines adults aged 65 years Flu Vaccines ('At risk adults' aged 18-64 years)
Progress		Reduction in healthcare appointments for pregnant women as all vaccinations are	Pre-school childhood programme Data gathering completed, this details the % vaccination uptake across all GP	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'

		now part of midwifery led care. Practice Nurse appointment time therefore freed up.	Practices and Clusters for the Scheduled routine vaccinations (Primary and Booster vaccinations) and Seasonal flu vaccinations for 2,3 and 4 year olds Draft Protocol developed to support local delivery model Model initially identified has raised some challenges and an alternative model has been proposed to Scottish Government (detailed separately below*) <u>Travel Health & Advice</u> - liaison with GP practices ongoing; likely to become Year 3 Outcome.	adults aged 18-64 Proposed alternative delivery model has been identified (see separate detail*). Approved Dec 2019. VTP paused by Scottish Government until 2021/22

*<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.

The proposal received approval from Scottish Government on 12th December 2019.

Pharmacotherapy

Since the introduction of the new GP Contract in 2018 the PCIP Executive Committee has invested **£896,538** (incorporating the previous PCIF resource £163,000) in pharmacy services which has enabled **21.5 wte** additional and permanent posts to be established to date in order to deliver the new pharmacotherapy model of service. The total earmarked resource for Pharmacotherapy in the original financial plan over the three year implementation programme was identified as **£1.1m**.

The Pharmacotherapy workstream has been complex and has had to contend with many variables e.g. recruitment issues, the need to change post bandings and skill mix which has then required the introduction of training programmes, access to accommodation etc. While it is appreciated that it hasn't been an easy landscape to manage operationally, from a PCIP Executive Committee there remains a lack of assurance that equitable access, value and consistent progress is being achieved.

In July 2020 the PCIP Executive Committee undertook a review of all investments and priority areas across the whole programme. Taking all of the above points into consideration, the Executive came to the difficult decision to halt the level of investment in the Pharmacotherapy workstream at the current position and to divert **£184k** (of the remaining earmarked funding of £203,462 in the financial plan) to contribute to the support required for the development of the Primary Care Mental Health Service workstream, described later in this section. This was supported by GP Sub Committee, IJB and NHS Borders.

This means that the committed investment of £896,538 to support recruitment to the level of 21.5 wte as approved to date will be honoured but there will be no further investment made into the pharmacotherapy service within the PCIP programme.

This decision has not been taken lightly however the investment in pharmacy services through PCIP at the level stated above has been significant; indeed it is a major proportion of the total funding allocation and has enabled the service to substantially grow and develop.

	Year 1	Year 2	Year 3
Plan /Outcomes	Develop a unified repeat prescribing system Ensure a sustainable process for hospital discharge letters Establish a process for medicines reconciliation	Embed the repeat prescribing system Create a process for Level 2 pharmacotherapy services	Fulfil outstanding Level 1 elements. Roll out the medication review & high risk medicines process 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. Process for Discharge Letters and Medicines Reconciliation has been progressed; one practice is still to be included in the roll out.	UPP awareness raising across practices. Pharmacotherapy reviews have been introduced in a number of practices and will be rolled out to all as the workforce plan progresses. Recruitment and development of additional technicians to allow roll out of support for IDLs.	Recruitment of 3 pharmacy technicians complete; training plan in place. Covid 19 has impacted the availability of accommodation in practices. Many staff have worked remotely during Covid and a Remote Working Procedure has been developed. Delivery plan reviewed in order to ensure equitable access to service across practices in light of recruitment and skill mix changes.

Community Treatment & Care Services

It has been acknowledged that there will be insufficient resource within PCIP allocation to fully deliver the workstream, however work is progressing to develop an appropriate model.

	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. Roll out to remaining NHS Borders Treatment Rooms. Develop plan for roll out to GP Treatment Rooms. Identify and plan interface with Urgent Care Workstream and establishment of ANP cohort.	Confirmation and of Treatment Room model and plan for roll out to GP Treatment Rooms. Implementation of the roll out plan for Treatment Rooms. Confirm plan for transfer of VTP services to treatment rooms in Year 4 Identify interface with wider MDT development and new 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. Roll out to remaining 6 NHS Borders Treatment Rooms will be complete by end of third quarter.	Review undertaken and new model for service delivery drafted; agreement for Phlebotomy to be first phase. The potential to support improved pathways across primary and secondary care has been identified and joint work is underway to develop the model accordingly. A series of three workshops has been arranged beginning 30th Oct to confirm the model to be progressed.

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 NHS Borders ANP strategy developed Begin recruitment of nurses to ANP roles	Develop local training pathway Demonstrate ANP roles working in two cluster areas (West & South)	Recruit remaining practitioners for coverage of all areas. Review of paramedic practitioner role. Outcome to inform wider development of service.
Progress	4 ANPs recruited for deployment into South and West Clusters. Governance and Communication protocols complete. Paramedic Practitioners Pilot in South Cluster established.	ANPs established in South and West Clusters Activity data collection processes for South & West clusters - review and confirm. Further 11 posts approved for recruitment by end of 2019/20. Local training pathway under development.	Recruitment has been very successful since June/July with however there have been limited fully trained applicants and therefore PCIP Executive agreed to appoint trainees and to establish a supported training process. It is anticipated that all posts will be filled by March 2021.

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. Framework for service developed.	Second phase of recruitment approved for a further 4 posts in 2019/20 Evaluation of service to take place before final recruitment phase is approved	Recruitment has improved significantly and it is anticipated that all posts will be filled by March 2021. In considering the economies of scale within this service as well as lessons learned from ways of working adopted through Covid 19, a review of the original delivery model has been undertaken and a revised approach agreed, which will see a virtual hub providing a single point of referral receipt and allocation.

Community Mental Health Workers

A "test of change" took place at one GP practice in October 2019 to test out a "see and treat" Mental Health model where patients with mild to moderate anxiety and depression were seen by a mental health practitioner and offered evidence based psychological therapy depending on their needs. The aim of this was to understand how the development of such a mental health model could assist GPs as well as offering an effective and efficient intervention to patients.

On the basis of a proposal following the success of this test of change, PCIP funding of £354k was allocated to scale the model up in one area as a first phase but due to a number of factors, this did not go ahead and further work was delayed because of the Covid 19 outbreak.

Once the immediate acute Covid crisis had abated it was decided to reconvene a group of key stakeholders from primary care, GP Practice and Mental Health in order to review the proposed approach and agree a primary care mental health model that could be developed across Borders.

A Primary Care Mental Health workshop took place in late May where shared goals and principles were discussed and agreed and subsequently a small sub group was remitted to consider possible models. On the 11th June 6 options were presented to the full group who undertook a non-financial options appraisal and a preferred option was identified. The preferred option was based on a "see and treat" model that utilises a skill mix/ Multi-Disciplinary Team approach. Assessment and treatment will take place in a variety of settings/formats and be as patient led as possible. Strong links will be made with secondary care and complementary/commissioned services to ensure that patients are able to get the most appropriate help with as few barriers as possible.

Following financial appraisal this model was identified as the overall preferred Borders-wide model at a cost of £845k per annum. Taking into account the already committed PCIP resource of £354k, this leaves a shortfall in funding of £491k. A joint funding solution between Mental Health and PCIP has been identified to resource this shortfall:

- Mental Health have committed to the repurposing of 3.7 WTE Action 15 Earmarked Funding into the new service, equating to £206k
- Following a robust review of PCIP priorities and resource commitments the PCIP Executive has identified a further £285k from within the existing financial plan to support the agreed model. This is made up of £184k from Pharmacotherapy as described previously and £101k across a number of other budget headings.

The PCIP Executive are confident that this is the most appropriate way forward and that the overall Plan will not exceed the £3.2 allocated resource envelope.

It has been agreed to name the new service "Renew".

	Year 1	**Year 2**	**Year 3**
Plan /Outcomes	Identify a service delivery model	First Implementer site to be established at one GP practice. Referral pathway confirmed. Evaluation of first implementer site and confirmation of plan. 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 consisting of Psychologists, CAAPs (Clinical Associate in Applied Psychology) now based in the first implementer practice; CPN recruitment underway. Referral pathway will be	Model reviewed and new approach agreed, joint funded with Mental Health services and PCIP. The model is based around Psychological Therapies. Began 5th October 2020 in two Clusters and will be Borderswide in Jan 2021.

		signed off Nov 2019. 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 Development of referral pathway for GP practices. 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. Staffing model identified.	First phase of recruitment complete. Recruitment to second phase underway.	

5. CHALLENGES AND RISKS

Across all of the workstreams a number of common challenges have been identified and described previously (below). Covid 19 has brought most of these challenges into sharper relief, in particular the difficulties in accessing accommodation and the call on appropriate IT infrastructure.

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.

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 to include 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. A whole-system review of primary care estate is to be undertaken which will feed into NHS Borders' Capital Management process which will include the requirements for PCIP.

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 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. Covid 19 has impacted on progress with this.

NHS 24

Colleagues from NHS 24 were previously in discussion with the PCIP Executive regarding a proposal to trial, evaluate and establish a Triage Programme in Scottish Borders whereby NH24 would 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. However, in recent weeks NHS24 has informed P&CS and PCIP Executive that they will no longer be pursuing this initiative and have diverted their resources toward the national programme for the Redesign of Unscheduled Care

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 table overleaf shows the current workforce plan in terms of 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.

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	2.3	1.4	0.0	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)	3.0	0.2	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
PLANNED INCREASE in staff WTE (1 April 2019 - 31 March 2020) [b]	3.4	4.2	0.0	0.0	0.0	7.8	0.0	0.0	0.0	3.4	0.0	4.5
PLANNED INCREASE in staff WTE (1 April 2020 - 31 March 2021) [b]	1.0	6.0	2.3	0.0	0.0	5.2	0.0	0.0	14.3	5.8	0.0	0.0
PLANNED INCREASE staff WTE (1 April 2021 - 31 March 2022) [b]	n/a	n/a	0.0	0.0	0.0	3.0	0.0	0.0	0.0	0.0	0.0	0.0
TOTAL staff WTE in post by 31 March 2022	9.7	11.8	2.3	0.0	0.0	16.0	0.0	0.0	14.3	9.2	0.0	4.5

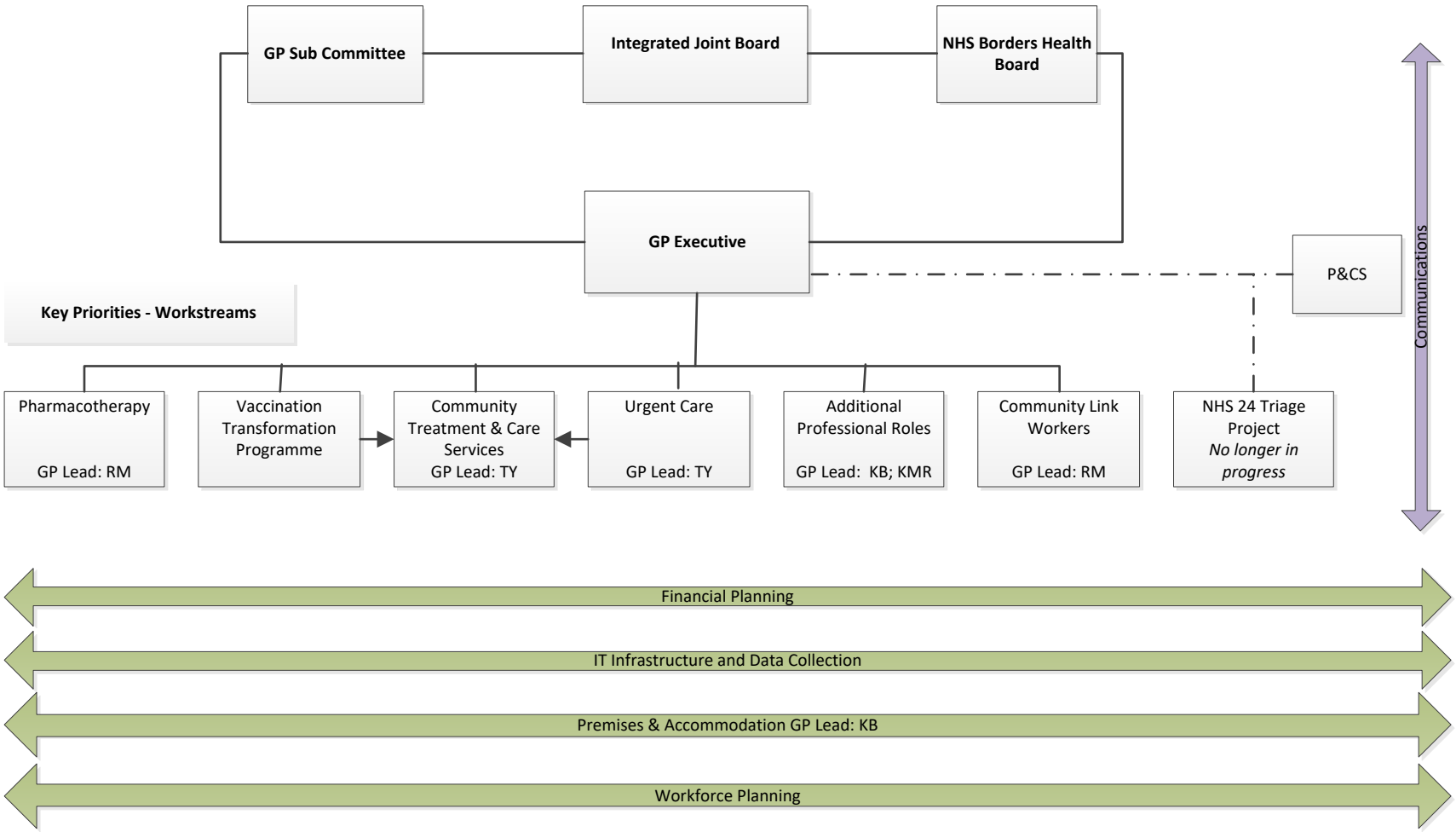
8. FINANCIAL PLANNING

Within the new governance framework, the PCIP 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 PCIP 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 2020 submission is attached at **Annex C** and gives actual spend together with estimated planned costs for the years 2018 – 2022. As described previously, Scottish Government has been informed of the £1.9m projected shortfall in resource needed to fully deliver PCIP in Borders, of which £1.5m relates to CTAC and VTP.

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 PCIP 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, PCIP Business Partner

Sandra Pratt, Associate Director, Strategic Change, NHS Borders

Chris Myers GM, Primary & Community Services

Nicola Lowdon, Associate Medical Director, Primary & Community Services

Simon Burt, GM, Mental Health Services, NHS Borders

Suzie Flower, ADoN, Primary Care NHS Borders

Paul Williams, Associate Director AHPs NHS Borders

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	339167		0	0	0	0	0	0	0	0
2019-20 actual spend	0	0	308576		0	0	354560	12500	177072	0	45089	4000
2020-21 planned spend	0	0	206541	54000	105000	12000	131095	27000	383843	27000	97350	4000
2021-22 planned spend	0	0	0	0	0	0	339826	29500	565295	37100	0	0
Total planned spend	0	0	854284	54000	105000	12000	825481	69000	1126210	64100	142439	8000

Table 2: Source of funding 2018-2022

Financial Year	Total Planned Expenditure (from Table 1)	Of which, funded from:		
		Unutilised PCIF held in IA reserves	Current year PCIF budget	Unutilised tranche funding held by SG
2018-19	339167		962647	
2019-20	901797		55980	139130
2020-21	1047829		994749	163008
2021-22	971721		945000	
Total	3260514	0	2958376	302138

ANNEX D **Proposed Ongoing Monitoring and Oversight of PCIP**

PCIP Ongoing Monitoring Oversight