Borders NHS Board

Meeting Date: 3 December 2020

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BORDERS PRIMARY CARE IMPROVEMENT PLAN: UPDATE REPORT AND NEXT STEPS

Purpose of Report:

The purpose of this report is to update the Board on the Borders Primary Care Improvement Plan (PCIP) and propose an ongoing governance model.

Recommendations:

The Board is asked to note the progress of PCIP to date and support the proposal to establish ongoing governance once services are mainstreamed.

Approval Pathways:

This report has been prepared and endorsed by the PCIP Executive Committee, the senior level membership of which reflects the three partner organisations designated within the national Memorandum of Understanding linked to the GP Contract (2018).

Executive Summary:

Background

- PCIP is part of the GP Contract introduced in 2018. It is defined through an agreed national Memorandum of Understanding (MoU) which mandates the delivery of specific priorities aimed at supporting people to access more easily the most appropriate healthcare to meet their needs which will release GP clinical time and will allow GPs to focus on their role as Expert Medical Generalists.
- The national MoU for PCIP was agreed by Scottish Government (Health and Integrated Authorities) and the BMA. This tripartite partnership is mirrored at a local level by the GP Sub Committee, NHS Borders and IJB who are jointly responsible for PCIP delivery.
- The PCIP Executive Committee is the body which oversees and directs the development and implementation of the PCIP programme in Borders. Its membership is at senior level and represents the three partner organisations.
- PCIP forms part of the terms and conditions of employment for all GPs and as such is not optional.

Summary

- Though slowing down in March / April work on PCIP has continued throughout the Covid pandemic and the PCIP Executive Committee have continued to meet.
- Through robust review of progress in all workstreams, the PCIP Executive Committee revised priorities and commitments in the PCIP financial plan and identified resource that could be diverted to contribute to a joint funding arrangement with Mental Health Services in order to establish a new and innovative Primary Care Mental Health service (described in the attached PCIP document). This decision was supported by GP Sub Committee, IJB and the Board Executive Team.
- It has proven difficult to recruit fully qualified Advanced Nurse Practitioners (ANPs); therefore the decision was taken to appoint trainee ANPs and to support them through their training with appropriate mentorship in place so that we can develop a local ANP workforce.
- Recruitment in general has improved over the last quarter which has allowed marked progress across the workstreams.
- The Community Treatment and Care Service workstream has been revisited and a model is currently being developed in partnership with secondary care.
- Scottish Government requested information templates to be submitted in October and November. These are attached separately alongside the updated Borders PCIP document which is a dynamic working document.
- In November 2019 Scottish Government asked all areas what the resource shortfall would be to deliver the full PCIP programme. Scottish Borders submitted an estimate of £1.9m (as reported to the Board previously). No further communication about this funding has been received from Scottish Government.
- The deadline for the delivery of the GP Contract is 31st March 2021. Following this, when the PCIP workstreams become embedded in mainstream operational services, it will be important to maintain ongoing oversight and monitoring to ensure that they continue to deliver the contractual agreement. A model for this governance has been proposed and is appended.

Impact of item/issues on:	
Strategic Context	GP Contract 2018 and associated Memorandum of Understanding. PCIP is consistent with the H&SCP's Strategic Plan.
Patient Safety/Clinical Impact	Patient safety is a core element of PCIP. PCIP will support patients to access the right care delivered by the most appropriate service in a timely fashion
Staffing/Workforce	Circa 70wte new posts will be established across a number of clinical and support services. All posts are resourced at a 52 week level in order to provide year-round services
Finance/Resources	A ringfenced resource allocation of £3.2m over the PCIP programme from Scottish Govt with the direct instruction from them that this cannot be used for saving targets or for any other purpose thanthe delivery of PCIP
Risk Implications	Availability of accommodation for new staff IT infrastructure

	Recruitment issues
Equality and Diversity	Attached
Consultation	GP Sub Committee

Documents appended:

- **1 - Current updated version PCIP Document (submitted to Scottish Government Nov 2020).**
- **2 - Covid PCIP3 Scottish Government Return (Oct 2020).**
- **3 - Financial Template Scottish Government Return (Nov2020).**
- **4 - Proposed model for the Ongoing Monitoring and Oversight of PCIP.**
- **5 - HIIA.**

PCIP Borders
Primary Care Improvement Plan

Scottish Borders Primary Care Improvement Plan

(Revised)

2018-21

Working v5.0 Amended 12th November 2020

Scottish Borders Health and Social Care PARTNERSHIP

NHS Borders

VERSION CONTROL

VERSION REVISED TO:	DATE CHANGED	CHANGES MADE
Final Version 22nd Oct 2019		
Working v2.0	15 / 11/19	Following approval of financial report at GP Executive 14/11/19, Workforce and Finance tables updated; page numbers amended.
Working v 3.0	13 / 12 / 19	Workforce and Finance tables updated. Sentence changed Page 7 to record approval from Scottish Govt for VTP proposal
Working v 4.0	9 / 1 / 2020	Workforce and Finance tables updated
Working v5.0	12/11/2020	General update to all sections

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1. INTRODUCTION

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

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

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

2. BACKGROUND

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

3. GOVERNANCE

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

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

Change of title

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

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

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

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

Clinical Governance

A consistent approach to the delivery of service and development of an appropriately skilled workforce is essential to ensure safe and appropriate patient care. Provision has been made within the PCIP for Band 8a roles in each workstream to manage this and to provide a clinical professional line for the individual disciplines. Each workstream also has a named GP Lead from the PCIP Executive Committee who works in liaison with the Band 8a postholder. In addition, resource has been allocated to allow time for GPs to mentor

and support the new staff appointed through PCIP, most particularly the Advanced Nurse Practitioners and Pharmacists.

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

Operational Governance

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

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

Ongoing Monitoring and Oversight of PCIP

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

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

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

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

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

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

4. KEY PRIORITIES (PCIP WORKSTREAMS)

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

The Vaccination Transformation Programme (VTP)

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

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

	Previously Completed	**Year 1**	**Year 2**	**Year 3**
Plan /Outcomes	School programme (including flu vaccines)	Pertussis/ whooping cough vaccine seasonal flu vaccination being provided by NHSB midwifery team	Continuation of 0-5 years programme work - pre-school childhood population Travel	Shingles (start) Seasonal Flu Adults 65 years and over Pneumococcal vaccines adults aged 65 years Flu Vaccines ('At risk adults' aged 18-64 years)
Progress		Reduction in healthcare appointments for pregnant women as all vaccinations are	Pre-school childhood programme Data gathering completed, this details the % vaccination uptake across all GP	Data gather completed, this details the % vaccination uptake across all GP Practices and Clusters for the 65 years and over population and the 'At risk'

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

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

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

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

The current scheduled routine programme of vaccinations for under 5yrs, for under 5yrs flu and adult vaccinations has been delivered successfully by GP practices for many years and from accommodation within practice premises. The alternative and preferred approach put forward would see NHS Borders taking over the

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

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

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

Pharmacotherapy

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

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

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

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

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

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

Community Treatment & Care Services

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

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

Progress	Model and SOP identified	Model implemented in 4 NHS Borders Treatment Rooms as first phase and evaluation ongoing. Roll out to remaining 6 NHS Borders Treatment Rooms will be complete by end of third quarter.	Review undertaken and new model for service delivery drafted; agreement for Phlebotomy to be first phase. The potential to support improved pathways across primary and secondary care has been identified and joint work is underway to develop the model accordingly. A series of three workshops has been arranged beginning 30th Oct to confirm the model to be progressed.

Urgent Care

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

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

Additional Professional Roles

First Contact Physiotherapists

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

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

Community Mental Health Workers

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

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

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

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

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

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

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

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

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

		signed off Nov 2019. Recruitment underway for next phase of posts required.	

Community Link Workers

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

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

5. CHALLENGES AND RISKS

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

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

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

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

6. ENABLERS AND INFRASTRUCTURE

Premises

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

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

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

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

The issues around access to appropriate accommodation at health centre sites for the new services being introduced through PCIP has been highlighted in Section 5. While some staff have been found accommodation

at a number of locations, it is currently not possible in some buildings and is causing great disruption at others. The problem will only increase as more services are established.

A Primary Care Premises Group was established some years ago within Primary & Community Services and while it has a wider role around Primary Care Premises Modernisation for that Clinical Board, it has been agreed to re-vitalise the group to include the two PCIP areas of work identified above as part of its remit. The GP Executive will oversee and monitor this element of the Group's workplan and the Group's membership will be widened to include GP Executive representation. A whole-system review of primary care estate is to be undertaken which will feed into NHS Borders' Capital Management process which will include the requirements for PCIP.

IT Infrastructure and Data Collection

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

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

NHS 24

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

7. WORKFORCE

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

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

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

Whole Time Equivalents

Financial Year	Service 2: Pharmacotherapy		Services 1 and 3: Vaccinations / Community Treatment and Care Services			Service 4: Urgent Care (advanced practitioners)			Service 5: Additional professional roles			Service 6: Community link workers
	Pharmacist	Pharmacy Technician	Nursing	Healthcare Assistants	Other [a]	ANPs	Advanced Paramedics	Other [a]	Mental Health workers	MSK Physios	Other [a]	
TOTAL staff WTE in post as at 31 March 2018	2.3	1.4	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
INCREASE in staff WTE (1 April 2018 - 31 March 2019)	3.0	0.2	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
PLANNED INCREASE in staff WTE (1 April 2019 - 31 March 2020) [b]	3.4	4.2	0.0	0.0	0.0	7.8	0.0	0.0	0.0	3.4	0.0	4.5
PLANNED INCREASE in staff WTE (1 April 2020 - 31 March 2021) [b]	1.0	6.0	2.3	0.0	0.0	5.2	0.0	0.0	14.3	5.8	0.0	0.0
PLANNED INCREASE staff WTE (1 April 2021 - 31 March 2022) [b]	n/a	n/a	0.0	0.0	0.0	3.0	0.0	0.0	0.0	0.0	0.0	0.0
TOTAL staff WTE in post by 31 March 2022	9.7	11.8	2.3	0.0	0.0	16.0	0.0	0.0	14.3	9.2	0.0	4.5

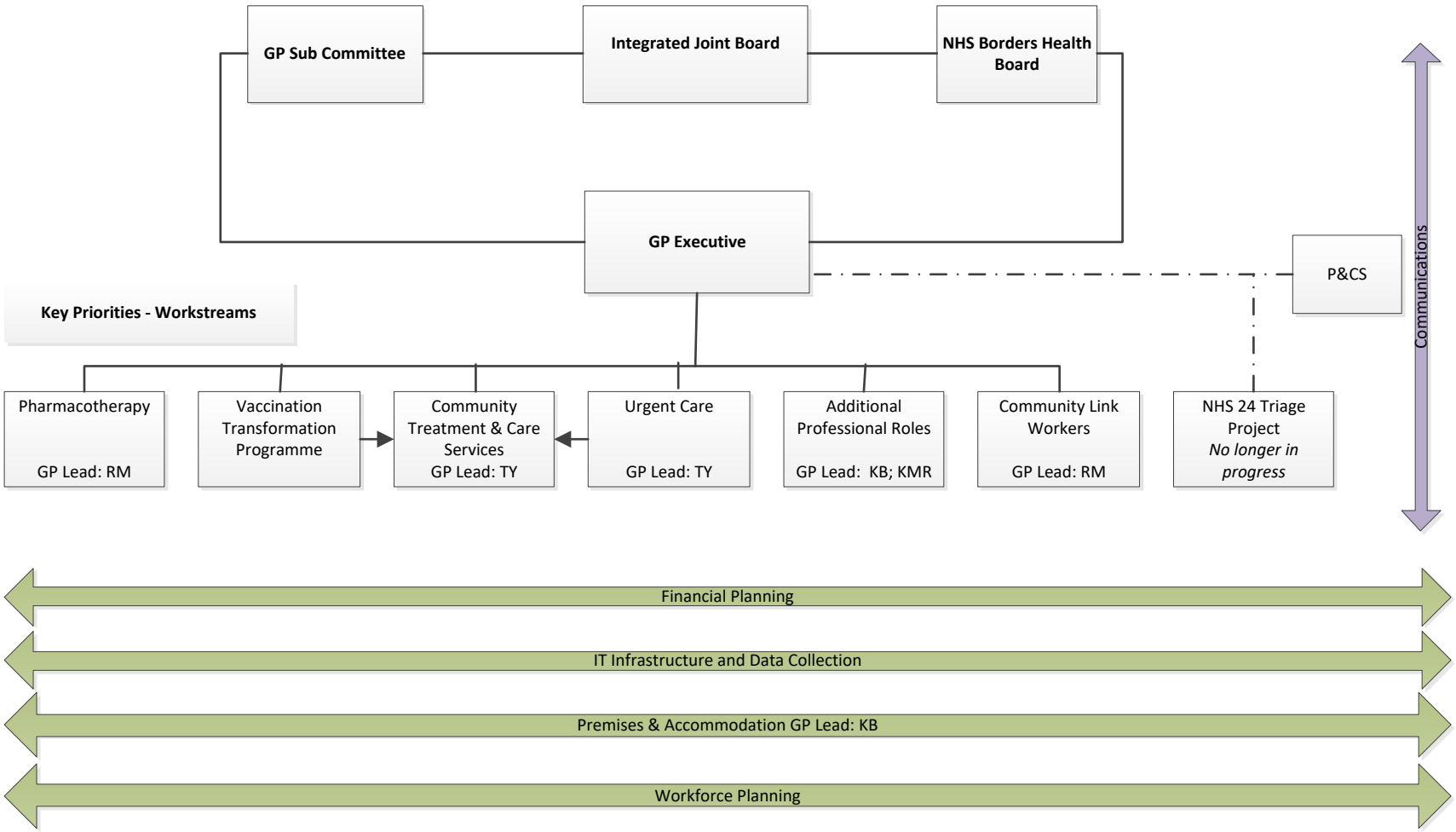
8. FINANCIAL PLANNING

Within the new governance framework, the PCIP Executive's Business Partner has undertaken a comprehensive review of the budget and commitments to date and has presented a confirmed financial outlook; this has been formally agreed by the PCIP Executive and allows robust forward planning. The information from this will inform the regular submissions made to Scottish Government in line with the required Local Implementation Tracker. The financial tables from the October 2020 submission is attached at **Annex C** and gives actual spend together with estimated planned costs for the years 2018 – 2022. As described previously, Scottish Government has been informed of the £1.9m projected shortfall in resource needed to fully deliver PCIP in Borders, of which £1.5m relates to CTAC and VTP.

9. SUMMARY

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

Annex A **Governance Structure**



Annex B PCIP Executive Membership

Dr Kevin Buchan, Chair GP Sub Committee

Rob McCullochGraham, Chief Officer, Health & Social Care Partnership

Dr Kirsty Robinson, GP Sub Committee

Dr Tim Young, GP Sub Committee

Dr Rachel Mollart, GP Sub Committee

Vivienne Buchan, PCIP Business Partner

Sandra Pratt, Associate Director, Strategic Change, NHS Borders

Chris Myers GM, Primary & Community Services

Nicola Lowdon, Associate Medical Director, Primary & Community Services

Simon Burt, GM, Mental Health Services, NHS Borders

Suzie Flower, ADoN, Primary Care NHS Borders

Paul Williams, Associate Director AHPs NHS Borders

Mags Baird, Project Manager, PCIP

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

Financial Year	Service 1: Vaccinations Transfer Programme (£s)		Service 2: Pharmacotherapy (£s)		Service 3: Community Treatment and Care Services (£s)		Service 4: Urgent care (£s)		Service 5: Additional Professional roles (£s)		Service 6: Community link workers (£s)	
	Staff cost	Other costs (staff training, equipment, infrastructure etc.)	Staff cost	Other costs (staff training, equipment, infrastructure etc.)	Staff cost	Other costs (staff training, equipment, infrastructure etc.)	Staff cost	Other costs (staff training, equipment, infrastructure etc.)	Staff cost	Other costs (staff training, equipment, infrastructure etc.)	Staff cost	Other costs (staff training, equipment, infrastructure etc.)
2018-19 actual spend	0	0	339167		0	0	0	0	0	0	0	0
2019-20 actual spend	0	0	308576		0	0	354560	12500	177072	0	45089	4000
2020-21 planned spend	0	0	206541	54000	105000	12000	131095	27000	383843	27000	97350	4000
2021-22 planned spend	0	0	0	0	0	0	339826	29500	565295	37100	0	0
Total planned spend	0	0	854284	54000	105000	12000	825481	69000	1126210	64100	142439	8000

Table 2: Source of funding 2018-2022

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

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

PCIP Ongoing Monitoring Oversight

Key: IAs need to input to all orange shaded cells
Grey cells are calculated cells - no input required

Choose from Drop Down List:

Integration Authority: Scottish Borders

NHS Board Area: Borders

Total Available ADP 2020-21 (£k): £358

ADP Funding - Expenditure Forecast 2020-21

All figures in £000s

		Actual YTD Spend £000s			Forecast Spend to the year-end £000s			2020-21 £000s
		Aug-20			Sept 20 to March 21 Spend			Full Year
Expenditure Category (choose from drop down list):	**Brief Description of Funded Activities:**	**Actual YTD Staff Costs**	**Actual YTD Non Staff Costs**	**Actual YTD Total Costs**	**Forecast Staff Costs**	**Forecast Non-Staff Costs**	**Total Forecast Costs**	**Total Costs 2020-21**
Reducing waiting times for treatment & support services	Assertive Engagement Service	30		30	42		42	72
Improved retention in treatment	Assertive Engagement Service	30		30	42		42	72
Improved access to treatment services	Assertive Engagement Service	41		41	57		57	98
Whole family approaches	Children and Families Link Worker Family Support	25		25	36		36	61
Development of advocacy services	Contribution to Children and adult advocacy	0		0	15		15	15
Continued development of recovery communities	Support Development of recovery community	8		8	12	1	13	21
Increased involvement of those with lived experience of ad	Support Development of infrastructure for involvemen	7		7	12		12	19
				0			0	0
				0			0	0
				0			0	0
				0			0	0
Total Expenditure		141	0	141	216	1	217	358

ADP Funding - Allocations 2020-21

All figures in £000s

	Expenditure	**Funding held at IA**		**IA Adjustment**	**Funding Gap**	**Funding held at SG**	**Request for Tranche 2**	
	2020-21 Forecast Expenditure	**2020-21 ADP interim allocation**	**Earmarked ADP Reserves**	**Other Funding contributed by IA for ADP (1)**	**Additional Funding Need 20-21 (2)**	**Deducted reserves**	**Additional 20-21 Allocation Request**	**Surplus ADP Funding held at SG (3)**
ADP Summary 2020-21	358	358	0		0	0	0	0

Guidance Notes

1 Enter positive number here only if the IA has other sources of own funding it can use towards the cost of ADP in 20-21.

2 Additional funding need is calculated as 20-21 Expenditure forecast minus ADP interim allocation minus Earmarked Reserves minus Other funding contributed by IA .

3 Surplus ADP 15 funding from 2020-21 or earlier to be held by SG.

2. Confirmation the ADP additional allocation requested is required in financial year 2020-21 [1]

No, I do not anticipate an additional ADP allocation will be required in financial year 2020-21.

Print Name

Robert McCulloch-Graham

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[1] Confirmation from IA Chief Officer or Chief Financial Officer that the additional ADP allocation requested for 2020-21 (yellow cell i32) is required and can be spent in full.

Key:	IAs need to input to all orange shaded cells
	Grey cells are calculated cells - no input required
	Choose from Drop Down List:
Integration Authority:	Scottish Borders
NHS Board Area:	Borders
Total Available Action 15 2020-21 (£k):	£506
Action 15 2019-20 Tranche 2 not drawn down (£k)	£152

Action 15 Mental Health Workforce Funding - Expenditure Forecast 2020-21

All figures in £000s

		Actual YTD Spend £000s			Forecast Spend to the year-end £000s			2020-21 £000s
		Aug-20			Sept 20 to March 21 Spend			Full Year
Expenditure Category (choose from drop down list):	**Brief Description of Funded Activities:**	**Actual YTD Staff Costs**	**Actual YTD Non Staff Costs**	**Actual YTD Total Costs**	**Forecast Staff Costs**	**Forecast Non-Staff Costs**	**Total Forecast Costs**	**Total Costs 2020-21**
Staff Costs (new workforce)	Primary Care Psychology B7 CAAP	51	0	51	47	0	47	98
Staff Costs (new workforce)	Primary Care Psychology B8a	27	0	27	44	0	44	71
Staff Costs (new workforce)	Primary Care Psuchology B4 assistant	11	0	11	19	0	19	30
Staff Costs (new workforce)	Well Being Service Manager B6	6	0	6	13	0	13	19
Staff Costs (new workforce)	Well Being Service Manager B5	29	0	29	59	0	59	88
Staff Costs (new workforce)	SBC Line Worker Manager	0	0	0	18	0	18	18
Staff Costs (new workforce)	SBC Peer Practitioner	0	0	0	15	0	15	15
Staff Costs (new workforce)	SBC Autism Co Ordinator	8	0	8	15	0	15	23
	Primary Care Consultant	0	0	0	26	0	26	26
	Primary Care Psychology 8a Mat Cover	0	0	0	42	0	42	42
				0			0	0
				0			0	0
Total Expenditure		132	0	132	298	0	298	430

Action 15 Mental Health Workforce Funding - Allocations 2020-21

All figures in £000s

	Expenditure	**Funding held at IA**		**IA Adjustment**	**Funding Gap**		**Funding held at SG**		**Request for Tranche 2**	
	2020-21 Forecast Expenditure	**2020-21 Action 15 interim allocation**	**Earmarked Action 15 Reserves**	**Other Funding contributed by IA for Action 15 (1)**	**Additional Funding Need 20-21 (2)**	**30% Tranche Two available for draw down (3)**	**Unutilised 18-19 and 2019-20 Action 15 Funding not drawn down (4)**	**Deducted reserves**	**Additional 20-21 Allocation Request**	**Surplus Action 15 Funding held at SG (5)**
Action 15 Summary 2020-21	430	354	0		76	152	306	0	76	382

Guidance Notes

1 Enter positive number here only if the IA has other sources of own funding it can use towards the cost of Action 15 in 20-21.

2 Additional funding need is calculated as 20-21 Expenditure forecast minus Action 15 interim allocation minus Earmarked Reserves minus Other funding contributed by IA .

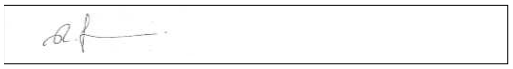
3 IA NRAC share of 30% of £17m.

4 2018-19 and 2019-20 Action 15 Tranche 2 funding not drawn down by IA.

5 Surplus Action 15 funding from 2020-21 or earlier to be held by SG.

2. Confirmation the Action 15 additional allocation requested is required in financial year 2020-21

Yes, I confirm the additional Action 15 allocation is required in financial year 2020-21 and can be spent in full.



Robert McCulloch-Graham

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[1] Confirmation from IA Chief Officer or Chief Financial Officer that the additional Action 15 allocation requested for 2020-21 (yellow cell K32) is required and can be spent in full.

Key: IAs need to input to all orange shaded cells
Grey cells are calculated cells - no input required

	Choose from Drop Down List:
Integration Authority:	Scottish Borders
NHS Board Area:	Borders
Total Available 2020-21 PCIF (£k):	£2,318
PCIF 20-21 Tranche 2 not drawn down (£k)	£1,159

1. Primary Care Improvement Fund - Expenditure Forecast 2020-21

All figures in £000s

		Actual YTD Spend £000s			Forecast Spend to the year-end £000s			Total Spend 2020-21 £000s
YTD Spend provided for the Period Ended:		Aug-20			Sept 20 to March 21 Spend			Full Year
Service Area (choose from drop down list of six priorities in the PCIF letter):	Brief Description of Funded Activities:	Actual YTD Staff Costs	Actual YTD Non Staff Costs	Actual YTD Total Costs	Forecast Staff Costs	Forecast Non Staff Costs	Total Forecast Costs	Total Costs 2020-21
Pharmacotherapy services	Develop Repeat Prescribing	341		341	555		555	896
Community Treatment and Care Services	Develop Service Plan	0		0	105		105	105
Urgent care services	Recruitment to ANP team	154		154	288		288	442
Additional Professional Roles (including MSK physi	Expand service FCP and MH Comm Team	68		68	425		425	493
Community Link Workers	Additional staff	63		63	88		88	151
	Project Support	35		35	40		40	75
				0			0	0
				0			0	0
				0			0	0
				0			0	0
				0			0	0
				0			0	0
Total Expenditure		661	0	661	1,501	0	1,501	2,162

Primary Care Improvement Fund - Funding Sources 20-21

All figures in £000s

	Expenditure	Funding held at IA				IA Adjustment		Funding Gap	Funding held at SG			Tranche 2
	2020-21 Forecast Expenditure	2020-21 PCIF interim allocation	Earmarked PCIF Reserves	Earmarked Other Primary Care Reserves	Baselined Pharmacy Funding	Other Funding contributed by IA for PCIF (1)	Earmarked Other PC Reserves used for non-PCIF (2)	Additional Funding Need 20-21 (3)	Tranche Two available for draw down (4)	Unutilised 18-19 and 19-20 PCIF Funding not drawn down (5)	Deducted reserves	Additional 20-21 Allocation Request
PCIF Summary 2020-21	2,162	995	0	0	164			1,003	1,159	1,234	0	1,003

Guidance Notes

1 Enter positive number here only if the IA has other sources of funding it can use towards the cost of PCIF in 20-21.

2 Enter positive number here only if the IA Earmarked Other Primary Care Reserves (e.g. PCTF) are being utilised in 20-21 for non-PCIF activity and hence are not available to fund PCIF activity. Full details of non-PCIF expenditure funded from these reserves must be provided in the 'Other PC Input Sheet'. Earmarked Other Primary Care Reserves should be utilised for PCIF wherever possible. Where these reserves are ring-fenced for local non-PCIF activity, this expenditure can be profiled over a longer time period. In this case, we would look to IAs to use reserves flexibly over PCTF/PCIF over time, as required to meet the resource need.

3 Additional funding need is calculated as 20-21 Expenditure forecast minus PCIF interim allocation minus Earmarked Reserves minus Baselined pharmacy funding minus Other funding contributed by IA plus Reserves utilised in-year for non-PCIF activity.

4 IA NRAC share of 50% of £110m minus Earmarked Reserves not already deducted from the interim allocation.

5 2018-19 and 2019-20 PCIF Tranche 2 funding not drawn down by IA.

6 Surplus PCIF funding from 2020-21 or earlier to be held by SG for future use.

2. Confirmation the PCIF additional allocation requested is required in financial year 2020-21

Yes, I confirm the additional PCIF allocation is required in financial year 2020-21 and can be spent in full.

Print Name

Robert McCulloch-Graham

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[1] Confirmation from IA Chief Officer or Chief Financial Officer that the additional PCIF allocation requested for 2020-21 (yellow cell N32) is required and can be spent in full.

Covid PCIP 3

Health Board Area: Scottish Borders

Health & Social Care Partnership: Borders Health & Social Care Partnership

Number of practices: 23

MOU PRIORITIES

n place / on target

partially in place / some concerns

lace / not on target

2.1 Pharmacotherapy	Practices with no access by 31/8/20	Practices with partial access by 31/8/20	Practices with full access by 31/8/20	Practices with no access by 31/3/21	Practices with partial access by 31/3/21	Practices with full access by 31/3/21
Practices with PSP service in place						
Practices with PSP level 1 service in place	0	23	0	0	23	0
Practices with PSP level 2 service in place	0	13	0	0	23	0
Practices with PSP level 3 service in place	2	21	0	0	23	0

Comment / supporting information

We would value Scottish Government's definition of "partial access" so that we can be sure to measure and record figures accordingly. This will inform local discussions that are underway currently to define what percentage completion constitutes "partial access" and therefore the figures submitted above may be amended in the next return .

Please detail the impact of Covid on implementation and where you are in this process, including the impact of the Covid response on previous projected delivery

Covid has seen some pharmacy staff repurposed to support wider Covid requirements. Across the service, during the Covid period the majority of pharmacists have been working remotely and face to face interventions have ceased. This has caused some issues for some staff because of dfficulties with IT infrastructure, however this is being addressed and wherever appropriate, pharmacotherapy staff are being enabled to work on site. Based on the evaluation of outcomes delivceered to date, it was agreed to fix investment in this workstream at 21.5wte new posts and to transfer some funding from the balance previously committed in the plan to allow the Additional Roles (Primary Care Mental Health Service element) workstream to be fully delivered. This is reflected in the Workforce Profile section.

2.2 Community Treatment and Care Services	Practices with no access by 31/8/20	Practices with partial access by 31/8/20	Practices with full access by 31/8/20	Practices with no access by 31/3/21	Practices with partial access by 31/3/21	Practices with full access by 31/3/21
Practices with access to phlebotomy service						
Practices with access to management of minor injuries and dressings service						
Practices with access to ear syringing service						
Practices with access to suture removal service						
Practices with access to chronic disease monitoring and related data collection						
Practices with access to other services						

Comment / supporting information This workstream has not yet started therefore there are no PCIP services listed above. However all GP Practices will currently have access to all or most of the above list of clinical interventions either through their own practice team or through NHS Borders existing treatment room services.

Please detail the impact of Covid on implementation and where you are in this process, including the impact of the Covid response on previous projected delivery submission

CTAC is the workstream least developed in Borders (see PCIP document) It has been highlighted that resources to enable full CTAC development form part of the identified respource gap previously submitted to Scottish Government. During Covid months work has been undertaken to explore the delivery of phlebotomy as a first deliverable. The PCIP Executive has developed a potential overarching CTAC model which the workstream group will develop collaboratively with Seconday Care. A practice survey is currently underway to determine which CTAC services are being delivered by existing services; results are expected by mid- October and will inform workshop discussion to develop an agreed service model.

2.3 Vaccine Transformation Program	Practices with no access by 31/8/20	Practices with partial access by 31/8/20	Practices with full access by 31/8/20	Practices with no access by 31/3/21	Practices with partial access by 31/3/21	Practices with full access by 31/3/21
Pre School - Practices covered by service			23			23
School age - Practices covered by service			23			23
Out of Schedule - Practices covered by service			0			0
Adult imms - Practices covered by service						
Adult flu - Practices covered by service						
Pregnancy - Practices covered by service			23			23
Travel - Practices covered by service	0	0	0			0

Comment / supporting information VTP deferred by Scottish Govt for 12 months. It remains the intention locally to merge VTP with CTAC. Work has continued during the Covid period to develop contractual arrangements linked to the local proposal agreed with Scottish Govt.

Please detail the impact of Covid on implementation and where you are in this process, including the impact of the Covid response on previous projected delivery NHS Borders has committed to supporting all practices by delivering Adult flu vaccinations in 2020/21 as part of an overall flu programme using a centralised team. This is to support delivery impacted by covid restrictions within GP premises and processes as well as GP capacity. Pre school and adults <65yrs at risk flu vacs are being delivered by GP practices.

2.4 Urgent Care Services	Practices with no access by 31/8/20	Practices with partial access by 31/8/20	Practices with full access by 31/8/20	Practices with no access by 31/3/21	Practices with partial access by 31/3/21	Practices with full access by 31/3/21
Practices supported with Urgent Care Service	18 practices with no access to ANP	5 Practices (in two clusters - West & South) with access to Trainees or a Trained ANP			23	

Comment / supporting information

Recruitment is underway for further ANP posts. There have been no fully trained applicants but 12 trainees were shortlisted for interview early September; 6 successfully appointed and will be supported through the training programme. An open recruitment programme is in place and the expectation is to fill all 15wte (ie a further 4wte) by March 2021

Please detail the impact of Covid on implementation and where you are in this process, including the impact of the Covid response on previous projected delivery

There was a brief delay to recruitment at the start of Covid mostly due to HR capacity, however recruitment was fully resumed late June / early July 2020.

Covid has impacted availability of appropriate accomodation for ANP staff. Some infrastructure issues have impeded progress with remote working; these issues are being addressed and accommodation is now priritised for PCIP ANPs.

Additional professional services

2.5 Physiotherapy / FCP	Practices with no access by 31/8/20	Practices with partial access by 31/8/20	Practices with full access by 31/8/20	Practices with no access by 31/3/21	Practices with partial access by 31/3/21	Practices with full access by 31/3/21
Practices accessing APP	15 practices with no access to FCP		8 practices (Central & East clusters)			23

Comment / supporting information

6.6wte x Band 7 anticipated in post by end of 2020/21. Band 8a now in post. Recruitment continues in order to achieve full complement by March 2021. The PCIP Executive has noted the impact of Covid on service delivery and learned lessons from this; consequently a revised centralised model is being developed to address the accommodation issues and the equity challenges due to ecomonomy of scale.

Please detail the impact of Covid on implementation and where you are in this process, including the impact of the Covid response on previous projected delivery

There was a brief delay to recruitment at the start of Covid, mostly due to HR capacity, however recruitment was fully resumed late June / early July 2020.

Covid has impacted the availability of appropriate accomodation for FCP staff. Some infrastructure issues impeded remote working; these issues are being addressed.

2.6 Mental health workers (ref to Action 15 where appropriate)	Practices with no access by 31/8/20	Practices with partial access by 31/8/20	Practices with full access by 31/8/20	Practices with no access by 31/3/21	Practices with partial access by 31/3/21	Practices with full access by 31/3/21
Practices accessing MH workers / support		0	0			23

Comment / supporting information

Testing of a 'see & treat' psychological therapies model in Borders was completed Dec 2019. Following consultation and an option appraisal, decisions were taken about the level of PCIP funding (which required some movement of funds between workstreams) and the transfer of Action 15 staff to support an agreed 'see & treat' centralised psychological therapies model . This model will be delived by the Mental Health Service across the Scottish Borders and started w/c 05/10, with 50% staff recruited as at 1st Oct. Expectation is to recruit fully by January 2021.

Please detail the impact of Covid on implementation and where you are in this process, including the impact of the Covid response on previous projected delivery servcie

Covid restrictionsh will bring challenges in delivering group therapies and access to accommodation for clinical intervention. However by working as a centralised service wider options can be explored which will help to mitigate some of the challenges Covid brings.

2.7 Community Links Workers	Practices with no access by 31/8/20	Practices with partial access by 31/8/20	Practices with full access by 31/8/20	Practices with no access by 31/3/21	Practices with partial access by 31/3/21	Practices with full access by 31/3/21
Practices accessing Link workers		23				23

Comment / supporting information

Please detail the impact of Covid on implementation and where you are in this process, including the impact of the Covid response on previous projected delivery

Covid has impacted the ability for the team to undertake their work in community settings. The range of services and activities available in the community has been drastically reduced and the impact on clients wellbeing has been notable. The service is working through a process to maintain wellbeing and build individuals confidence in re-engaging with activities as they become available

2.8 Other locally agreed services (insert details)	Practices with no access by 31/8/20	Practices with partial access by 31/8/20	Practices with full access by 31/8/20	Practices with no access by 31/3/21	Practices with partial access by 31/3/21	Practices with full access by 31/3/21
Practices accessing service						

Comment / supporting information

As reported in previous submissions NHS24 had been in discussion with NHS Borders and the PCIP Executive and had offered to deliver a triage service across all practices.

However in September 2020 NHS24 informed NHSBorders that this was no longer something they could pursue due to the national focus on the Redesign of Unscheduled Care.

Please detail the impact of Covid on implementation and where you are in this process, including the impact of the Covid response on previous projected delivery

2.9 Overall assessment of progress against PCIP

Specific Risks

Availability of accommodation for both clinical intervention and administrative work within Practice premises;
IT / Wi-fi connectivity;
Recruitment;
Pace of recovery to the new reality post COVID;
FLU/COVID Vaccs delivery pressure;

A risk to the delivery of the total PCIP is the shortfall in the level of funding - a shortfall of £1.9m was identified to Scottish Government in Nov/Dec 2019

Barriers to Progress

Please detail any barriers to progress and what could be done to overcome those barriers.

Funding - a shortfall in funding of £1.9m was identified to Scottish Government at their request in Nov / Dec 2019. This figure included resources to enable development of CTAC and VTP. No further communication about this has been received therefore progression of these workstreams continues to be an issue.
Within the response to Scottish Government re shorfall as request was made for Health Boards to receive additional ring-fenced capital allocation for Primary Care to assist in addressing the numerous premises and accommodation issues.

Recruitment - we have not intentionally delayed recruitment or work on PCIP because of Covid though recruitment has remained a consistent pressure across all workstreams throughout the programme. Over the last two months however, we have seen increased interest in advertised posts which has enabled workstreams to progress,

Accommodation - availability of suitable clinical space for PCIP posts has been an ongoing issue which has been compounded by the need to accommodate Covid restrictions.

Issues FAO National Oversight Group

Funding - a shortfall in funding of £1.9m was identified to Scottish Government at their request in Nov / Dec 2019. This figure included resources to enable development of CTAC and VTP. No further communication about this has been received therefore progression of these workstreams continues to be an issue and the delivery of the PCIP as a complete plan is at risk. It would be helpful if the National Oversight Group could update about this and secure the additional funding. Feedback about the request for specific Primary Care capital allocation would be welcome.

The PCIP Executive routinely scrutinises and monitors all workstreams and as circumstances change eg recruitment issues, failing to meet outcomes etc, makes decisions about and amendments to the plan in order to maintain overall progress and achieve the right results for patients and GPs. This has included the need to make some changes to resources previously allocated in the PCIP to individual workstreams which has seen some funding transferred from one workstream to another; these decisions are evidence-based but have also been impacted by the shortfall in PCIP funding as descrbed above. The most recent changes are reflected in the workforce profile and future financial profiles spreadsheets.

Ongoing Governance: The PCIP Executive Committe has identified that ongoing governance will be essential after completion of the national PCIP development and implementation programme at the end of March 2021as the new posts and services move into mainstream delivery. Therefore a proposal has been drafted to recommend the local establishment of a PCIP Ongoing Monitoring and Oversight Committee after March 2021 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. This committee will have a membership reflective of the tripartite nature of the MoU.

Health Inequalities

Covid has highlighted existing health inequalities and without mitigation the response to Covid is likely to increase health inequalities. Ministers are keen to see all sectors renewing their efforts on this and will be encouraging all sectors to work together. HSCPs and GPs are already taking significant actions to close the gap. HSCPs are using their position to bring sectors together to help take a whole-system approach to big issues. GPs are playing their part - whether through referrals to services for weight management or smoking cessation, or through outreach to the communities which are hardest to reach and where most inequality is experienced.
Please provide any comments on the impact of Covid on health inequalities and any measures taken to mitigate this impact.
HIIA completed and signedd off by the PCIP Executive Committee

Further Reflections

Please add any other reflections on the impact of the pandemic, for example:
New developments (e.g. IT, services) which were brought in during Covid which support contract delivery and aims.
COVID has encouraged GPs and ckinical colleagues to make use of technology where appropriate and where IT infrastructure allows eg 'NearMe' to manage care of patients during and recovery from the first wave of the pandemic.

Any other services / developments which are locally agreed.
N/a
Any other general comments.

The ability and support locally to continue work on PCIP throughout the Covid period has been positive and appreciated by all involved.

Recent improvement in recruitment has greatly contributed to progress across the workstreams. Oversight by the PCIP Executive Committee has been been a crucial element in enabling PCIP to develop at an improved pace and also in sustaining work on PCIP development throughout the Covid period.

The PCIP Executive is particularly pleased about the pychological therapies model developed to deliver a primary care mental health service (Under Additional Roles) and whichbegan early October. This has been developed collaboratively and with joint funding PCIP / Action 15 monies.

Workforce profile

Health Board Area: Scottish Borders
Health & Social Care Partnership: Borders Health & Social Care

Table 1: Workforce profile 2018 - 2022 (headcount)

Financial Year	Service 2: Pharmacotherapy		Services 1 and 3: Vaccinations / Community Treatment and Care Services			Service 4: Urgent Care (advanced practitioners)			Service 5: Additional professional roles			Service 6: Community link workers
	Pharmacist	Pharmacy Technician	Nursing	Healthcare Assistants	Other [a]	ANPs	Advanced Paramedics	Other [a]	Mental Health workers	FCP Physios	Other [a]	
TOTAL headcount staff in post as at 31 March 2018	3	2				0	0	0	0	0	0	0
INCREASE in staff headcount (1 April 2018 - 31 March 2019)	3	1				0	0	0	0	0	0	0
INCREASE in staff headcount (1 April 2019 - 31 March 2020)	5	5				8	0	0	0	5	0	5
PLANNED INCREASE in staff headcount (1 April 2020 - 31 March 2021) [b]	1	6				5	0	0	15	4	0	0
PLANNED INCREASE staff headcount (1 April 2021 - 31 March 2022) [b]	0	0				3	0	0	0	0	0	0
TOTAL headcount staff in post by 31 March 2022	12	14	0	0	0	16	0	0	15	9	0	5

[a] please specify workforce types in the comment field

[b] If planned increase is zero, add 0. If planned increase cannot be estimated, add n/a

Table 2: Workforce profile 2018 - 2022 (WTE)

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

[a] please specify workforce types in the comment field

[b] If planned increase is zero, add 0. If planned increase cannot be estimated, add n/a

Comment:

PCIP Borders
Primary Care Improvement Plan

ONGOING MONITORING & OVERSIGHT AFTER 31st MARCH 2021

AIM

This paper highlights the need for ongoing monitoring and oversight of the new posts and services introduced through the new GP Contract as the delivery of the Primary Care Improvement Plan (PCIP) programme concludes and these services become mainstreamed. It also proposes a potential draft model for this purpose.

BACKGROUND

National context

In 2018 the new GMS Contract was developed and agreed between the British Medical Association (BMA) and Scottish Government. As part of the new contract a Memorandum of Understanding ("MoU") was established between The Scottish Government, the Scottish General Practitioners Committee of the British Medical Association, Integration Authorities and NHS Boards to deliver the Primary Care Improvement Plan (PCIP). As the responsibilities of the Integration Authorities will typically be delivered through the Health and Social Care Partnerships (HSCPs), for the purposes of the MoU, HSCPs are referred to as being responsible for the planning and commissioning of primary care services.

At a local level this translates into a tripartite agreement between HCSPs, Health Boards and GP Sub Committees to deliver the PCIP in collaboration with other relevant stakeholders.

Scottish Government have allocated recurring resources to support the delivery of PCIP; for Borders this equates to £3.2m at the time of writing and this is being allocated over the three years of the programme. In all Scottish Government allocation letters from the Primary Care Directorate, it has been stated explicitly that "PCIF (ie PCIP) funding (including the baselined GP pharmacy funding being treated as PCIF) is *not subject to any general savings requirements and must not be used to address any wider funding pressures."*

Local Context

NHS Borders | Scottish Borders Health and Social Care Partnership | Scottish Borders Council

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.

As part of the PCIP revitalisation process, it was evident that a more robust governance framework was required; aGP Executive Committee was therefore introduced in April 2019 with membership from GP Sub Committee, NHS Borders and Borders Health &Social Care Partnership at senior level and with delegated decision-making authority within the triumvirate agreed overall PCIP plan. The GP Executive Committee 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 Committee 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.

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 paper.

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 funding plan for Band 8a roles in each workstream to manage this and 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 across practices to mentor and support the new staff appointed through PCIP, most particularly the Advanced Nurse Practitioners and Pharmacists.

Operational Governance

Working in GP practices may be a very different experience for the new PCIP staff members; 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 for all posts have been agreed and require to be monitored.

In total,approximately 70wte new, permanent posts will be established across Borders through PCIP. These postholders will deliver a range of new or reconfigured primary care services which will allow patients to be seen by the most appropriate health or social care professional to meet their needs and in a timely manner. This will allow GPs to free up clinical time to focus on more complex patient care in their role as Expert Medical Generalists.

ASSESSMENT

The development of the new services and the governance framework described previously has required stringent oversight and monitoring by the PCIP Executive Committee in order to maintain a fair and

equitable approach across all GP practice areas, to ensure the appropriate use of the allocated resource in line with the specifications laid down within the MoU and to ensure that the principles and requirements of the MoU have not been eroded.

Recruitment to posts has not always been easy across the workstreams and where workforce plans have faltered because posts could not be filled, decisions have been required to agree a different approach / skill mix, how best to manage vacancies etc in order to ensure delivery of the new service.

There has been some general misunderstanding about what PCIP actually is and what it means for GPs, for patients and for existing health and social care services. During the course of the programme PCIP has often been seen as "something additional to do" rather than as a huge opportunity (with attached resource) not only to broaden primary care services but also tooffer new career pathways which will in turn support recruitment potential and professional growth. The PCIP Executive Committee has had a crucial role in managing these misperceptions, in improving knowledge and awareness about PCIP, its workstreams and as a true enabler for shifting the balance of care which is in line with local and national strategic direction.

It is evident therefore that the PCIP Executive Committee has been vital in steering the development and progress of PCIP in Borders within a robust governance framework and through appropriate scrutiny and monitoring.

The PCIP programme as a project is due to conclude on 31st March 2021, at which point the new posts and services will be mainstreamed and will then fall under the operational management of the relevant Heads of Service within Scottish Borders Council (for Community Link Workers) and NHS Borders.

It must be recognised that in May 2020 Scottish Government deferred the work on the Vaccination Transformation Programme for 12 months across Scotland which means that that workstream will require development and oversight post March 2021.

<u>After 31st March 2021</u>

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

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

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

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

It is therefore proposed that consideration is given to the establishment of an ongoing oversight and monitoring function to support the PCIP services after the end of the PCIP Programme in March 2021.

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

RECOMMENDATION

It is recommended that a PCIP Monitoring & Oversight Committee is established once the PCIP Executive Committee has completed the PCIP development and implementation programme.

This new Committee would consist of senior level representation from GP Practice, NHS Borders and H&SCP to mirror the tripartite nature of the original MoU and in recognition that the posts and services introduced through PCIP, while mainstreamed, remain an integral part of the GP contract and require to be maintained as such.

Members would have the delegated authority to make decisions within the triumvirate agreed PCIP plan about any proposed changes to the established PCIP services, agree the management of vacancies and ongoing use of invested resources to ensure that the terms of the GP contract continue to be met and patients continue to benefit.

The vacancy management arrangements within NHS Borders as previously described would continue for all PCIP funded posts.

While the operational management and professional oversight of the posts would sit with the service managers in liaison with the practices, regular update and performance reports would be taken by the Heads of Service to the PCIP Monitoring & Oversight Committee who would provide a scrutiny and monitoring function as well as agreeing any proposed changes to the posts or services.

The Committee would also receive regular financial reports linked to the PCIP investment. These reports would use the post files and financial coding processes in order to track and monitor the specific resources committed through PCIP.

The Committee would provide regular updates and an annual report on PCIP services and the delivery of the agreed outcomes to GP Sub Committee, NHS Borders (via P&CS Clinical Board and BET) and the IJB . The proposed governance structure for the PCIP Monitoring & Oversight Committee is shown at **Annex C**

The Committee core membership would be:

- Chair of GP Sub Committee (Chair of Committee)
- 3 x GP Executive members
- General Manager, P&CS
- General Manager, Mental Health
- Chief Officer, H&SCP
- Business Finance Partner, H&SCP
- Associate Director of Nursing, P&CS
- Associate Director of AHPs
- Associate Medical Director, P&CS
- Contracts Manager

The PCIP Project Manager would continue to be a member of the Committee whilst in post (until August 2021) to provide co-ordination and continuity during the transition to mainstreaming of the programme and to support the Committee as currently.

It is acknowledged that the PCIP Monitoring & Oversight Committee will require to engage with public representatives and Partnership colleagues as PCIP services progress and develop. Where specific engagement is needed this will be put in place accordingly. The governance structure for the Committee will ensure overarching public and Partnership engagement.

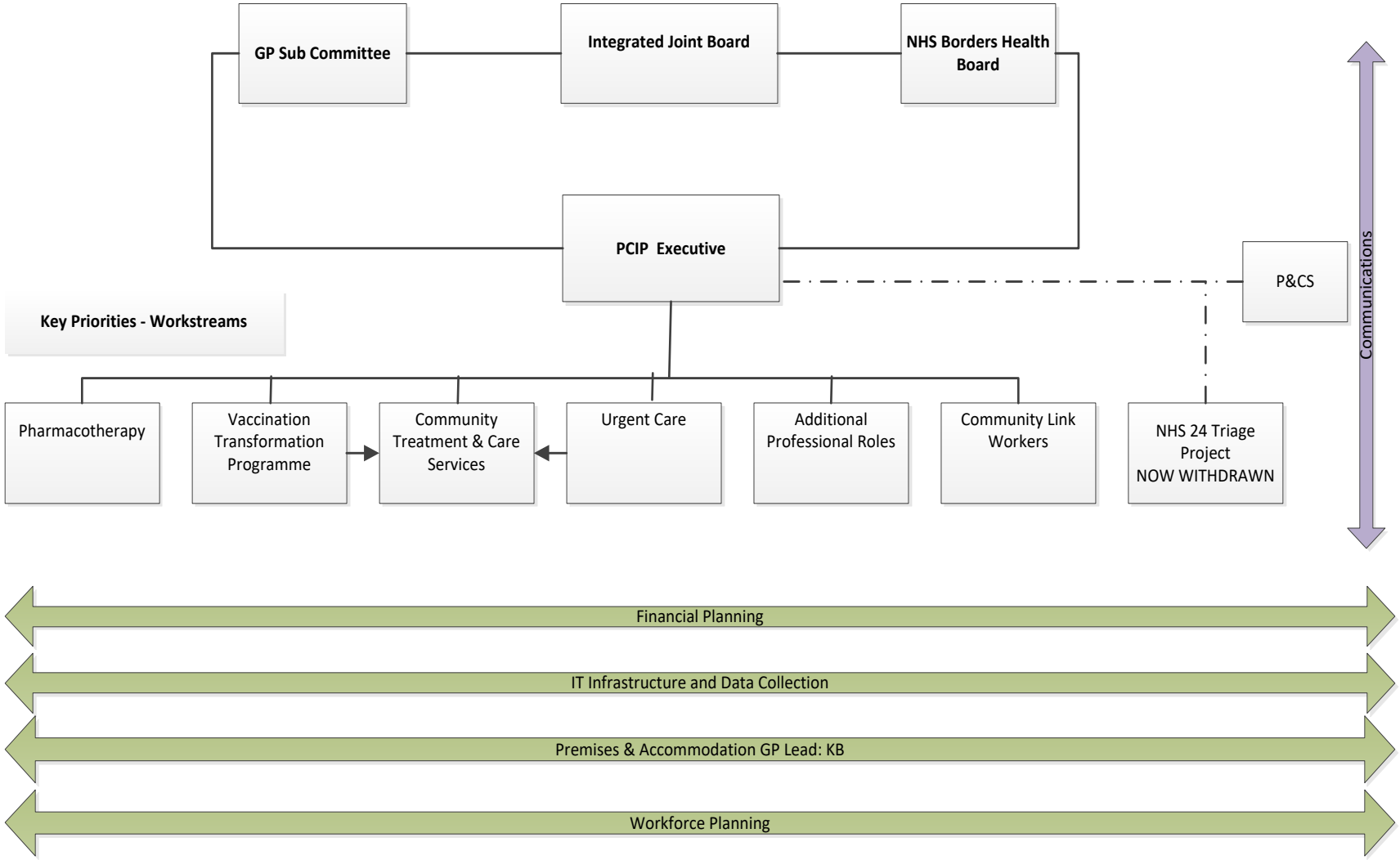
Sandra Pratt

Executive Lead for PCIP. NHS Borders

8th October2020

Final Version 8th October 2020

Annex A Current PCIP Executive Committee Governance Structure

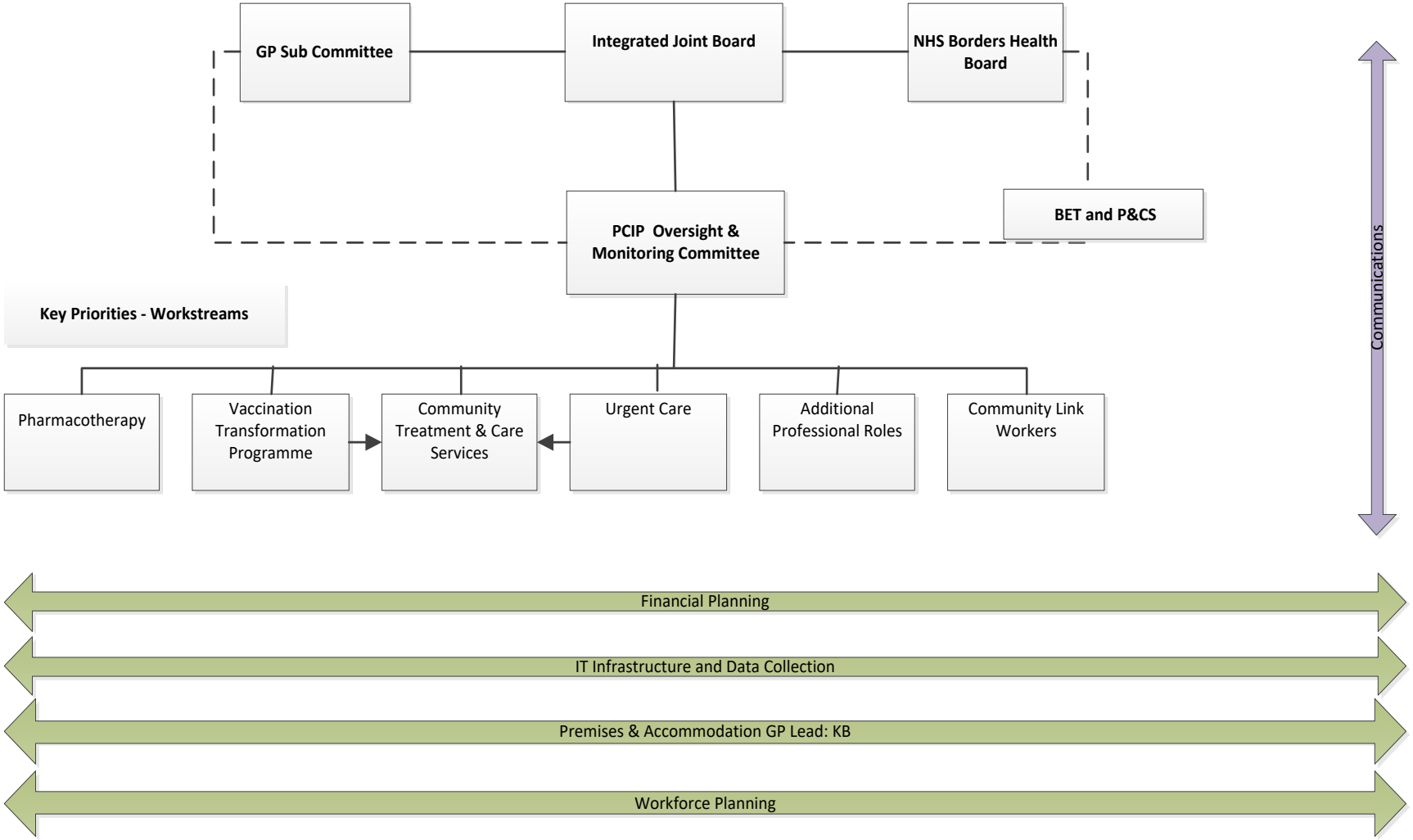


Annex B

PCIP Executive Committee: current membership

- Chair GP Sub Committee (Chair)
- 3 GP Executive members
- Chief Officer, H&SCP
- Executive Lead, NHS Borders
- General Manager, P&CS
- General Manager, Mental Health
- Associate Director of Nursing, P&CS
- Associate Director of AHPs
- Associate Medical Director, P&CS
- PCIP Business Finance Partner
- Project Manager

Annex C **Proposed PCIP Oversight & Monitoring Committee Governance Structure**



Health inequalities impact assessment: Workbook for workshop participants

Introduction

Carrying out a Health Inequalities Impact Assessment (HIIA) will help you to consider the impact of your policy* on people. Using this workbook, alongside the HIIA: Answers to frequently asked questions guide, will help you to work through the process and strengthen your policy's contribution towards health equity.

The workshop is a core element of the HIIA and, together with a group of key stakeholders, you will work through six questions to identify any impacts your policy will have on: different population groups; health inequalities; and people's human rights. Policies do not impact on people in the same way – impact assessment is a way to consider how people will be affected differently. It will also help you to meet the requirements of the Public Sector Equality Duty by considering those groups who are protected under the Duty (information about the Duty is available at www.scotland.gov.uk/Topics/People/Equality/PublicEqualityDuties. During the workshop, the facilitator or lead for the impact assessment will take you through the process and outline the next steps.

The six questions in the workshop are:

1 Who will be affected by this policy?

2 How will the policy impact on people?

3 How will the policy impact on the causes of health inequalities?

4 How will the policy impact on people's human rights?

5 Will there be any cumulative impacts as a result of the relationship between this policy and others?

6 What sources of evidence have informed your impact assessment?

* The word 'policy' represents any option, procedure, practice, strategy or proposal being assessed.

You should identify impacts as positive or negative, remembering that some policies may have no impacts for a population group.

Positive impact: would demonstrate the benefit the policy could have for a population group: how it advances equality, fosters good relations, contributes to tackling health inequalities or upholds human rights.

Negative impact: would mean that a population group is at risk of being disadvantaged by the policy, there is a risk of breaching the human rights of people or the requirements of the Equality Duty, or that there is a risk of widening health inequalities.

No impact: If you find that the policy will have no impacts for some groups, you do not need to record this information.

Further information on Health Inequalities is available from NHS Health Scotland Website

http://www.healthscotland.scot/health-inequalities

Question 1: Who will be affected by this policy/programme?

Example: Keep this brief, such as 'Children aged 5–12 years'.

There is no need to explore subgroups yet, just provide an indication of how well-defined the target group is at this stage.

Borders population, registered with a GP Practice

Question 2: How will the policy/programme impact on people?

When thinking about how the policy/programme might impact on people, think about it in terms of the right for **everyone** to achieve the highest possible standard of health. The Right to Health includes both the right to healthcare and the right to a range of factors that can help us lead a healthy life (the determinants of health). Equality and non-discrimination are fundamental to this right.

The Right to Health has four related concepts: goods, facilities and services should be available, accessible, acceptable and of good quality.

When thinking about how the policy/programme might impact on people, their human rights and the factors that help people to lead healthy lives, consider and discuss:

- Is the policy/programme **available** to different population groups?
- Is the policy/programme **accessible**, (e.g. in terms of physical access, communication needs, transport needs, health literacy, childcare needs, knowledge and confidence)?
- Is the policy/programme **acceptable** to different population groups (e.g. is it sensitive to age, culture and sex)?
- Is the policy/programme of good **quality**, enabling it to have its desired effects and support the above?

Apply these questions to each population group in the following table. Try to identify any factors which can contribute to poorer experiences of health and any potential positive or negative impacts of the policy. Think about people, not characteristics, such as how the policy/programme impact on the right to health of a disabled older man with low literacy who lives in a deprived area.

Population groups and factors contributing to poorer health	Potential Impacts and explanation why	Recommendations to reduce or enhance such impacts
Age: older people; middle years; early years; children and young people.	Service changes within the programme will have minimal impact on Borders population; services will still be delivered within the GP Practice, at the local Health Centre. However the appointment may be with another highly qualified health care professional.	Receptionists within each practice will undergo specific training as 'care navigators' Appointment with a GP is still available A robust communication plan will be in place to ensure engagement / involvement with Patients/Families, Public & Carers when necessary
Disability: physical impairments; learning disability; sensory impairment; mental health conditions; long-term medical conditions.	Service changes within the programme will have minimal impact on Borders population; services will still be delivered within the GP Practice, at the local Health Centre. However the appointment may be with another highly qualified health care professional.	Receptionists within each practice will undergo specific training as 'care navigators' Appointment with a GP is still available A robust communication plan will be in place to ensure engagement / involvement with Patients/Families, Public & Carers when necessary
Gender Reassignment: people undergoing gender reassignment	Service changes within the programme will have minimal impact on Borders population; services will still be delivered within the GP Practice, at the local Health Centre. However the appointment may be with another highly qualified health care professional.	Receptionists within each practice will undergo specific training as 'care navigators' Appointment with a GP is still available A robust communication plan will be in place to ensure engagement / involvement with Patients/Families, Public & Carers when necessary
Marriage & Civil Partnership: people who are married, unmarried or in a civil partnership.	Service changes within the programme will have minimal impact on Borders population; services will still be delivered within the GP Practice, at the local Health Centre. However the appointment may be with another highly qualified health care professional.	Receptionists within each practice will undergo specific training as 'care navigators' Appointment with a GP is still available A robust communication plan will be in place to ensure engagement /

		involvement with Patients/Families, Public & Carers when necessary
Pregnancy and Maternity: women before and after childbirth; breastfeeding.	Service changes within the programme will have minimal impact on Borders population; services will still be delivered within the GP Practice, at the local Health Centre. However the appointment may be with another highly qualified health care professional.	Receptionists within each practice will undergo specific training as 'care navigators' Appointment with a GP is still available A robust communication plan will be in place to ensure engagement / involvement with Patients/Families, Public & Carers when necessary
Race and ethnicity: minority ethnic people; non-English speakers; gypsies/travellers; migrant workers.	Service changes within the programme will have minimal impact on Borders population; services will still be delivered within the GP Practice, at the local Health Centre. However the appointment may be with another highly qualified health care professional.	Receptionists within each practice will undergo specific training as 'care navigators' Appointment with a GP is still available A robust communication plan will be in place to ensure engagement / involvement with Patients/Families, Public & Carers when necessary
Religion and belief: people with different religions or beliefs, or none.	Service changes within the programme will have minimal impact on Borders population; services will still be delivered within the GP Practice, at the local Health Centre. However the appointment may be with another highly qualified health care professional.	Receptionists within each practice will undergo specific training as 'care navigators' Appointment with a GP is still available A robust communication plan will be in place to ensure engagement / involvement with Patients/Families, Public & Carers when necessary
Sex: men; women; experience of gender-based violence.	Service changes within the programme will have minimal impact on Borders population; services will still be delivered within the GP Practice, at the local Health Centre. However the appointment may be with another highly qualified health care professional.	Receptionists within each practice will undergo specific training as 'care navigators' Appointment with a GP is still available A robust communication plan will be in place to ensure engagement /

		involvement with Patients/Families, Public & Carers when necessary
Sexual orientation: lesbian; gay; bisexual; heterosexual.	Service changes within the programme will have minimal impact on Borders population; services will still be delivered within the GP Practice, at the local Health Centre. However the appointment may be with another highly qualified health care professional.	Receptionists within each practice will undergo specific training as 'care navigators' Appointment with a GP is still available A robust communication plan will be in place to ensure engagement / involvement with Patients/Families, Public & Carers when necessary
Looked after (incl. accommodated) children and young people	Service changes within the programme will have minimal impact on Borders population; services will still be delivered within the GP Practice, at the local Health Centre. However the appointment may be with another highly qualified health care professional.	Receptionists within each practice will undergo specific training as 'care navigators' Appointment with a GP is still available A robust communication plan will be in place to ensure engagement / involvement with Patients/Families, Public & Carers when necessary
Carers: paid/unpaid, family members.	Service changes within the programme will have minimal impact on Borders population; services will still be delivered within the GP Practice, at the local Health Centre. However the appointment may be with another highly qualified health care professional.	Receptionists within each practice will undergo specific training as 'care navigators' Appointment with a GP is still available A robust communication plan will be in place to ensure engagement / involvement with Patients/Families, Public & Carers when necessary
Homelessness: people on the street; staying temporarily with friends/family; in hostels, B&Bs.	Service changes within the programme will have minimal impact on Borders population; services will still be delivered within the GP Practice, at the local Health Centre. However the appointment may be with another highly qualified health care professional.	Receptionists within each practice will undergo specific training as 'care navigators' Appointment with a GP is still available A robust communication plan will be in place to ensure engagement /

		involvement with Patients/Families, Public & Carers when necessary
Involvement in the criminal justice system: offenders in prison/on probation, ex-offenders.	Service changes within the programme will have minimal impact on Borders population; services will still be delivered within the GP Practice, at the local Health Centre. However the appointment may be with another highly qualified health care professional.	Receptionists within each practice will undergo specific training as 'care navigators' Appointment with a GP is still available A robust communication plan will be in place to ensure engagement / involvement with Patients/Families, Public & Carers when necessary
Addictions and substance misuse	Service changes within the programme will have minimal impact on Borders population; services will still be delivered within the GP Practice, at the local Health Centre. However the appointment may be with another highly qualified health care professional.	Receptionists within each practice will undergo specific training as 'care navigators' Appointment with a GP is still available A robust communication plan will be in place to ensure engagement / involvement with Patients/Families, Public & Carers when necessary
Staff: full/part time; voluntary; delivering/accessing services.	Certain staff currently employed by the GP Practice may change to NHSB, for certain hours of their contract, for example Nurses who work within the treatment room. There are currently no planned changes for any other member of the Primary Care Teams, Volunteers or those delivering/accessing services.	A workplace oversight group will be in place that includes HR, Partnership / Unions, Practice Manager, GP, Workforce rep.
Low income	Service changes within the programme will have minimal impact on Borders population; services will still be delivered within the GP Practice, at the local Health Centre. However the appointment may be with another highly qualified health care professional.	Receptionists within GP practices across Borders will undergo specific training as 'care navigators' Appointment with a GP is still available A robust communication plan will be in place to ensure engagement /

		involvement with Patients/Families, Public & Carers when necessary
Low literacy / Health Literacy includes poor understanding of health and health services (health literacy) as well as poor written language skills.	Service changes within the programme will have minimal impact on Borders population; services will still be delivered within the GP Practice, at the local Health Centre. However the appointment may be with another highly qualified health care professional.	Receptionists within each practice will undergo specific training as 'care navigators' Appointment with a GP is still available A robust communication plan will be in place to ensure engagement / involvement with Patients/Families, Public & Carers when necessary
Living in deprived areas	Service changes within the programme will have minimal impact on Borders population; services will still be delivered within the GP Practice, at the local Health Centre. However the appointment may be with another highly qualified health care professional.	Receptionists within each practice will undergo specific training as 'care navigators' Appointment with a GP is still available A robust communication plan will be in place to ensure engagement / involvement with Patients/Families, Public & Carers when necessary
Living in remote, rural and island locations	Service changes within the programme will have minimal impact on Borders population; services will still be delivered within the GP Practice, at the local Health Centre. However the appointment may be with another highly qualified health care professional.	Receptionists within each practice will undergo specific training as 'care navigators' Appointment with a GP is still available A robust communication plan will be in place to ensure engagement / involvement with Patients/Families, Public & Carers when necessary
Discrimination/stigma	Service changes within the programme will have minimal impact on Borders population; services will still be delivered within the GP Practice, at the local Health Centre. However the appointment may be with another highly qualified health care professional.	Receptionists within each practice will undergo specific training as 'care navigators' Appointment with a GP is still available A robust communication plan will be in place to ensure engagement /

		involvement with Patients/Families, Public & Carers when necessary
Refugees and asylum seekers	Service changes within the programme will have minimal impact on Borders population; services will still be delivered within the GP Practice, at the local Health Centre. However the appointment may be with another highly qualified health care professional.	Receptionists within each practice will undergo specific training as 'care navigators' Appointment with a GP is still available A robust communication plan will be in place to ensure engagement / involvement with Patients/Families, Public & Carers when necessary
Any other groups and risk factors relevant to this policy/programme	N/A	N/A

To comply with the general equality duty of the Equality Act 2010 when conducting impact assessment, you must demonstrate 'due regard' for the need to:

- eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under the Act;
- advance equality of opportunity between people who share a relevant protected characteristic and those who do not share it;
- foster good relations between people who share a relevant protected characteristic and those who do not share it.

This means that you must identify, record and eliminate (through appropriate policy changes) any impacts that could amount to unlawful discrimination under the act. Wherever possible you should also try to identify, record and enhance any impacts that enable the policy to advance equality of opportunity or foster good relations.

Question 3: How will the policy/programme impact on the causes of health inequalities?

The wider environmental and social conditions in which we are born, grow, live, work and age are shaped by the distribution of power, money and resources. These conditions can lead to health inequalities. While considering how your policy will impact on people and their right to health, it is also important to think about how it may impact on the causes of health inequalities (see the table below). Further information on the causes of health inequalities can be found in NHS Health Scotland's Health Inequalities Policy Review.

Not all policies/programmes will be able to act or impact on these causes, but it will be useful to reflect on whether yours will. Think about any opportunity this policy/programme might offer to reduce inequalities and also try to identify any ways in which it might inadvertently increase inequalities (you may find the prompts in Appendix 1 helpful).

You may have discussed some of these issues when considering question 2.

Will the policy impact on?	Potential impacts and any particular groups affected	Recommendations to reduce or enhance such impacts
Income, employment and work • Availability and accessibility of work, paid/ unpaid employment, wage levels, job security. • Tax and benefits structures. • Cost/price controls: housing, fuel, energy, food, clothes, alcohol, tobacco. • Working conditions.	N/A	
The physical environment and local opportunities • Availability and accessibility of housing, transport, healthy food, leisure activities, green spaces. • Air quality and housing/living conditions, exposure to pollutants. • Safety of neighbourhoods, exposure to crime. • Transmission of infection.	N/A	

• Tobacco, alcohol and substance use.		
Education and learning • Availability and accessibility to quality education, affordability of further education. • Early years development, readiness for school, literacy and numeracy levels, qualifications.	N/A	
Access to services • Availability of health and social care services, transport, housing, education, cultural and leisure services. • Ability to afford, access and navigate these services. • Quality of services provided and received.	N/A	
Social, cultural and interpersonal • Social status. • Social norms and attitudes. • Tackling discrimination. • Community environment. • Fostering good relations. • Democratic engagement and representation. • Resilience and coping mechanisms.	N/A	

Question 4: How will the policy/programme impact on people's human rights?

Human rights are the basic rights and freedoms which everyone is entitled to in order to live with dignity. They can be classified as **absolute**, **limited** or **qualified**. Absolute rights must not be restricted in any way. Other rights can be limited or restricted in certain circumstances where there is a need to take into account the rights of other individuals or wider society.

Not all policies/programmes will be able to demonstrate an impact against human rights but it will be useful to consider if yours will. Think about the potential impacts you have identified and consider whether these could help fulfil or breach legal obligations under the Human Rights Act. Can you think of any actions that might promote positive impacts or mitigate negative impacts? The following table includes rights that may be particularly relevant to health and social care policies/programmes.

Articles	Potential areas for consideration	Potential impacts and any particular groups affected	Recommendations to reduce or enhance such impacts
The right to life (absolute right)	• Access to basic necessities such as adequate nutrition, clean and safe drinking water. • Suicide. • Risk to life of/from others. • Duties to protect life from risks by self/others. • End of life questions. • Duties of prevention, protection and remedy, including investigation of unexpected death.	N/A	
The right not to be tortured or treated in an inhuman or degrading way (absolute right)	• Should not cause: fear; humiliation; intense physical or mental suffering; or anguish. • Prevention of ill-treatment, protection and rehabilitation of survivors of ill-treatment.	N/A	

	• Duties of prevention, protection and remedy, including investigation of reasonably substantiated allegations of serious ill-treatment. • Dignified living conditions.		
The right to liberty (limited right)	• Right not to be deprived of liberty in an arbitrary fashion. • Detention under mental health law. • Review of continued justification of detention. • Informing reasons for detention.	N/A	
The right to a fair trial (limited right)	• When a person's civil rights, obligations or a criminal charge against a person comes to be decided upon. • Staff disciplinary proceedings. • Malpractice. • Right to be heard. • Procedural fairness. • Effective participation in proceedings that determine rights such as employment, damages/ compensation.	N/A	
The right to respect for private and family life, home and correspondence	• Family life, including outwith blood and formalised relationships. • Privacy. • Personal choices, relationships. • Physical and moral integrity (e.g. freedom from non-consensual	N/A	

(qualified right)	treatment, harassment or abuse). • Participation in community life. • Participation in decision-making. • Access to personal information. • Respect for someone's home. • Clean and healthy environment. • Legal capacity in decision-making. • Accessible information and communication e.g. phone calls, letters, faxes, emails.		
The right to freedom of thought, belief and religion (qualified right)	• Conduct central to beliefs (such as worship, appropriate diet, dress).	N/A	
The right to freedom of expression (qualified right)	• To hold opinions. • To express opinions, receive/impart information and ideas without interference by a public authority.	N/A	
The right not to be discriminated against	• All of the rights and freedoms contained in the Human Rights Act must be protected and applied without discrimination. • Discrimination takes place when someone is treated in a different way compared with someone else in a similar situation. • Indirect discrimination happens when someone is treated in the	N/A	

	same way as others that does not take into account that person's different situation. • An action or decision will only be considered discriminatory if the distinction in treatment cannot be reasonably and objectively justified.		
Any other rights relevant to this policy e.g.	• Convention on the Rights of the Child • Convention on the Elimination of All Forms of Discrimination against Women • Convention on the Rights of Persons with Disabilities	N/A	

Question 5: Will there be any cumulative impacts as a result of the relationship between this policy/programme and others?

Consider the potential for a build-up of negative impacts on population groups as a result of this policy/programme being combined with other policies/programmes, e.g. relocation of services at the same time as changes to public transport networks.

PMO / Transformational change programme PASC programme P&Cs

Question 6: What sources of evidence have informed your impact assessment?

Formal sources of evidence to consider include population data and statistics, consultation findings and other research. However, your professional or personal experience and knowledge of individuals and communities (and the potential impact of a policy on them) is equally as valuable. Further information can be found in the planning a workshop section. http://www.healthscotland.scot/publications/planning-resources-hiia-scoping-workshop

What evidence have you used to support your impact assessment thinking? Have you identified any areas where more evidence is needed or where there are gaps in your current knowledge to inform the assessment?

Evidence type	Evidence available	Gaps in evidence
Population data e.g. demographic profile, service uptake.	Practice list data VTP: uptake data FCP: activity data ANP: activity data Demographic data – SBC	
Consultation and involvement findings e.g. any engagement with service users, local community, particular groups.	GP Executive Committee Engagement with key care providers: ANPs, FCPs, P&Cs management team Work-stream steering groups	Service users, Families, Carers CLW
Research e.g. good practice guidelines, service evaluations, literature reviews.	Clinical / Professional guidelines PCIP 2019 The 2018 GMS contract in Scotland, BMA Primary Care ihub network Realistic Medicine Public Protection guidance & Legislation	
Participant knowledge e.g. experiences of working with different population groups, experiences of different policies/projects/programmes.	Professional knowledge & experience of various healthcare professionals	

Summary of discussion

The facilitator or lead for the impact assessment will bring the workshop to a close and will recap on how your group has:

- identified what the potential impacts of the policy are on people and their right to health
- identified what potential impacts the policy may have on the causes of health inequalities
- identified what potential impacts the policy may have on people's human rights as set out in the Human Rights Act.
- considered how the policy impacts on the specific requirements in the Public Sector Equality Duty
- identified any actions to tackle these impacts, promote equality and the right to health
- identified any potential effects as a result of the relationship between this policy and others
- identified evidence sources to draw on and where there are gaps in your evidence.

Next steps

A report of this discussion will be written to identify the next steps. You will be asked to comment on this report to ensure that it provides an accurate record of this workshop. Next steps will be coordinated by the project lead and may involve prioritising the impacts, identifying and gathering further sources of evidence (including any consultation) in order to make recommendations from the impact assessment, followed by undertaking and monitoring any actions identified.

Thank you for participating in this workshop.

Appendix 1: Messages from the Health Inequalities Policy Review

<table>
<tr><th colspan="2">Structural</th><th>Behavioural</th></tr>
<tr><th>Fundamental causes</th><th>Wider environmental influences</th><th>Individual experiences</th></tr>
<tr><td rowspan="4">Global economic forces

Macro socio-political environment

Political priorities and decisions

Societal values to equity and fairness

Unequal distribution of power, money and resources

Poverty, marginalisation and discrimination</td><td>Economic and work
Availability of jobs.
Price of basic commodities (e.g. rent, fuel).</td><td>Economic and work
Employment status.
Working conditions.
Job security and control.
Family or individual income.
Wealth.
Receipt of financial and other benefits.</td></tr>
<tr><td>Physical
Air and housing quality.
Safety of neighbourhoods.
Availability of affordable transport.
Availability of affordable food.
Availability of affordable leisure opportunities.</td><td>Physical
Neighbourhood conditions.
Housing tenure and conditions.
Exposure to pollutants, noise, damp or mould.
Access to transport, fuel poverty.
Diet.
Exercise and physical activity.
Tobacco, alcohol and substance use.</td></tr>
<tr><td>Learning
Availability and quality of schools.
Availability and affordability of further education and lifelong learning.</td><td>Learning
Early cognitive development.
Readiness for school.
Literacy and numeracy.
Qualifications.</td></tr>
<tr><td>Services
Accessibility, availability and quality of public, third sector and private services; activity of commercial sector.</td><td>Services
Quality of service received.
Ability to access and navigate.
Affordability.</td></tr>
</table>

	Social and cultural • Community social capital, community engagement. • Social norms and attitudes. • Democratisation. • Democratic engagement and representation.	**Social and cultural** • Connectedness, support and community involvement. • Resilience and coping mechanisms. • Exposure to crime and violence.
Key components of a health inequalities strategy		
Fundamental causes	**Wider environmental influences**	**Individual experiences**
• Policies that redistribute power, money and resources • Social equity and social justice prioritised	• Legislation, regulation, standards and fiscal policy. • Structural changes to the physical environment. • Reducing price barriers. • Ensuring good work is available for all. • Equitable provision of high quality and accessible education and public services.	• Equitable experience of socio-economic and wider environmental influences. • Equitable experience of public services. • Targeting high risk individuals. • Intensive tailored individual support. • Focus on young children and the early years.
Examples of effective interventions		
Fundamental causes	**Wider environmental influences**	**Individual experiences**
• Minimum income for health (healthy living wage) • Progressive taxation (individual and corporate). • Active labour market policies	• Housing: Extend Scottish Housing Quality Standard; Neighbourhood Quality Standard. • Air/water: Air pollution controls; water fluoridation. • Food/alcohol: restrict advertising; regulate retail outlets; regulate trans-fats and salt content. • Transport: drink-driving regulations, lower speed limits, area-wide traffic calming schemes. • Price controls: Raise price of harmful commodities through taxation; reduce price barrier for healthy products and essential services.	• Training – culturally/inequalities sensitive practice. • Linked public services for vulnerable/high risk individuals. • Specialist outreach and targeted services.

Interventions requiring people to opt-in are less likely to reduce health inequalities. Consider the balance of actions at structural and individual levels.