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.

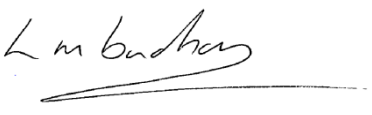
Now, through dedicated tripartite collaboration and partnership approach, the careful planning and implementation of our PCIP has successfully made use of its PCIP funding to provide significant workforce resources to practices. Recognising the limitations of funding, the process has been agile, innovative 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.

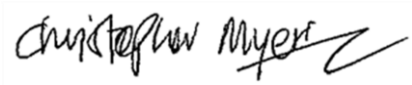
Sufficient funding remains our biggest challenge to date as we await national direction regarding future funding allocation to enable us to fully implement the GMS contract. We continue to work hard on squeezing out the maximum gains from our funding through continual oversight at PCIP Executive Committee. 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

Journey

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.

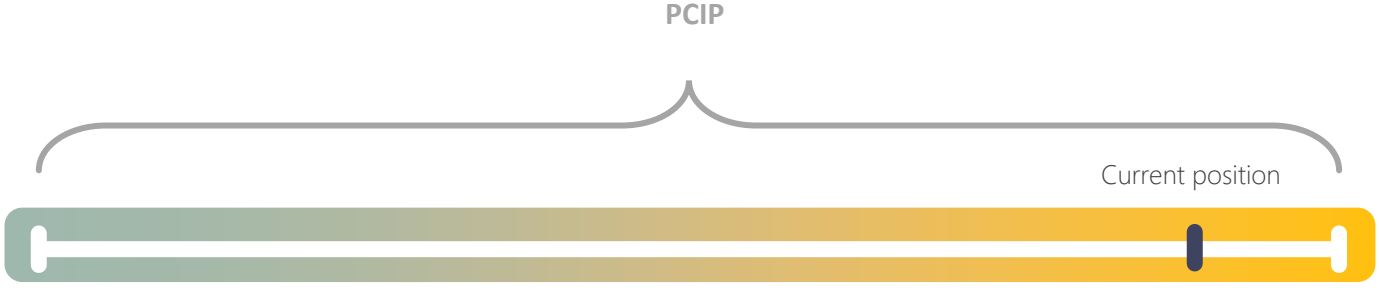
SG advised that all 6 MoU service areas should remain in scope, however following the SG/SGPC letter of December 2020, they agree that the following services should be reprioritized to the following three services:

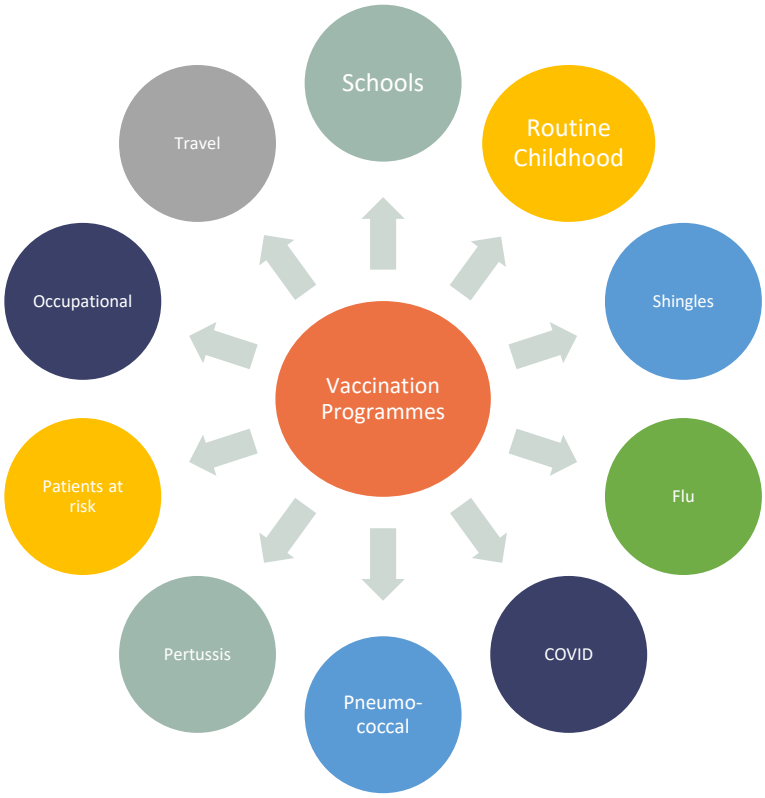
- Vaccination Transformation Programme (VTP)
- Pharmacotherapy
- Community Treatment and Care Services (CTAC)

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.





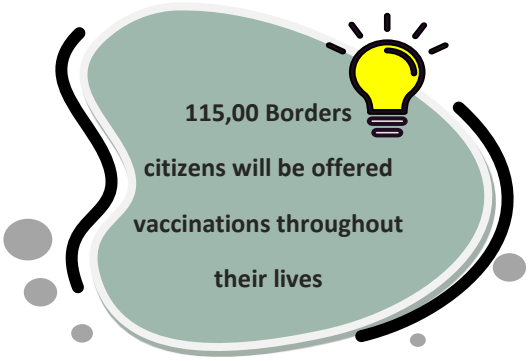
WHAT WE SET OUT TO DELIVER

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.

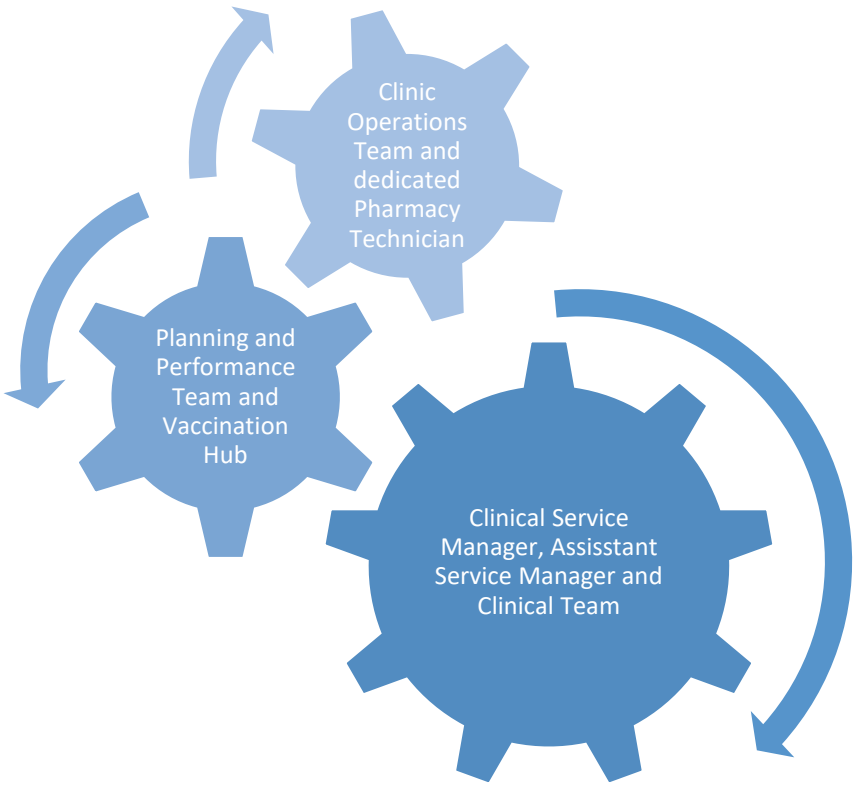
While the UK Joint Committee on Vaccination and Immunisation (JCVI) and Public Health Scotland (PHS) will continue to guide national policy and vaccination programmes, delivery must be managed and implemented by NHS health boards and their local partners to suit their local population, geography and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

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.

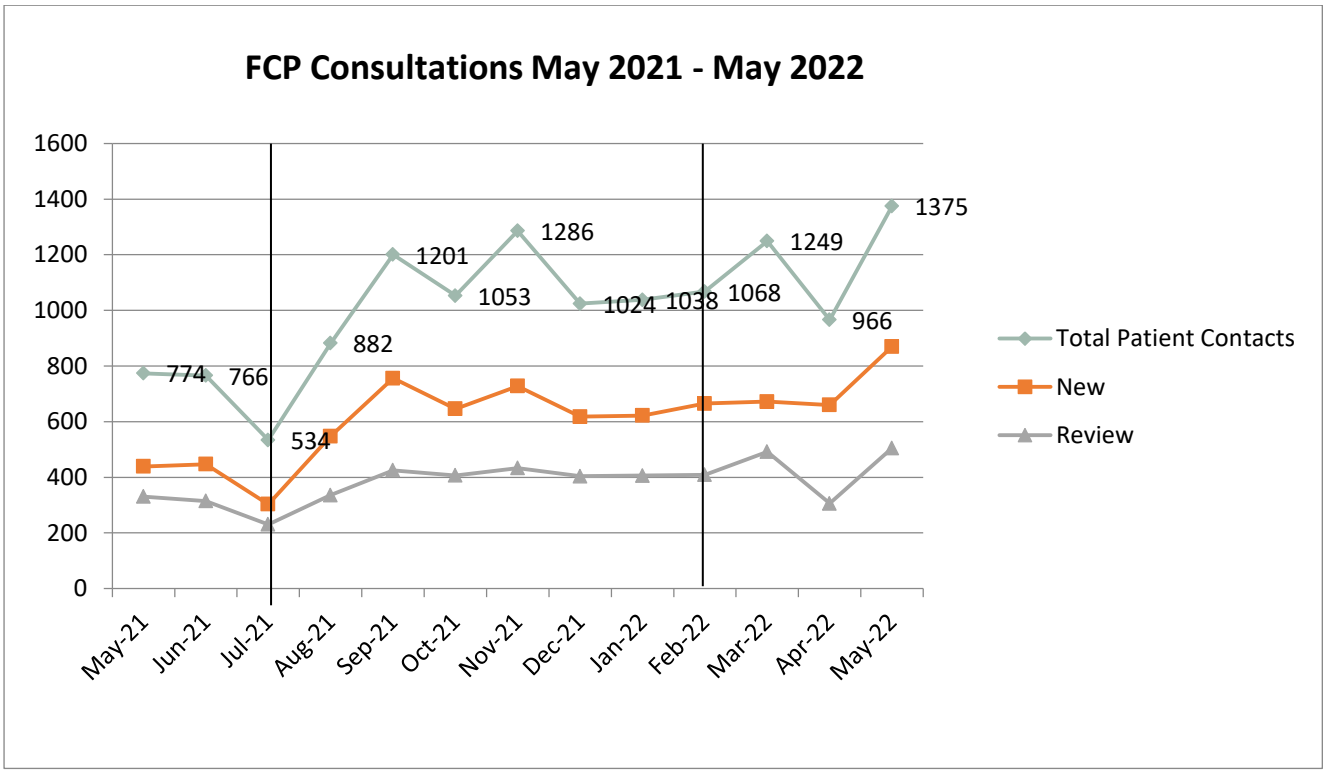
3. The APP lead represents The Borders at the National APP Primary Care Network.

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?

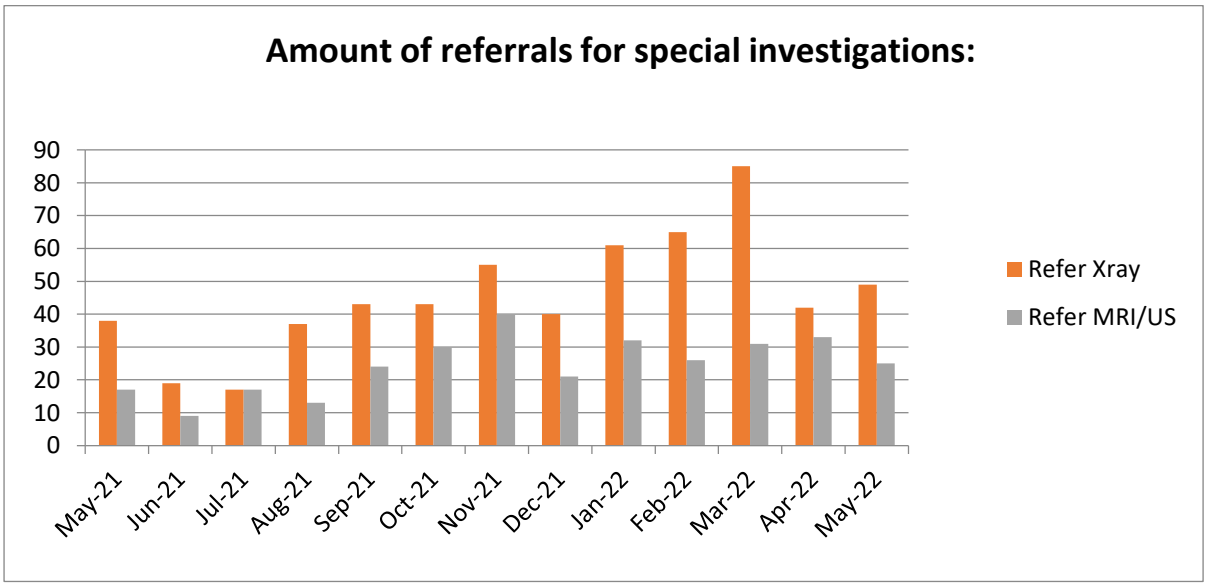
1) Impact on GP workload:



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.

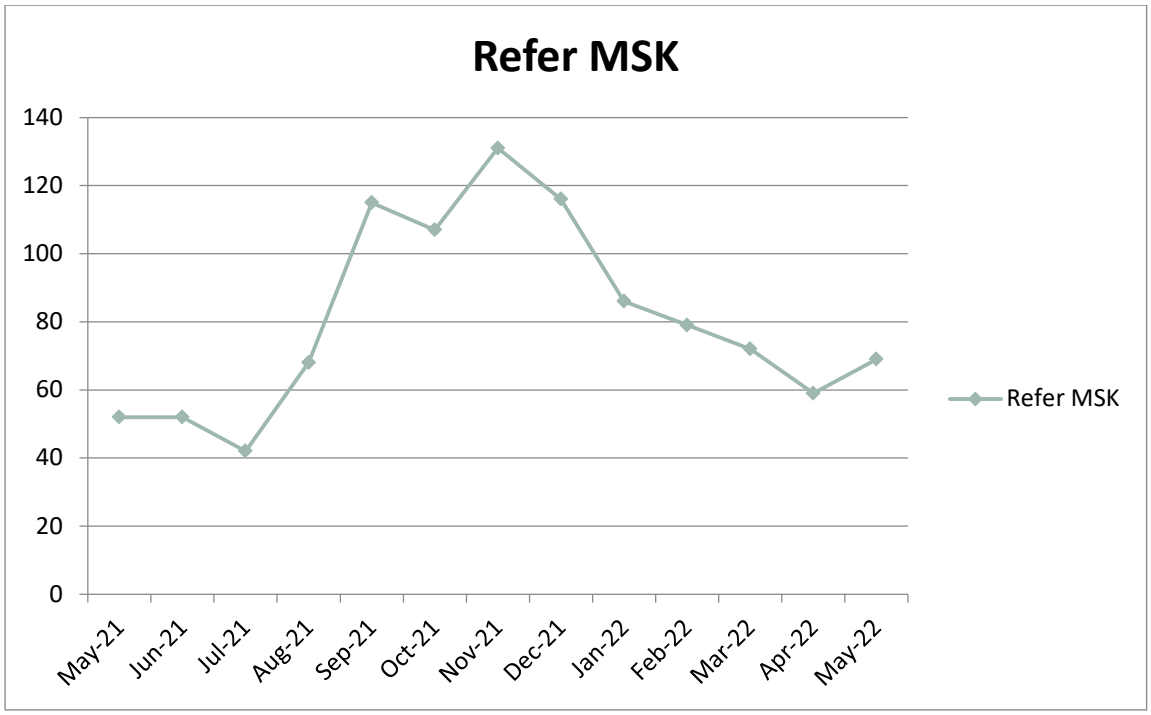
2) X-ray and MRI referrals:
    - 3.7% average referral rate for x-ray views
    - 2.1% average referral rate for MRI views



3). Wider system benefits:

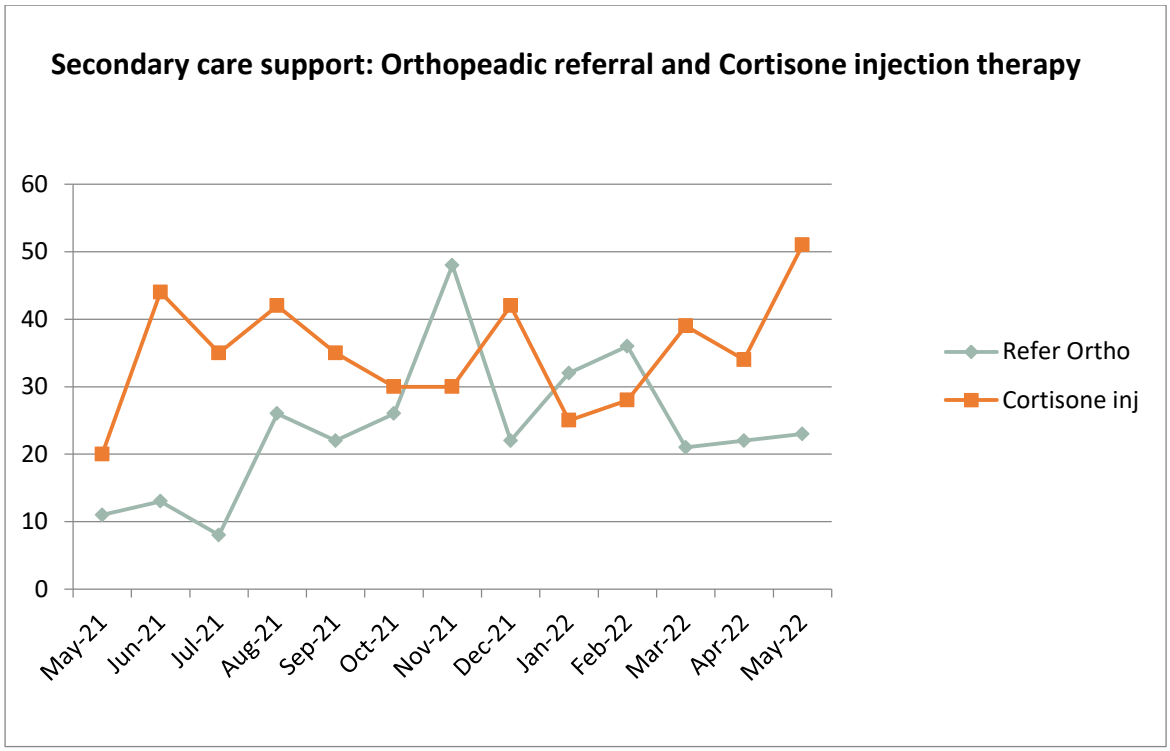
MSK activity:

- 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?

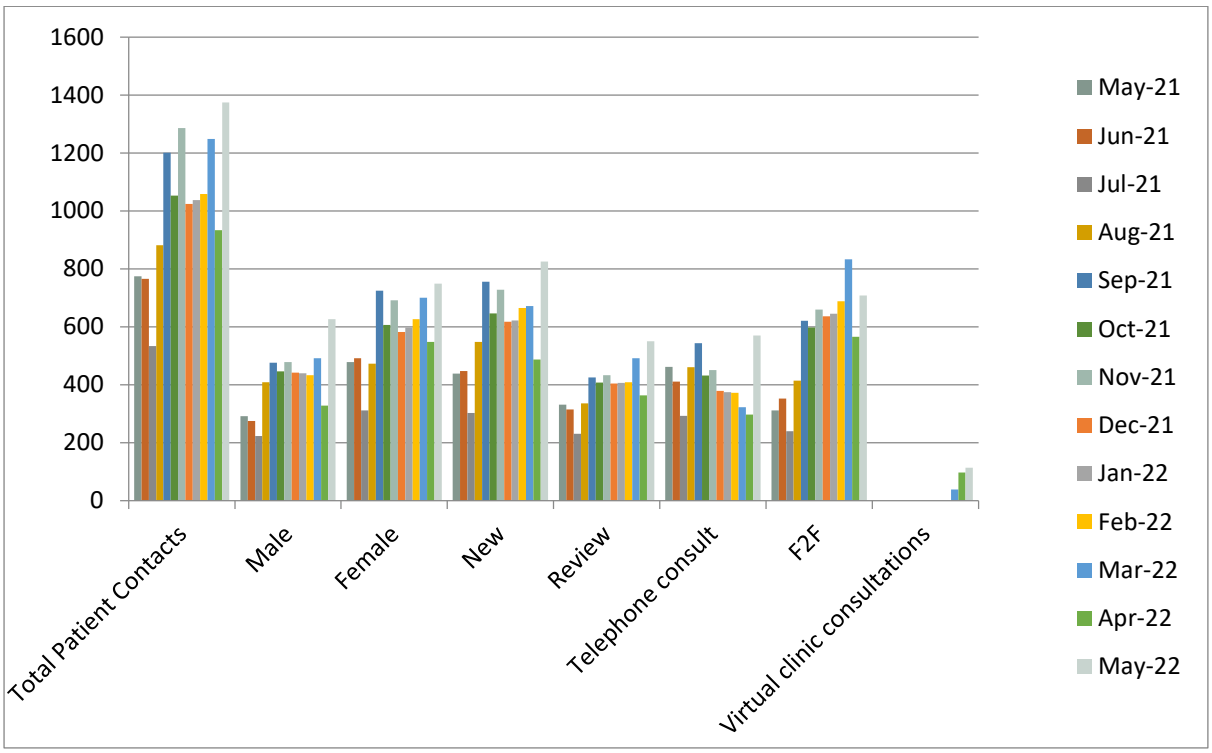
1) HR: To be in line with National service delivery of 1:12 000 population ratio over a 50 week service the Borders are in need of 372.61 additional FCP hours per week.

- 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

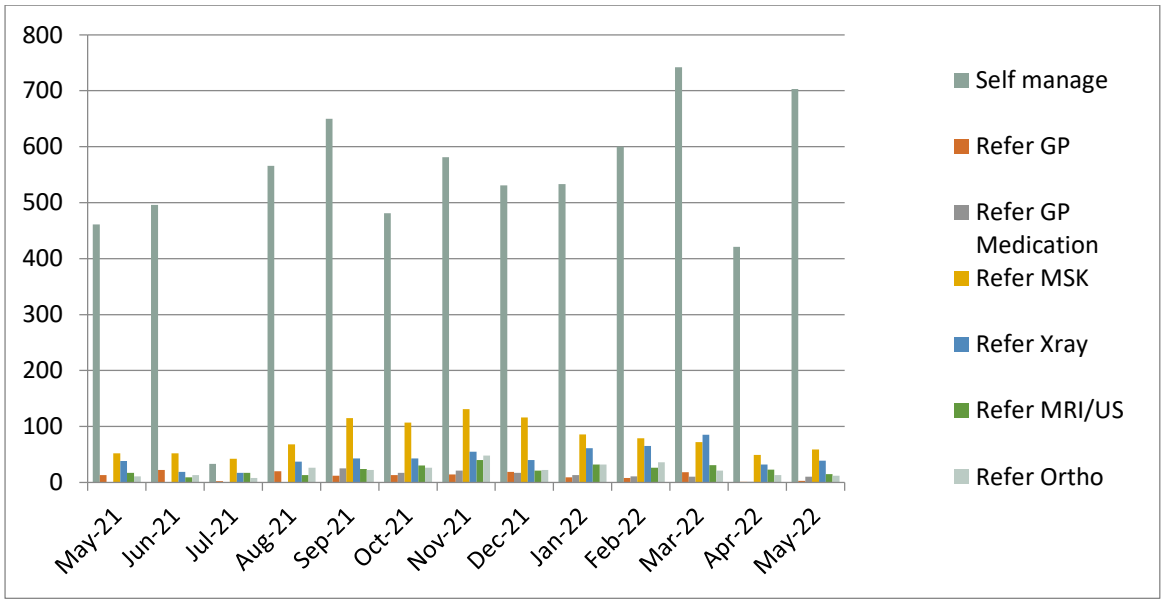
2) IT systems:

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.

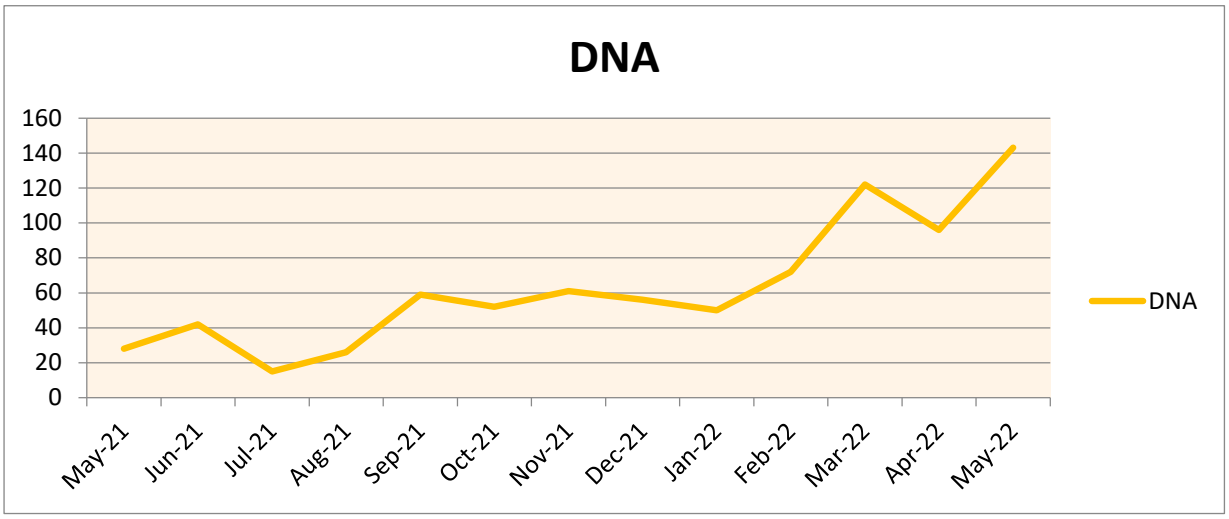
How do we deliver a virtual hybrid model?



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

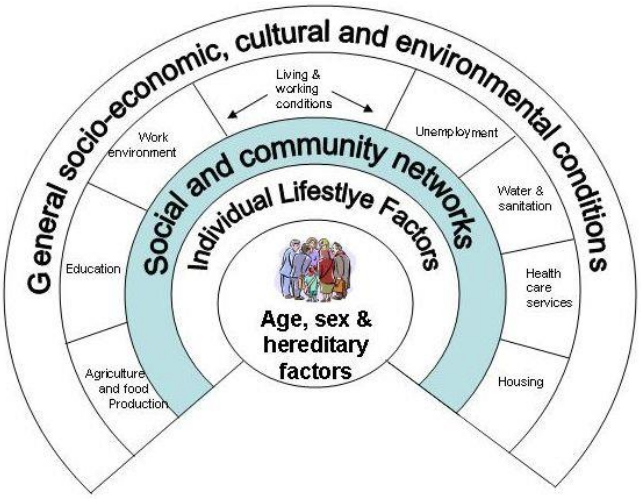
with community partners, third sector etc. to develop inclusive communities & in addressing gaps/unmet need in communities.

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.

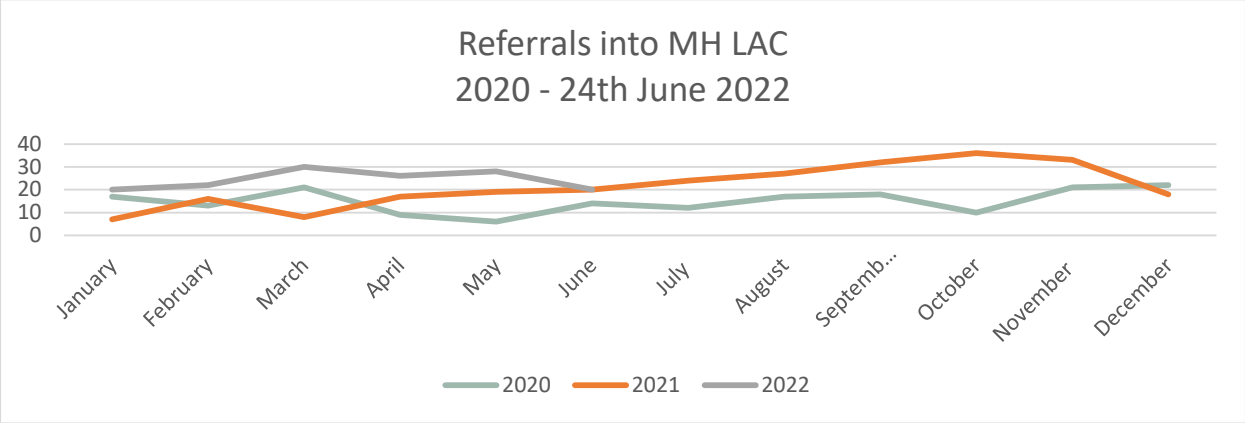
Our role in working with local communities:

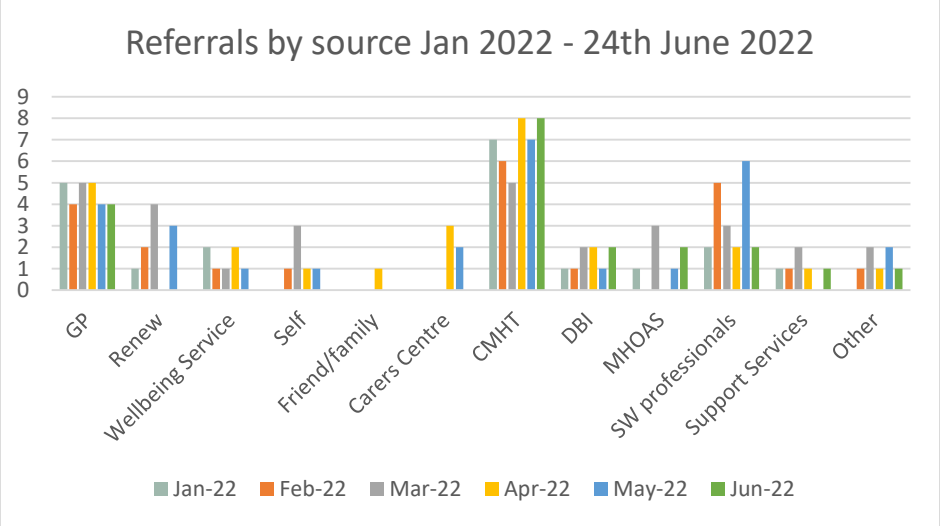
- Challenging stigma & discrimination.
- Enabling people to live as independently as possible in their own community.
- Raising awareness of what supports good mental health
- Working together to support the involvement of people.

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)

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Scottish Borders

PCIP Executive Committee