

**Scottish Borders Primary Care Improvement Plan**

**(Revised)**

**2018-21**

Working v6.0 Amended26th May 2021



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1. **INTRODUCTION**

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

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

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

1. **BACKGROUND**

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

1. **GOVERNANCE**

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

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

Change of title

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

The PCIP Executive Committee meets monthly and provides regular reports to GP Sub Committee and IJB as well as to NHS Borders Executive Team and NHS Borders Board as appropriate. A governance diagram is at **Annex A** and membership list at **Annex B**

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

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

Clinical Governance

A consistent approach to the delivery of service and development of an appropriately skilled workforce is essential to ensure safe and appropriate patient care. Provision has been made within the PCIP for Band 8a roles in each workstreamtomanage thisand to provide a clinical professional linefor the individual disciplines.Each workstream also has a named GP Lead from the PCIP Executive Committee who works in liaison with the Band 8a postholder. In addition, resource has been allocated to allow time for GPs to mentor and support the new staff appointed through PCIP, most particularly the Advanced Nurse Practitioners and Pharmacists.

AnHealth Inequalities Impact Assessmentwas undertaken undertaken across the PCIP in 2019 and has now been been updated (**at Annex C**).

Operational Governance

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

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

Ongoing Monitoring and Oversight of PCIP

The PCIP Executive Committee was established to oversee the PCIP Programme until its conclusion on 31st March 2021. Following the issue of the Joint Letter from Scottish Government and BMA [[1]](#footnote-2)in December 2020, this deadline has now been extended in varying degrees across the PCIP priorities and in order to support delivery of the contract in line with these revised deadlines, the PCIP Executive Committee will continue in its current form until 2023/24. As set out in the previous version of Borders PCIP it is apparent that ongoing oversight and monitoring will be essential as the new posts and services move into mainstream delivery in order to protect the major investment in primary care delivered through PCIP and to safeguard the core aims and principles set out in the MoU as part of the national GP contract.

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

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

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

It was thereforerecommended to GP Sub Committee, NHS Borders and IJB that consideration should be given to the establishment of an ongoing monitoring and oversight function to support the PCIP services after the end of the PCIP Programmein March 2021. The paper describing this is at **Annex D**. The establishment of aPCIP Ongoing Monitoring & Oversight Committee was agreed by all three partner organisations at their formal meetings in December 2020.

Since the Joint Statement from Scottish Government and BMA has extended the deadlines for PCIP delivery, the establishment of the Ongoing Monitoring & Oversight Committee as described will take place after completion of the contract delivery in 2023/24 at which point the PCIP Executive Committee will cease. The appended document will be updated according to the new contract deadlines.

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

1. **KEY PRIORITIES (PCIP WORKSTREAMS)**

The key priorities have been developed in line with the MoU and are managed through individual workstreams.As set out in the GP Contract and confirmed again recently by Scottish Government the new models of care within each workstream have been developed in relation to activity as at 2018. The additional posts appointed and planned within each workstream are detailed in **Section 7**.

**The Vaccination Transformation Programme (VTP)**

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

***However***, at the outset of Covid 19, Scottish Government paused VTP for 12 months therefore the revised local model was not progressed. In line with the requirement to deliver flu vaccinations in 2020, the GP Executive worked with NHS Borders to put in place local arrangementsfor 2020/21.

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|  | **Previously Completed** | **Year 1** | **Year 2** | **Year 3** |
| Plan /Outcomes | School programme (including flu vaccines) | Pertussis/ whooping cough vaccine  seasonal flu vaccination being provided by NHSB midwifery team | Continuation of 0-5 years programme work - pre-school childhood population  Travel | Shingles (start)  Seasonal Flu Adults 65 years and over  Pneumococcal vaccines adults aged 65 years  Flu Vaccines (‘At risk adults’ aged 18-64 years) |
| Progress |  | Reduction in healthcare appointments for pregnant women as all vaccinations are now part of midwifery led care.  Practice Nurse appointment time therefore freed up. | Pre-school childhood programme  Data gathering completed, this details the % vaccination uptake across all GP Practices and Clusters for the Scheduled routine vaccinations (Primary and Booster vaccinations) and Seasonal flu vaccinations for 2,3 and 4 year olds  Draft Protocol developed to support local delivery model  Model initially identified has raised some challenges and an alternative model has been proposed to Scottish Government (detailed separatelybelow\*)  Travel Health &Advice - liaison with GP practices ongoing; likely to become Year 3Outcome. | Data gather completed, this details the % vaccination uptake across all GP Practices and Clusters for the 65 years and over population and the ‘At risk’ adults aged 18-64  Proposed alternative delivery model has been identified (see separate detail\*). Approved Dec 2019.  VTP paused by Scottish Government until 2021/22 |

\*Alternative model for under 5 non-flu and flu vaccinations, adult vaccinations and adult flu vaccinations

The VTP workstream initially identified a model of delivery for all under 5 non-flu vaccinations to be taken over by NHS Borders with plans to subsequently incorporate child flu and adult flu vaccination programmes. This model raised some challenges in terms of the high cost attached to both the additional NHS Borders workforce required and the change to the current IT and data sharing infrastructure necessary to enable non-practice staff to provide the service. A further significant issue was the lack of suitable and accessible accommodation from which to provide the service equitably across the area. Within the original model consideration had been given to the vaccination service being provided from a central point in each locality or cluster given that it has proved impossible to find space in every health centre. However this also proved extremely difficult; even if it were possible, the public transport infrastructure is limited and there is a concern that the more vulnerable or poorer members of the community would either choose not / be unable to travel out of their home setting for their vaccinations or would not be able to afford to do so.

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

The current scheduled routine programme of vaccinations for under 5yrs, for under 5yrs flu and adult vaccinations has been delivered successfully by GP practices for many years and from accommodation within practice premises. The alternative and preferred approach put forward in 2019 would see NHS Borders taking over the element of practice nurse time required to deliver this vaccination programme, thereby becoming health board salaried hours. This would allow the practices to divert the element of their budget currently attached to these hours to support additional capacity within the practice e.g. by developing further professional roles / advanced practitioners etc. The use of existing accommodation and IT infrastructure would continue thereby removing the problem highlighted previously around changes to IT, sourcing space elsewhere and the need for patients to travel for vaccinations. This would maximise the potential to sustain our current good vaccination rates and minimise the risk of a reduction in them and to herd immunity. The approach proposed has been tested successfully in one GP practice.

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

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

Changes SinceCovid

In light of the covid 19 pandemic the delivery deadline for VTP was paused by Scottish Government. The Joint Letterfrom Scottish Government and BMA in December 2020 confirmed that the deadline for delivery is now October 2021. Building on the experience of delivering the significant flu vaccination programme during Covid for winter 2020/21 and from the current Covid 19 vaccination programme, the VTP workstream is reviewing and revising the delivery model agreed in 2019.

Information on the new model will be included within the next update of this document. There is no PCIP resource available for VTP within the existing plan; the costs for VTP formed part of the £1.9m shortfall in funding identified to Scottish Government (see Introduction) and identified within the May 2021 Scottish Government Implementation Tracker (Financial table shown at **Annex E**). Work is currently underway in collaboration with NHS Borders Primary Care & Community Services to develop an integrated approach to vaccinations which will incorporate and safeguard the PCIP specifications for VTP. To inform this work Scottish Government’s Directorate for Primary Care were asked if there will be a new DES for GPs to deliver the new cohorts requiring vaccination or will Boards expect a further allocation to deliver the extended groups as part of the Boards’ wider vaccination responsibility. It was confirmed that i) a DES may be created to support where GPs may need to deliver the new vaccinations to the extended cohorts but this would only be short term until Boards build up their own capacity and ii) that there will be a further allocation but this would be from Public Health sources in Scottish Government rather than PCIP.

**Pharmacotherapy**

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

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

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

*This meant that the committed investment of £896,538 to support recruitment to the level of 21.5wte as approved to date would be honoured but it was agreed at that time that there would be no further investment made into the pharmacotherapy service within the PCIP programme.*

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

Changes SinceCovid

The Joint Letter stated that “*Regulations will be amended so that NHS Boards are responsible for providing a Level One Pharmacotherapy service to every general practice for 2022-23*.” The service is currently reviewing skill mix requirements to deliver PCIP in light of this and details of the amended workstrean plan will be included in the next update of this document.

**Community Treatment & Care Services**

It has been acknowledged that there will be insufficient resource within PCIP allocation to fully deliver this workstream, however work has continued in order to develop an appropriate modelthat can be introduced as resources allow. This work is in partnership with secondary care, mental health and community services so that a whole system approach is being taken and as part of this broader service, resources also being repurposed or transferred from the wider organisations with PCIP funding forming a proportion of the overall investment.

The model will be based on a centralised hub approach with Phlebotomy as the first priority, in accordance with the MoU. A Test of Change for the phlebotomy element of the service will begin early May2021 in one Cluster area. The Joint Letter stated that “Regulations will be amended so that Boards are responsible for providing a community treatment and care service for 2022-23” – this will inform the delivery plan for the workstream which will be described in detail in the subsequent version of Borders PCIP.

**Urgent Care**

The main focus for Urgent Care has been on the development and establishment of an Advanced Nurse Practitioner model.

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|  | **Year 1** | **Year 2** | **Year 3** |
| Plan/ Outcomes | SAS pilot in South Cluster  NHS Borders ANP strategy developed  Begin recruitment of nurses to ANP roles | Develop local training pathway  Demonstrate ANP roles working in two cluster areas ( West & South) | Recruit remaining practitioners for coverage of all areas.  Review of paramedic practitioner role. Outcome to inform wider development of service. |
| Progress | 4 ANPs recruited for deployment into South and West Clusters.  Governance and Communication protocols complete.  Paramedic Practitioners Pilot in South Cluster established. | ANPs established in South and West Clusters  Activity data collection processes for South & West clusters - review and confirm.  Further 11 posts approved for recruitment by end of 2019/20.  Local training pathway under development. | Recruitment has been very successful since June/July 2020however there have been limited fully trained applicants and therefore PCIP Executive agreed to appoint trainees and to establish a supported training process. All trainees will have completed their training in a phased manner by 2023/24.  At May 2021, all posts have been filled with the exception of one which will be utilised as a Physician Assistant post from October 2021. |

**Additional Professional Roles**

**First Contact Physiotherapists**

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

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|  | **Year 1** | **Year 2** | **Year 3** |
| Plan /Outcomes | Initial phase of FCP service established in East and part of Central cluster | Roll out of model | Final phase roll out to remaining practices |
| Progress | 3.4 wte (5 staff) FCPs appointed to all of east and part of central (Gala HC & Melrose/Newtown St Boswells) clusters.  Framework for service developed. | Second phase of recruitment approved for a further 4 posts in 2019/20  Evaluation of service to take place before final recruitment phase is approved | Recruitment has improved significantly and Interviews for the remaining 3.2wte vacant posts are being held mid-May 2021  In considering the economies of scale within this service as well as lessons learned from ways of working adopted through Covid 19, a review of the original delivery model has been undertaken and a revised approach agreed, which will see a virtual hub providing a single point of referral receiptand allocation. |

**Community Mental Health Workers**

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

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

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

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

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

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

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

It has been agreed to name the new service “Renew”.

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|  | **Year 1** | **Year 2** | **Year 3** |
| Plan /Outcomes | Identify a service delivery model | First Implementer site to be established at one GP practice.  Referral pathway confirmed.  Evaluation of first implementer site and confirmation of plan.  Recruitment to further posts identified and roll out to remainder of Cluster | Roll out of model to all practices |
| Progress | Model developed | First Implementer site identified in South Cluster.  PCMHT consisting of Psychologists, CAAPs (Clinical Associate in Applied Psychology) now based in the first implementer practice; CPN recruitment underway.  Referral pathway will be signed off Nov 2019.  Recruitment underway for next phase of posts required. | Model reviewed and new approach agreed, joint funded with Mental Health services and PCIP.  The model is based around Psychological Therapies. Began 5th October 2020 in two Clusters and has now been rolled out across Borders giving all GP practices full access to the service. |

**Community Link Workers**

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

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|  | **Year 1** | **Year 2** | **Year 3** |
| Plan /Outcomes | Development of the service model | Recruitment to additional posts  Development of referral pathway for GP practices.  Roll out of model across all GP practices | Evaluation and further development of service model |
| Progress | Building on the existing service delivery model with the Local Area Coordinators and CLW hours, the new model of service has been identified and will incorporate additional posts.  Staffing model identified. | First phase of recruitment complete.  Recruitment to second phase underway. | The service has been significantly impacted by Covid 19 as they have been unable to provide individual support in client’s homes or community settings due to the current restrictions. The service is working hard to re-establish as Covid restrictions are reduced and PCIP Executive will review the approach and service provision as this develops |

1. **CHALLENGES AND RISKS**

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

1. Accommodation: space within existing health centre premises is already at a premium and making available appropriate clinical space for use by the additional staff appointed through the PCIP is proving difficult. This has the potential to inhibit or even prevent the establishment of the new services in some areas and carries the risk of inequitable access across Borders.This issue is being addressed through the work on Premises (see Section 6)
2. IM&T: access to the relevant IT systems is not available at every health centre site for the new services being introduced and the different needs of the new services for appropriate recording and collection of data has added to the complexity of issues highlighted to date. This brings the risk of not being able to appropriately and safely deliver and record clinical activity. Work is underway with IM&T to address these issues (see Section 6)
3. Recruitment: A range of new posts are being created across various disciplines and at various levels within the workstreams. Recruitment at senior levels of skill and therefore at higher Bandings can prove difficult as there are not necessarily the numbers of suitably qualified professionals available nationally; this has particularly applied to ANPs and to FCPs, though not solely. Conversely, Pharmacotherapy have had difficulty with the lack of available Technicians. While service leads have tried to review skill mix and develop training programmes to develop staff into roles where recruitment has been problematic, this takes time. Core senior level posts are crucial in terms of clinical leadership, professional supervision clinical governance and also in delivery of specific clinical practice. Inability to recruit to posts will cause delays in delivering the proposed new PCIP services.
4. **ENABLERS AND INFRASTRUCTURE**

**Premises**

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

*“The National Code of Practice for GP Premises sets out how the Scottish Government will support a shift, over 25 years, to a new model for GP premises in which GPs will no longer be expected to provide their own premises. The measures outlined in the Code represent a significant transfer in the risk of owning premises away from individual GPs to the Scottish Government.*

*Premises and location of the workforce will be a key consideration in delivering the multi-disciplinary*

*arrangements envisaged in the HSCP Primary Care Improvement Plan”.*

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

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

A Primary Care Premises Group was established some years ago within Primary & Community Services and while it has a wider role around Primary Care Premises Modernisation for that Clinical Board, it has been agreed to re-vitalise the grouptoinclude the two PCIP areas of work identified above as part of its remit. The PCIPExecutive have a lead responsibility for ensuring that premises issues associated to the Contract are addressed, and act as a key Reference Group to the Primary Care Premises Group which has a broader remit for premises (including areas such as Asset Management) than implementation of the contract. The PCIP Executive oversee and monitor the contractual element of the Group’s workplan and the Group’s membership includesPCIP Executive representation. A whole-system review of primary care estate is to be undertaken which will feed into NHS Borders’ Capital Management process; this will include the requirements for PCIP.

**IT Infrastructure and Data Collection**

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

The Head of IM&T isworking to establish a designated primary care function within the IT service. This new team will work alongside the workstream leads and GP Executive to address these points.Covid 19 has impacted on progress with this.

**NHS 24**

Colleagues from NHS 24 were previously in discussion with the PCIP Executive regarding a proposal to trial, evaluate and establish a Triage Programme in Scottish Borders whereby NH24 would manage the triage of calls and signpost / redirect certain referrals received through GP practices to more appropriate services in order to free up GP clinical time for more complex cases. However, in early 2020NHS24 has informed P&CS and PCIP Executive that they will no longer be pursuing this initiative and have diverted their resources toward the national programme for the Redesign of Unscheduled Care

1. **WORKFORCE**

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

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

The table overleaf shows the current workforce plan in terms of whole time equivalents (wte) as reported in the May 2021 Implentation Tracker. It must be noted however that this is a fluid picture and can change as service models are evaluated and progressed and as highlighted previously, recruitment difficulties may impact on the skill mix and timetable.

**Whole Time Equivalents**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Financial Year | Service 2: Pharmacotherapy | | Services 1 and 3: Vaccinations / Community Treatment and Care Services | | | Service 4: Urgent Care (advanced practitioners) | | | Service 5: Additional professional roles | | | Service 6: Community link workers |  |  |  |
| Pharmacist | Pharmacy Technician | Nursing | Healthcare Assistants | Other [a] | ANPs | Advanced Paramedics | Other [a] | Mental Health workers | MSK Physios | Other [a] |  |  |  |
| TOTAL staff WTE in post as at 31 March 2018 | 2.3 | 1.4 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |  |  |  |
| INCREASE in staff WTE (1 April 2018 - 31 March 2019) | 3.0 | 0.2 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |  |  |  |
| INCREASE in staff WTE (1 April 2019 - 31 March 2020) | 3.4 | 4.2 | 0.0 | 0.0 | 0.0 | 7.0 | 0.0 | 0.0 | 3.7 | 3.4 | 0.0 | 4.5 |  |  |  |
| INCREASE in staff WTE (1 April 2020 - 31 March 2021) | 1.0 | 7.2 | 2.3 | 0.0 | 0.0 | 7.0 | 0.0 | 0.0 | 14.3 | 5.8 | 0.0 | 0.0 |  |  |  |
| PLANNED INCREASE staff WTE (1 April 2021 - 31 March 2022) [b] | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 2.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |  |  |  |
| TOTAL staff WTE in post by 31 March 2022 | 9.7 | 13.0 | 2.3 | 0.0 | 0.0 | 16.0 | 0.0 | 0.0 | 18.0 | 9.2 | 0.0 | 4.5 |  |  |  |
| Total staff (WTE) required for full delivery | 9.7 | 20.4 | 17.2 | 13.5 | 12.5 | 16.0 | 0.0 | 0.0 | 18.0 | 9.2 | 0.0 | 10.8 |  |  |  |

1. **FINANCIAL PLANNING**

Within the new governance framework, in the third quarter of 2020 the PCIP Executive’s Business Partner undertook a comprehensive review of the budget and commitments to date and presented a confirmed financial outlook; this was formally agreed by the PCIP Executive and allows robust forward planning. The information from this informsthe regular submissions made to Scottish Government in line with the required Local Implementation Tracker. The financial tables from the May 2021submission is attached at**Annex E**and gives actual spend together with estimated planned costs for the years 2018 – 2022. As described previously, in December 2019 Scottish Government were informed of the £1.9m projected shortfall in resource needed to fully deliver PCIP in Borders, of which £1.5m related to CTAC and VTP. In the May 2021 Implementation Tracker this shortfall figure has been reviewed and recorded in detail, as requested.

Additonal Non Recurring Allocation 2020-21

Scottish G Health Finance wrote to all NHS Boards in February to notify them of an allocation of funding being made to Integration Authorities in respect of outstanding balances on the Primary Care Improvement Fund. The allocation respresents the sum of Scottisg Governmengt held unused funding accumulated over the three years of the MoU 2018-2021. For NHS Borders this figure is £1,096,943 from 2018 to 2021.

The funds are non recurring and therefore cannot be used to fund permanent staff on any other recurring expenditure. The funding is ringfenced to support enabling works to deliver PCIP prioriteis in full and as such cannot be used for savings. NHS Borders Director of Finance confirmed that the funding will be carried forward to 2021-22 through the IJB mechansim and will be reinstated in full next financial year.

PCIP Executive met on the 22nd April 2021 to take forward the financial plan required for the usage of this additional funding with the aim of producing a planned programme of spend for onward approval by the IJB, GP Sub Committee and NHS Borders Board. A subsequent session to finalise the proposed programme of spend is scheduled for 13th May. While this non-recurring allocation will not be recorded within the PCIP Implementation Tracker, a regular financial report will be given to PCIP Executive on commitments and expenditure against it.

1. **SUMMARY**

This revised Primary Care Improvement Plan is set in the context of the recognisedneed to continue pace and progress across the programme and the consequent introduction of a revitalised local governance framework. The document reflects not only the good progress made over the last twelve months during the Covid pandemic but also the more robust planning now in place for the remainder of the PCIP delivery programme. It is a dynamic working document and will be updated as the new services are progressed and implemented.

**Annex A Governance Structure**



**Annex B PCIP Executive Membership**

Dr Kevin Buchan, Chair GP Sub Committee

Rob McCullochGraham, Chief Officer, Borders Health & Social Care Partnership

Dr Kirsty Robinson, GP Sub Committee

Dr Tim Young, GP Sub Committee

Dr Rachel Mollart, GP Sub Committee

Vivienne Buchan, PCIP Business Partner

Sandra Pratt, Strategic Lead, PCIP

Chris Myers GM, Primary & Community Services, NHS Borders

Nicky Berry, Director of Clinical Operations, NHS Borders

Nicola Lowdon, Associate Medical Director, Primary & Community Services, NHS Borders

Mags Baird, Project Manager, PCIP

**ANNEX C Health Inequalities Impact Assessment**



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

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**ANNEX E Table 1: Spending Profile 2018 – 2022 (£s)**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Financial Year | | | Service 1: Vaccinations Transfer Programme (£s) | | Service 2: Pharmacotherapy (£s) | | | | Service 3: Community Treatment and Care Services (£s) | | | Service 4: Urgent care (£s) | | Service 5: Additional Professional roles (£s) | | Service 6: Community link workers (£s) | |  |  |  |
| Staff cost | Other costs (staff training, equipment, infrastructure etc.) | Staff cost | | | Other costs (staff training, equipment, infrastructure etc.) | Staff cost | Other costs (staff training, equipment, infrastructure etc.) | | Staff cost | Other costs (staff training, equipment, infrastructure etc.) | Staff cost | Other costs (staff training, equipment, infrastructure etc.) | Staff cost | Other costs (staff training, equipment, infrastructure etc.) |  |  |  |
| 2018-19 actual spend | | |  |  | 339167 | | |  |  | |  |  |  |  |  |  |  |  |  |  |
| 2019-20 actual spend | | |  |  | 308574 | | |  |  | |  | 364560 |  | 177206 |  | 45089 | 4000 |  |  |  |
| 2020-21 actual spend | | |  |  | 206541 | | | 54000 | 105000 | | 12000 | 217521 | 23000 | 352271 | 16100 | 97350 | 4000 |  |  |  |
| 2021-22 planned spend | | |  |  |  | | |  |  | |  | 260400 | 29000 | 598213 | 46600 |  |  |  |  |  |
| Total planned spend | | | 0 | 0 | 854282 | | | 54000 | 105000 | | 12000 | 842481 | 52000 | 1127690 | 62700 | 142439 | 8000 |  |  |  |
| Total spend required for full delivery | | | 588000 | 147330 | 1113282 | | | 68800 | 986111 | | 798445 | 842481 | 52000 | 1127690 | 62700 | 314439 | 36000 |  |  |  |
|  | | | |  | | | | | | | | | | | | | | |  |  |  |  |
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|  | | | |  |  |  |  |
|  | | | |  |  |  |  |
|  | | | | | | Comment: The financial template reflects actual levels of spend as they relate to the profile of staff recruitment ie part year costs in year and full year recurring costs the subsequent year. Non recurring funding to support the central team have been allocated to the services. Funding from Action 15 relates to the 2019-20 3.7wte stat under Mental Health workers. The total wtestaff required for full delivery is the additional wte required to deliver all of the objectives detailed in the MoU. In terms of VTP the staff costs relate to direct salary costs of vaccinators for delivery of vaccination services included under the MoU. A fully costed model to provide vaccination services in NHS Borders is through a central vaccination team staffed and delivered by NHS Borders, which has identified further costs relating to infrastructure and overhead costs to support VTP sevices for PCIP. These costs are included in the total spend required for full delivery and the associated wte are included under the additional funding required for full delivery. Full costs are also included for the delivery of a proposed NHS Board CTAC service. These costs are caveated as there is further work necessar to confirm a final agreed model for the delivery of PCIP CTAC. | | | | | | | | | | | | | | | | | |  |  |  |  |
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1. *Joint Letter - GMS Contract Update for 2021/22 and Beyond (Scottish Government and BMA 2nd December 2020)* [↑](#footnote-ref-2)