Scottish Borders Health and Social Care Partnership
Integration Joint Board

20 September 2023

Primary Care Improvement Plan
Annual Programme Report

Report by Cathy Wilson – General Manager, Primary and Community Services

1. PURPOSE AND SUMMARY

1.1. **To update the Integration Joint Board on progress made with implementation of the Primary Care Improvement Plan (PCIP) for period April 2022 – March 2023.**

1.2. The purpose of this report is to provide a comprehensive overview of the achievements, challenges, and future goals pertaining to the delivery on the commitments outlined in the General Medical Services (GMS) 2018 contract.

2. RECOMMENDATIONS

2.1. **The Scottish Borders Health and Social Care Integration Joint Board (IJB) is asked to:-**

a) note the content of the report attached in the attached report and consider the issues raised in the report.

3. ALIGNMENT TO STRATEGIC OBJECTIVES AND WAYS OF WORKING

3.1. It is expected that the proposal will impact on the Health and Social Care Strategic Framework Objectives and Ways of Working below:

Alignment to our strategic objectives					
Rising to the workforce challenge	Improving access	Focusing on early intervention and prevention	Supporting unpaid carers	Improving our effectiveness and thinking differently to meet need with less	Reducing poverty and inequalities
x	x	x	x	x	x

Alignment to our ways of working					
People at the heart of everything we do	Good agile teamwork and ways of working – Team Borders approach	Delivering quality, sustainable, seamless services	Dignity and respect	Care and compassion	Inclusive co-productive and fair with openness, honesty and responsibility
x	x	x	x	x	x

4. INTEGRATION JOINT BOARD DIRECTION

4.1. A Direction is not required.

5. BACKGROUND

5.1. New GMS GP Contract - 2018

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. The New GMS GP Contract refocused the role of GPs as Expert Medical Generalists (EMGs) working within a Multi-disciplinary Team (MDT). The aim of this is to reduce GP and GP Practice workload. New staff will be employed by Health Boards and will work with practices and clusters.

5.2. The Health Board would be required to shift GP workload and responsibilities to members of a wider primary care multi-disciplinary team when it is safe and appropriate to do so, while also demonstrating an improvement for patient care.

5.3. It is a requirement of the MoU that Integrated Authorities develop and review a local Primary Care Improvement Plan (PCIP). The aim of the plan is to identify and integrate key areas to be transformed to achieve the GP contract goals with the expectation that reconfigured services will continue to be provided in or near GP practices.

5.4. 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 reflected gaps in delivering the GP Contract Offer commitments as originally intended by April 2021.

5.5. 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.

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

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

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

5.8. November 2021

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.

5.9. March 2022

By March 2022 the Health Board had delivered VTP in full, partially delivered Pharmacotherapy (level 1 Acute Prescriptions) and CTAC was a still to be delivered. Modelling and planning were complete and implementation was waiting for funding allocation before it could go ahead.

5.10. August 2022

Allocation from Scottish was released in August 2022 and was insufficient for fully implementing CTAC. This triggered a review of the strategic plan as a new model was required to fit within the financial envelope. This led to a reduced model, CTAC Phase 1, providing only phlebotomy services.

5.11. March 2023

As a direct result therefore and without any dialogue with the Board / Partnership regarding how the position on these reserves may have changed since they were brought forward on 01 April 2022 or any legal, contractual or strategic commitments that may have been entered into during the year, the SG has unilaterally deducted the full £1.523m from Scottish Borders 2022/23 PCIF allocation, resulting in no Tranche 2 payment being made.

6. IMPACTS

Community Health and Wellbeing Outcomes

6.1. It is expected that the proposal will impact on the National Health and Wellbeing Outcomes below:

N	Outcome description	Increase / Decrease / No impact
1	People are able to look after and improve their own health and wellbeing and live in good health for longer.	Increase
2	People, including those with disabilities or long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.	Increase
3	People who use health and social care services have positive experiences of those services, and have their dignity respected.	Increase
4	Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.	Increase
5	Health and social care services contribute to reducing health inequalities.	Increase
6	People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and well-being.	Increase
7	People who use health and social care services are safe from harm.	Increase
8	People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.	Increase
9	Resources are used effectively and efficiently in the provision of health and social care services.	Increase

Financial impacts

6.2. As this report serves as a reflection on the previous financial year that concluded in March 2023, it is important to note that a comprehensive overview of the Primary Care Improvement Funding (PCIF) allocation and its impacts on future plans is provided in the full report.

6.3. For detailed information and analysis, please refer to page 45 in the attached report, where you will find a comprehensive breakdown of the financial allocations and their effects on our future initiatives.

Equality, Human Rights and Fairer Scotland Duty

6.4. In 2018, Health Boards were informed that national Health Inequalities Impact Assessment had been conducted, relieving them of the requirement to complete a local PCIP strategic impact assessment. However, starting from April 2023, we now recognise the importance of fulfilling our legal duty by conducting comprehensive impact assessments for PCIP.

6.5. As evidence of our commitment, the recent PCIP Bundle Proposal work and its associated impact assessments for each distinctive workstream exemplify our dedication to compliance with our responsibilities. These assessments provide robust evaluations of the potential effects of our initiatives on equality, human rights, and our fairer Scotland duty.

6.6. Moving forward, we acknowledge the need to complete impact assessments for each outstanding workstream, as emphasised in the recent PCIP 6 Letter. In our next Annual report (due in June 2024), we will seamlessly integrate our findings and patient outcomes under each service of the 2023-2024 report. This integration will ensure patient engagement, transparency, accountability, and a comprehensive understanding of the impact of our plans.

Legislative considerations

6.7. The primary legislative consideration is the delivery of the 2018 GMS contract through the PCIP contract. Implementing CTAC is a core element of this proposal. Delivery of this service will mean we will meet the stipulations in the contract by delivering the services outlined in the Primary Care Improvement Plan.

Climate Change and Sustainability

6.8. Reduced travel in provision of Pharmacotherapy and continued provision of CTAC locally in the community and making this sustainable long terms will mean reduced travel to for associated staff and patients respectively. This will have Carbon reduction impacts and will also decrease impacts of transport on air quality.

Risk and Mitigations

6.9. Failure to deliver PCIP presents a number of strategic and operation risks to the IJB and Health Board:

Risk	Description
Access to Primary Care Services	Providing a CTAC service is essential to providing a safe, equitable and accessible community-based healthcare. By failing to deliver this, it is likely that patient access to primary care will be limited by capacity and that this may vary by practice/location.
Access to Secondary Care Services	The delivery of a primary care CTAC service provides the foundation for an enhanced CTAC model (Secondary Care access to CTAC services), moving workload away from hospital services. Without primary care CTAC this is unlikely to be deliverable.
GP engagement	GP Practices may choose to implement a work to rule approach to various pharmacotherapy and CTAC services – following BMA guidance[5]. This would push activity back to secondary and acute care services increasing pressure at Hospital front door.

GP Sustainability	There is a risk that primary care provision within general practice will be unsustainable and the local population will not have access to adequate primary care services. The Health Board is responsible for the provision of GMS to its local population. Should a GP Partnership give notice on their contract it will be up to the Health Board to find a mechanism to continue service delivery. This may mean undertaking a tender exercise to find another provider or it may mean the Health Board taking on responsibility for service provision and running the practice as a 2c model. There is evidence that 2c practices are more expensive than independent GP practices.
Contract Failure/-Penalties	The Health Board is responsible for delivery of the 2018 GMS Contract. Failure to implement PCIP will result in failure to deliver the contract. Should PCIF funds not be fully utilised, additional 'transitionary' payments will be incurred. These additional payments will represent additional expenditure at no added value.
Management Capacity	The capacity of the existing P&CS management team is insufficient to undertake the potential increased activity that arises from failure to meet the contract and the consequent impact on GP sustainability within Scottish Borders.
Polypharmacy Enhanced Service	Delivery of Polypharmacy savings is predicated on GP engagement. There is a risk that GPs do not have sufficient capacity, or otherwise do not wish to engage with the delivery of the polypharmacy programme.
Polypharmacy Fees	GPs have indicated a rate of £39.60 per review is contingent upon delivery of the proposed investment in PCIP. Should this fail to be delivered the proposed rate would revert to £70.00 per review at an additional cost of up to £243k.
Polypharmacy Savings	There is a risk that the level of savings achieved through polypharmacy reviews is insufficient to support the additional investments identified. Savings are modelled on information provided within the national polypharmacy guidance which indicates a range of between £50-£200 per review (net prescribing cost reduction). Should savings delivery be at minimum levels this would result in net benefit (after GP fees) of £83k. This is insufficient to deliver the required investment and it is likely that the GP fees abatement would therefore be removed and a further liability of £243k incurred in addition to failure to deliver the proposed model. This would result in a net deficit on the polypharmacy service of £160k, although recurring savings of £400,000 would be realised after year 2.

7. CONSULTATION

Communities consulted

7.1. Impact Assessments currently exist in draft mode for outstanding CTAC and Pharmacotherapy models.

7.2. To engage with affected groups, and understand the impact of this proposal on relevant communities, a new engagement exercise will be carried out.

Integration Joint Board Officers consulted

7.3. The IJB Chief Financial Officer and the IJB Chief Officer have been consulted, and all comments received have been incorporated into the final report.

Approved by:

Chris Myers – Chief Officer, Health and Social Care Partnership and IJB

Author(s)

Cathy Wilson – General Manager, Primary and Community Services
Owain Simpson – Senior Project Manager, Primary Care Improvement Plan

For more information on this report, contact us at primary.care@borders.scot.nhs.uk

PCIP Borders
Primary Care Improvement Plan

2023

Primary Care Improvement Plan

Annual Programme Report

PCIP Executive Committee Report

“There is more to be done. As services mature, we need to look more widely at the whole system, taking into account health inequalities and GP sustainability across NHS Borders. We need to be creative in how we are able to deliver the GP Contract and strengthen Primary Care locally.”

- Dr Rachel Mollart

GP Sub-Committee Chair

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Foreword

Notes from the PCIP Executive Chair – Cathy Wilson

In the ever-changing landscape of healthcare, the Scottish Borders has embarked on a journey to transform primary care services through the Primary Care Improvement Plan (PCIP). Last year, faced with financial challenges, we set out on a path of innovation and progress, aiming to implement and deliver the General Medical Services (GMS) 2018 contract.

Looking back on the year ending in March 2023, this report serves as a reflection of the remarkable progress made in implementing the PCIP in the Scottish Borders. With tripartite collaboration and careful allocation of PCIP funding, we have been able to provide significant workforce resources to practices to help meet the needs of our patients. We have adopted an agile and innovative approach, responding to the evolving needs of our patients. The positive impact that this work has had on practice workload and the support it has provided to meet healthcare needs has served as a powerful motivation for all involved.

However, funding availability continues to be our greatest challenge. As we eagerly await national direction regarding future recurring funding allocation to support rapid and full implementation of the GMS contract, we remain dedicated to maximising the potential of our current resources. The PCIP Executive Committee has undertaken meticulous oversight to ensure that every opportunity for improvement is identified – even prepared to make difficult decisions to prioritise and safeguard the services that would have the greatest impact on GP sustainability.

I would like to express my deepest gratitude to our valued patients, GPs, and all the dedicated individuals and organisations that have contributed to the progress and success of the PCIP. Your commitment and unwavering support in our shared goals are deeply appreciated. United in purpose, we are transforming primary care, one milestone at a time. With a deep focus on GP sustainability, we are creating a future where exceptional healthcare is accessible to all – leaving an indelible mark on the wellbeing of our communities.

Notes from the Chair of the GP Executive – Dr Rachel Mollart

Reflecting on the last year of PCIP development in NHS Borders we need to remember a lot has been achieved, with high levels of recruitment and retention across all work streams within the financial envelope from Scottish Government. We have a highly efficient PCIP Executive Committee where decisions are made with rigorous financial scrutiny and tripartite agreement, getting the best value for every pound spent.

Despite this the GMS 2018 GP Contract remains partially delivered following delivery date 1-4-23. GP's are in desperate need of this support. Significant financial challenges for contract delivery have been faced in the last year with Scottish Government withholding a proportion of Tranche 2 money despite PCIP Executive Committee having committed NHS Borders unspent reserve. This has severely limited our ability to develop and expand PCIP work streams. With limited resource, capacity within some work streams is capped resulting in an inability to remove all the designated

workload from GP's. This workload is passed back to GP's to continue to complete when often it is no longer GP's contractual responsibility. As new services mature and become embedded in GP practices, Scottish Government need to follow with commitment to ongoing baselined recurrent funding including uplift for pay awards, work force planning and consideration given to the realistic cost of full contract delivery.

There is more to be done. PCIP Exec plan to expand data collection to allow measurement of efficiency in service provision and value for money; this will be supported with improved data collection systems. As services mature we need to look more widely at the whole system, taking into account Health Inequalities and GP Sustainability across NHS Borders. We need to be creative in how we are able to deliver the GP Contract and strengthen Primary Care locally, with increased investment through saving opportunities or unspent reserves. Expanded delivery of GP Contract and investment in Primary Care will result in improved patient care and outcomes with highly functioning multi-disciplinary teams delivering high value care in community settings; right place, right person, right time.

Notes from the Chief Officer of the Integration Joint Board – Chris Myers

Primary Care providers including General Practices work to support the needs of people across the Scottish Borders as the front door of the health service. However, in the context of increasing need and our rural GP recruitment challenges, access to General Practice was a key theme highlighted by our communities as part of the engagement for our Health and Social Care Strategic Framework.

Our Primary Care Improvement Plan is fundamental in rising to our workforce challenges to improve access. The redesign outlined in this plan, along with the recruitment and training of a significant number of skilled healthcare professionals across our community services, means that we have a more diverse workforce expertly supporting a significant and growing number of people who need access to services in Primary Care, and onward to the broader Health and Social Care Partnership.

I would like to thank everyone involved in the implementation of the Primary Care Improvement Plan for making great strides forward over the past year, so that people who need Primary Care services have improved access and get the right care, in the right place at the right time.

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

Dr. Rachel Moüart
Dr Rachel Mollart
GP Sub Chair
GP Executive

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

“United in purpose, we are transforming primary care, one milestone at a time. With a deep focus on GP sustainability, we are creating a future where exceptional healthcare is accessible to all – leaving an indelible mark on the wellbeing of our communities. “

Cathy Wilson – Primary and Community Services General Manager

& PCIP Executive Chair

PCIP Timeline

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

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

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

2018

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

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

SG funding 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 programme 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 remobilisation progress.

Journey

December 2021

Joint letter SG/SGPC

In December 2021, the Government issued a letter announcing an 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

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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.

March 2022

Position

The position at the end of March 2022, against the three priority areas from MoU2, was as follows:

- Vaccination Transformation Programme (VTP) – delivered in full (supported by non-recurrent funding)
- Pharmacotherapy (level 1 Acute Prescriptions) – partially implemented
- CTAC – not yet implemented

Modelling and planning were complete for final implementation however this was paused pending confirmation of resources to support further investment.

August

2022

Scottish Government Annual Allocation

Scottish Government confirmed the 2022/23 PCIF allocation in August 2022. In common with the position across NHS Scotland, the level of funding available to primary care within Scottish Borders was insufficient to meet the projected costs outlined within the local PCIP.

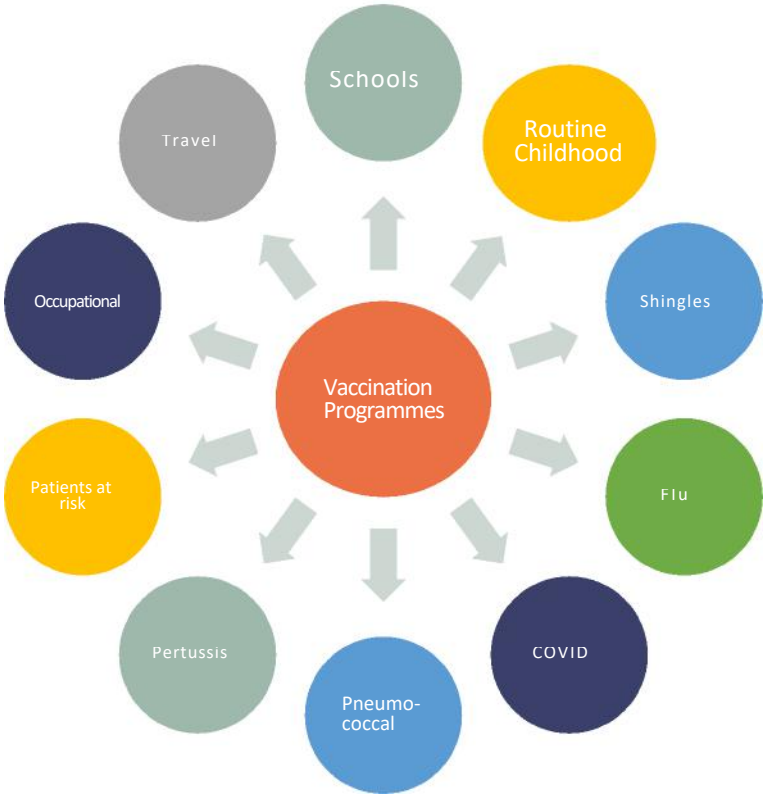
At this stage a strategic review was undertaken which identified a revised CTAC Phase I model to deliver a minimum PCIP commitment. Discussions on implementation were predicated on use of non-recurrent resources held within the IJB reserves to bridge investment pending confirmation of future Scottish Government allocations.

March

2023

Adjustment to Health Board's Funding Allocation

In March 2023 Scottish Government made adjustment to the Health Board's RRL funding allocation to offset slippage on prior year PCIF allocations against funding allocated in 2022/23. This adjustment had the effect of reducing non-recurrent IJB reserves held for PCIP by £1.523m – this triggered a review of Scottish Borders' PCIP strategic plan.



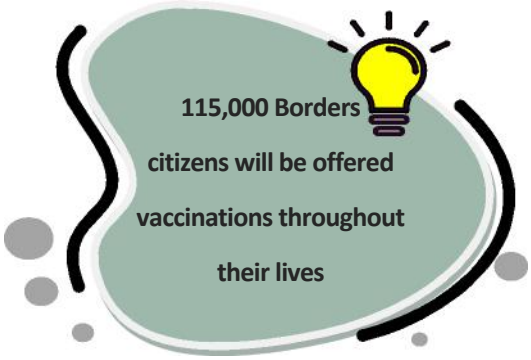
WHAT WE SET OUT TO DELIVER

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.

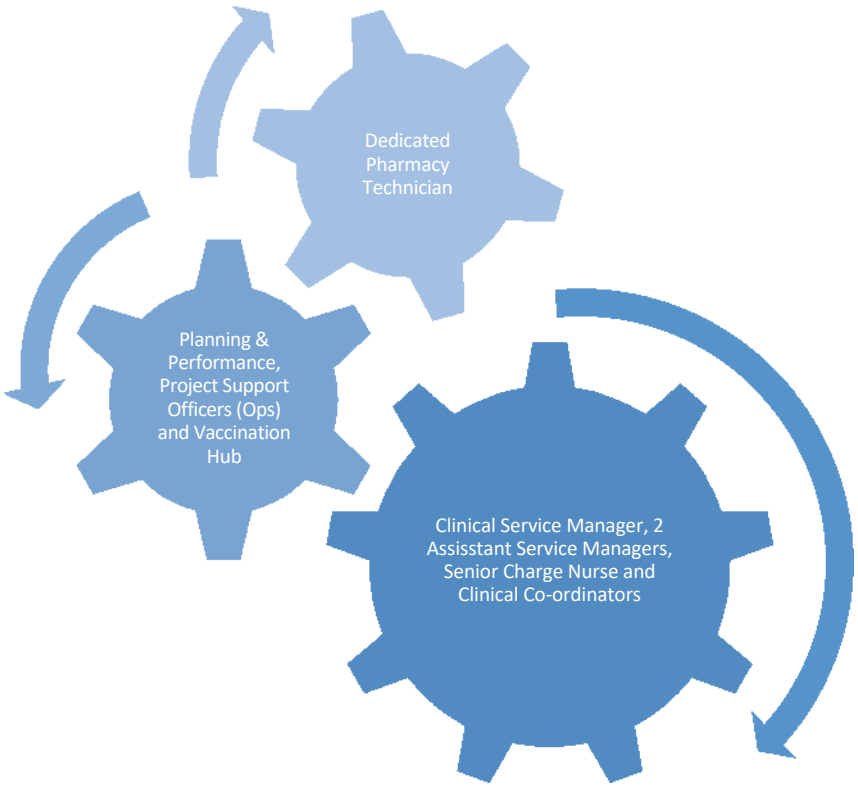
While the UK Joint Committee on Vaccination and Immunisation (JCVI) and Public Health Scotland (PHS) will continue to guide national policy and vaccination programmes, delivery must be managed and implemented by NHS health boards and their local partners to suit their local population, geography and 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 two Assistant Service Managers (Planning and Operational) and the following staff:

- Senior charge nurse, Clinical Co-ordinators, vaccinators (nurses) and healthcare support workers.
- Planning and performance Co-ordinator to manage planning, uptake monitoring, change and improvement Project Support Officers manage clinic set up, logistics, kit and vaccine transport.
- Vaccination Hub for patient contacts, admin and staffing, including a coordinator, supervisors, admin officers and call handlers.
- 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 (31 March 2023)	Permanent		Fixed Term		As & When	
	In Post	Vacant	In Post	Vacant	In Post	Vacant
Clinical Management	2.0	0.0	0.0	0.0	0.0	0.0
VTP (Babies, Pre-School, Travel & Selective)	3.6	0.00	0.00	0.00	0.00	0.00
Adult Vaccinations (Shingles, Pneumo, Flu & CV- 19)	4.0		0.00	0.00	0.54	0.00
School Immunisations	5.06	0.00	0.53	0.00	0.00	0.00
Total:	14.66	0.00	0.53	0.00	0.54	0.00

VACCINATION ACTIVITY & UPTAKE- As of March 2023, the Vaccination Service has given over 493,000 vaccinations, including over 347,00 COVID vaccinations (since December 2020), and 146,00 vaccinations across routine childhood, pneumococcal, shingles, flu, selective and travel programme.

Programme	Vaccinations given	Uptake range
Routine childhood (baby/pre-school)	16,500	94 – 97%
Pneumococcal	7,500	67% uptake – eligible every 5 years 63% uptake 2 – 64 at risk 43% uptake over 65
Shingles	4,000	71% uptake aged 70 -79 71% overall uptake
Selective referrals	500	-
Travel	500	-
Flu	117,00	55 - 93% (all programmes)
COVID	347,00	86 – 99%

"Very efficient service. I did not have to wait to get my vaccinations and was directed straight away to a vaccinator who discussed the vaccines I was getting"

"My husband had an appointment for his jags and asked if could get mine they were very obliging and I came up ¡i today and received both of mine"

"Initially it was tricky to book online and first available appointment was 3 months away. However yesterday my sister suggested I try to reschedule and I got my appointment for today!"

"deserves a medal for being a lovely vaccinator- very kind and put me at ease"

Public Feedback:
Childhood Vaccinations

"The receptionist was so helpful and the vaccinator was child-friendly and she explained properly about the vaccine and the effects after. Very satisfied"

"Very friendly vaccinator who spoke to my child as well as me and made us both feel very comfortable for a quick pleasant visit"

What we set out to deliver

The GMS Contract (2018), subsequent Memorandum of Understandings and the draft directions released in April 2023 outlined a commitment to the development of HSCP (Health and Social Care Partnership) 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 28 whole time equivalent (WTE) completing work raging from the original Level 1 – 3 as per the GMS 2018 contract. NHS Board allocated staff funded prior to PCIP were later removed early on in the plan to refocus on efficiencies, reducing the workforce to 21 WTE with further funding cuts leading to a current workforce of 16wte (Pharmacists and Technicians).

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 organised mainly focusing on supporting Level 1 prescribing, hospital discharge letters, clinic letters and repeat prescribing (increasing serial prescribing). This service has continued up until now, the release of the draft directions in April 2023 will necessitate a change in direction of service delivery.

The Pharmacotherapy service is now defined as ‘Management of all acute and repeat prescriptions, medicines reconciliation, performing polypharmacy reviews and serial prescribing (GP to only provide immediate care to prevent injury of a patient or the worsening of a patient’s clinical condition). Making available sufficient staff to ensure that an adequate service continues to be available, during annual leave, sickness absence or parental leave taken by the staff who routinely operate the service.’

Workforce

Based on our 2018 original plan we would have had 1wte member of pharmacy team per 5000 patients, with the reduction in funding available the ratio is now 1wte to 7500 patients. The team consists of staff ranging from Band 4 technicians to Band 8a pharmacists which provide a good spread of skill mix to complete the levels 1-3 pharmacotherapy work.

What has been achieved by March 2023?

Workload

Data collection has been a focus of work. The project began by creating task sheets for staff members to use as a guide in completing assigned work. These sheets include the necessary read codes that need to be referenced. A new read code template includes all the codes required to record the daily work completed by each staff member to maximize the data collected for review. This focus has also gained the support of stakeholders to utilize software now available to us (EMIS Enterprise), which will automatically pull this data from the practices, in contrast to the staff having to run manual searches.

We have learned that practice workload for Level 1 tasks is subject to wide variation (complexity of work assigned to the team, level of experience, skill mix and different practice demographics are key components of this), to minimise variation this is being addressed by standardisation of practice work using the Universal Prescribing Policy and the use of task sheets developed by the team. The suggestion of allocating staff to practices based on treated patients and not practice size would allow a pharmacy service to be provided based on equity rather than equality.

Service Delivery

A wide variance in the work that each practice would like the team to complete, that is the skill set of the team and how work is completed in practice, has led to significant challenges in delivering an equitable service. With this fact now realized, the team has turned their focus in conjunction with the pharmacy support workers to deliver increased serial prescribing as this can benefit many aspects of day-to-day GP practice work. The prompt for an annual review provides patient safety measures.

There has been an initial review to consider developing HUB working for the pharmacotherapy team, this will provide peer support and daily supervision of the team. We also expect hub working to allow sharing of work between staff members. The sharing of workload between staff members is expected to improve workflow implementation for immediate discharge and clinic letters.

Acute Requests

Acute requests are in many practices the main workload assigned to the Pharmacotherapy team. Although difficult to ascertain exact numbers, the team are beginning to take active steps to reduce the quantity by utilising other services available, for example serial prescribing and use of limited repeats. We have taken steps to collaboratively work with Health Improvement Scotland to reduce the numbers, which will increase safety of prescribing and equity in the service.

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 2023/24 to maximize the number of repeat medications that are managed via the serial prescribing route, currently we average at 4% over the Board.

Workforce Development

Over the past 48 months, we have been developing 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; one who is awaiting their registration certificate, two who will qualify spring 2024, and two who will qualify in Autumn 2024. Of these trainee pharmacy technicians, we only have permanent positions for three of the five trainees due to budget demands on the service. The pharmacist team consists of nearly 70% Band 8a pharmacists, reducing the progression available for less experienced pharmacists in years to come.

GP Impact

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

With the proposed draft directions from Scottish Government the model of pharmacotherapy in NHS Borders will need to respond to support delivery of the directions.

Key Risks:

Service resilience has been challenging, trying to maintain a service with vacancies is not possible. The definition of Pharmacotherapy previously quoted, includes covering annual, sickness and parental leave. The difficulty with this ask is that with low team numbers there is very limited flex in the allocations to move staff without leaving other noticeable gaps in practices.

Remote working from hubs is a 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.

Vacancy Management is an ongoing issue, not only locally but also nationally. Within the rural setting of NHS Borders, trained Pharmacy Technicians (not already employed by the Board) are becoming harder to find. Newly qualified staff (particularly pharmacists) are also moving away to the cities for a large part of their career. This is causing movement within teams and sectors rather than new employees joining the NHS.

Leadership As teams grow in size, more time is required to lead the changes required within practices and support the less experienced staff. We are currently developing new supervision models to support leadership, training and service delivery.

Travel Time All Pharmacy staff have the Borders General Hospital (BGH) as their work base and 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 has resulted in a significant loss of clinical time for teams. (e.g. loss of 8 hours per week for a GP Practice in East historically). The recent allocations have reduced travel time by half to nearly 9 hrs for the whole team, improving efficiency of work across the Board.

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 pharmacotherapy team member 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 an optimum staffing model but this will be difficult to deliver due to current funding and workforce availability.

Delivered March 2022

Due by since April 2022

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;

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 /	Medicine Administration	Phlebotomy (secondary care)

Weight / Height / Urinalysis / Diabetic Foot Screening)		
Phlebotomy (primary care)	Phlebotomy (secondary care)	Post bariatric surgery measurements
Suture removal	Resus trolley and equipment	PSA monitoring
Wound Dressings	24 hour heart rate monitoring removal	Ring pessaries
	24 hour urine collection	Spirometry
	Glucose tolerance testing (? If not done by	Visual acuity
	MRSA Screening	

Following further review from PCIP Executive and the Integrated Joint Board a request was made for the service to focus on providing all phlebotomy in each practice in addition to exisiting treatment room provision.

A staffing model was developed, however there is no recurring funding for CTAC services and the plans have therefore been unable to move forward.

Staffing model for phlebotomy only model role out;

	Mid-point cost inc new pay award	WTE	Cost	WTE inc 21% uplift	Cost inc 21%uplift
Clinical Band 3	34,737	10.97	381,065	13.27	460,960
Clinical Band 7	65,937	1.00	65,937	1.21	79,784
Clinical Band 6	55,047	2.00	110,094	2.42	133,214
Admin Band 2	30,144	0.50	15,072	0.61	18,388
TOTAL		14.47	572,168	17.51	692,345

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 one to one meetings with practices and members of NHS Borders staff. Written communication has also been provided.

For the internal organisational change process a workforce steering group has been establish which

has staff, partnership and HR representation. This group is currently paused awaiting further decision regarding the funding of CTAC services.

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
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. No funding allocation has yet been made for CTAC delivery and therefore the overall affordability of the proposal remains uncertain.
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.
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.
TUPE of staff, organisational change and wider staff engagement	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 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.
Project delay risk	Project timelines have slipped considerably and delivery by the new 2023 deadline will not be met. Without a clear agreement for financial funding the project team are unable to create a timeline for the rollout of these services.

Renew Annual Report 2022/23

The Renew service was established in NHS Borders in October 2020 utilising funding from PCIP, Action 15 and psychology services, with the aim of offering a "see and treat" model for mild to moderate anxiety and depression for those aged 18 and above, using evidence based psychological therapies in primary care. The aim is to reduce GP Mental Health workload as well as increase the range and access of psychological therapies.

Key Performance Indicators – Renew 2022/23

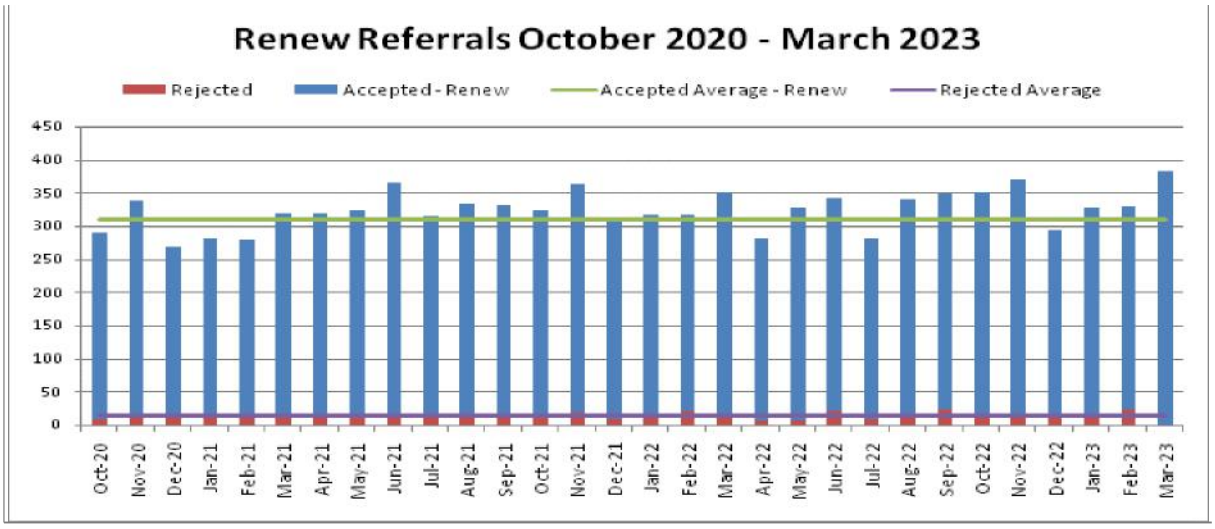
KPI 1: Demand for the service

Referrals:

All GP Practices have referred to Renew.

In the last financial year we received 3820 referrals between April 2022 and March 2023, average 318 per month. Since Renew started we have received a total of 9667 referrals of which 9307 have been accepted. This is an average of 310 referrals per month.

Figure 1: Referrals to Renew October 2020- March 2023.

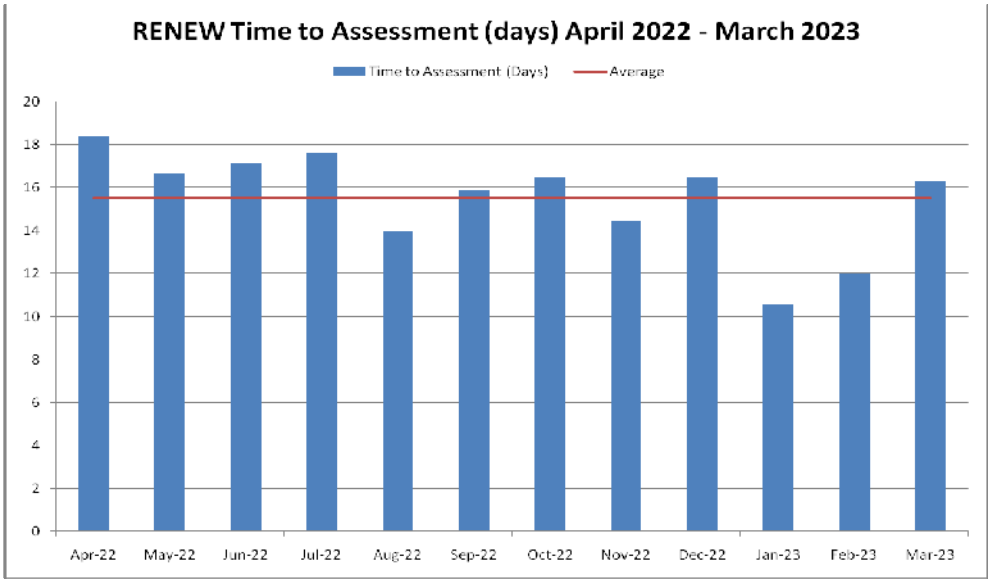


KPI 2: Speed of Access/Service Efficiency to see and treat

Assessment

In the last financial year time from referral to assessment was 15 days. This is a very slight increase to the average of time to assessment since we started to March 2023 of 13 days, but in general we continue to prioritise seeing people referred to us for an assessment appointment within a month.

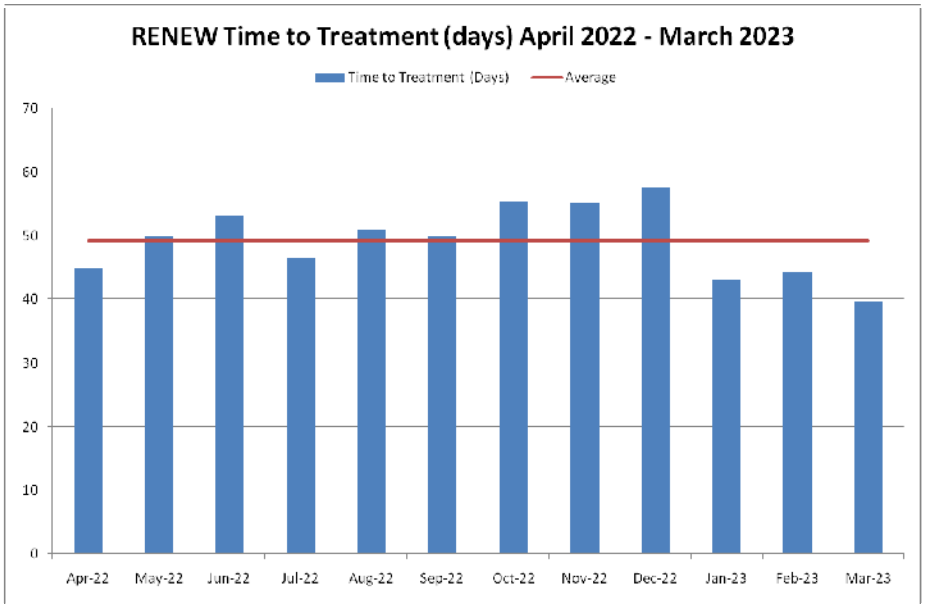
Figure 2: Renew – Time to Assessment in Days: April 2022-March 2023



Treatment

95% of treatment is delivered within 18 weeks with an average time to treatment start being 49 days. One to one individual therapy for more complex issues usually take longer in terms of treatment starts.

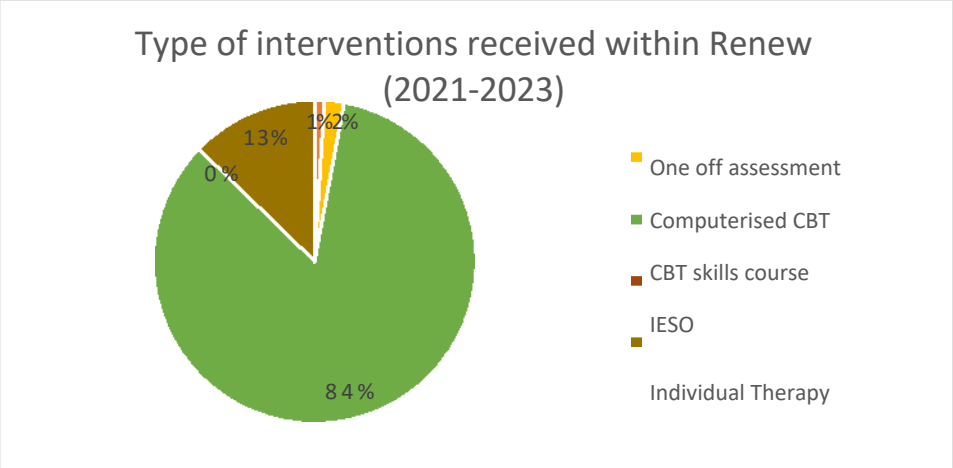
Figure 3: Renew Time to Treatment start in days: April 2022- March 2023



Treatment Interventions Offered

We continue to offer a range of interventions as the Figure 4 below indicates, all of which are evidence based:

Figure 4: Overview of types of interventions offered in Renew between 2021 and 2023.



Skills courses:

Our CBT Skills courses (low mood, anxiety and low self-esteem) continue to be the mainstay of the service and we have recently made some changes that have improved flow and accessibility. We currently offer four low mood and four anxiety courses per week (rotating on an 8 week basis). Patients attending these courses demonstrate reliable improvement in routine outcome scores (50% reliable improvement in anxiety course, and 59% reliable improvement in low self-esteem course), which is consistent with the literature.

In 2023/24 we will review these courses further to improve the course materials and online delivery. We continue to ask and monitor patient feedback on the courses to ensure they are meeting service need.

Digital Interventions:

We offer a range of effective evidence based digital therapy offerings for patients accessing Renew. Beating the Blues has now been phased out and replaced by Silvercloud which offers 14 different modules of evidence based computerized CBT (cognitive behavioral therapy). Modules offered include: depression, depression and anxiety, health anxiety, social anxiety, and generalized anxiety disorder. Silvercloud is appropriate and effective for people who have mild to moderate mental health problems. People Silvercloud are supported in its use by members of our digital mental health team, who check in at regular intervals. We are aiming to improve uptake in these interventions and develop ways of supporting full engagement with the whole treatment, which produces the best results.

IESO is a further digital intervention offered as part of the service. Offered in three tiers from guided self-help to higher intensity interventions for depression and anxiety. In this service patients make a 1:1 appointment and engage with a therapist via text, access is quick, usually within 2 weeks. People referred to this service from NHS Borders experience 67.7% reliable improvement following treatment. This effective treatment can be offered in evenings or weekends which suit people who have work or family commitments find it difficult to access appointments in working hours.

Guided self-help

The service also offers guided self-help which can suit those who need more individualized support with an intervention.

1:1 Interventions:

These are provided in the service by Enhanced Psychological Practitioners (EPPS), Clinical Associates in Applied Psychology and Clinical Psychologists. These interventions are provided by video link and in exceptional circumstances where it is clinically indicated in person.

KPI 3: Service Outcomes – service valued by GP's and patients and treatments effectiveness

1. GP Feedback:

88% GP's rate Renew excellent or very good (May 2022).

Some GP comments (May 2022):

Some of their comments about the service are:

- *Encouraging lack of hoops for us to jump through - we can leave assessment to our more expert colleagues*
- *We previously had a massive gap in MH provision in Borders and ! believe Renew has filled this gap well.*
- *Before it was very confusing to keep up with what services were still available and what were not.*
- *! found single point of referral for triage to different treatment modalities works really well.*
- *Patient feedback and ! have also noticed that they have an initial consultation quickly to discuss problems and develop a plan about most appropriate approach and ! think the patients find this discussion and choice helpful and empowering.*

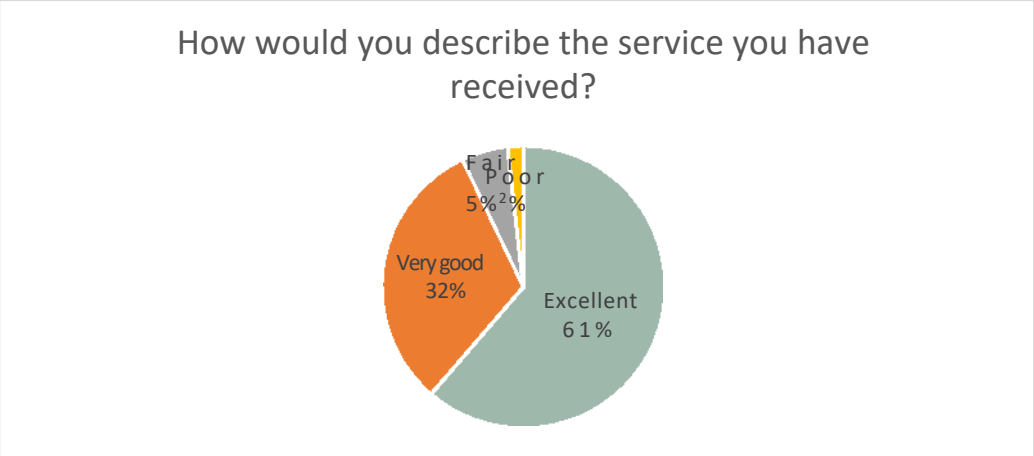
2. Service user feedback:

We gather routine service feedback using the Client Satisfaction Questionnaire (CSQ-8), a brief questionnaire which allows people using the service to rate its acceptability in a range of areas. Feedback in this section summarizes analysis of completed CSQ-8 questionnaires.

A) How would you rate the service you received?

93% of people rate the service as excellent or very good as Figure 5 indicates.

Figure 5: Overview of how our patients rated the service received in Renew (2021 – 2023)



B) How has the service helped you deal with your problems?

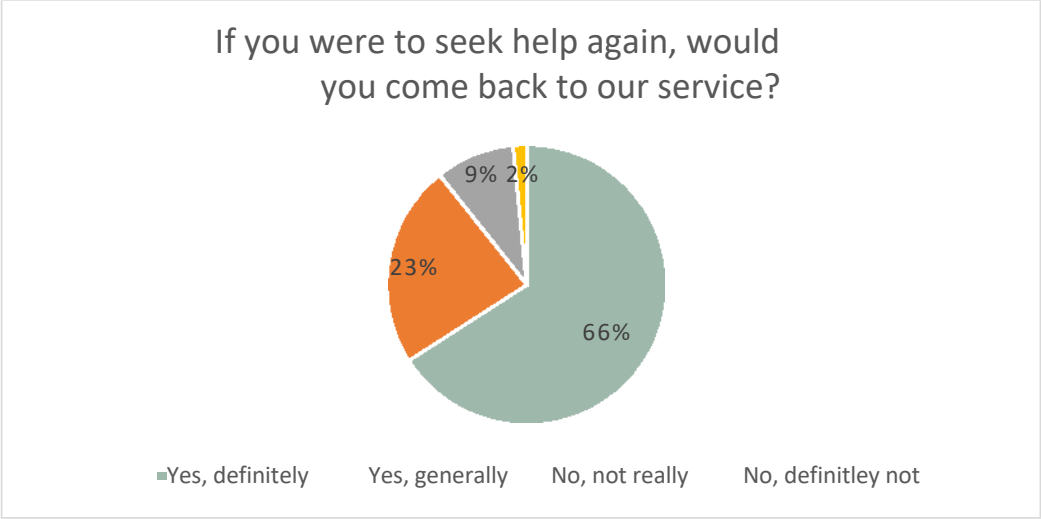
96% of people positively rated the interventions they were offered as helping them a great deal or somewhat as Figure 6 illustrates.

Figure 6: How has Renew helped people deal with their problems? (2021 -2023)

C) If you were to seek help again, would you come back to our service?

89% of people said if they were to seek help again they would come back to Renew as Figure 7 illustrates.

Figure 7: Renew: If you were to seek help again would you come back to our service? (2021 – 2023)



Here are a few comments from people using the service:

Thank you very much for the course. I was dubious about being in a group but because it was a small group I felt comfortable. I think the course was structured really well and I've learnt that even though I'll always probably be an anxious person I can move forward with all of the tools you've given me. (Skills Course)

I am happy with the service, I understand it takes more time than just the course to continue helping myself but I think the course has gave me the tools to help with my self-esteem and anxiety (Skills Course)

I really enjoyed working through the modules on this course. It was nice to get feedback from my supporter every so often as well to keep me motivated. I have learned so much and so much about myself. 100% beneficial to me and would absolutely recommend. (SilverCloud computerised cbt)

3. Treatment effectiveness

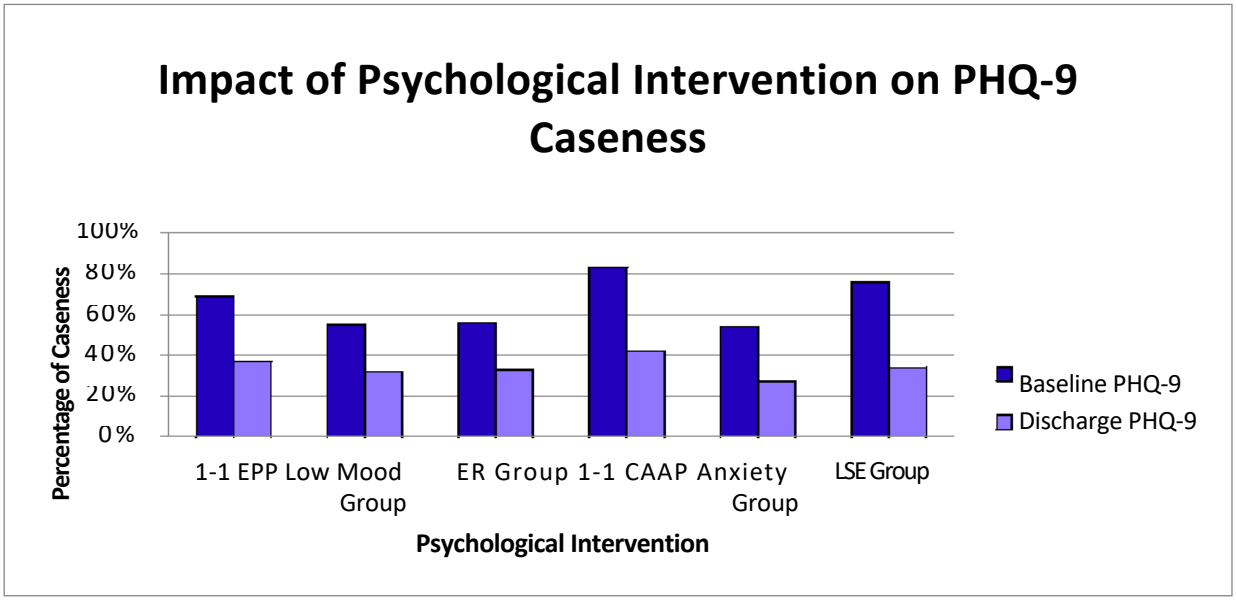
Renew aims to treat low mood/depression and anxiety that presents in a primary care setting. We measure what we call “caseness”, which is whether there is a significant enough need for an evidence based treatment to be administered. We collect routine clinical measures of depression and anxiety use nationally accepted measures called the PHQ-9 and GAD-7 which are are collected pre and post intervention in order to capture this and monitor treatment effectiveness.

Patients are routinely administered PHQ-9 (a widely accepted measure of low mood and depression) and GAD-7 (a widely accepted measure of anxiety administered with the PHQ-9) at assessment and discharge. The data in Charts 1 and 2 demonstrates the percentage of patients achieving “caseness” on each of these measures pre and post intervention.

a) PHQ-9- Low mood and Depression.

The PHQ-9 is a widely accepted measure of low mood and depression which is measured at assessment and discharge. The data in this chart below demonstrates the percentage of patients achieving "caseness" pre and post intervention. Figure 8 below shows an improvement in symptoms and caseness across all interventions offered for low mood and depression.

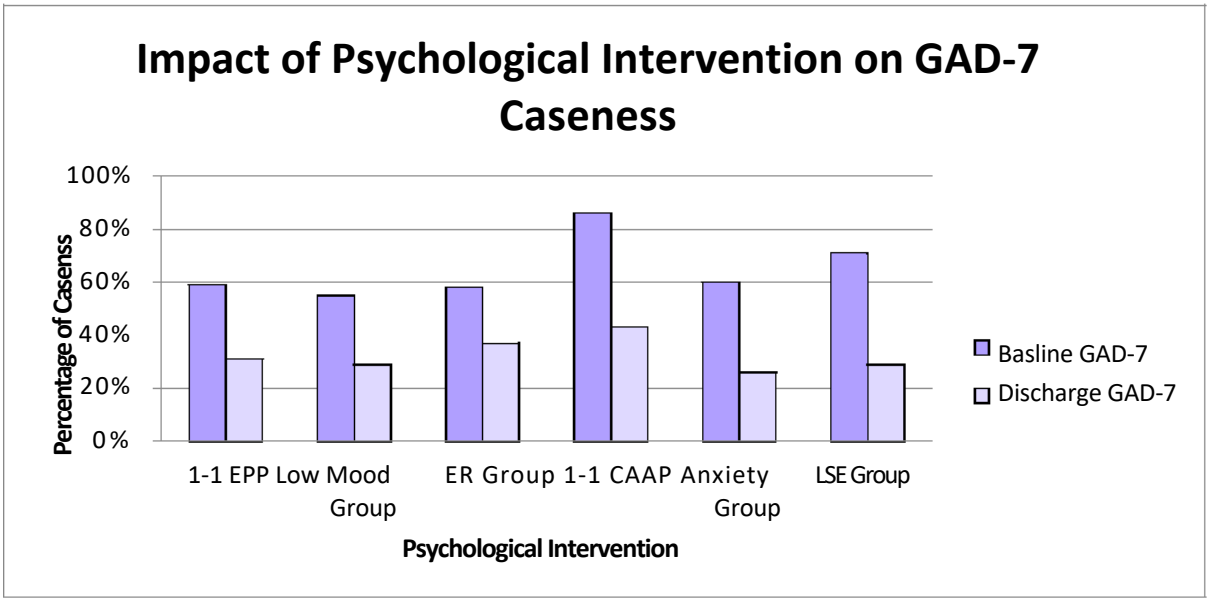
Figure 8: Impact of Psychological Intervention on depression/low mood in Renew as measured by PHQ-9



b) GAD-7 – Anxiety

The GAD-7 is a widely accepted measure of anxiety which is measured at assessment and discharge. The data in this chart below demonstrates the percentage of patients achieving "caseness" pre and post intervention. Figure 9 below shows an improvement in symptoms and caseness across all interventions offered for anxiety.

Figure 9: Impact of Psychological Intervention on Anxiety in Renew as measured by GAD-7



c) Reliable improvement

Outcome data collected by the service demonstrates reliable improvement across all interventions offered within Renew. Reliable improvement is a term in primary care psychological services that suggests efficacy and acceptability of treatment options for patients.

Summary

In general, Renew has performed well over the past financial year. Demand continues to be strong for the service from all GP practices and in the past year has remained relatively steady with a 1% increase over the financial year.

However, the type of referrals to the service seems to be changing with an increase in complexity and risk. This may be either as a result of Covid or as we emerge from Covid, the presenting problems may be changing. We are therefore starting a review of referral reasons to ensure we understand and consider how to respond to any significant changes. This is important to consider in terms of the gap between Renew and secondary care services.

The centralized model continues to work well and helps us to maximize flow and be able to see people soon and offer interventions centrally via telephone or Near Me, so we are not limited by geographical area. We now have an administrative base for the service at SBC Headquarters in Newton St Boswells.

We have established weekly meetings with secondary care adult psychology to ensure easier transitions between the services and this is making patient journeys smoother and more consistent.

We continue to work closely with the DBI (Distress Brief Intervention) Service, the clinical lead for this service is now based within Renew and patients are benefiting from this change.

Aims for 2023/24:

Our aims in the coming financial year are:

- To continue to monitor flow and reduce treatment backlogs
- Analyse referrals to ensure the model, flow and treatments fit demand.
- Consider how to meet changes in demand and gaps that have come to light between Renew and secondary care services
- Continue to improve and enhance the digital therapeutic offering (e.g. cCBT) by embedding Silvercloud, increasing uptake and establishing engagement appointments

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. The service has carried one 0.5 WTE vacancy from February 2023. We have been successful in international recruitment with the new member of staff to join the service in September 2023.

The service is funded for 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"

Key Focus areas:

1. Multidisciplinary teams:

The team is well integrated in all 23 of the 23 GP practices within the Borders. The FCP work-stream have been using a hybrid delivery in the last year to move away from a silo working model imbedded in the GP practices. The key priorities of FCP remain to be a service of excellence in being:

- 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 and orthotics
- 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. Digital innovation:
   FCP together with the MSK and podiatry work streams are working hard to establish a relationship to have a digital solution for additional triage and self management options within the Borders. We are exploring the PHIO product learning from other Boards that have embraced technology.

5. 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. 1(70% clinical time /30% time to work towards our professional four pillars of practice.
2. n228.375 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.

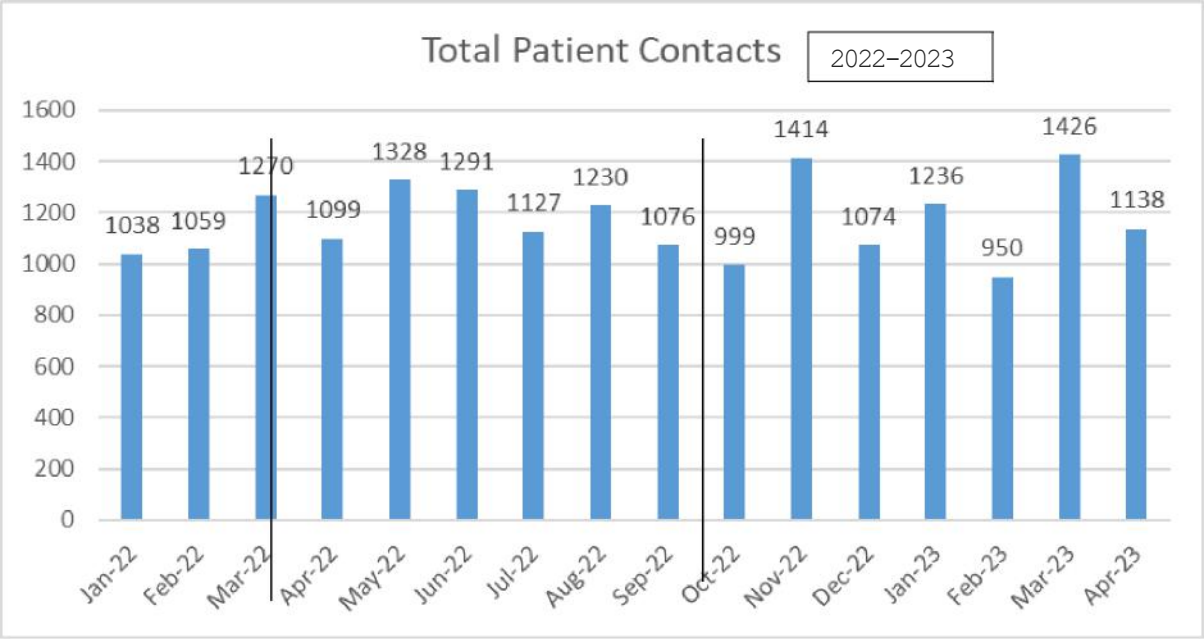
2. Education and training:
   i. 100% of the FCPs are cortisone injection therapy trained.
   ii. 100% FCP staff members are IRMER trained and refer for special investigations including MRI scans
   iii. 1 member of staff are completing their qualification in independent prescribing for non-medical prescribers with four more members of staff to follow in the next 24 months.
3. The APP lead represents The Borders at the National APP Primary Care Network.

6. 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.

7. Digital:
   a. The change over to the hybrid IT system, to deliver the service, has been evaluated over the last year and continuous improvement are made.

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.

- 1282.33 (2022-2023) compared to 1016.52 (2021-2022) average consultations per month with a 73% average of self-management and no further referral/intervention required.
- 15388 (2022-2023) compared to 13216 (2021-2022)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

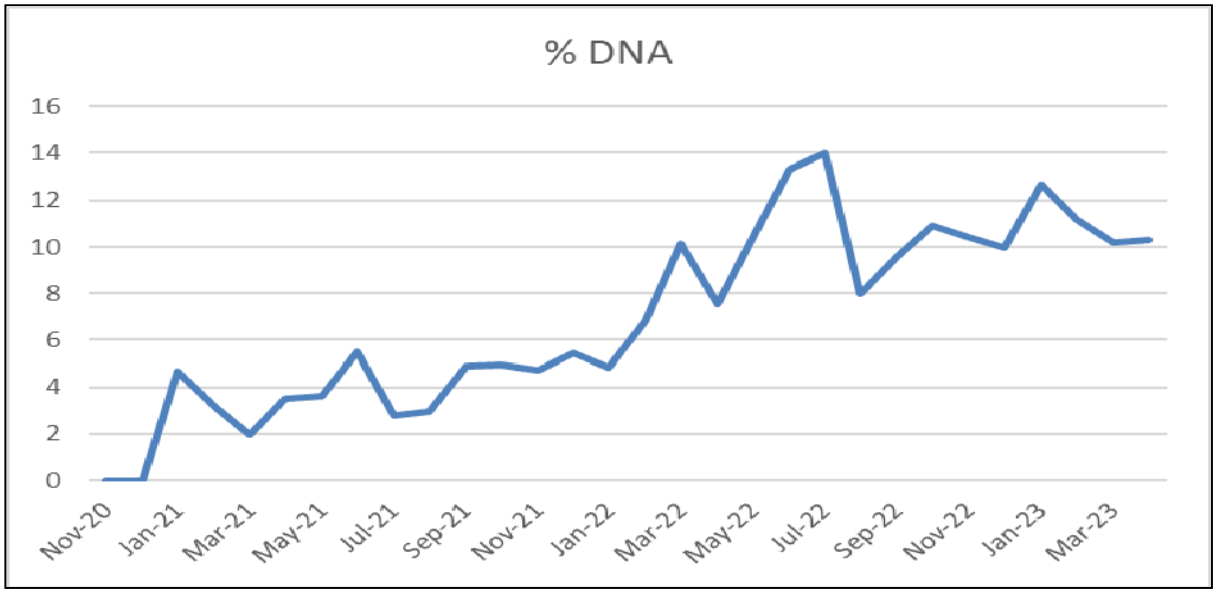
- Automated booking messaging system for appointments and reminders

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.

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 and 11.2% in 2023) with each practice moving over to the hub system has been noticed.

To address DNAs, we are currently re-evaluating the delivery model of FCP.

The initial focus of the Scottish Borders Primary Care Improvement Plan 2018-2021 was the development and establishment of an Advanced Nurse Practitioner model. 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.

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.

The ANP service is highly valued and supports 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 releases 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 ANPs 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.

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:

The ANP lead role has been vacant now for 6 months and it is demonstrable through iMatter results that this has had a major impact of moral and job satisfaction within the PCIP Urgent Care workstream. It is a top priority to resolve the issues surrounding the changes to the job with secondary care and recruit to the role as soon as possible.

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 do we aim to achieve in the coming year?

- In the coming weeks we aim to recruit a combined clinical lead role whose time will be split between primary and secondary care. Their focus will be on the development of the proposed ANP academy
- We are hoping to develop an ANP academy - training ANPs in both secondary and primary care to develop a resilient and competent workforce capable of handling high volumes of work independently. The objective for this is that it will be much less resource intensive to train an ANP through this pathway than the previous model of a single practice taking on responsibility for the support and training of any ANPs it takes on through PCIP.

Community PCIP Links Worker Service

On the 8th September 2022 PCIP Executive decided to discontinue funding for the Community Link Workers (CLW) due to inadequate funding from the Scottish Government for PCIP. The workstream was prioritised for deep evaluation as it was operated under a model that was considered inadequate for its intended purpose. Additionally, the service was set during the pandemic, which presented challenges in fully integrating it with practices due to staff proximity restrictions in back offices in GP surgeries. This hindered the optimisation of information sharing and coordination, impacting the effectiveness of the service.

Despite these constraints, the dedicated team of 2.5 full-time equivalent community link workers and two full-time equivalent Local Area Coordinators continues to serve the community. Over a two-year period, while funded with through PCIF, they managed to identify and attend to 40 GP patients in need. However, the available data did not demonstrate a significant easing of GP workloads as a direct result of CLW. Despite efforts made, the overall impact on alleviating pressures and reducing the workload of GPs was limited.

Nevertheless, Local Area Coordination services continue to be available as part of the broader service offered under our Health and Social Care Partnership.

Accommodation constraints remains a central theme regarding the implementation of PCIP workstreams. Buchan and Associates were previously commissioned by Hub South East on behalf of NHS Borders to conduct a review of primary care premises, taking account of the implementation of PCIP and new housing developments with the objective of identifying investment priorities. The review was published in October 2021 and outlined significant immediate pressures faced by many practices when seeking to find space for the new workforce within primary care.

Resource constraints within NHS Borders Estates and IM&T services have also limited change and improvement works required to implement PCIP workstreams. Despite these challenges, P&CS have managed to progress work that has delivered benefits to patients, staff and services using health centres and community hospitals.

Key achievements

- Revised premises governance to accelerate decision making, increase accountability and retain a "bigger picture" view of the NHS Borders estate.
- Streamlined pathways and a dedicated digital "premises portal" for requesting space, equipment and technology required for patient treatment and administration.
- Introduction of policies to improve sustainability of service delivery, such as "shared bookable spaces", sourcing equipment from within NHS Borders estate before purchasing new equipment and the prioritisation of clinical rooms for clinical activities.
- New assistant service manager in post from August 2022 with time dedicated to leading premises delivery.
- Mapping of rooms vs services in all primary care health centres and community hospitals, enabling the expansion of services and a fairer approach to space management.
- Completion of minor estate and IM&T works across many sites to increase clinic capacity and improve fixtures and fittings.
- Investment in clinical and non-clinical equipment, furniture and IT equipment.
- Removal and disposal of a significant volume of redundant equipment to release space and improve the environment for patients and staff.
- Digital room booking platform options appraisal completed, awaiting IT resource availability to progress implementation.

Key challenges and risks

- Limited resources to progress tactical and strategic, preventing delivery of recommendations outlined in the Buchan Report.
- Limited space to support PCIP services within the finite footprints of health centres and community hospitals. Work is transferring from GP practices but not the associated accommodation.
- Competition between PCIP workstreams for the same space.

PRIMARY CARE IMPROVEMENT FUND OVERVIEW

Background

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.

The majority of PCIP activity is funded entirely by Scottish Government Primary Care Improvement Fund allocation, with only a relatively smaller amount of resource coming from NHS Borders baseline and other funding across the CTCS (£0.840m) and MH Renew (£0.320m).

2022/23

Planned Funding Allocation

On 11 August 2022, NHS Borders and Scottish Borders Health and Social Care Partnership (the Board / Partnership) received its Annual PCIF funding letter. The national PCIP funding envelope was £170 million in 2022-23. 2022/23, NHS Borders' NRAC proportion is 2.15% of the national resource envelope equating to a PCIF allocation of **£3.648m**, an increase of **£0.352m** from 2021/22.

Within the August allocation letter, the Scottish Government stated that agreement had been made with the Cabinet Secretary for Health and Social Care that Integration Authorities should draw down existing reserves balances and that 2022/23 allocations would reflect reserves held.

The Tranche 1 allocation letter identified that (based on a forecast submitted to SG on 30 November 2021) PCIF reserves held by Scottish Borders was **£0.079m**, which would therefore be deducted from the above NRAC allocation, in addition to **£0.161m** baseline funding, the latter of which has been the case each year since the inception of PCIP.

The letter stated that there would be two allocations made during the year on a 70:30 basis, taking into account the deductions highlighted in 2.3 above. Based specifically on the annex schedule of funding allocation therefore, the PCIP Executive has, in the time since the Tranche 1 allocation letter, specifically directed the net balance outlined in the table below **(£3.569m)** across PCIP workstreams

which, at the end of January 2023, is, with the exception of slippage of **£0.032m**, expected to be spent in full.

Actual slippage at 31 March 2022 was **£0.426m**, **£0.347m** higher than forecast at 30 November 2021.

This slippage was carried forward to 2022/23 and consolidated with a balance of **£1.097m** brought forward from an additional ad-hoc non-recurring allocation made by the SG in late 2020/21 as a total of **£1.523m**. PCIP Executive has been working to direct this funding non-recurrently across a range of initiatives during 2022/23 in order to further support the delivery of the PCIP workstreams.

The Board / Partnership has never had to report back on the use of the non-recurrent allocation to the Scottish Government since it was made in late 2020/21, nor on what plans / commitments / expenditure has been made on the slippage carried forward at any point during 2022/23 and there has been no request for information, nor any discussion with Boards / Partnerships during the last year with regards to this.

Planned PCIP Funding 2022/23

	2022/23 PCIF Allocation £'000
2022/23 NRAC Allocation	**3,648**
Tranche 1	2,554
Less: Baselined Funding	(161)
PCIF Initial Allocation	2,314
Tranche 2*	1,094
2022/23 Tranche 1 and 2 Allocations	**3,408**
Add Back Baseline Funding	161
Actual Funding Allocation	**3,569**
Funding Allocation withheld by SG	**79**

Actual Funding Allocation

On 09 March 2023, the Board / Partnership received its Tranche 2 allocation letter. Tranche 2 allocations, as stated in the letter, were to be made based on 30% of the overall £170m allocated via NRAC, less additional reserves as of March 2022, stating that "*the additional reserve deductions reflect the difference between November 2021 and the final March 2022 position*".

The allocation letter states that additional funding has been made to a small number of Integration Authorities (IAs) who held legal commitments against PCIF reserves prior to Tranche 1 being issued. In the absence of any request for this information by the SG, Scottish Borders is not one of them.

What has happened is that the SG has referenced the Scottish Borders Health and Social Care Partnership Annual Accounts that the IJB approved and published late in 2022.

With hindsight, even though there has never been a request to report back on reserves brought forward this financial year from a PCIP-tracker perspective, there was always a prevalent risk that the SG would update its thinking around Tranche 2 allocations, stating that *"the approach to second tranche allocations will also be informed by updated financial data on the reserve positions as at 31 March 2022, which Scottish Government officials have separately requested from IAs."* Given however that no information had been sought by SG directly from Boards / Partnerships or any dialogue offered regarding non-recurrent reserves brought forward or any plans / commitments / expenditure against them made during the year, this risk was believed to be low and as a result, the Scottish Borders Partnership has continued to plan, direct, manage and report on additional non-recurring initiatives which require funding from this resource.

As a direct result therefore and without any dialogue with the Board / Partnership regarding how the position on these reserves may have changed since they were brought forward on 01 April 2022 or any legal, contractual or strategic commitments that may have been entered into during the year, the SG has unilaterally deducted the full **£1.523m** from Scottish Borders 2022/23 PCIF allocation, resulting in no Tranche 2 payment being made.

Impact on 2022/23 and Future Years Plans

During 2022/23, the Health and Social Care Partnership and Health Board, in order to deliver as much of the MOU as it can, then fully directed and committed the allocation as soon as it practicably could, directing all of the allocation with the exception of the anticipated £0.079m retained as notified by the SG in the Tranche 1 allocation letter.

Workstream	PCIP 3-Year Recurring Investment £'000
VTP	16
Pharmacotherapy	879
CTAC	121
Urgent Care	883
FCP	528
Mental Health	669
Community Link Workers	150
Central Costs	49
22/23 Pay Inflation and Drift (Funded Recurrent)	273
Total Expenditure	**3,569**
Funded by:	
2.15% of £170m*	(3,648)
Withheld by SG	79
Forecast Expenditure	
Total	**(3,569)**

This is in direct comparison to the Tranche 2 allocation letter which advised that no additional tranche will be made beyond Tranche 1, which was an allocation of **£2.553m**. As a result of no additional tranche, Scottish Borders has had to utilise almost **£1.100m** of its non-recurring PCIP Reserve (a non-recurring allocation made by SG at the end of 2020/21 which had been earmarked for the acquisition of Order Comms system, ANP Training and a Test of Change for CTCS. This resource is therefore no longer available and it is anticipated that the remaining reserve figure of £0.383m will again be clawed back by the SG during 2023/24 in a similar manner.

2023/24 Outlook

Presently, it is not yet known what the 2023/24 PCIF allocation will be. In relation to next year, the Scottish Government has stated that "the minimum budgeted position for PCIF in future years is £170m subject to Agenda for Change uplifts available for recruited staff. We will work with Chief Financial Officers on the exact processes for how the PCIF will be allocated next year, including exploring the possibility of baselining the fund. Baselining the fund would ensure that all funding (staff and non-staff costs) would be uplifted in line with the annual uplift applied to funding allocations to Health Boards.

On any carried over reserves from 2022-23, you should assume for the time being that you should continue to reinvest any locally held reserves in the implementation of PCIPs in 2023-24 before new funding is requested. The only exception to this is where IAs have a prior agreement with Scottish Government to hold reserves to cover legal commitments in future years. In this case, we would expect you to hold sufficient reserves to cover those legal commitments and only use reserves on PCIP implementation in 2023-24 where they are surplus to the commitments agreed with Scottish Government."

As a result of the statement underlined above, it is likely therefore that the 2023/24 allocation will be reduced by £0.383m of the remaining IJB reserves brought forward from 2022/23.

As outlined earlier also, should this happen, this will mean an inability to fund non-recurrently EMIS training, FCP Prescriber training, Order Comms, ANP training and a CTCS Test of Change.

Without a substantial increase in funding allocation (in the region of £2.4m or 67%), PCIP remains financially unaffordable, resulting in an inability to fund the costs of VTP that are now being incurred or to contribute towards the implementation of CTCS. Both of these are directly in contravention of MOU, as a result of insufficient PCIF funding.

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

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 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.

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 reinvest 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 (2023/24). Over 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	0

In total therefore, £0.318m has been received to date. In February 2021, a report was approved by GP Executive, 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 going forward) 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.

“

I would like to thank everyone involved in the implementation of the Primary Care Improvement Plan for making great strides forward over the past year, so that people who need Primary Care services have improved access and get the right care, in the right place at the right time.

”

- 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	Malcolm Clubb – Lead Pharmacist Primary and Community Services
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
Premises	Rob Cleat – Primary and Community Services Premises Lead
Communications	Clare Oliver – Communications Manager
Finance	Paul Mcmenamin–Deputy Director of Finance / Finance Business Partner (IJB)

PCIP Executive Committee

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

PCIP Project Management

Senior Project Manager	Owain Simpson

June 2023

Scottish Borders

PCIP Executive Committee

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