To:	**Renfrewshire Integration Joint Board**
On:	**29 June 2018**
Report by:	**Chief Finance Officer**
Heading:	**Financial Report 1st April 2017 to 31st March 2018**

1. Purpose

1.1. The purpose of this report is to advise the Integration Joint Board (IJB) of the Revenue Budget year end outturn for the HSCP for the financial year 2017/18.

2. Recommendations

2.1. It is recommended that the IJB:

- Note the year-end financial position; and
- Approve the proposed transfers to Earmarked Reserves in section 9.6 and Appendix 7 of this report.

3. Current Financial Position

3.1. Budget Monitoring throughout 2017/18 has shown the IJB projecting a break-even position subject to the draw down of reserves to fund any shortfalls, and, the transfer of specific ring-fenced monies (including Scottish Government funding for Health Visitors and the Primary Care Improvement Fund) and agreed commitments to ear marked reserves. At the close of 2017/18, as anticipated, the IJB showed an overspend of £2.052m. The IJB approved the drawdown of reserves throughout 2017/18, in order to deliver a breakeven position, leaving an overall reserves balance of £3.442m, of which £2.5m is ring-fenced or earmarked for specific commitments in 2018/19. The balance of £930k will be carried forward as a general contingency to manage unanticipated budget pressures in future years in support of our Strategic Plan priorities. Appendix 7 provides a summary of the IJB's reserves at 31 March 2018.

Division	Year End Position
Social Work – Adult Services	breakeven
Renfrewshire Health Services	breakeven
Total Renfrewshire HSCP	**breakeven**

3.2. The key pressures are highlighted in section 4 and 5.

3.3. Appendices 3 and 4 provide a reconciliation of the main budget adjustments applied this current financial year.

4. Social Work – Adult Services

Year End Outturn: Breakeven

4.1. Throughout 2017/18, the Chief Finance Officer's budget monitoring reports to the IJB forecast a breakeven position (subject to the draw down of general reserves and resources made available by Renfrewshire Council). The final outturn position, inclusive of the draw down of reserves and net of the ear marked reserves of £484k, was a breakeven. This position was achieved by using a combination of reserves carried forward from the 2016/17 budget allocation and a proportion of the additional £4.4m of resources made available by Renfrewshire Council as part of their 2017/18 budget allocation to the IJB for Adult Social Care.

4.2. In order to fund short term non-recurring restructuring costs of the Care at Home Service throughout the first quarter of 2018/19, and costs relating to the replacement of the SWIFT Adult Social Care ICT system an additional £484k was drawn down (from the resources made available by Renfrewshire Council as part of their 2017/18 budget allocation) at the year end and moved to earmarked reserves. The remaining balance of c£1.6m will be carried forward as a non-recurring balance by Renfrewshire Council to be made available to the HSCP in 2018/19.

4.3. The main broad themes of the final outturn position are:

- An underspend of £174k in Older People services mainly in relation to vacancies within HSCP managed LA Care Homes due to staff turnover and occupancy levels;
- An underspend in Learning Disabilities of £434k and in Addictions of £174k, mainly due to a number of vacant posts and the current client profile of care packages within these areas; and
- An overspend in Physical Disabilities of £526k mainly due to pressures within the Adult Placement budget reflecting both the impact of increasing demand and SDS.

5. Renfrewshire Health Services

Year End Outturn: Breakeven

5.1. A breakeven position was reported to the IJB throughout 2017/18 subject to the draw-down of general reserves and transfer of ring fenced balances at the year end to ear marked reserves. These relate to commitments made in 2017/18 in relation to national priorities which will not be fully delivered until future years. These include: funding received for the delivery of national and local priorities including Primary Care Transformation Monies and Health Visiting Monies).

5.2. The final outturn position, inclusive of the draw-down of reserves and net of the ear marked reserves of £2.958m, was a breakeven.

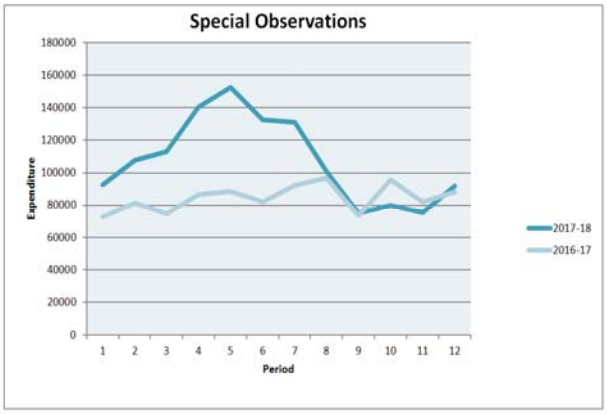
5.3. The main broad themes of the final outturn position are:

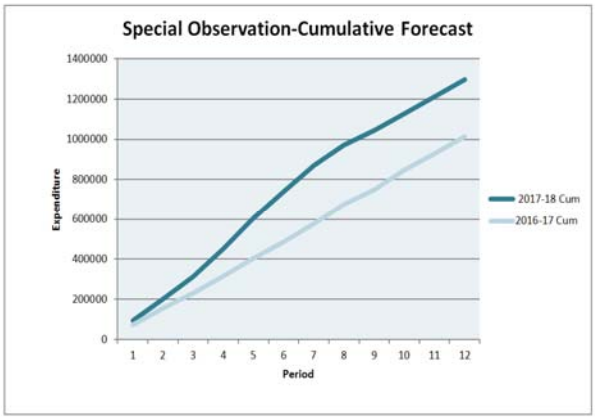
- An underspend of £458k in Adult Community Services due to turnover across the Rehabilitation and District Nursing services, and an underspend in relation to external charges for Adults with Incapacity (AWI) bed usage;
- Underspends within Addiction Services, Planning and Health Improvement, the Integrated Care Fund and Children's Services reflecting staff turnover including planned management of vacancies to enable service model

change which links directly to the reduction in Speech and Language Therapy funding from 2018/19, and, use of non-recurring monies to maximise the transfer to ear marked reserves; and An underspend of £418k in Renfrewshire Hosted Services due to vacant administrative posts in the Primary Care screening service and an underspend within Podiatry due to a combination of staff turnover and maternity/unpaid leave, some of which were covered by bank staff.

5.4. These underspends offset the overspend in Mental Health Services of £1.263m due to the significant costs (overtime, agency and bank costs) associated with patients requiring enhanced levels of observation across all ward areas.

5.5. The graphs below summarise the fluctuation in enhanced observation costs over the past 2 years. In 2017/18 spend increased by £278k from £1.015m in 2016/17 to £1.293m for 2017/18.





6. Prescribing

6.1. As detailed in Appendix 5, the final outturn position across all Partnerships to 31 March 2018 was an overspend of £6.7m, with Renfrewshire HSCP reporting a £1.368m overspend. However, under the risk sharing arrangement across NHSGGC this has been adjusted to report a cost neutral position.

6.2. The main contributor to the above overspend was, as previously reported, largely due to additional premiums paid for drugs on short supply (there are currently an unprecedented number of drugs on short supply for which significant premium payments are being made).

7. Funding Allocations 2018/19

7.1. In the 2018/19 Delegated Health and Social Care Budget report to the IJB on 23 March 2018 the CFO referred to the letter of the 14 December 2017, from the Director of Health Finance, Scottish Government, setting out the draft budget for 2018/19 for NHS Boards. This included narrative which set out the expectations that the funding settlement for Health Boards would allow for progress to be made in:

"delivering the commitment that more than half of frontline spending will be in community health services by the end of this parliament. The funding in 2018-19 is designed to support a further shift in the share of the frontline NHS budget dedicated to mental health and to primary, community and social care. The Cabinet Secretary for Health and Sport expects NHS Boards and Integration

Authorities to contribute to this Programme for Government commitment and it will be essential that this is clearly evidenced as part of plans for 2018-19"

7.2. Also included within the letter were details of the:

Core Areas of Investment including:

Mental Health Strategy

7.2.1. Increasing the level of investment in mental health services - £17 million towards the commitment to increase the workforce by an extra 800 workers over the next 5 years; and for transformation in CAMHS (provided on the basis that it is in addition to existing 2017/18 spending levels by NHS Boards and IJBs). Therefore, total spending on mental health and CAMHS services must increase as a minimum by £17 million above inflation.

7.2.2. On the 23 May 2018, Penny Curtis, the Head of Mental Health and Protection of Rights wrote to all Integration Authority Chief Officers to confirm the 2018/19 funding for Action 15 of the Mental Health Strategy. This letter is included in Appendix 8 of this report and confirms Renfrewshire HSCP's allocations from 2018/19 to 2020/21 based on our NRAC share of 3.4%:

- 2018/19 = £0.374m
- 2019/20 = £0.577m
- 2020/21 = £0.815m

Primary Care Fund

7.2.3. £110 million in 2018-19 to support the expansion of multidisciplinary teams for patient care, and a strengthened and clarified role for GPs as expert medical generalists and clinical leaders in the community.

7.2.4. Also, on the 23 May 2018, Richard Foggo, the Deputy Director and Head of Primary Care wrote to all IA's CO's to confirm the 2018/19 funding for the Primary Care Improvement Fund. This letter is included in Appendix 9 of this report and confirms Renfrewshire HSCP's allocation of £1.814m for 2018/19.

8. Set Aside Budget

8.1. Work continues to be progressed in relation to the sum set aside for hospital services, however arrangements under the control of Integration Authorities are not yet operating as required by the legislation and statutory guidance.

8.2. In the meantime, IJBs and Health Boards are required to agree a figure for the sum set aside to be included in their respective 2017/18 annual accounts. Where the required arrangements are not yet in place, Integration Authorities should use the sum identified by the Health Board and made available to the Integration Authority when the budget was agreed for 2017/18. This does however mean that the set aside recorded in the annual accounts will not reflect actual hospital use in 2017/18. This is a transitional arrangement for 2017/18. As a result of communication from the Scottish Government, the draft set-aside budget of £29.582m has been confirmed by the NHS Board as the final set aside budget for 2017/18. The figure is based on the average of 2013/14 and 2014/15 activity with a 1% uplift applied to budgets.

9. Services Hosted by other HSCP's

9.1. Appendix 6 provides a summary of all hosted services across Greater Glasgow and Clyde. There is no risk sharing arrangement in place in relation to hosted services therefore each IJB is responsible for managing the services they host.

10. Other Delegated Services

Description	Full Year Budget	Final Outturn	Variance
Garden Assistance Scheme	£369k	£370k	(£1k)
Housing Adaptations	£905k	£910k	(£5k)
Women's Aid	£89k	£83k	£6k
Total	**£1,363k**	**£1,363k**	**£0k**

10.1. The table above shows the costs of other Renfrewshire Council services delegated to the IJB. Under the 2014 Act, the IJB is accountable for these services, however, these continue to be delivered by Renfrewshire Council. Renfrewshire HSCP monitors the delivery of these services on behalf of the IJB. The summary position for the period to 31 March 2018 is a breakeven.

11. Reserves

11.1. At its meeting of 24 November 2017, the IJB approved the Revised Reserves Policy, which recommended creation of reserves of up to 2% of net expenditure. This amount refers to general reserves only and excludes any earmarked reserves which are held for specific purposes.

"In light of the size and scale of the IJB's responsibilities, over the medium term the level of general reserves proposed is a maximum of 2% of the net budget of the IJB. This will be in addition to any identified ear marked reserves which are excluded from this calculation. The % to be held will be dependent on the yearend position and ability at that time to transfer monies into a reserve for future use."

11.2. It is important for the long term financial stability of both the IJB and of the parent bodies that sufficient usable funds are held in reserve to manage unanticipated pressures from year to year. Similarly, it is also important that in-year funding available for specific projects and government priorities are able to be earmarked and carried forward into the following financial year, either in whole or in part, to allow for the spend to be committed and managed in a way that represents best value for the IJB in its achievement of the national outcomes.

11.3. For the IJB, reserves can be held for three main purposes:

- a working balance to help cushion the impact of uneven cash flows;
- a contingency to cushion the impact of unexpected events or emergencies (this also forms part of the general reserves); and
- a means of building up funds, often referred to as earmarked reserves, to meet known or predicted requirements; earmarked reserves are accounted for separately but remain legally part of the General Fund.

11.4. As detailed in Appendix 7, the opening reserves position for 2017/18 was £5.494m. This figure included £2.094m of Primary Care balances carried forward by Renfrewshire HSCP (as the host authority) on behalf of the 6 NHSGGC HSCP's. The relevant balances were then transferred to each HSCP at the start of 2017/18.

11.5. As detailed in Appendix 7 the total amount drawn down from reserves in 2017/18 was £3.925m. As well as the transfer of Primary Care balances this included a draw-down of £1.519m from the general reserve to fund the on-going pressures within the Care at Home service.

11.6. Consistent with the IJB's Reserves Policy Members are asked to approve the following ear marked reserves for draw down as required in 2018/19 totalling £1.873, details of which are included below and Appendix 7 of this report.

- *Health Visiting Monies: £181k* In line with the Scottish Government priority to increase the number of Health Visitors by 2019/20 the programme to increase the numbers within each NHSGGC HSCP is well advanced. In 2017/18, the funding for these posts was allocated to each HSCP as a block allocation to be drawn down as the programme of recruitment progressed. £181k has been transferred to earmarked reserves to be drawn down in 2018/19 as vacancies are filled.
- *Primary Care Transformation Monies: £438k:* As members will be aware ring-fenced funding for Primary Care transformation projects were allocated to IJBs in 2016/17 and 2017/18. In order to maximise the benefits from these allocations, the remaining funding was transferred to earmarked reserves at the end of this financial year to be drawn down in 2018/19 as required.
- *GP Premises Fund: £414k:* Renfrewshire share of NHSGGC monies allocated for GP premises improvement.
- *Funding to Mitigate Delays in Delivery of Approved Savings: £339k.*
- *Tannahill Diet and Diabetes Pilot: £17k*
- *Care at Home / Locality redesign non-recurring implementation costs: £399k*
- *Set up costs in relation to planned placement: £35k*
- *ICT SWIFT update costs: £50k.*

12. Living Wage Update 2017/18

12.1. In May 2016, Renfrewshire HSCP established a working group to lead the national commitment to ensure that the Living Wage was paid to all care workers providing direct care and support to adults in care homes, care at home and housing support services in Renfrewshire. During the course of the financial year, agreement was reached with all contracted providers of care at home services, care homes for older adults and our providers of supported living services. The working group also sought to implement agreement with providers of out of area placements.

12.2. In 2017/18 further negotiations took place with providers to agree a rate to allow providers to pay the new Living Wage of £8.45 per hour from 1st May 2017 plus on-costs. Agreement has been reached with all care at home service providers and the majority of our providers of supported living services, however national providers of supported living have raised concerns relating to the impact multiple negotiations across different local authorities in Scotland is having on their business model e.g. not all Scottish councils have agreed to pay an enhanced rate for sleepover. On this basis, two providers of supported living services advised that they could not accept the offered rate for sleepover. Renfrewshire Council's procurement team continue to liaise with these providers and have offered to support future negotiations, however, until a national approach to the Living Wage uplift is agreed, it is likely that these providers will not agree to accept the uplift offered. One further provider noted that they could not accept the offered day rate as only a relatively small proportion of their services were located in Renfrewshire, the majority of their

services are provided in another local authority area and this authority has not offered a rate sufficient to universally implement £8.45 per hour. This Provider advised the Council that they were working with their workforce in consultation with their union to undertake a job evaluation exercise. The Provider hopes that as a result of this exercise they will be in a position to implement the Living Wage into their salary scales with any salary increases backdated as appropriate.

12.3. Renfrewshire HSCP continues to review out of area placements. Where placements have been made off contract, the HSCP are considering whether Scotland Excel's national framework for Adult Residential placements would provide a viable form of contract. All rates currently paid under this contract are paid based on the current Scottish Living Wage.

13. Living Wage Increase 2018/19

13.1. For 2018/19 the new Living Wage rate has been set at £8.75, an increase of 30p from the 2017/18 rate. In line with the current practice adopted for uprating provider rates to reflect Living Wage increases, a % increase has been applied which includes the impact of on-costs. All contracted providers of care at home services and supported living services have been offered an increase to allow the payment of the new Living Wage rate. To date 4 care at home providers have accepted the increase and we await a response from the remaining 3, for supported living services 5 providers have accepted the increase and we await a response from the remaining 6. The 3 Contracted providers of adult residential services within Renfrewshire will be offered an increase of 3.39% in line with the agreed increase for the NCHC 18/19 for the payment of the new Living Wage. Once accepted, all Living Wage uplifts will be backdated to 1st May 2018.

13.2. Renfrewshire HSCP continues to review out of area placements. Where placements have been made from Scotland Excel's national framework for Adult Residential all rates currently paid are based on the current Scottish Living Wage. Where placements have been made off contract, host local authority rates are considered if applicable. If there is no host local authority rate available, the providers will be offered a % increase to allow the payment of the new Living Wage from 1st May 2018.

14. National Care Home Contract 2018/19

14.1. The terms of the contract for 2018/19 were negotiated by COSLA and Scotland Excel with Scottish Care and the Coalition of Care and Support Providers in Scotland (CCPS). An increase of 3.39% was agreed which includes an allowance to support delivery of £8.75 per hour to all care staff from 1st May 2018. A Minute of Variation (MOV) has been issued to 17 of the 18 providers of care homes for older adults in Renfrewshire (1 provider is currently in the process of assigning to another organisation, once the process is complete the MOV will be issued to the new provider), to date 12 have accepted, we await a response from 5 providers.

Implications of the Report

1. **Financial –** Financial implications are discussed in full in the report above.
2. **HR & Organisational Development** – none
3. **Community Planning -** none
4. **Legal –** This is in line with Renfrewshire IJB's Integration Scheme

5. **Property/Assets** – none.

6. **Information Technology –** none

7. **Equality & Human Rights –** The recommendations contained within this report have been assessed in relation to their impact on equalities and human rights. No negative impacts on equality groups or potential for infringement have been identified arising from the recommendations contained in the report. If required following implementation, the actual impact of the recommendations and the mitigating actions will be reviewed and monitored, and the results of the assessment will be published on the Council's website.

8. **Health & Safety** – none**.**

9. **Procurement** – Implementation of the living wage impact on existing contracts with providers and their ability to deliver within the allocated funding package**.**

10. **Risk** – There are a number of risks which should be considered on an ongoing basis: adequate funding to deliver core services.

11. **Privacy Impact** – none.

List of Background Papers – None.

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Any enquiries regarding this paper should be directed to Sarah Lavers, Chief Finance Officer (Sarah.Lavers@renfrewshire.gov.uk / 0141 618 6824)

Appendix 1

Social Work Revenue Budget Position
1st April 2017 to 31st March 2018

Subjective Heading	Annual Budget	Actual to Date	Variance		
	£000's	£000's	£000's	%	
Employee Costs	30,995	30,726	269	0.9%	underspend
Property Costs	384	625	(241)	-62.8%	overspend
Supplies and Services	1,733	1,709	24	1.4%	underspend
Contractors	60,527	60,782	(255)	-0.4%	overspend
Transport	691	651	40	5.8%	underspend
Administrative Costs	258	263	(5)	-1.9%	overspend
Payments to Other	2,518	2,528	(10)	-0.4%	overspend
Gross Expenditure	**97,106**	**97,284**	**(178)**	**-0.2%**	**overspend**
Income	**(33,409)**	**(33,587)**	178	-0.5%	underspend
NET EXPENDITURE	**63,697**	**63,697**	**-**	**0.00%**	**breakeven**

Position to 31st March is a breakeven

Client Group	Annual Budget	Actual to Date	Variance		
	£000's	£000's	£000's	%	
Older People	39,485	39,048	437	1.1%	underspend
Physical or Sensory Difficulties	7,263	7,789	(526)	-7.2%	overspend
Learning Difficulties	14,121	13,687	434	3.1%	underspend
Mental Health Needs	2,090	2,346	(256)	-12.2%	overspend
Addiction Services	789	615	174	22.1%	underspend
Integrated Care Fund	(51)	212	(263)	515.7%	overspend
NET EXPENDITURE	**63,697**	**63,697**	**-**	**0.00%**	**breakeven**

Position to 31st March is a breakeven

Appendix 2

Health Revenue Budget Position
1st April 2017 to 31st March 2018

Subjective Heading	Annual Budget £'000	YTD Actuals £'000	Variance		
			£'000	%	
Employee Costs	44,202	44,015	187	0.4%	underspend
Property Costs	8	29	(21)	-262.5%	overspend
Supplies and Services	10,163	10,257	(94)	-0.9%	overspend
Purchase Of Healthcare	2,429	2,483	(54)	-2.2%	overspend
Resource Transfer	17,041	17,041	-	0.0%	breakeven
Family Health Services	83,651	83,655	(4)	0.0%	overspend
Set Aside	29,582	29,582	-	0.0%	breakeven
Gross Expenditure	**190,034**	**187,062**	**2,972**	**0.02**	**underspend**
Income	**(4,659)**	**(4,645)**	(14)	0.3%	overspend
NET EXPENDITURE	**185,375**	**182,417**	**2,958**	**1.60%**	**underspend**

Position to 31st March is a breakeven

Care Group	Annual Budget £'000	YTD Actuals £'000	Variance		
			£'000	%	
Addiction Services	2,668	2,495	173	6.5%	underspend
Adult Community	9,023	8,565	458	5.1%	underspend
Children's Services	5,323	5,206	117	2.2%	underspend
Learning Disabilities	1,170	1,148	22	1.9%	underspend
Mental Health	19,034	20,297	(1,263)	-6.6%	overspend
Hosted Services	10,527	10,109	418	4.0%	underspend
Prescribing	36,271	36,271	-	0.0%	breakeven
Gms	24,222	24,222	-	0.0%	breakeven
Other	21,234	21,234	-	0.0%	breakeven
Planning & Health	1,253	1,044	209	16.7%	underspend
Other Services	1,935	2,372	(437)	-22.6%	overspend
Resource Transfer	17,041	17,043	(2)	0.0%	overspend
Integrated Care Fund	3,134	2,829	305	9.7%	underspend
Set Aside	29,582	29,582	-	0.0%	breakeven
NET EXPENDITURE	**185,375**	**182,417**	**2,958**	**1.60%**	underspend

Position to 31st March is a breakeven

For Information

1. Adult Community Services includes: District and Out of Hours Nursing; Rehabilitiation Services and Equipu
2. Children's Services includes: Community Services-School Nursing and Health Visitors; Specialist Services-CAMHS and SLT
3. GMS = costs associated with GP services in Renfrewshire
4. Other = costs associated with Dentists, Pharmacists, Optometrists
5. Hosted Services = board wide responsibility for support to GP's for areas such breast and bowel screening and board wide responsibilty for Podiatry
6. Other Services = Business Support staff; Admin related costs,

Appendix 3

2017/18 Adult Social Care Financial Allocation to Renfrewshire HSCP	
	£k
2017/18 Renfrewshire HSCP Opening Budget:	60,468.4
	60,468.4
Adjustments to Base Budget:	
Impact of increase in the Living Wage and changes in sleepover costs	1,989.0
Inflationary pressures on commisioned contracts	1,170.0
Impact of demographic and socio-economic demand pressures	1,276.6
Transfers from Corporate	65.4
Adult Social Care Budget as reported @ 26 May 2017	**64,969.4**
Budget Adjustments posted in month 4	
Realignment of Resource Transfer from Child Care Services	-19.2
Sensory Impairment Carry Forward	9.0
Adult Social Care Budget as reported @ 21 July 2017	**64,959.2**
Budget Adjustments posted in month 6	
2017/18 Pay Award	557.9
Realignment of Vehicle Insurance to Corporate	-23.6
Adult Social Care Budget as reported @ 15 September 2017	**65,493.5**
Budget Adjustments posted in month 8	
2017/18 Pay Award Correction	-3.8
Adult Social Care Budget as reported @ 10 November 2017	**65,489.7**
Budget Adjustments posted in month 9	
2 x Income Maximisation Posts to C&P	-70.0
Finance Business Partner Upgrade to Corporate	-5.4
Adult Social Care Budget as reported @ 8 December 2017	**65,414.3**
Budget Adjustments posted in month 13	
Scotland Disclosure transferred to Child Care	-40.4
Backsneddon Property Costs	-21.3
2018/19 Renfrewshire HSCP Carry Forward	-1,655.9
Adult Social Care Budget as reported @ 31 March 2018	**63,696.7**

Appendix 4

2017/18 Health Financial Allocation to Renfrewshire HSCP	
	£k
2016/17 Renfrewshire HSCP Closing Budget:	157,676.9
less: non recurring budgets (allocated annually)	-4,021.9
= base budget rolled over	**153,655.0**
Additions:	
Social Care Integration Fund to transfer to Council	3,480.0
Hospice - Transfer of Hospice budget to HSCP 1st April	2,300.1
Hospices - Adjustments to match agreed allocation following reparenting	182.5
	5,962.6
Reductions:	
LD Supplies RAM	-7.9
GMS Budget Adjustment to reflect expenditure	-1,394.3
*GMS = costs associated with GP services in Renfrewshire	
	-1,402.2
Budget allocated as per 2017/18 Financial Allocation 31st May 2017	**158,215.4**
Budget Adjustments posted in month 3	
Finance Staff Transfer-Mgt Transfer to HSCP	80.8
Prescribing Budget Adjustment	-384.5
	-303.7
Non-Recurring:	
CAMHS Mental Health Bundle- Funding for various posts	265.6
Carers/Veterans - Part of Social Care Fund	240.0
Protection Funding due to Service Redesign	3.2
	508.8
Health Budget as reported @ 30th June 17	**158,420.5**
Budget Adjustments posted in month 4	
Additions:	
GMS Budget Adjustment to reflect expenditure	2,220.2
*GMS = costs associated with GP services in Renfrewshire	
	2,220.2
Non-Recurring:	
SESP -Diabetes Funding - Funding Divided between Podiatry, PHI & Adult C	343.3
Funding - To fund Infant Feeding Advisor Post	7.1
	350.4
Savings:	
Complex Care savings - Partnerships Share	-91.0
	-91.0
Health Budget as reported @ 31st July 17	**160,900.1**
Budget Adjustments posted in month 5	
Additions:	
Prescribing Spend to Save - Budget Transfer	419.0
Health Visitor Girfec Framework - Budget to Reflect Staff Profile	353.0
	772.0
Non-Recurring:	
Correct Budget Coding Error	-50.0
Carers Information Strategy Funding	140.1
	90.1
Health Budget as reported @ 31st August 17	**161,762.2**
Budget Adjustments posted in month 6	
Non-Recurring:	
GMS Budget Adjustment to reflect expenditure	1,335.8
	1,335.8
Health Budget as reported @ 30th September 17	**163,098.0**
Budget Adjustments posted in month 7	
Additions:	
Transfer of CMHT Admin Staff from Corporate	120.6
FHS GMS Adjustment	-67.4
	53.2
Non-Recurring:	
Modern Apprentice 50% Funding	16.5
Primary Care Support: PCTF Redesign	168.7
Primary Care Support: Cluster Funding	112.0
FHS: Reduction in SESP Funding	-117.2
	180.0
Health Budget as reported @ 31st October 17	**163,331.2**
Budget Adjustments posted in month 8	
Non-Recurring:	
MH INNOVATION FUND - CHILDRENS	25.0
Smoking Prevention	123.3
	148.3
Health Budget as reported @ 30th November 17	**163,479.5**
Budget Adjustments posted in month 9	
Reductions:	
GMS 17-18 ADJ	-2.9
	-2.9
Non-Recurring:	
Tabacco Funding	22.0
	22.0
Health Budget as reported @ 31st December 17	**163,498.6**
Budget Adjustments posted in month 11	
Non-Recurring:	
Budget for Communications Aid Bid (CAM)	19.3
	19.3
Health Budget as reported @ 28th February 18	**163,517.9**
Budget Adjustments posted in month 12	
Additions:	
Recur Final GMS X-Chgs	101.0
	101.0
Non-Recurring:	
GMS X-CHG NR Final	1,291.2
CAMCHP232 PC TRANS FUND REN	71.0
Syrian Refugee	16.8
GMS X-CHG Syrian Refugee	10.6
Funding for Pathway Co-ordinator Post	2.1
	1,391.7
Health Budget as reported @ 31st March 18	**165,010.6**

Appendix 5

NHS GGC Budget Performance April 2017 to March 2018

CHP	GG&C Phased Allocation	Expenditure (adjusted for errors and misallocations)	Performance £	Performance %
EAST DUNBARTONSHIRE COMMUNITY HEALTH PARTNERSHIP	£18,671,323	£19,235,785	-£564,462	-3.02%
EAST RENFREWSHIRE COMMUNITY HEALTH & CARE PARTNERSHIP	£15,383,975	£16,224,492	-£840,517	-5.46%
GLASGOW NORTH EAST	£40,055,724	£40,878,194	-£822,470	-2.05%
GLASGOW NORTH WEST	£38,949,869	£39,688,312	-£738,443	-1.90%
GLASGOW SOUTH	£46,279,369	£47,245,124	-£965,755	-2.09%
INVERCLYDE COMMUNITY HEALTH PARTNERSHIP	£17,766,592	£18,703,507	-£936,915	-5.27%
RENFREWSHIRE COMMUNITY HEALTH PARTNERSHIP	£34,622,369	£35,990,185	-£1,367,816	-3.95%
UNKNOWN CHP - NHS GREATER GLASGOW & CLYDE	£6,365,969	£6,053,573	+£312,396	+4.91%
WEST DUNBARTONSHIRE COMMUNITY HEALTH PARTNERSHIP	£18,925,543	£19,720,608	-£795,065	-4.20%
Total NHS Greater Glasgow and Clyde	**£237,020,733**	**£243,739,781**	**-£6,719,048**	**2.83%**

Appendix 6

Partnership Hosted Budget Position at 31st March 2018

Host	Service	Budgeted Net Expenditure to Date	Actual Net Expenditure to Date	Variance to Date	Comment
East Dunbartonshire	Oral Health	£10,094,335	£10,094,336	-£1	
	Total	**£10,094,335**	**£10,094,336**	**-£1**	
East Renfrewshire	Learning Disability	£8,194,990	£8,194,990	£0	The service is shown as break even as the operational underspend is ring-fenced as part of the ongoing service redesign.
	Total	**£8,194,990**	**£8,194,990**	**£0**	
Glasgow	Continence	£3,728,094	£3,683,091	£45,003	
Glasgow	Sexual Health	£9,704,080	£9,697,602	£6,478	
Glasgow	Mh Central Services	£7,536,521	£7,707,927	-£171,406	Overspends in Junior Docs & unachieved savings offset by underspending in the clinical training budget for nurses
Glasgow	MH Specialist services	£11,765,826	£11,517,713	£248,113	Underspends in a number of services due in the main to vacancies & turnover
Glasgow	Alcohol + Drugs Hosted	£16,707,215	£16,585,776	£121,439	Underspends in a number of services due in the main to vacancies & turnover.
Glasgow	Prison Healthcare	£6,997,720	£7,177,437	-£179,717	This overspend relates to supplies, mainly drugs. Within employee costs, there are some pressures associated with increased sessional costs which are offset by vacancies and turnover in other professions.
Glasgow	HC In Police Custody	£2,550,161	£2,274,008	£276,153	The underspend within the Police Custody Healthcare service is largely as a result of medical and nursing vacancies.
Glasgow	Old Age Psychiatry	£19,024,486	£20,947,550	-£1,923,064	The majority of the overspend relates to unachieved savings. Work is on-going to progress plans to secure delivery of these savings within 2018.19.
Glasgow	General Psychiatry	£36,710,374	£36,885,493	-£175,119	Overspends mainly due to agency usage to cover vacancies and mat leave, and unfunded sessions which are currently under review.
	Total	**£114,724,478**	**£116,476,598**	**-£1,752,120**	
Inverclyde	General Psychiatry	£5,510,382	£5,469,258	£41,124	
Inverclyde	Old Age Psychiatry	£2,483,587	£3,357,004	-£873,417	Inherited budget pressure linked to unfunded special obs within the service. Orginal budget pressure of £1.2m has been significantly reduced by the local team since the IJB went live
	Total	**£7,993,969**	**£8,826,262**	**-£832,293**	
Renfrewshire	Podiatry	£6,414,143	£6,235,691	£178,452	As previously reported, this underspend reflects turnover in the Primary Care service due to vacant administrative posts within the screening services and an underspend within Podiatry due to a combination of staff turnover and maternity/unpaid leave, some of which are covered by bank staff along with efficiencies in the supplies budget.
Renfrewshire	Primary Care support	£4,112,360	£3,873,082	£239,278	
Renfrewshire	General Psychiatry	£6,971,663	£7,471,809	-£500,146	As reported throughout the year there is no budget for Special Observations whithin Elderly or Mental Health Inpatients which continues to be the main pressure.
Renfrewshire	Old Age Psychiatry	£5,786,721	£6,589,023	-£802,302	
	Total	**£23,284,887**	**£24,169,605**	**-£884,719**	
West Dunbartonshire	MSK Physio	£5,975,057	£5,858,142	£116,915	Underspend mainly due to staff turnover, secondments and maternity leave, as well as efficiencies within supplies/non pays budgets.
West Dunbartonshire	Retinal Screening	£803,380	£798,272	£5,108	Underspends within non pays budgets, mainly due to efficiencies against equipment maintenance contracts, have offset pays overspend due to additional sessions/overtime implemented to address waiting times and backlog of Grading.
West Dunbartonshire	Old Age Psychiatry	£1,472,994	£1,541,243	-£68,249	Pressures within pays budgets due to bank usage to cover absence and special obvs as well as unachieved staff turnover savings targets.
	Total	**£8,251,430**	**£8,197,657**	**£53,773**	
Total		**£172,544,088**	**£175,959,448**	**-£3,415,360**	

Consumed By:-	
Glasgow	£102,656,225
East Dunbartonshire	£9,769,396
East Renfrewshire	£8,733,524
Renfrewshire	£26,860,553
Inverclyde	£14,082,008
West Dunbartonshire	£13,857,742
Total	**£175,959,448**

Appendix 7

Reserves Balances at 31st March 2018

Earmarked Reserves	Opening Position 2016/17 £000's	Amounts Drawn Down in 2017/18	New Reserves	Closing Position 2017/18 £000's	Movement in Reserves in 2017/18
PCTF Monies Allocated in 16/17 and 17/18 for Tests of Change and GP Support	1,100	-1,100	438	438	-662
GP Digital Transformation	289	-289		0	-289
GP Premises Fund - Renfrewshire share of NHSGGC funding for GP premises improvement	705	-705	414	414	-291
Funding for Temp Mental Health Posts	82	-82			-82
Primary Care Transformation Fund Monies	39			39	0
District Nurse 3 year Recruitment Programme	150			150	0
Health & Safety Inspection Costs to Refurbish Mental Health Shower Facilities	35	-35			-35
Prescribing	450			450	0
Funding to Mitigate Any Shortfalls in Delivery of Approved Savings in 18/19			339	339	339
Health Visiting			181	181	181
Tannahill Diet and Diabetes Pilot Project			17	17	17
TOTAL Delegated Health Ear Marked Reserves	**2,850**	**-2,211**	**1,389**	**2,028**	**-822**
Care @ Home Redesign/Locality Services Redesign Associated Costs			399	399	399
Costs Associated With Addictional Set Up Costs For Specific Planned Placement			35	35	35
ICT Swift Update Costs			50	50	50
TOTAL Adult Social Care Ear Marked Reserves	**-**	**-**	**484**	**484**	**484**
TOTAL EARMARKED RESERVES	**2,850**	**-2,211**	**1,873**	**2,512**	**-338**

General Reserves	Opening Position 2016/17 £000's	Amounts Drawn Down in 2017/18	New Reserves	Closing Position 2017/18 £000's	Movement in Reserves in 2017/18
Renfrewshire HSCP - Health delegated budget under spend carried forward	1,125	-195		930	-195
Renfrewshire Council under spend carried forward	1,519	-1,519			-1,519
TOTAL GENERAL RESERVES	**2,644**	**-1,714**	**0**	**930**	**-1,714**

OVERALL RESERVES POSITION	**5,494**	**-3,925**	**1,873**	**3,442**	**-2,052**

Population Health Directorate
Mental Health and Protection of Rights Division

Scottish Government
Riaghaltas na h-Alba
gov.scot

T: 0131-244 07119 F: 0131-244 2846
E: Pat.McAuley@gov.scot

Chief Officers, Integration Authorities

cc: Chief Executives, NHS Boards
Directors of Finance, NHS Boards
Chief Executives, Local Authorities
Angiolina Foster, Chief Executive, NHS24
Caroline Lamb, Chief Executive, NES
Colin McKay, Chief Executive, MWC
Health & Justice Collaboration Improvement Board

Your ref:
Our ref:

23 May 2018

Dear Colleague

ACTION 15 OF THE MENTAL HEALTH STRATEGY – PLANNING AND FUNDING FROM 2018/19

As part of the Mental Health Strategy 2017-2027, Scottish Government Ministers made a commitment to provide funding to support the employment of 800 additional mental health workers to improve access in key settings such as Accident and Emergency departments, GP practices, police station custody suites and prisons. The detail is set out in Action 15 of the Mental Health Strategy. The funding will be available from this year (£12 million, of which £11 million is the subject of this letter) and will rise to £35 million in 2021-22.

Background

You will know that last year, Ministers established the *Health & Justice Collaboration Improvement Board* (HJCIB). The Board draws together some of the most senior leaders from Health, Justice and Local Government. Its purpose is to lead the creation of a much more integrated service response to people whose needs draw upon the work of our Health and Justice services. As you might expect, our mutual response to people who suffer mental illness and distress is a significant theme in the Board's interests. Membership of the Board is set out an Annex A.

Ministers asked the Board to consider how our commitment to additional mental health workers might best be delivered.

National test of change

The Board has subsequently set out an approach that will test improvements in national arrangements for service delivery. This involves the Ambulance Service, NHS24 and Police Scotland, and £1 million has been set aside for this initiative. The current thinking on these ideas is set out at Annex B.

Local improvements

The Board has also adopted some broad principles (helpfully informed by a Short Life Working Group with membership from Integration Authorities, Health Boards, justice and local government) that it believes are likely to inform credible local improvements. These include recognition that:

- the application of additional resources should result in additional services commensurate with the commitment in the Mental Health Strategy to provide 800 additional mental health workers by 2021-22;

- the nature of the additional capacity will be very broad ranging – including roles such as peer and support workers;

- prospective improvements may include the provision of services through digital platforms or telephone support;

- improvement may include development for staff who are not currently working in the field of mental health.

Links to the Primary Care Improvement Fund

Richard Foggo has written to Integration Authority Chief Officers and NHS Chief Executives today regarding the Primary Care Improvement Fund (PCIF) allocation for 2018-19. His correspondence should be read in conjunction with this letter.

As outlined in Richard's letter, nearly £10 million was invested during 2016-18 via the Primary Care Mental Health Fund (PCMHF) to encourage the development of new models of care to ensure that people with mental health problems get the right treatment, in the right place, at the right time. In 2018-19, the Primary Care Improvement Fund (£45.750 million) is a single allocation to provide maximum flexibility to local systems to deliver key outcomes.

The PCIF includes recurring funding for mental health services, building on the funding for primary care mental health previously provided. Although it is separate to this funding line, there is likely to be close cross-over between the services, particularly in general practice settings, and in some cases the staff may be the same individuals.

As set out in the letter, Primary Care Improvement Plans should demonstrate how this funding is being used to re-design primary care services through a multi-disciplinary approach, including mental health services.

PCIPs should also show how wider services, including the mental health services which are the subject of this letter, integrate with those new primary care services.

Planning and Partnerships for Delivery of 800 Mental Health Workers

We want to ensure that IAs are able to utilise the additional resources for 800 mental health workers and the PCIF flexibly to support sustainable mental health and primary care service redesign. As far as possible we want to ensure that the planning processes, governance and evaluation processes are aligned.

Planning: by 31 July

We are asking that Integration Authorities each develop a plan by 31 July that sets out goals for improving capacity in the settings outlined in Action 15 of the Mental Health Strategy. We would like the plan from each Authority to set out:

- How it contributes to the broad principles set out under *Local Improvements* on page 2;
- How it takes account of the views of local Justice and other Health partners in the area about what improvements should be introduced
- How it fits with other local plans currently in development.
- Initial scoping of potential staffing changes over the next four years as a result of this additional funding, towards the committed 800.

Our reason for asking you to do this is that it will help the H&JCIB to shape discussions around future collaboration – including further consideration of national proposals. We will let you know about our thinking as consequence of these discussions over the summer.

This should include demonstrating additionality of the new workforce, such as information about the numbers of additional staff being recruited, existing staff being up-skilled (who are currently not working within mental health services) and the settings which will allow the Scottish Government to demonstrate progress against the national commitment. If it is possible, this could be through a supplementary to your Primary Care Improvement Plans or it could be through a linked document

In the longer term, we anticipate that Primary Care Improvement Plans might start to allow an increasingly integrated approach to mental health planning and delivery of the 800 mental health worker commitment. As set out in Richard Foggo's letter, it is important that the PCIPs from the outset show links with broader community developments, and the 800 mental health worker commitment. Over time, we anticipate that this may develop into a single statement of the approaches being developed.

Consultation and Engagement

The H&JCIB recognises that redesigning services to meet people's needs across health and justice settings is complex and that it will require collaborative partnership working across organisational boundaries.

We recognise that this is a complex area that involves many partners, but it will be essential that your emerging plans demonstrate how Justice and Health partners (both Health Boards and GPs) have been consulted and included in preparation of the plan. If that is not possible to deliver fully in the timescales, an indication of consultation and engagement plans would be very helpful.

Governance

Giving primacy to Integration Authorities to deliver the national commitment for 800 mental health workers in the Primary Care Improvement Plans simplifies local governance arrangements. At local level, Integration Authorities will hold NHS Boards and councils to account for delivery of the milestones set out in their plans, in line with the directions provided to the NHS Board and Council by the Integration Authority for the delivery of Strategic Plans.

At national level, we will consider how we can ensure that Ministers have the necessary assurances about delivery of the overall 800 staff over four years.

Monitoring and Evaluation

You will need to plan for and demonstrate a clear trajectory towards 800 additional mental health workers under the funding for this commitment over the next four years, and we will consider what national oversight arrangements should be in place to offer assurance on that point.

The plans should also include consideration of how the changes will be evaluated locally.

Allocation methodology and future funding

IAs have delegated responsibilities for adult Mental Health services therefore we are asking you to work with Health and Justice partners to deliver a holistic perspective on the additional mental health requirements in key settings (including but not restricted to A&E, GP practices, prisons and police custody suites).

The Scottish Government therefore plans to allocate funding for local improvements to Integration Authorities (via their associated NHS Health Board). National tests of change will continue to be funded centrally.

The expected allocation of additional funds over the next period in total and to each Integration Authority is set out at Annex C. The funding should be considered as *earmarked recurring* funding. It should be assumed therefore that staff may be recruited on a permanent basis to meet the requirements of the commitment. We will engage with IAs and others on any plans to baseline these funds beyond 2021/22 subject to Parliamentary approval of the budget.

This is intended to guide your thinking about the future in terms of the funding over the next four years under this commitment. In broad terms, the distribution presumes a local share of the funding based on National Resource Allocation Committee (NRAC) principles and we would encourage partnership working across IA

boundaries, as per the statutory duty on IAs to work together particularly within Health Board areas[1].

In this initial year of funding, the funding will issue in two tranches starting with allocation of 70% of the funding in June 2018. A high level report on how spending has been profiled must be submitted to SG by the start of September and, subject to confirmation via this report that IAs are able to spend their full 100% allocation in-year, the remaining 30% of funding will be allocated in November 2018. An outline template for making the start-September report is at Annex D. A final template will be issued before September.

We understand that the detail of these plans will take some time to develop and that your ideas about what is necessary will change as the extent and depth of understanding and service response improve over time. We also know that tackling these issues in a more effective way over time will do a lot to improve the help that we provide to communities. We are grateful to Chief Officers and to partners for your commitment to prioritising delivery of this commitment in keeping with the ambition in the Mental Health Strategy.

Please share your plans with Pat.McAuley@gov.scot If you have questions about the process or require further information, please contact Pat on 0131 244 0719.

Penny Curtis
Head of Mental Health and Protection of Rights Division

[1] Given Action 15 of the Mental Health Strategy explicitly specifies prison settings, a population NRAC does not take account of, it is requested that the plans of those partners hosting significant prisons populations include outlines of additional funding requirements they might have based on any available need assessments.

Appendix 8

ANNEX A

Membership of the Health and Justice Collaboration Improvement Board

Paul Johnston (co-chair)	DG Education, Communities & Justice
Paul Gray (co-chair)	DG Health and Social Care
Iain Livingstone	Police Scotland
Alasdair Hay	Scottish Fire and Rescue Service
Pauline Howe	Scottish Ambulance Service
Colin McConnell	Scottish Prison Service
Karyn McCluskey	Community Justice Scotland
David Harvie	Crown Office and Procurator Fiscal Service
Robbie Pearson	Healthcare Improvement Scotland
Jane Grant	NHS GG&C
Cathie Curran	NHS Forth Valley
David Williams	IA Chief Officers Group
Shiona Strachan	Clackmannanshire & Stirling IJB
Sally Louden	COSLA
Joyce White	SOLACE
Andrew Scott	Scottish Government
Neil Rennick	Scottish Government
Gillian Russell	Scottish Government

NHS24 / Police Scotland / Scottish Ambulance Service Collaboration Project

IMPROVING THE MANAGEMENT OF, AND RESPONSE TO, MENTAL HEALTH CRISIS AND DISTRESS FOR THOSE PRESENTING TO SCOTTISH AMBULANCE SERVICE & POLICE SCOTLAND

What are we trying to accomplish?

To support the realisation of Action 15 – Mental Health Strategy (Scotland) 2017-2027, this project (test of change) will improve the care pathway for people suffering from mental illness / mental distress and poor mental well-being who are being supported by Police Scotland and/or the Scottish Ambulance Service.

This initial (draft) proposal has been shared with senior colleagues across all three partner agencies. To date we have received a positive response to the overarching principles of the First Response Test of Change concept, which is aligned to:

Integration with strategic priorities across all service providers.
Integration and facilitation of a joint co-productive / collaborative approach to future service development and delivery.

The project will initially be implemented across a specified geographical area, and delivered within a "test and learn" environment.

The project aim is:

To improve the care pathway for people suffering from mental illness / mental distress and poor mental well-being presenting to Police Scotland and / or Scottish Ambulance Service. By increasing access for Police Scotland and Scottish Ambulance Control Room and Frontline Staff to designated mental health professionals within NHS 24, working closely with locality based care and support services, to provide an appropriate and enhanced mental health triage and assessment of need service.

The project will also aim to (1) Reduce deployment of frontline Police Scotland and Scottish Ambulance Service staff to manage patients in mental distress/ suffering from poor mental health or mental well-being, and (2) Reduce demand placed on locality based Emergency services to manage individuals in mental health crisis / mental distress.

The current service provision for patients who contact Police Scotland / Scottish Ambulance Service requiring mental health care and support is described in Appendix 1.

Significant analysis of the demand placed on NHS 24, Scottish Ambulance Service, Police Scotland and NHS Emergency Departments to manage the mental health and

well-being of the population has been gathered and this will be used to determine outcome measures and key performance indicators for the test of change. Key findings from this work have identified:

People with a Mental Health Problem are three times more likely than the general population to attend the Emergency Department.
The peak presentation time to the Emergency Department is after 11pm, and this patient group are five times more likely to be admitted in the out of hours period.
Frequent callers to emergency services are more likely to be already known and supported by locality based mental health services.

The benefits of an improved care pathway (Appendix 2) for individuals contacting in mental distress / with poor mental health are:

The ability to provide the level of support required to reduce distress and safely manage the needs of the individual effectively either via telephone support or ongoing referral to appropriate locality based services.
Reduction in the need for people to be transferred by / to emergency services.
Reduction in unnecessary demand being placed on Emergency Departments

Project (service) outcomes will be reviewed and reported on monthly, and project activities will be coordinated to ensure that changes tested and implemented successfully within the "test and learn" environment are, if appropriate and feasible, spread across the wider service.

How will we know that a change is an improvement?

A framework of evaluation will be developed in consultation with all partners, including the locality based integrated joint board supporting the "test and learn" phase. This framework will include both quantitative and qualitative measures. Qualitative data will also be used, to gain insights and feedback from individuals utilising the service, staff, partners and wider stakeholders.

Qualitative Outcome measures – across the triumvirate model

Individual experience in relation to outcomes, satisfaction levels, and any follow up action
Partner experience in relation to appropriateness of contacts received, and any follow up/re-triage required at a local level
Staff experience – NHS 24 / Police Scotland / Scottish Ambulance Service

Quantitative Outcome measures – across the triumvirate model

Number of mental health calls managed within the test & learn environment.
Number of mental health calls resulting in a final disposition of self care and our web based content
Numbers of mental health calls across the range of possible outcomes
Reduction in demand to emergency services including ED attendance
Number of contacts signposted to community based services

The project team have had the opportunity to liaise with other service providers who have implemented a first response service to manage the mental health needs of the population they serve. This service model incorporates mental health professionals working across a number of service areas, including Police Control Centres.

Data from Cambridgeshire and Peterborough Crisis Care Concordant (comparing 6 months pre intervention, 8 months post intervention) showed:

ED attendance for any "mental health" need – down 25%
Admission to Acute Trust for MH patients from ED – down 19%
Mental Health Ambulance Conveyances – down 26%
111 Calls and OOH GP appointments – down 45% and 39%

What changes can we make that will result in improvement?

The timetable below highlights the key milestones of the initial test of change proposal:

TIMESCALE	OUTCOME
To Month 3	Briefing Paper re ToC to sponsor Identification of ToC Geographical Area Establish Programme Board / Governance and Assurance Structure. Recruitment of Frontline Mental Health Professionals Recruitment of project staff Establish Shared Outcome Measures across all partner agencies. Planning and preparation; Process, Operations, Technology and Information
Month 3 – Month 6	Training and Locality Pathway Development. Phase One of Implementation of TOC.
Month 6 – Month 9	Evaluation of Phase One Implementation. Phase 2 / Whole System Implementation.
Month 9 – Month 12	Project Evaluation. Development Proposal for further / future upscaling of model – national learning and implementation plan

Project Team

The Project Team will compromise of three distinct groupings, all of which will be aligned to the current Service Transformation Plans in place across NHS 24 / Police Scotland and the Scottish Ambulance Service:

Programme Board (Quarterly Meetings)

Programme Lead(s) – PS / SAS / NHS24
Communication and Engagement Lead
Evaluation Lead
Locality Representative(s)
Project Manager (NHS 24)
Executive Leadership Representation from PS / NHS24 / SAS
Executive Sponsor : Scottish Government Mental Health Division

Implementation Group (Monthly Meetings)

Programme Leads
Project Manager
Data Analyst
Locality Representatives – including service users.
Frontline Police Scotland & Scottish Ambulance Service Representatives
Communication and Engagement Lead

Project (Service) Delivery Team (Daily / Weekly Meetings)

Project Manager
Communication & Engagement
Team Leader(s)
Mental Health Support Workers
Mental Health Advisors
Mental Health Specialist Practitioners
Learning & Development Advisor

Financial Implications

The final budget required to deliver this proposed test of change model is dependant on the needs and demand of the agreed geographical area where the pilot will be implemented. The table below details a workable draft budget, with reference given to particular roles and responsibilities required to ensure a smooth delivery of the project across all three partner areas. Several of these roles will straddle across all three components of the project.

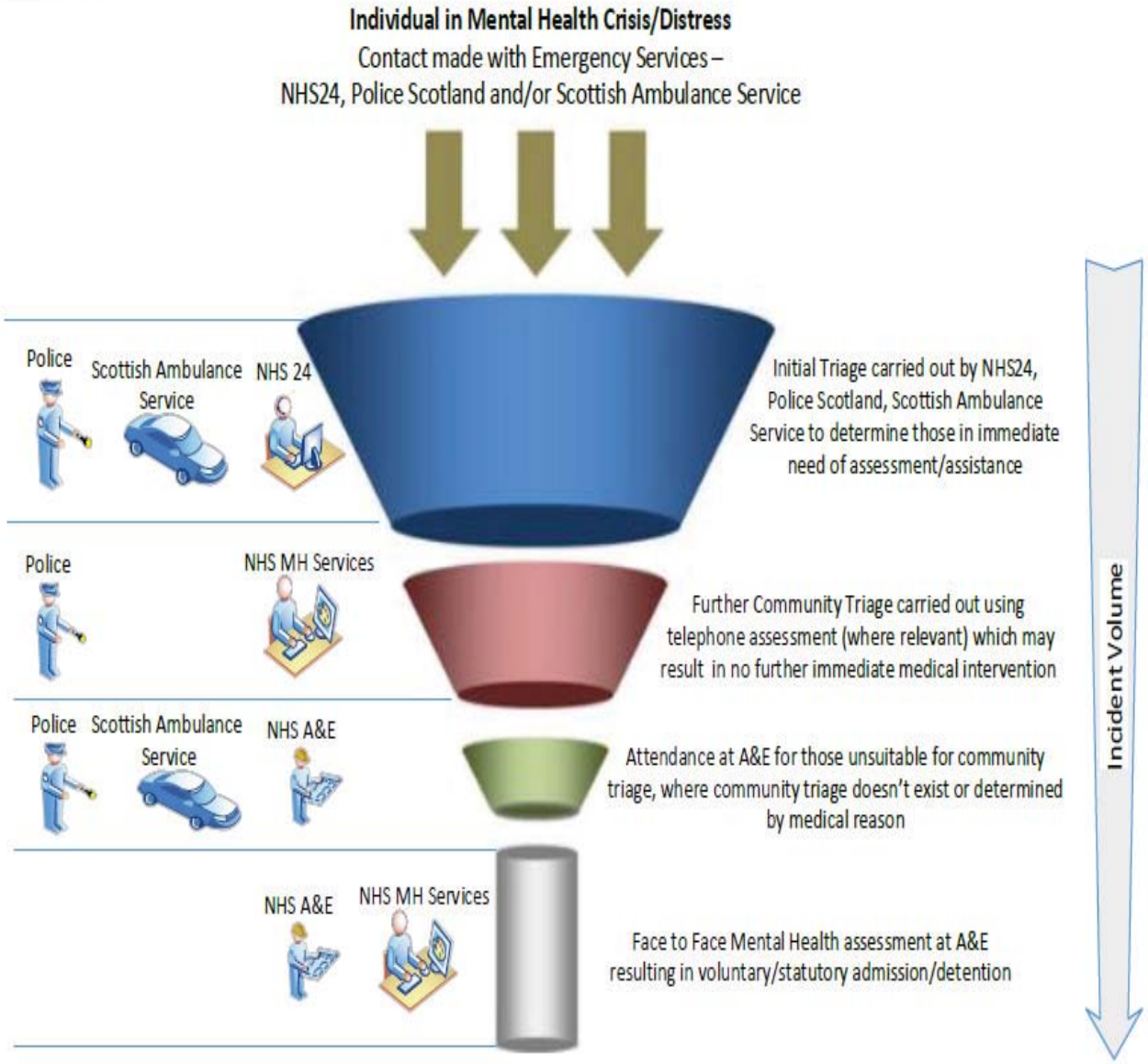
Appendix 8

Details	Amount
Infrastructure, Development & Implementation of Model - Senior Programme Leadership - Communication and Engagement - Learning & Education - Technology / Systems Upgrade	£117,144
Service Delivery Staffing - Mental Health Clinical Service Manager (1xWTE Band 8a) - Mental Health Team Leaders (2x WTE Band 7) - Mental Health Call Operators (5x WTE Band 3) - Mental Health and Well-being Advisors (4x WTE Band 4) - Mental Health Specialist Practitioner (4x WTE Band 6) *** This would ensure at least 16 new Mental Health Professionals being recruited to support direct patient care***	£669,288
Evaluation and Programme Management Project Administrator Data Analyst / Researcher	£81,582

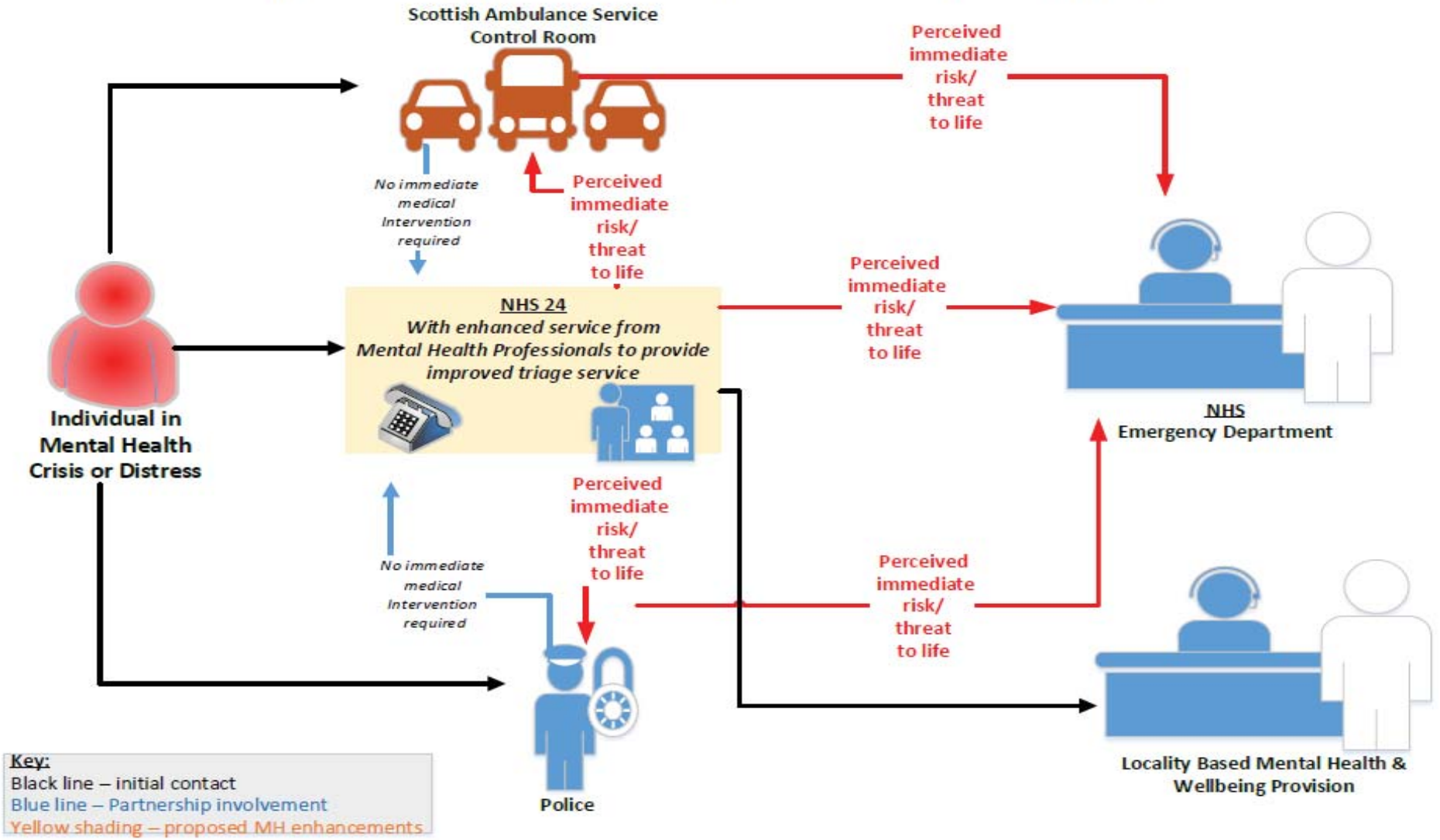
The proposed draft budget for year 1 would be **£868,014.**

Appendix 1: Current Service provision

Appendix 1



Appendix 2 – Proposed Enhanced Mental Health Pathways First Response



ANNEX C

Breakdown of funding

Please note - these figures are only provided as a guide using the NRAC formula calculator for 2018/19. [2] The formula changes only very slightly each year therefore it is not possible to provide an exact figure over the next 4 years.

Allocations by Territorial Board – 2018/2019 £11 Million		
NHS Board	**Target Share**	**NRAC Share**
NHS Ayrshire and Arran	7.409%	£815,006
NHS Borders	2.104%	£231,456
NHS Dumfries and Galloway	2.979%	£327,738
NHS Fife	6.806%	£748,636
NHS Forth Valley	5.419%	£596,129
NHS Grampian	9.873%	£1,085,983
NHS Greater Glasgow & Clyde	22.337%	£2,457,118
NHS Highland	6.442%	£708,660
NHS Lanarkshire	12.348%	£1,358,226
NHS Lothian	14.80 4%	£1,628,474
NHS Orkney	0.483%	£53,077
NHS Shetland	0.490%	£53,907
NHS Tayside	7.848%	£863,306
NHS Western Isles	0.657%	£72,285

Breakdown of estimated allocation per IJB - 2018/2019 £11 Million					
NHS Board	**NRAC Share %**	**NRAC Share £**	**HSCP Name**	**HSCP NRAC Share %**	**NRAC Share £**
Ayrshire & Arran	7.41%	815,006	East Ayrshire	2.43%	£267,351
			North Ayrshire	2.72%	£299,538
			South Ayrshire	2.26%	£248,118
Borders	2.10%	231,456	Scottish Borders	2.10%	£231,456
Dumfries & Galloway	2.98%	327,738	Dumfries and Galloway	2.98%	£327,738
Fife	6.81%	748,636	Fife	6.81%	£748,636
Forth Valley	5.42%	596,129	Clackmannanshire and Stirling	2.55%	£280,549
			Falkirk	2.87%	£315,580
Grampian	9.87%	1,085,983	Aberdeen City	3.92%	£431,203

[2] As per the footnote on page 5, Action 15 of the Mental Health Strategy explicitly specifies prison settings, a population NRAC does not take account of, it is requested that the plans of those partners hosting significant prisons populations include outlines of additional funding requirements they might have based on any available need assessments.

			Aberdeenshire	4.23%	£465,384
			Moray	1.72%	£189,396
Greater Glasgow & Clyde	22.34%	2,457,118	East Dunbartonshire	1.82%	£199,776
			East Renfrewshire	1.56%	£171,667
			Glasgow City	12.09%	£1,329,497
			Inverclyde	1.65%	£181,485
			Renfrewshire	3.40%	£373,503
			West Dunbartonshire	1.83%	£201,190
Highland	6.44%	708,660	Argyll and Bute	1.85%	£203,883
			Highland	4.59%	£504,777
Lanarkshire	12.35%	1,358,226	North Lanarkshire	6.43%	£706,750
			South Lanarkshire	5.92%	£651,476
Lothian	14.80%	1,628,474	East Lothian	1.83%	£201,801
			Edinburgh	8.32%	£915,205
			Midlothian	1.57%	£173,170
			West Lothian	3.08%	£338,298
Orkney	0.48%	53,077	Orkney Islands	0.48%	£53,077
Shetland	0.49%	53,907	Shetland Islands	0.49%	£53,907
Tayside	7.85%	863,306	Angus	2.15%	£237,042
			Dundee City	2.96%	£325,907
			Perth and Kinross	2.73%	£300,357
Western Isles	0.66%	72,285	Eilean Siar (Western Isles)	0.66%	£72,285

Allocations by Territorial Board – 2019/2020 £17 million		
NHS Board	**Target Share**	**NRAC Share**
NHS Ayrshire and Arran	7.409%	£1,259,555
NHS Borders	2.104%	£357,705
NHS Dumfries and Galloway	2.979%	£506,503
NHS Fife	6.806%	£1,156,983
NHS Forth Valley	5.419%	£921,290
NHS Grampian	9.873%	£1,678,337
NHS Greater Glasgow & Clyde	22.337%	£3,797,365
NHS Highland	6.442%	£1,095,201
NHS Lanarkshire	12.348%	£2,099,076
NHS Lothian	14.804%	£2,516,732
NHS Orkney	0.483%	£82,029
NHS Shetland	0.490%	£83,311
NHS Tayside	7.848%	£1,334,200
NHS Western Isles	0.657%	£111,713

Breakdown of estimated allocation per IJB - 2019/2020 17 Million					
NHS Board	**NRAC Share %**	**NRAC Share £**	**HSCP Name**	**HSCP NRAC Share %**	**NRAC Share £**
Ayrshire & Arran	7.41%	1,259,555	East Ayrshire	2.43%	£413,178
			North Ayrshire	2.72%	£462,922
			South Ayrshire	2.26%	£383,455
Borders	2.10%	357,705	Scottish Borders	2.10%	£357,705
Dumfries & Galloway	2.98%	506,503	Dumfries and Galloway	2.98%	£506,503
Fife	6.81%	1,156,983	Fife	6.81%	£1,156,983
Forth Valley	5.42%	921,290	Clackmannanshire and Stirling	2.55%	£433,575
			Falkirk	2.87%	£487,715
Grampian	9.87%	1,678,337	Aberdeen City	3.92%	£666,404
			Aberdeenshire	4.23%	£719,229
			Moray	1.72%	£292,703
Greater Glasgow & Clyde	22.34%	3,797,365	East Dunbartonshire	1.82%	£308,745
			East Renfrewshire	1.56%	£265,303
			Glasgow City	12.09%	£2,054,677
			Inverclyde	1.65%	£280,477
			Renfrewshire	3.40%	£577,233
			West Dunbartonshire	1.83%	£310,930
Highland	6.44%	1,095,201	Argyll and Bute	1.85%	£315,091
			Highland	4.59%	£780,110
Lanarkshire	12.35%	2,099,076	North Lanarkshire	6.43%	£1,092,250
			South Lanarkshire	5.92%	£1,006,826
Lothian	14.80%	2,516,732	East Lothian	1.83%	£311,875
			Edinburgh	8.32%	£1,414,407
			Midlothian	1.57%	£267,626
			West Lothian	3.08%	£522,823
Orkney	0.48%	82,029	Orkney Islands	0.48%	£82,029
Shetland	0.49%	83,311	Shetland Islands	0.49%	£83,311
Tayside	7.85%	1,334,200	Angus	2.15%	£366,337
			Dundee City	2.96%	£503,674
			Perth and Kinross	2.73%	£464,188
Western Isles	0.66%	111,713	Eilean Siar (Western Isles)	0.66%	£111,713

Allocations by Territorial Board – 2020/2021 £24 million		
NHS Board	**Target Share**	**NRAC Share**
NHS Ayrshire and Arran	7.409%	£1,778,196
NHS Borders	2.104%	£504,995

NHS Dumfries and Galloway	2.979%	£715,064
NHS Fife	6.806%	£1,633,388
NHS Forth Valley	5.419%	£1,300,645
NHS Grampian	9.873%	£2,369,417
NHS Greater Glasgow & Clyde	22.337%	£5,360,986
NHS Highland	6.442%	£1,546,166
NHS Lanarkshire	12.348%	£2,963,402
NHS Lothian	14.804%	£3,553,033
NHS Orkney	0.483%	£115,805
NHS Shetland	0.490%	£117,615
NHS Tayside	7.848%	£1,883,576
NHS Western Isles	0.657%	£157,712

Breakdown of estimated allocation per IJB - 2020/2021
24 Million

NHS Board	NRAC Share %	NRAC Share £	HSCP Name	HSCP NRAC Share %	NRAC Share £
Ayrshire & Arran	7.41%	1,778,196	East Ayrshire	2.43%	£583,310
			North Ayrshire	2.72%	£653,537
			South Ayrshire	2.26%	£541,348
Borders	2.10%	504,995	Scottish Borders	2.10%	£504,995
Dumfries & Galloway	2.98%	715,064	Dumfries and Galloway	2.98%	£715,064
Fife	6.81%	1,633,388	Fife	6.81%	£1,633,388
Forth Valley	5.42%	1,300,645	Clackmannanshire and Stirling	2.55%	£612,106
			Falkirk	2.87%	£688,539
Grampian	9.87%	2,369,417	Aberdeen City	3.92%	£940,806
			Aberdeenshire	4.23%	£1,015,383
			Moray	1.72%	£413,228
Greater Glasgow & Clyde	22.34%	5,360,986	East Dunbartonshire	1.82%	£435,875
			East Renfrewshire	1.56%	£374,545
			Glasgow City	12.09%	£2,900,720
			Inverclyde	1.65%	£395,968
			Renfrewshire	3.40%	£814,917
			West Dunbartonshire	1.83%	£438,960
Highland	6.44%	1,546,166	Argyll and Bute	1.85%	£444,835
			Highland	4.59%	£1,101,332
Lanarkshire	12.35%	2,963,402	North Lanarkshire	6.43%	£1,542,000
			South Lanarkshire	5.92%	£1,421,401
Lothian	14.80%	3,553,033	East Lothian	1.83%	£440,294
			Edinburgh	8.32%	£1,996,810
			Midlothian	1.57%	£377,825
			West Lothian	3.08%	£738,104

Orkney	0.48%	115,805	Orkney Islands	0.48%	£115,805
Shetland	0.49%	117,615	Shetland Islands	0.49%	£117,615
Tayside	7.85%	1,883,576	Angus	2.15%	£517,182
			Dundee City	2.96%	£711,069
			Perth and Kinross	2.73%	£655,325
Western Isles	0.66%	157,712	Eilean Siar (Western Isles)	0.66%	£157,712

Allocations by Territorial Board – 2021/2022 £32 million		
NHS Board	**Target Share**	**NRAC Share**
NHS Ayrshire and Arran	7.409%	£2,370,927
NHS Borders	2.104%	£673,327
NHS Dumfries and Galloway	2.979%	£953,418
NHS Fife	6.806%	£2,177,851
NHS Forth Valley	5.419%	£1,734,193
NHS Grampian	9.873%	£3,159,222
NHS Greater Glasgow & Clyde	22.337%	£7,147,981
NHS Highland	6.442%	£2,061,555
NHS Lanarkshire	12.348%	£3,951,202
NHS Lothian	14.804%	£4,737,378
NHS Orkney	0.483%	£154,407
NHS Shetland	0.490%	£156,821
NHS Tayside	7.848%	£2,511,435
NHS Western Isles	0.657%	£210,283

Breakdown of estimated allocation per IJB - 2021/2022 £32 Million					
NHS Board	**NRAC Share %**	**NRAC Share £**	**HSCP Name**	**HSCP NRAC Share %**	**NRAC Share £**
Ayrshire & Arran	7.41%	2,370,927	East Ayrshire	2.43%	£777,747
			North Ayrshire	2.72%	£871,383
			South Ayrshire	2.26%	£721,797
Borders	2.10%	673,327	Scottish Borders	2.10%	£673,327
Dumfries & Galloway	2.98%	953,418	Dumfries and Galloway	2.98%	£953,418
Fife	6.81%	2,177,851	Fife	6.81%	£2,177,851
Forth Valley	5.42%	1,734,193	Clackmannanshire and Stirling	2.55%	£816,141
			Falkirk	2.87%	£918,051
Grampian	9.87%	3,159,222	Aberdeen City	3.92%	£1,254,408
			Aberdeenshire	4.23%	£1,353,844
			Moray	1.72%	£550,970
Greater Glasgow &	22.34%	7,147,981	East Dunbartonshire	1.82%	£581,167

Clyde					
			East Renfrewshire	1.56%	£499,394
			Glasgow City	12.09%	£3,867,627
			Inverclyde	1.65%	£527,957
			Renfrewshire	3.40%	£1,086,555
			West Dunbartonshire	1.83%	£585,280
Highland	6.44%	2,061,555	Argyll and Bute	1.85%	£593,113
			Highland	4.59%	£1,468,442
Lanarkshire	12.35%	3,951,202	North Lanarkshire	6.43%	£2,056,001
			South Lanarkshire	5.92%	£1,895,202
Lothian	14.80%	4,737,378	East Lothian	1.83%	£587,059
			Edinburgh	8.32%	£2,662,414
			Midlothian	1.57%	£503,767
			West Lothian	3.08%	£984,138
Orkney	0.48%	154,407	Orkney Islands	0.48%	£154,407
Shetland	0.49%	156,821	Shetland Islands	0.49%	£156,821
Tayside	7.85%	2,511,435	Angus	2.15%	£689,576
			Dundee City	2.96%	£948,093
			Perth and Kinross	2.73%	£873,766
Western Isles	0.66%	210,283	Eilean Siar (Western Isles)	0.63%	£210,283

ANNEX D

ACTION 15 - OUTLINE 2018-19 INTEGRATION AUTHORITY FINANCIAL REPORTING TEMPLATE, DUE FOR RETURN BY SEPTEMBER 2018

IA area

Summary of agreed spending breakdown for 2018-19 with anticipated monthly phasing

Actual spending to date against profile, by month

Remaining spend to end 2018-19, by month

Projected under/ over spend by end 2018-19

Is it expected that the full second tranche will be required in 2018-19?

Please return to:

Pat McAuley
3ER, St Andrew's House, Regent Road, Edinburgh EH1 3DG

Or by email to:
Pat.McAuley@gov.scot

Directorate for Population Health
Primary Care Division
T: 0131 244 2305

E: Richard.Foggo@gov.scot

Integration Authority Chief Officers
NHS Board Chief Executives

23 May 2018

Dear Colleagues,

PRIMARY CARE IMPROVEMENT FUND: ANNUAL FUNDING LETTER 2018-19

I am writing to confirm the 2018-19 funding allocations for the Primary Care Improvement Fund element of the wider Primary Care Fund, which will be used by Integration Authorities to commission primary care services, and allocated on an NRAC basis through Health Boards to Integration Authorities (IAs).

This letter should be read in close conjunction with two other letters due to issue, which will set out additional ring-fenced resources being made available to IAs in 2018-19:

- A second letter from my Division covering the allocation and use of an additional £5 million for Out of Hours primary care; and
- A letter from Penny Curtis, Deputy Director Mental Health Division, regarding funding of 'Action 15' of the Mental Health Strategy. Action 15 is a four-year commitment to deliver 800 more mental health workers in a range of settings, including primary care, and £11 million is being made available to IAs for this in the first year[1].

Background

Last year we brought together the Out of Hours, Primary Care Transformation Fund and Mental Health Funds into a single funding allocation, referred to as the Primary Care Transformation Fund (PCTF). My colleagues Penny Curtis and Linda Gregson wrote to you on 9 August 2017 to set out the 2017-18 allocation in your area and associated deliverables. An End of Year template for your completion is at Annex F.

[1] Note: for the avoidance of doubt, SG is also continuing to fund the development of primary care mental health services, in a similar way to previous years. This funding for primary care mental health now forms part of the Primary Care Improvement Fund. The £11m Action 15 funding referenced in the section above is additional to it.

Several key developments have taken place since then. These include:

- Scottish Government and BMA agreement to proceed with the 2018 General Medical Services contact following a poll of the GP profession – January 2018[2].
- Publication of the Memorandum of Understanding (MoU) between Scottish Government, British Medical Association, Integration Authorities and NHS Boards – draft published November 2017 and finalised 19 April 2018[3]. This determines the priorities of Integration Authorities over the next period and should be read in conjunction with this funding letter.
- Primary Care National Workforce Plan – published 30 April 2018[4].
- Passing of Scottish Government Budget Bill in February 2018 confirming increase in Primary Care Fund from £72m in 2017-18 to £110m in 2018-19.
- Wider contextual developments (e.g. the new Oral Health Action Plan and ongoing work by the Health and Justice Collaboration Improvement Board to further develop 'Action 15' of the Mental Health Strategy, which committed to 800 new mental health workers in health and justice settings).

Taken together, these set the terms of the main deliverables we expect in 2018-19 and beyond. Further information on them is at Annex C.

2018-19 approach

The Scottish Government is investing a total of £115.5 million in the Primary Care Fund (PCF) in 2018-19. There are a number of elements to the overall Primary Care Fund:

- Primary Care Improvement Fund (the subject of this letter);
- General Medical Services;
- National Boards; and
- Wider Primary Care Support including Out of Hours Fund.

These are described in more detail in Annex B.

Primary Care Improvement Fund (PCIF)

An in-year NRAC allocation to IAs (via Heath Boards) will comprise £45.750 million of the £115.5 million Primary Care Fund. This in-year allocation is hereafter referred to as the *Primary Care Improvement Fund*.

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[2] British Medical Association and Scottish Government (2017), *The 2018 GMS Contract in Scotland* http://www.gov.scot/Resource/0052/00527530.pdf

[3] *Memorandum of Understanding between Scottish Government, British Medical Association, Integration Authorities and NHS Boards - GMS Contract Implementation in the context of Primary Care Service Redesign*, published in draft 13 November 2017 and published as final 19 April 2018: http://www.gov.scot/Resource/0053/00534343.pdf

[4] http://www.gov.scot/Publications/2018/04/3662

Primary Care Improvement Plans should set out how this additional funding will be used and the timescale for the reconfiguration of services. Further information is at Annexes D and E.

Total PCIF allocation by Board area

The 2018-19 funding allocation for the PCIF is £45.750 million.

Allocation of the fund, by Health Board and IA, is shown in Annex A. All figures are calculated using NRAC. The money must be used by IAs for the purposes described in this letter. The PCIF (including £7.800 million 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.

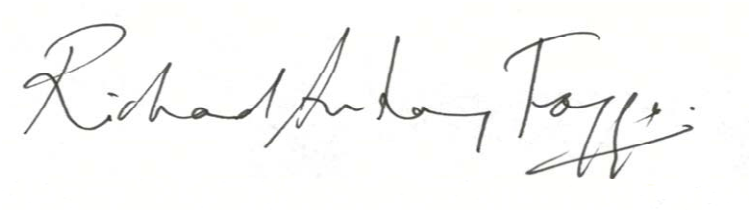
The fund must be delegated in its entirety to IAs. We do not anticipate any adjustment to these figures locally except in two circumstances:

- Marginal changes may be made with the agreement of the Health Board and Integration Authorities to reflect local arrangements, for example in relation to management arrangements within and between Integration Authorities.
- Health Boards and IAs may work collaboratively within their area to jointly resource pre-existing commitments which clearly fall within the scope of the MoU. An example of this would be early adopter link workers who are already in post in areas of higher socio-economic deprivation. This joint working to deliver the overall commitment to links workers (or other MoU related area(s)) can be appropriately reflected in PCIPs for all the IAs concerned. Such a joint approach should be considered especially where it is considered that continuation of such a service in an IA could disproportionately impact on funding available for other activities under the MoU.

Integration Authorities should set out their plans on the basis that the full funds will be made available and will be spent by them within financial year 2018-19. In this initial year of funding, the funding will issue in two tranches starting with allocation of 70% of the funding in June 2018. A high level report on how spending has been profiled must be submitted to SG by the start of September and, subject to confirmation via this report that IAs are able to spend their full 100% allocation in-year, the remaining 30% of funding will be allocated in November 2018. An outline template for making the start-September report is at Annex G. A final template will be issued before September.

I look forward to continuing to work with you in this pivotal year for primary care transformation.

Yours faithfully,



RICHARD FOGGO
Deputy Director and Head of Primary Care Division

Copy: Local Authority Chief Executives
COSLA Chief Executive
Integration Authority Chief Finance Officers
Health Board Directors of Finance
Health Board Directors of Pharmacy
Health Board Directors of Planning and Policy
Health Board Medical Directors
Primary Care Leads
Health Board Out of Hours Clinical Leads
Scottish Executive Nurse Directors (SEND)
Health Board AHP Directors
Health Board Directors of Public Health

ANNEX A

PRIMARY CARE IMPROVEMENT FUND: ALLOCATION BY BOARD AND INTEGRATION AUTHORITY

Allocation By Territorial Health Board

Allocations by Territorial Board 2018-19				
	2018-19 Target share	2018-19 NRAC Share	2017-18 Allocation now in 18-19 Baseline	2018-19 Allocation
NHS Ayrshire and Arran	7.41%	£3,389,685	£569,300	£2,820,385
NHS Borders	2.10%	£962,647	£161,300	£801,347
NHS Dumfries and Galloway	2.98%	£1,363,090	£229,100	£1,133,990
NHS Fife	6.81%	£3,113,646	£521,800	£2,591,846
NHS Forth Valley	5.42%	£2,479,354	£415,000	£2,064,354
NHS Grampian	9.87%	£4,516,701	£755,400	£3,761,301
NHS Greater Glasgow & Clyde	22.34%	£10,219,379	£1,718,200	£8,501,179
NHS Highland	6.44%	£2,947,380	£494,100	£2,453,280
NHS Lanarkshire	12.35%	£5,648,985	£947,700	£4,701,285
NHS Lothian	14.80%	£6,772,970	£1,132,000	£5,640,970
NHS Orkney	0.48%	£220,754	£75,000	£145,754
NHS Shetland	0.49%	£224,204	£76,200	£148,004
NHS Tayside	7.85%	£3,590,567	£601,900	£2,988,667
NHS Western Isles	0.66%	£300,639	£103,000	£197,639
Total	100.00%	£45,750,000	£7,800,000	£37,950,000

**Pharmacists in GP Practices funding was a recurring allocation in 2017-18 and will be included in Boards' 2018-19 baseline funding.*

Allocation by Integration Authority: overview of full £45.750 breakdown

Total Bundle £45.750m			
NHS Board	**2018-19 NRAC Share**	**IA Name**	**IA Share**
Ayrshire & Arran	3,389,685	East Ayrshire	1,111,935
		North Ayrshire	1,245,806
		South Ayrshire	1,031,944
Borders	962,647	Scottish Borders	962,647
Dumfries & Galloway	1,363,090	Dumfries and Galloway	1,363,090
Fife	3,113,646	Fife	3,113,646
Forth Valley	2,479,354	Clackmannanshire and Sti	1,166,827
		Falkirk	1,312,527
Grampian	4,516,701	Aberdeen City	1,793,412
		Aberdeenshire	1,935,573
		Moray	787,716
Greater Glasgow	10,219,379	East Dunbartonshire	830,888
& Clyde		East Renfrewshire	713,977
		Glasgow City	5,529,498
		Inverclyde	754,813
		Renfrewshire	1,553,435
		West Dunbartonshire	836,768
Highland	2,947,380	Argyll and Bute	847,966
		Highland	2,099,414
Lanarkshire	5,648,985	North Lanarkshire	2,939,438
		South Lanarkshire	2,709,546
Lothian	6,772,970	East Lothian	839,311
		Edinburgh	3,806,420
		Midlothian	720,229
		West Lothian	1,407,010
Orkney	220,754	Orkney Islands	220,754
Shetland	224,204	Shetland Islands	224,204
Tayside	3,590,567	Angus	985,878
		Dundee City	1,355,476
		Perth and Kinross	1,249,213
Western Isles	300,639	Eilean Siar (Western Isles	300,639
Total	**45,750,000**		**45,750,000**

Allocation by Integration Authority: IA share of £7.8m baselined funding[5]

£7.8m from Boards' Baseline Funding			
NHS Board	**Baselined funding**	**IA Name**	**IA Share**
Ayrshire & Arran	569,300	East Ayrshire	186,750
		North Ayrshire	209,234
		South Ayrshire	173,316
Borders	161,300	Scottish Borders	161,300
Dumfries & Galloway	229,100	Dumfries and Galloway	229,100
Fife	521,800	Fife	521,800
Forth Valley	415,000	Clackmannanshire and S	195,306
		Falkirk	219,694
Grampian	755,400	Aberdeen City	299,941
		Aberdeenshire	323,717
		Moray	131,742
Greater Glasgow	1,718,200	East Dunbartonshire	139,698
& Clyde		East Renfrewshire	120,042
		Glasgow City	929,683
		Inverclyde	126,908
		Renfrewshire	261,181
		West Dunbartonshire	140,687
Highland	494,100	Argyll and Bute	142,153
		Highland	351,947
Lanarkshire	947,700	North Lanarkshire	493,134
		South Lanarkshire	454,566
Lothian	1,132,000	East Lothian	140,278
		Edinburgh	636,186
		Midlothian	120,376
		West Lothian	235,161
Orkney	75,000	Orkney Islands	75,000
Shetland	76,200	Shetland Islands	76,200
Tayside	601,900	Angus	165,266
		Dundee City	227,223
		Perth and Kinross	209,410
Western Isles	103,000	Eilean Siar (Western Isle	103,000
Total	**7,800,000**		**7,800,000**

[5] Being treated as part of the PCIF. Note that there is no difference between the use for PCIP purposes of the baselined £7.8 million and the remainder of the PCIF this year.

Allocation by Integration Authority: tranche 1 and tranche 2 of £37.950 million in-year allocation[6]

£37.95m split into Tranche 1 and Tranche 2							
NHS Board	**2018-19 Board Allocation**	**Tranche 1 (70%)**	**Tranche 2 (30%)**	**IA Name**	**IA Share**	**Tranche 1 (70%)**	**Tranche 2 (30%)**
Ayrshire & Arran	2,820,385	1,974,270	846,116	East Ayrshire	925,185	647,629	277,555
				North Ayrshire	1,036,572	725,600	310,972
				South Ayrshire	858,629	601,040	257,589
Borders	801,347	560,943	240,404	Scottish Borders	801,347	560,943	240,404
Dumfries & Galloway	1,133,990	793,793	340,197	Dumfries and Galloway	1,133,990	793,793	340,197
Fife	2,591,846	1,814,292	777,554	Fife	2,591,846	1,814,292	777,554
Forth Valley	2,064,354	1,445,048	619,306	Clackmannanshire and Stirling	971,521	680,065	291,456
				Falkirk	1,092,833	764,983	327,850
Grampian	3,761,301	2,632,910	1,128,390	Aberdeen City	1,493,471	1,045,429	448,041
				Aberdeenshire	1,611,857	1,128,300	483,557
				Moray	655,973	459,181	196,792
Greater Glasgow & Clyde	8,501,179	5,950,825	2,550,354	East Dunbartonshire	691,189	483,832	207,357
				East Renfrewshire	593,935	415,754	178,180
				Glasgow City	4,599,815	3,219,871	1,379,945
				Inverclyde	627,905	439,534	188,372
				Renfrewshire	1,292,253	904,577	387,676
				West Dunbartonshire	696,081	487,257	208,824
Highland	2,453,280	1,717,296	735,984	Argyll and Bute	705,813	494,069	211,744
				Highland	1,747,467	1,223,227	524,240
Lanarkshire	4,701,285	3,290,899	1,410,385	North Lanarkshire	2,446,305	1,712,413	733,891
				South Lanarkshire	2,254,980	1,578,486	676,494
Lothian	5,640,970	3,948,679	1,692,291	East Lothian	699,032	489,323	209,710
				Edinburgh	3,170,234	2,219,164	951,070
				Midlothian	599,854	419,898	179,956
				West Lothian	1,171,850	820,295	351,555
Orkney	145,754	102,028	43,726	Orkney Islands	145,754	102,028	43,726
Shetland	148,004	103,603	44,401	Shetland Islands	148,004	103,603	44,401
Tayside	2,988,667	2,092,067	896,600	Angus	820,612	574,428	246,184
				Dundee City	1,128,253	789,777	338,476
				Perth and Kinross	1,039,803	727,862	311,941
Western Isles	197,639	138,347	59,292	Eilean Siar (Western Isles)	197,639	138,347	59,292
Total	**37,950,000**	**26,565,000**	**11,385,000**		**37,950,000**	**26,565,000**	**11,385,000**

[6] Total PCIF minus the £7.8 million baselined amount. Note that there is no difference between the use for PCIP purposes of the baselined £7.8 million and the remainder of the PCIF this year.

ANNEX B

OVERVIEW OF NATIONAL PRIMARY CARE FUNDING ARRANGEMENTS

Primary Care Fund 2018-19

The Scottish Government is investing a total of £115.5 million in the Primary Care Fund (PCF) in 2018-19. There are a number of elements to the overall Fund:

- Primary Care Improvement Fund;
- General Medical Services;
- National Boards; and
- Wider Primary Care Support including Out of Hours.

The full Primary Care Fund breakdown is below.

Primary Care Fund £m	2018-19	Notes
Primary Care Improvement Fund: Service redesign through Primary Care Improvement Plans	**45.750**	Wider MDT development across 6 priority areas in the GMS contract/ MoU, including Pharmacy, CLW, Vaccination Transformation Programme, primary care mental health and Pharmacy First.
GMS: Income & Expenses Guarantee Professional Time Activities Rural package GP Additional support GP clusters (PQLs) **GMS Total**	 23.000 2.500 2.000 3.075 5.000 **35.575**	Additional support includes oxygen, occ health, parental leave, sickness, appraisal and GP retainers scheme
National Boards	**16.569**	Cluster support (HIS and LIST), SAS Strategy/national board transformation, practice nurse training
Wider Primary Care Support: National Support Primary Care Infrastructure Out of Hours GP Recruitment and Retention **Wider Primary Care Support Total**	 5.606 2.000* 5.000 5.000 **17.642**	National support includes primary care development, GP sustainability reccs, community eyecare review, evaluation
Total: Primary Care Fund *£10m Premises Fund available in 2018-19 from a separate funding source	**115.500**	

The table above demonstrates the allocation of the entirety of the Primary Care Fund. A separate letter will be prepared and copied to IAs in due course providing a

breakdown of which elements of the Primary Care Fund are in direct support of General Practice, contributing to the Scottish Government's commitment to invest an additional £250 million in direct support of General Practice by the end of this Parliament.

Primary Care Improvement Fund

An in-year NRAC allocation to IAs (via Heath Boards) will comprise £45.750 million of that £115.5 million Primary Care Fund. This in-year allocation is hereby referred to as the Primary Care Improvement Fund (PCIF). Primary Care Improvement Plans should set out how this additional funding will be used and the timescale for the reconfiguration of services.

In 2018-19, for the PCIF, we are continuing the process of radical simplification we began last year. As agreed with the *Scottish Government – Chief Officer Advisory Group on Primary Care*, we are making a single broad allocation, to provide maximum flexibility to local systems to deliver key outcomes. This is a successor fund to activities previously funded including:

- Pharmacy teams in General Practice
- Vaccination Transformation Programme
- Primary Care Transformation Fund
- Community Links Workers
- Mental Health Primary Care Fund
- Pharmacy First

Primary Medical Services

A separate Primary Medical Services (PMS) revenue allocation letter will issue in due course, which will include the elements of the Primary Care Fund that relate to General Medical Services (GMS) such as the £23 million income guarantee associated with the new GMS contract.

National NHS Boards will also receive letters setting out the outcomes associated with their funding allocations.

Out of Hours Fund

IAs will be expected to maintain and develop a resilient out of hours service that builds on the recommendations set out in Sir Lewis Ritchie's report *Pulling Together*, building effective links and interface between in and out of hours GP services.

Therefore, IAs will receive an in-year NRAC allocation *additional* to the Primary Care Improvement Fund of £5 million for investment in Out of Hours.

A separate letter will set out further detail before the end of May on the allocation and use of the £5 million.

Wider Elements of Primary Care Fund

Funding from the Primary Care Fund outwith the IA-led allocation includes:

- Support to GP sustainability recommendations and national evaluation;
- Support to GP Recruitment and Retention; and
- Funding for National Boards to support primary care transformation.

Future funding profile

To aid in preparation of the Primary Care Improvement Plans, IAs and Health Boards should note that the Primary Care Fund is expected to increase substantially over the next three years. The Scottish Government has announced its commitment to increase the overall PCF to £250 million by 2021-22. The detail of the funding breakdown within that is a matter for Ministers and the annual Parliamentary budgeting process.

However – *strictly as a planning assumption, and subject to amendment by Ministers without notice* – IAs may wish to note our expectation that the Primary Care Improvement Fund will increase to approximately £55 million in 2019-20, £110 million in 2020-21, and £155 million in 2021-22. This will, as this year, be distributed on an NRAC basis.

All PCIF in-year allocations should be considered as *earmarked recurring* funding. It should be assumed therefore that staff may be recruited on a permanent basis to meet the requirements set out in the MoU. We will engage with IAs and others on any plans to baseline these funds.

Linked non-Primary Care Fund funding

Linked funding from outwith the Primary Care Fund in 2018-19 includes:

- The £10 million annual Premises Fund to fund interest-free secured loans to GP contractors who own their premises, as set out in the National Code of Practice for GP Premises.
- The £11 million Mental Health 'Action 15' fund, which will be the subject of a separate letter this month from Penny Curtis.

National trends in funding for primary care

In March 2017 the Cabinet Secretary for Health and Sport announced that in addition to the funding for the provision of general medical services, funding in direct support of general practice will increase annually by £250 million by the end 2021-22. In 2017-18 £71.6 million was committed through the Primary Care Fund in direct support of general practice. Further investment will see this increase over the three financial years from 1 April 2018 to £250 million in 2021-22.

This forms part of the commitment during this Parliament to extra investment of £500 million per year for Primary Care funding. This will raise the primary care budget from 7.7% of the total NHS frontline budget in 2016-17 to 11% by 2021-22.

ANNEX C

SUMMARY OF KEY POLICY DEVELOPMENTS IN PRIMARY CARE 2017-18

GMS contract offer: key elements

The contract offer to GPs[7], jointly negotiated by the BMA and the Scottish Government, sets out a refocused role for GPs as Expert Medical Generalists (EMGs) and recognises the GP as the senior clinical decision maker in the community. This role builds on the core strengths and values of general practice, involves a focus on undifferentiated presentation, complex care, and whole system quality improvement and leadership.

This refocusing of the GP role will require some tasks currently carried out by GPs to be carried out by members of a wider primary care multi-disciplinary team – where it is safe, appropriate, and improves patient care. Integration Authorities, the Scottish GP Committee (SGPC) of the British Medical Association (BMA), NHS Boards and the Scottish Government have agreed priorities for transformative service redesign in primary care in Scotland over a three year planned transition period. These priorities include vaccination services, pharmacotherapy services, community treatment and care services, urgent care services and additional professional services including acute musculoskeletal physiotherapy services, community mental health services and community link worker services. GPs will retain a professional role in these services in their capacity as expert medical generalists. The contract offer also sets out new opportunities for GP-employed practice staff.

The contract improves the formula used to determine GP funding, and proposals for the next phase of pay reform, and proposes significant new arrangements for GP premises, GP information technology and information sharing. The effect of these arrangements will be a substantial reduction in risk for GP partners in Scotland, and a substantial increase in practice sustainability.

Practice core hours will be maintained at 8am-6.30pm (or as previously agreed through local negotiation). Online services for patients will be improved, and online appointment booking and repeat prescription ordering will be made available where the practice has the functionality to implement online services safely.

The contract sets out how analytical support from Information Services Division of NHS National Services Scotland will be further embedded. Practices will supply information on practice workforce and on demand for services to support quality improvement and practice sustainability.

Memorandum of Understanding

The Memorandum of Understanding (MoU) with Integration Authorities, the British Medical Association, NHS Boards and the Scottish Government[8] set out the

[7] British Medical Association and Scottish Government (2017), *The 2018 GMS Contract in Scotland* http://www.gov.scot/Resource/0052/00527530.pdf

[8] http://www.gov.scot/Resource/0053/00534343.pdf

principles underpinning primary care in Scotland, including respective roles and responsibilities.

The seven key principles for service redesign in the document are:

- Safe
- Person-Centred
- Equitable
- Outcome focused
- Effective
- Sustainable
- Affordability and value for money

The MoU provided the basis for the development by IAs, as part of their statutory Strategic Planning responsibilities, of clear IA Primary Care Improvement Plans, setting out how allocated funding will be used and the timescales for the reconfiguration of some of the key services currently delivered under GMS contracts.

The MoU underpins the new Scottish GMS contract; and enables the move towards a new model for primary care that is consistent with the principles, aims and direction set by the Scottish Government's National Clinical Strategy (NCS) and the Health and Social Care Delivery Plan.

Workforce Plan

The third section of the National Workforce Plan[9] was published on 30 April 2018.

Scottish Ministers have committed to a significant expansion of the wider Multi-Disciplinary Team (MDT), including the training of an additional 500 advanced nurse practitioners, 250 Community Links Workers to be in place by 2021 in practices serving our poorest populations, and 1,000 paramedics to work in the community. General Practice will further be supported by ensuring all practices are given access to a pharmacist by the end of this parliamentary period. An additional investment of £6.9 million will be made in nursing in primary care, particularly general practice nursing and district nursing.

The publication of *National Health and Social Care Workforce Plan: Part 1 – a framework for improving workforce planning across NHS Scotland*[10] last June signalled the beginning of a process to further improve workforce planning across health and social care. It set out new approaches to workforce planning across Scotland, within a framework for wider reform of our health and care systems. Part 2 of the Workforce Plan – *A framework for improving workforce planning for social care in Scotland*[11] – published jointly by the Scottish Government and COSLA, set out a whole system, complementary approach to local and national social care workforce planning, recognising our new integrated landscape.

[9] http://www.gov.scot/Publications/2018/04/3662
[10] http://www.gov.scot/Resource/0052/00521803.pdf
[11] http://www.gov.scot/Resource/0052/00529319.pdf

Part 3, the primary care workforce plan, marks an important further step in that journey. It addresses the following main issues:

- how primary care services are in a strong position to respond to the changing and growing needs of our population, alongside the evidence of the significant benefits that will be delivered through focusing our workforce on prevention and self-management.
- The shape of the existing primary care workforce, including recent trends in workforce numbers
- The anticipated changes in the way services will be reconfigured to meet population need
- How the MDT will be strengthened to deliver an enhanced and sustainable workforce
- Our approach to recruiting 800 more doctors into general practice over the next decade and supporting and retaining the existing workforce
- How we will work with partners to ensure that better quality and more timely data is developed to drive effective local and national workforce planning.
- A commitment to work alongside partners including the RCN to understand the requirements for sustaining and expanding the district nursing workforce. By September 2018 we will better understand the requirements and investment needed to grow this workforce.

Other key policy developments

GP Clusters

The approach to quality which began with the move away from the Quality and Outcomes Framework introduced in the 2004 GMS contract will continue. Following the publication of *Improving Together: A National Framework for Quality and GP Clusters in Scotland*[12] in January 2017, work is now underway to continue to develop the collaborative learning role of GP clusters, to help identify and improve the quality of services in their locality. Healthcare Improvement Scotland and National Services Scotland, through Local Intelligence Support Teams (LIST) will continue to support clusters to gather intelligence to establish what these priorities are, and how to collect and evaluate data to determine what action is needed. Work is now underway to further refine the National Framework, with input from Integration Authorities, and this work will continue in 2018/19. Support should be made available from Public Health locally to help identify suitable cluster outcomes for improvement.

Community Eyecare

As indicated in last year's letter, the Community Eyecare Services Review[13] required Integration Authorities to consider the full eyecare needs of their communities when planning and commissioning services. Work is now underway in taking forward the recommendations, particularly around revising the General Ophthalmic Services Regulations. We would expect Integration Authorities to continue to work with

[12] https://beta.gov.scot/publications/improving-together-national-framework-quality-gp-clusters-scotland/documents/00512739.pdf?inline=true
[13] http://www.gov.scot/Publications/2017/04/7983

optometrists and NHS Board Optometric Advisers in considering how eyecare services can be delivered more effectively in their area, as work to implement further recommendations around clinical and quality improvement will continue in 2018/19.

Oral Health

On 24 January 2018, the Scottish Government published the *Oral Health Improvement Plan* (OHIP)[14]. The OHIP sets the direction of travel for oral health improvement and NHS dentistry for the next generation, and has a strong focus on preventing oral health disease, meeting the needs of the ageing population and reducing oral health inequalities. This does not form part of the PCIF, but appropriate links should be identified where possible.

Pharmacy

Our strategy 'Achieving Excellence in Pharmaceutical Care'[15]. was published in August 2017, and sets out the priorities, commitments and actions for improving and integrating NHS pharmaceutical care in Scotland over the next five years. It is driven by two main priorities: Improving NHS Pharmaceutical Care and Enabling NHS Pharmaceutical Care Transformation.

Achieving Excellence emphasises the important role the pharmacy team in NHS Scotland has to play as part of the workforce, making best use of their specialist skills and much needed expertise in medicines. It describes how we see pharmaceutical care evolving in Scotland along with the crucial contribution of pharmacists and pharmacy technicians, working together with other health and social care practitioners, to improve the health of the population, especially for those with multiple long term and complex conditions.

[14] http://www.gov.scot/Publications/2018/01/9275
[15] http://www.gov.scot/Resource/0052/00523589.pdf

ANNEX D

CORE REQUIREMENTS OF PRIMARY CARE IMPROVEMENT PLANS REQUIREMENT 1: PREPARATION OF PRIMARY CARE IMPROVEMENT PLANS (PCIPS)

The MoU requires IAs to:

1. Develop three-year Primary Care Improvement Plans (PCIPs), consulting NHS Boards and other partners. These must be agreed with the local GP Subcommittee of the Area Medical Committee, with the arrangements for delivering the new GMS contract being agreed with the Local Medical Committee (LMC),and
2. Through the Plans, commission, deliver and resource (including staff resources) the six priority services identified in the MOU and the Contract document ("Blue Book") in support of the new GP contract.

Process

Initial Plans, with evidence of appropriate local consultation and agreements, will be completed by 1 July 2018 and shared with the National Oversight Group by the end of that month. They should be kept under review and updated at least annually.

The Plans are to be developed collaboratively with advice and support from GPs; and explicitly agreed with the local GP Subcommittee of the Area Medical Committee (and, in the context of the arrangements for delivering the new GMS contract, explicitly agreed with the Local Medical Committee).

Key partners and stakeholders (including patients, carers, and representatives of service providers such as the third sector) should be as engaged as possible in the preparation, publication and regular review of the Plans. There will also be a need for appropriate engagement with specific professionals and groups. For example, on the pharmacotherapy service, Directors of Pharmacy and others such as area pharmaceutical committees (or area clinical forums) and local pharmacy contractors committees will have a strong need for engagement on its implementation locally.

We appreciate that achieving full engagement within the challenging initial timescale for the PCIP may be difficult, and some of the more detailed dialogue may take place after the plans are submitted. They will be living documents, and regularly reviewed and updated.

Content

The transfer of services in the six priority areas (detailed under Requirement 2 below) will be a major component of PCIPs, and we expect that PCIPs will show a funding profile for each area.

Good communications and understanding across the wider health and social care interfaces with both services and professional groups (e.g. primary/secondary, community health and social care services, district nursing, out of hours services,

mental health services) will also be required to address direct patient care issues, such as prescribing, referrals, discharges, follow up of results and signposting. An important principle here is that each part of the system respects the time and resources of the other parts. There should not be an assumption that patient needs or work identified in one part of the service must be met by another without due discussion and agreement. This should ensure that patients do not fall through gaps in the health and care system.

Wider spending on those services should form part of IAs' broader strategic planning and commissioning role, and it would be helpful if PCIPs could reference how these services will work together.

IAs, in preparing PCIPs, should also consider the underpinning need for strong collective leadership from all parts of the local system, and how best to support it. Measures to build the leadership capability of GP Sub-Committees, and Cluster Quality Leads, as well as wider capability and capacity, should form a key part of Plans. NHS Education for Scotland is likely to be a key partner for IAs in delivering programmes to support that capacity-building. PCIPs may also address practical support to the programmes of work, such as coordination or programme management.

Wider considerations

Connection to Action 15 of the Mental Health Strategy

Primary Care Improvement Plans should show clear connections to the plans being prepared under Action 15 of the Mental Health Strategy for delivery of 800 more mental health staff in general practice, Accident and Emergency, prisons and police custody suites over the next three years. Penny Curtis will be writing to you separately on this matter.

Some of the same staff may be counted both as part of the MOU delivery (for example as part of the development of primary care mental health and/or the work on links workers) and the delivery of the general practice element of the 800. This is acceptable, and Penny Curtis's letter will set out how we expect additionality to be accounted for in terms of the 800. It would be helpful to see any cross-over clearly articulated in both PCIPs and existing plans (or those in development) regarding Action 15 of the Mental Health Strategy.

Inequalities

Whilst we recognise that the key determinants of health inequality lie outside general practice services and health care generally, there remain opportunities to strengthen the role of general practice and primary care in mitigating inequality. All PCIPs should include a section on how the services will contribute to tackling health inequalities. The community links worker service will be one aspect of this, as will the developing quality improvement role of GP Clusters, but IAs will wish to consider what more can be done to ensure there is parity of access for all groups, and that the workload of GPs in the most deprived areas is manageable.

IAs are also subject to the new Fairer Scotland Duty which came into force from April 2018. Guidance on the new duty is available on the SG website[16]. The duty aims to ensure that public bodies take every opportunity to reduce inequalities of outcome, caused by socio-economic disadvantage, when making strategic decisions. We would therefore strongly encourage IAs to consider how they can meet their obligations under the duty as they develop their PCIPs. In particular, all IAs should have completed an inequalities assessment, and make reference to this in their PCIP.

Sustainability

All IAs should also consider the sustainability of general practices in their area including the recruitment and retention of local GPs. Where there are specific sustainability issues, these should be discussed with GP representatives, and consideration given to how the PCIP can best support the sustainability of general practice locally.

National support will continue to be made available through the multi-partner Improving General Practice Sustainability Advisory Group which, over the past year, has made significant progress in delivering the practically focused recommendations for reducing workload pressures, including actions to improve interface working and improved signposting of patients to appropriate primary care services and to self-care. During 2018 the Group will focus on supporting local partners to address local sustainability issues.

Rural, remote and island communities

The needs of rural, remote and island communities should be addressed in PCIPs if they form part of the IA area.

The expectation is that the contract workload reduction measures and new services must be made available to *every* practice where it is reasonably practical, effective and safe to do so.

The service redesign requires practices to be involved via their GP clusters, so they have a say in how services will work locally.

Governance

A new National Oversight Group with representatives from the Scottish Government, the SGPC, Integration Authorities and NHS Boards will oversee implementation by NHS Boards of the GMS contract in Scotland and the IA Primary Care Improvement Plans, including clear milestones for the redistribution of GP workload and the development of effective MDT working, including with non-clinical staff.

At local level, Integration Authorities will hold Health Boards and Councils to account for delivery of the milestones set out in the Plan, in line with the directions provided

[16] http://www.gov.scot/Publications/2018/03/6918

to the Health Board and Council by the Integration Authority for the delivery of Strategic Plans.

Directors of Pharmacy will be leading on the implementation of the pharmacotherapy services during the three year trajectory, to ensure governance arrangements are in place, workforce planning and capacity issues are addressed, and the initial momentum is maintained. This will be taken forward through the recently established Pharmacotherapy Service Implementation Group which will form part of the governance arrangements under the new National Oversight Group.

The Vaccination Transformation Programme is overseen by a Programme Board with representatives from the Scottish Government, SGPC, Trade Unions, Health Protection Scotland, Health Boards, and Directors of Nursing. It is responsible for realising the benefits of vaccination transformation nationally, and managing, monitoring and evaluating progress made by each Health Board. The Vaccination Transformation Programme Board links into the National Oversight Group by reporting to the Primary Care Programme Board.

Other stakeholder groups such as dentistry and optometry should also be engaged with.

Evaluation

At local level, all PCIPs should include consideration of how the changes will be evaluated locally.

Healthcare Improvement Scotland and LIST analysts from National Services Scotland will work with IAs to provide support and learning in development of the new services.

At the national level, the Scottish Government plans to publish a 10-year Primary Care Monitoring and Evaluation Strategy in June 2018, setting out our overarching approach to evaluating primary care reform.

We will also publish a Primary Care Outcomes Framework before then, which maps out planned actions and priorities against the changes we are working towards. The Framework was co-produced by the Primary Care Evidence Collaborative, which includes NHS Health Scotland, the Scottish School of Primary Care, Healthcare Improvement Scotland, NHS Education for Scotland, National Services Scotland, the Alliance, and the Scottish Government.

ANNEX E

CORE REQUIREMENTS FOR PRIMARY CARE IMPROVEMENT PLANS 2018-21 REQUIREMENT 2 – SERVICE TRANSFER

The MoU requires IAs to:

1. Develop three-year Primary Care Improvement Plans (PCIPs), consulting NHS Boards and other partners. These must be agreed with the local GP Subcommittee of the Area Medical Committee, with the arrangements for delivering the new GMS contract being agreed with the Local Medical Committee (LMC),and

2. Through the Plans, commission, deliver and resource (including staff resources) the six priority services identified in the MOU and the Contract document ("Blue Book") in support of the new GP contract.

This Annex sets out the six core requirements for service transfer in PCIPs over the three year period.

IAs should work with a range of professionals in NHS Boards and practices, reflecting the service priority areas, to plan and manage service transfers in a way that ensures patient safety and maximises benefits to patient care. The nature and speed of delivery at a local level will vary based on local factors such as the extent to which comparable services are already in place, upon local geography, and prioritisation based on local demographics and demand. The new services should be provided within GP practices or clusters of practices, or be closely located.

Delivery of the Vaccination Transformation Programme, pharmacotherapy service and community treatment and care service (and within that, specifically phlebotomy) have been identified as the key immediate priorities, in that responsibility for these services will be fully transferred to IAs by the end of the transition period in April 2021. However, the other aspects of service transfer should also be considered urgent, and requiring of significant progress over the three years of Plan to deliver the arrangements set out in the MOU and the new GMS contract document.

Service 1) Vaccination Transfer Programme

High level deliverable: All services to be Board run by 2021.

By 2021, vaccinations will have moved away from a model based on GP delivery, to one based on NHS Board delivery through dedicated teams.

The Vaccination Transformation Programme can be divided into different work streams:
1. pre-school programme
2. school based programme
3. travel vaccinations and travel health advice
4. influenza programme
5. at risk and age group programmes (shingles, pneumococcal, hepatitis B)

We expect IAs and NHS Boards to have all five of these programmes in place by April 2021. The order and rate at which IAs and NHS Boards make the transition may vary but progress is expected to be delivered against locally agreed milestones in each of the 3 years, including significant early developments in financial year 2018-19.

The Vaccination Transformation Programme includes all vaccination work in primary care, whether previously delivered by IAs or not. For the avoidance of doubt, this includes childhood immunisations in every case.

Governance and oversight

The Vaccination Transformation Programme is overseen by a Programme Board with representatives from the Scottish Government, SGPC, Trade Unions, Health Protection Scotland, Health Boards, and Directors of Nursing. It is responsible for realising the benefits of vaccination transformation nationally, and managing, monitoring and evaluating progress made by each Health Board. The Vaccination Transformation Programme Board links into the National Oversight Group by reporting to the Primary Care Programme Board.

Service 2) Pharmacotherapy services

High level deliverable: Pharmacotherapy Service to the patients of every practice by 2021.

The GP contract includes an agreement that every GP practice will have access to a pharmacotherapy service. To date, investment from the GP Pharmacy Fund has meant that we have exceeded the initial target to recruit 140 wte pharmacists, together with a number of wte pharmacy technicians. The combined skill mix of these pharmacists and technicians are supporting over one third of GP practices across Scotland. An outturn exercise will be completed shortly confirming the total recruitment figures over the three year period up to the end of March 2018.

The PCIP should set out a three year trajectory from April 2018 to April 2021, to establish a sustainable pharmacotherapy service which includes pharmacist and pharmacy technician support to the patients of every practice. Pharmacists and pharmacy technicians will become embedded members of core practice clinical teams and, while not employed directly by practices, the day-to-day work of pharmacists and pharmacy technicians, will be co-ordinated by practices and targeted at local clinical priorities. Implementation of the pharmacotherapy service will be led by Directors of Pharmacy during the three year trajectory period through the Pharmacotherapy Service Implementation Group.

Pharmacists and pharmacy technicians will take on responsibility for:

a) Core elements of the service, including: acute and repeat prescribing, medicines reconciliation, monitoring high risk medicines
b) Additional elements of the service, including: medication and polypharmacy reviews and specialist clinics (e.g. chronic pain)

By the end of the three year period, PCIPs should be able to demonstrate appropriate delivery of both the core and additional elements of the service in response to local needs.

There will be an increase in pharmacist training places to support this work.

<u>Chronic Medication Service</u>

In addition, PCIPs should also take into account the contribution of the Chronic Medication Service (CMS) available in all local community pharmacies, and ensure the appropriate links between the pharmacotherapy service and CMS are embedded to make best use of total capacity.

Under this centrally funded service, community pharmacists can carry out an annual medication review, as well as regular monitoring and feedback to the practice for patients registered for this service. Involving community pharmacists in the medication review of people with a stable long term condition will support pharmacists in GP practices and GPs to concentrate on more complex care. Making full use of the clinical capacity within community pharmacy can improve the pace and efficiency of delivery of the pharmacotherapy service in GP practices.

Other Centrally Funded Community Pharmacy Services

GP practice teams should also make full use of the other NHS services available through local community pharmacies as part of local triaging arrangements.

Community pharmacists can provide self-care advice on a range of common (uncomplicated) clinical conditions. Children, the elderly, people with medical exceptions, and those on low incomes can also make full use of the Minor Ailment Service (MAS). We will be looking to see how we can develop the MAS on a national basis, based on the outcomes of the extended MAS pilot in Inverclyde.

Smoking cessation support and sexual health advice (including access to Emergency Hormonal Contraception) are also available through the community pharmacy Public Health Service.

Pharmacy First

Also included in your 2018-19 funding allocation are monies to support the continuation of the Pharmacy First service introduced in community pharmacies across Scotland from winter 2017-18.

Linked to the MAS, Pharmacy First allows community pharmacists to treat uncomplicated urinary tract infections in women and impetigo in children without the need for a GP appointment or prescription, opening access to treatment both in and out-of-hours.

Taken together, the NHS Services available through the network of community pharmacies at both local and national levels builds on the role of pharmacists as part of the multidisciplinary team in primary care, making the best use of their clinical skills and providing convenient routes of access to appropriate primary care.

Service 3) Community Treatment and Care Services

High level deliverable: A service in every area, by 2021, starting with phlebotomy.

These services include, but are not limited to, basic disease data collection and biometrics (such as blood pressure), chronic disease monitoring, the management of minor injuries and dressings, phlebotomy, ear syringing, suture removal, and some types of minor surgery as locally determined as being appropriate.

Phlebotomy should be delivered as a priority in the first stage of the PCIP.

There will be a three year transition period to allow the responsibility for providing these services to pass from GP practices to IAs. By April 2021, these services will be commissioned by IAs, and delivered in collaboration with NHS Boards that will employ and manage appropriate nursing and healthcare assistant staff.

Community treatment and care services should be prioritised for use by primary care. They should also be available for secondary care referrals if they would otherwise have been workload for GPs (i.e. if such use means they are directly lifting workload from GPs). It is essential that the new funding in direct support of General Practice is only used to relieve workload from General Practice. Work from secondary care sources should be funded from other streams.

IAs should consider how this service might best be aligned with wider community treatment and care services used by secondary care.

Service 4) Urgent care (advanced practitioners)

High level deliverable: A sustainable advanced practitioner service for urgent unscheduled care as part of the practice or cluster based team, based on local needs and local service design.

The MoU sets out the benefits of utilising advanced practitioners to respond to urgent unscheduled care within primary care, including being the first response to a home visit or responding to urgent call outs, freeing up GPs to focus on their role as expert medical generalists. These practitioners will be available to assess and treat urgent or unscheduled care presentations and home visits within an agreed local model or system of care.

Where service models are sufficiently developed, advanced practitioners may also directly support GPs' expert medical generalist work by carrying out routine assessments and monitoring of chronic conditions for vulnerable patients at home, or living in care homes. These advanced practitioners may be advanced paramedics or advanced nurse practitioners. It is for the IAs, in collaboration with GP clusters, to determine the best provision for their locality.

By 2021, there should be a sustainable advanced practitioner provision in all IA areas, based on appropriate local service design.

Service 5) Additional Professional roles

High level deliverable: In most areas, the addition of new members of the MDT such as physiotherapists or mental health workers acting as the first point of contact.

By 2021 specialist professionals should be working within the local MDT to see patients as the first point of contact, as well as assessing, diagnosing and delivering treatment, as agreed with GPs and within an agreed model or system of care. Service configuration may vary dependent upon local geography, demographics and demand.

Physiotherapy services focused on musculoskeletal conditions

IAs may wish to develop models to embed a musculoskeletal service within practice teams to support practice workload. In order to provide a realistic alternative for patients, access times must be comparable to those of general practice. Priority for the service, such as focusing on elderly care, will be determined by local needs as part of the PCIP.

Mental health

As indicated in last year's letter, the Mental Health Strategy 2017-27[17] commits to action 23, "test and evaluate the most effective and sustainable models of supporting mental health in primary care, by 2019". It describes the primary care transformation that will improve this - up skilling of all Primary Care team members on mental health issues, the roles of clinical and non-clinical staff, and the increased involvement of patients in their own care and treatment through better information and technology use.

In previous years, nearly £10m was invested via the Primary Care Mental Health Fund (PCMHF) to encourage the development of new models of care to ensure that people with mental health problems get the right treatment, in the right place, at the right time. In 2018-19, further mental health funding is included within the £45.750 million for IAs, and Primary Care Improvement Plans must demonstrate how this is being used to re-design primary care services through a multi-disciplinary approach, in conjunction with how other mental health allocations are being managed (including that of Action 15 within the Mental Health Strategy).

Action 15 of the Mental Health Strategy 2017-2027 is to increase the workforce to give access to dedicated mental health professionals to all A&Es, all GP practices, every police station custody suite, and to our prisons. Over the next 5 years we have committed to additional investment which will rise to £35 million in the final year for 800 additional mental health workers in those key settings. The first tranche of funding for Action 15 is set at £11 million in 2018-19. Following detailed consideration of this matter by the Health and Justice Collaboration Improvement Board, a separate letter will be issued to you regarding funding for Action 15, which should be read in conjunction with this letter. It will include a requirement to count

[17] http://www.gov.scot/Publications/2017/03/1750

and monitor the number of additional mental health workers needed to deliver this commitment.

Others

A link could be made, if wished, with community pharmacy as part of Pharmacy First and in support of the GP Sustainability report actions.

Service 6) Community Link Workers

High level deliverable: Non-clinical staff, totalling at least 250 nationally, supporting patients who need it, starting with those in deprived areas.

Community link workers are based in or aligned to a GP practice or cluster and work directly with patients to help them navigate and engage with wider services, often serving a socio-economically deprived community or assisting patients who need support because of (for example) the complexity of their conditions, rurality, or a need for assistance with welfare issues.

As part their PCIP, IAs should assess local need and develop link worker roles in every area, in line with the Scottish Government's manifesto commitment to deliver 250 link workers over the life of the Parliament. The roles of the link workers will be consistent with assessed local need and priorities, and function as part of the local models/systems of care and support. However, the primary intention of this work is to act as one of the ways in which local systems can tackle health inequalities, and therefore the expectation is that the first priority for link workers will be more deprived areas.

It is essential that IAs work together to ensure that they have identified a **national trajectory towards 250 additionally-provided staff** (which could include upskilled staff or those receiving new contracts) by the end of the period. It will be for the national Oversight Group to maintain oversight of this national trajectory.

The 53 'early adopter' link workers who are already in post in areas of higher socio-economic deprivation are the foundation of the build-up towards 250, and continuation of these posts should be considered to be a priority. It is, however, entirely for IAs to decide whether any changes to the scope, oversight, employer or lead responsibility for these posts are required in the light of emerging learning and the developing PCIPs.

The 'early adopter' posts were not initially distributed on an NRAC basis, so Health Boards and IAs should, where necessary, work collaboratively within their area to jointly resource early adopter link workers. This is also the case for additional link workers that may in future be specifically jointly targeted by IAs on areas of the highest deprivation within a Health Board.

This joint working in support of the overall commitment to link workers can be reflected in PCIPs for all the IAs concerned, and will be welcomed.

Such a joint approach should be considered especially where it is considered that continuation of the early adopter service in an IA could disproportionately impact on funding available in that IA for other activities under the MoU.

Support for this work is available to IAs from ScotPHN (Kate Burton) who can support IA work to develop and implement the role of link workers during 2018-19; and from NHS Health Scotland on the development of local evaluation and learning.

ANNEX F

END YEAR REPORT

We would be grateful for a high level report on spend, impact and plans for any carry forward for your overall spending from the Primary Care Transformation Fund in 2017-18. This should include a high level breakdown of the outcomes achieved in 2017-18 across in hours, out of hours and mental health funded by your 2017-18 Primary Care Transformation Fund allocation. When responding, it would also be helpful if this could also include an explanation of how any underspend from 2016-17 that your Integration Authorities were able to carry forward into 2017-18 was spent.

A template for your use is below.

Test of Change Summary Table		
IA Name		
Primary Care Outcome[18]	*Select from the table of primary care outcomes that best fits your test of change*	
Primary Care Outcome	*add a secondary outcome if appropriate.*	
Section 1: 2017-18 actual spend		
Funding allocated to this test of change in 2017-18		£
High level breakdown of actual spend incurred:		
Actual spend		£
Total underspend carried forward to 2018-19		£
Plans for use of the underspend in support of Primary Care Improvement Plans:		
Impact & key learning points:		

[18] Primary Care Outcomes:

1 We are more informed and empowered when using primary care

2 Our primary care services better contribute to improving population health

3 Our experience as patients in primary care is enhanced

4 Our primary care workforce is expanded, more integrated and better co-ordinated with community and secondary care

5 Our primary care infrastructure – physical and digital – is improved

6 Primary care better addresses health inequalities

Appendix 9

ANNEX G

OUTLINE 2018-19 INTEGRATION AUTHORITY FINANCIAL REPORTING TEMPLATE, DUE FOR RETURN BY SEPTEMBER 2018

IA area

Confirmation that PCIP, agreed with the local GP Subcommittee of the Area Medical Committee, is **in place (date submitted)**

Summary of agreed spending breakdown for 2018-19 by service area, with anticipated monthly phasing

Actual spending to date against profile, by month, by service area

Remaining spend to end 2018-19, by month, by service area

Projected under/ over spend by end 2018-19

Is it expected that the full second tranche will be required in 2018-19?

Please return to:

Laura Cregan
Primary Care Division
1ER, St Andrew's House, Regent Road, Edinburgh EH1 3DG

Or by email to:
Laura.cregan@gov.scot