Edinburgh Integration Joint Board

REPORT

Primary Care Improvement Plan (PCIP) 6.0 Tracker Submission

Edinburgh Integration Joint Board

8 August 2023

Executive Summary	This report updates progress and should be read together with the 'tracker' (appendix 1) which was submitted to Scottish Government as part of the governance process for PCIP funding (by 12.5.23) and following agreement through the Lothian GP Sub Committee/LMC (24.4.23). The EIJB Performance & Development Committee approved submission (12.4.23) in lieu of the IJB.

Recommendations	It is recommended that the **Edinburgh Integration Joint Board:** 1. Note this summary of progress and associated issues as of March 2023 and the end of the PCIP investment period 2. Note a new requirement for this (6.0) tracker to be agreed by the NHS Lothian Chief Executive. 3. Recognise the disconnect between population growth and PCIP share and consider how this should be pursued. 4. Consider the merit of an annual comprehensive IJB report and brief on Primary Care, following the end of the PCIP investment period.

Directions

Direction to City of Edinburgh Council, NHS Lothian or both organisations		✓
	No direction required	x
	Issue a direction to City of Edinburgh Council	
	Issue a direction to NHS Lothian	
	Issue a direction to City of Edinburgh Council and NHS Lothian	

Report Circulation

5. EHSCP Performance and Development Committee (12.4.23)
6. EHSCP EMT (13.4.23)
7. Primary Care Leadership & Resources Group (28.4.23)
8. NHS Lothian EMT (tbc)
9. Lothian GP Sub Committee / LMC (24.4.23)

Main Report

Background

10. 'Trackers' of PCIP progress are required by Scottish Government each 6 months. This offers the opportunity to review progress internally and consolidate into a single summary report. The last comprehensive review of both PCIP and the associated 'Transformation' of Primary Care in Edinburgh, can be found in the August 2021 submission.

11. One intention of the PCIP reporting, has been to inject some optimism into Primary Care in Edinburgh and build ownership; that despite all the challenges we are making steady progress.

12. A host of other non-PCIP support is offered to practices by the Edinburgh Primary Care Support Team; support to Clinical Quality networks, grants to improve the application of technology, support for 'clinical admin' etc. This report references some of these but concentrates on the PCIP fund.

13. Whilst the report demonstrates continued progress, we also rehearse the parallel message that the weight of population increase, relative lack of medical staff and pandemic workload 'hangover', continues to threaten to overwhelm several of our practices at any time.

14. In South-East Edinburgh several practices have had no choice but to close their lists formally, whilst many others effectively informally restrict access to registration as they cannot support all requests. We anticipate this situation becoming more pronounced in North-East Edinburgh during 2023. The removal

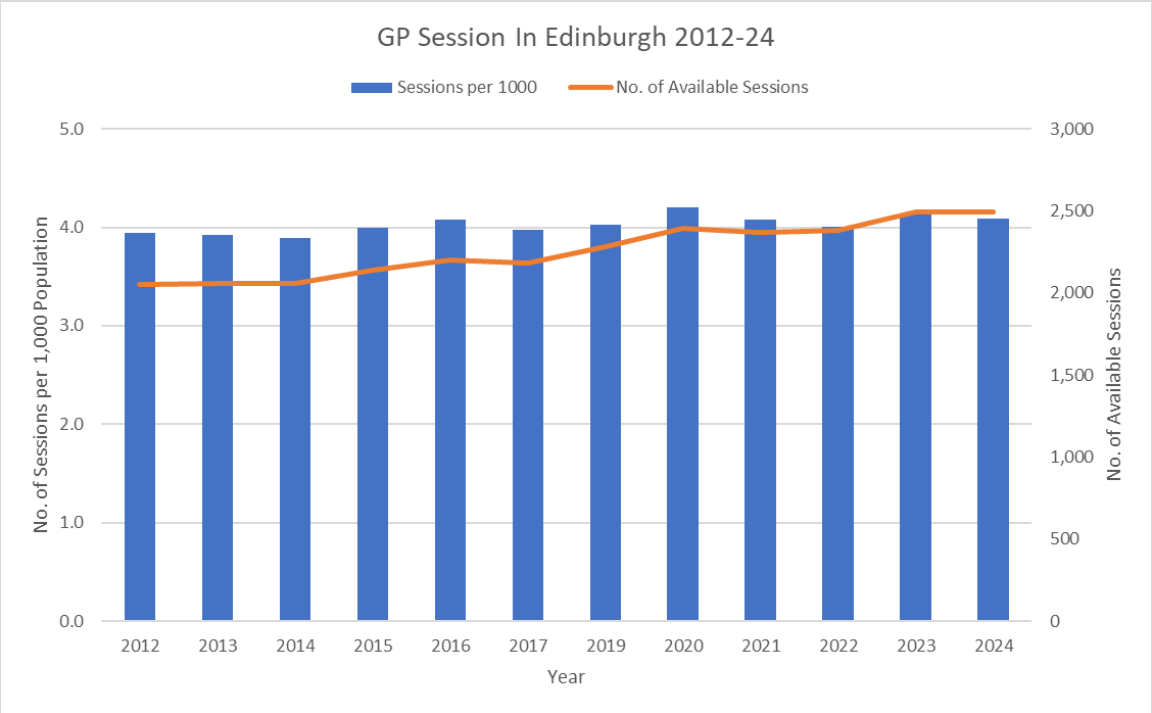
of ‘restricted’ status in 2021 has simply made this pressure less obvious. In reality, almost every Edinburgh practice needs to limit access to patients seeking to join their list.

15. In making this situation explicit, is important to acknowledge the flexibility and resilience of Edinburgh Primary Care in response to the population challenge. As of January 2023, c90,000 more patients were registered than in 2012 and we expect to confirm a GMS population of 600,000 in April this year.

16. This report comes at the end of the investment phase of the PCIP. £14.2M of PCIP funds have been committed, along with £2.9M of Transformation and Stability Funds and the reinvestment of c£1M of ex- 17C funding. We anticipate a further allocation of c£4.7M for Covid related vaccination. Application of this combined fund of £22.8M continues be reported to and guided by the Edinburgh Primary Care Leadership and Resources Group (L&R) as agreed by the EIJB.

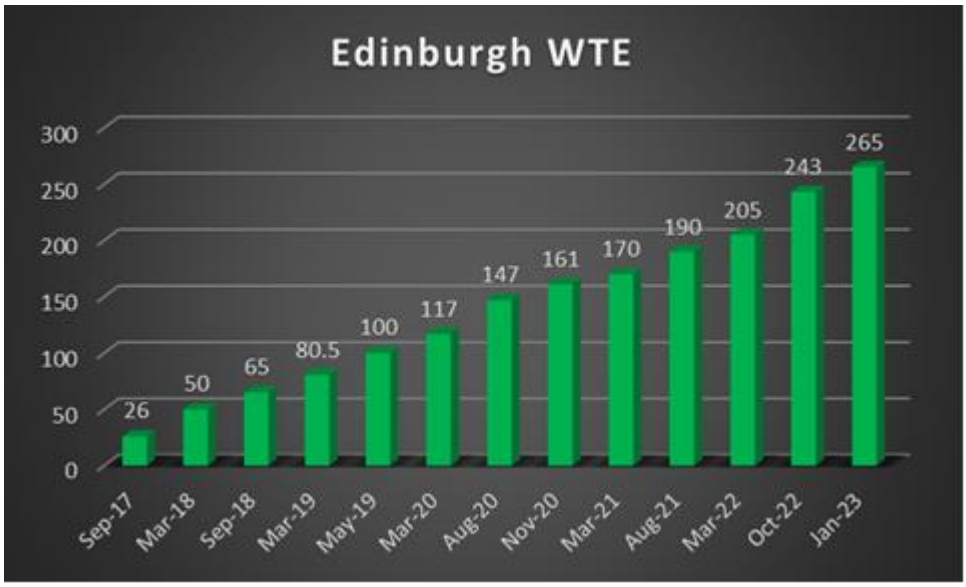
17. The workload challenge resulting from population increase and complexity was well established before the PCIP funding began to be invested in mid-2018. At the beginning of the investment period, Edinburgh HSCP estimated that c600 weekly sessions of additional medical capacity were required to re-establish stability and the PCIP funds were to be deployed to try to impact on this deficit. The additional workload and staffing challenges subsequently brought by the pandemic, are common to primary care across the world.

18. Figure 1 (below) shows the number of GP sessions available in Edinburgh (using a consistent sessional yield of 6 sessions per GP on the Performers List.



The blue columns demonstrate a relatively stable picture despite population building, with c2500 medical sessions available to the City per week, or 4 per 1000 people. The brown line shows the absolute number building, as we continue to attract more GPs and build the GP Performers List. Whilst this is a much more positive picture than in many primary care systems across the UK, it demonstrates that the ratio of GPs to population has been unable to get beyond 4 sessions per 1000, when it should be nearer 5.

19. PCIP Staffing progress (Figure 2)



As can be seen in Figure 2 the PCIP staffing continues to grow steadily, although vacancies reduce these numbers by 10-15% at any time. The number will increase to c300wte, excluding the (non PCIP) vaccination workforce. The removal of the underspend now limits flexibility round opportunistic appointments and has made workforce planning more restrictive.

20. The previous report anticipated two further developments which would give the potential to add capacity to the combined impact of PCIP + Transformation and Stability (T&S) Fund + 17C reinvestment.

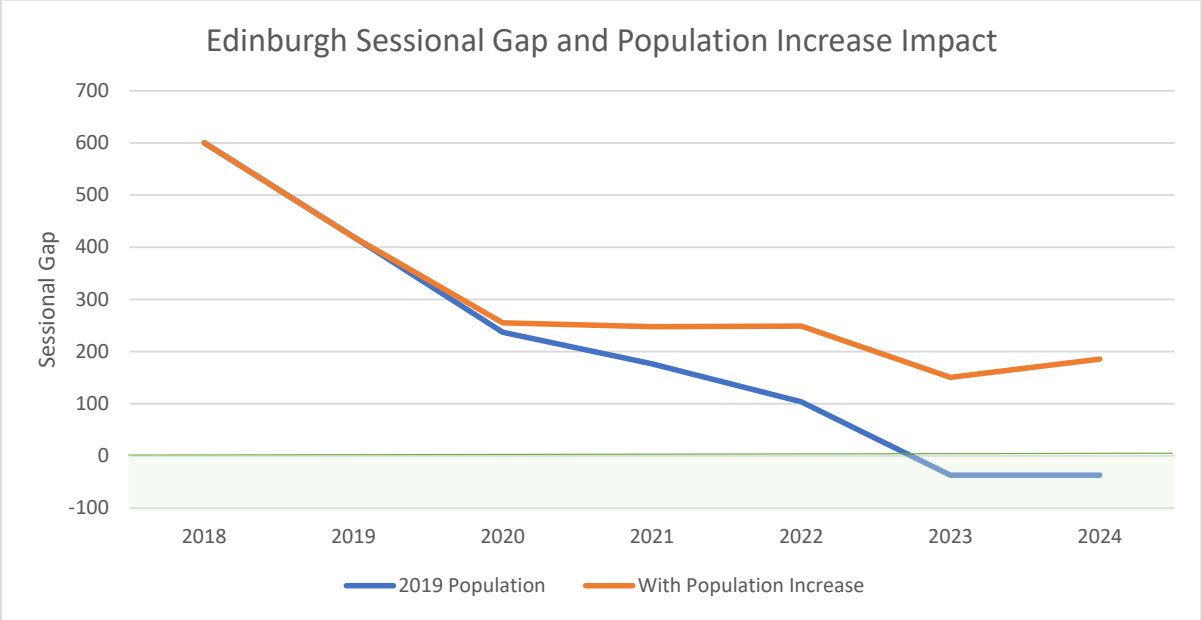
- Vaccination Workforce; as this settles, a net benefit to Community Treatment and Care (CTAC) workforce for the periods between the spring booster and winter flu/covid campaigns, is now within reach.

- Secondly, the anticipated funding for the Primary Care Mental Health & Wellbeing Teams (PCMHWBTs) has not materialised and is not anticipated during 2023/4. This has caused understandable frustration and significant difficulty in terms of capacity across primary care, as the greatest reported increase demand comes from distress and anxiety.

<u>Aspiration vs Delivery</u>

21. In 2018 the Edinburgh IJB considered and supported the first Edinburgh PCIP. An important, if financially modest, investment in evaluation of the PCIP was supported as part of our plan. This resource has proved invaluable. Figure 3 (below) shows the impact of PCIP capacity with and without population increase. The blue line shows the impact of additional PCIP resource on closing the estimated clinical (medical) sessional gap, based on population remaining stable since 2019. The brown line demonstrates the same impact after accounting for the actual 50k population increase since 2018. In short, the undoubted impact of the growing and increasingly effective PCIP workforce, has been materially diluted by population increase.

22. Figure 3 Impact of PCIP in Medical Session Equivalents



23. As was seen in Figure 2, we have almost reached the point where we have appointed all the staff we are funded for. We anticipated a recurring underspend on these staff of c£1M and have agreed that this funding is recycled through our Transformation and Stability (T&S) fund to be able to be paid directly to practices for phlebotomy. In turn, this satisfies one of the expectations of the New Contract where phlebotomy was to be delivered by CTACs. It was recognised that to support CTACs to do this would require a very resource intensive and expensive service to be established. To illustrate,

we estimated that we could deliver phlebotomy at c£9 per episode, where practices could do this for c£3 per episode. Practices can very economically, provide almost 1000hrs additional capacity per week, or an average of 14hrs per practice a week.

24. The easiest way to understand the average picture for Edinburgh practices, is that they now have an 'allocation' of c1.0wte PCIP resource per 2500 patients. The average Edinburgh practice of 8500 will have c3.5wte. Aa a rough guide, 0.7wte will be delivered outside the practice through vaccination and CTAC support and with another c2.5-3.0wte recognised as embedded members of the Multidisciplinary Team (MDT). If the practice had a 17C contract, they may have chosen to retain an element of direct funding as part of their PCIP allocation. Practices with high levels of deprivation are also augmented by 'core' Community Link Workers, who are not counted against their PCIP allocation.

25. Appendix 2 is a detailed spreadsheet which shows the benefit to each practice of the PCIP, retained ex-17C and T&S investments. This is essential for transparency and allows all practices sight of what benefit other practices are receiving. The spreadsheet results in regular and very welcome challenges from practices, seeking to understand if they have been disadvantaged or why some other practices have been advantaged.

26. Whilst we believe that there has been and continues to be a commitment to equity, we explicitly acknowledge those practices where we assess that they have been under or over resourced (shown in orange on Appendix 2). At next opportunity (ie staff movement) these investments will be adjusted in each practice.

27. Turnover of appointed staff and the training and support required for new MDT members has been referred to as 'turbulence' for the last couple of years, with the expectation that this would settle. The current situation is that this effect is no longer a significant factor outside pharmacotherapy and CTACs. With both, significant additional training is required for most new staff and the likelihood is

that relatively high turnover will continue (albeit less than the current rate). This may reasonably be considered as a symptom of service strength – although no less frustrating for a practice which has invested considerable effort with a new member of staff who then moves on.

28. For other groups of practice embedded staff, the experience is of more stability. This is testament to the efforts of our practices in welcoming the MDT staff into their teams and most consider their roles to be well appreciated and dynamic, with opportunity to evolve and innovate. We continue to maintain the clear commitment never to move embedded staff out of a practice to solve a problem elsewhere – unless we have the explicit agreement of the host practice.

29. Table 1 (below) gives an assessment of the equivalent sessional impact of all the PCIP investments. The assessment is a mix of objective evaluation such as the direct workload contribution of fully embedded physiotherapists, mental health nurses and ANPs, along with the more elusive estimates attached to pharmacotherapy and Link Workers. The final column estimates how much of the 'full benefit' we have had from these investments to date. Although this full benefit estimate is subjective, there is some substantiation available, such as our (2023) Evaluation Report on CTACs.

30. Table 1 Overall PCIP Impact Assessment

Staff Group	No. of WTE	No. of Weekly Appointments	Adjusted Sessional Equivalent Contribution Per Week (75%)	% of Delivery Achieved
ANP	26	1,872	90	80%
PA	5	350	13	80%
SAS AP	5	150	15	80%
MSK	19.1	764	57	90%
APP	1.2	46	5	95%
CTAC	23	782	31	50%
Mental Health	25	1,225	62	90%
Link Working	21.9	262	13	80%
Pharmacotherapy*	94.6	N/A	170	70%
Vaccination**	50	9,000	113	80%
Total	**270.8**	**14,451**	**568**	

***Assuming 60% of total to account for non-workload activity.**

****Assuming 5mins per patient for 450k annual vaccination population.**

31. The number of weekly appointments is an evaluation-based average based on staff being present and fully trained. The 'Adjusted Sessional Equivalent (ASE)' reduces this number by 25% to account for absence and staff inexperience, before converting to the equivalent number of medical sessions which would otherwise have been required to deliver the service. The ASE can be seen to apply differentially across the PCIP programs, but nevertheless provides us with an **estimate** of the extent to which the investments impact on workload. The real impact is of course much more nuanced and described by the individual evaluations.

32. Vaccination provides a good example. GPs and Practice Nurses will recall delivering flu vaccinations in intense one-off weekend clinics, where a single practitioner might deliver c150 in a day. This would no longer be possible with the consent, checks and information gathering required and GP/PNs would be obliged to work within this framework. With delivery of 9000 per week over the course of a year, this is therefore calculated as equivalent to 150 sessions of GP time. It should be noted that this ratio includes housebound and care home residents who would be much more time consuming than patients attending a practice clinic. The estimate of workload impact therefore combines both work **removed** (flu/pneumococcal/travel) and paid for by the PCIP, with work **diverted** (covid) from GMS and paid for with additional funds.

33. Pharmacotherapy has been a success in terms of the workforce building and increasingly being trained to make an impact on workload, clinical quality and safety. There is much more to be done with the development of hubs for 'Level 1' support and meeting our own target of 80-85% of qualified pharmacists being Independent Prescribers. Our evaluation cannot use weekly appointments but estimated that the average pharmacotherapy staff member in post contributes 3 sessions per week across the grades from technician to team leads. The average member of the pharmacotherapy team uses 20% of their capacity for non GMS delivery and the Team Lead's contribution is reduced by 50% to account for their other duties. The sessional contribution is therefore determined by staff in post less c5.0wte for team leads, x 3 for average

sessional contribution, x 0.8 for non-workload activity x 0.75 to account for leave and experience, giving c170 sessions per week as a realistic estimate of contribution.

34. Edinburgh did not embrace CTACs early in the process, but we have been building quickly to a recognisable network able to consistently remove a growing portion of the Practice Nursing workload. We undertook a review of current and anticipated contribution at the end of 2022. As a result of this, we are confident that activity can be increased significantly over 2023 as further capacity is put in place. Further assessment of the impact on Practice Nurses workload and consequent opportunity, is being considered.

35. Setting aside the complexity of reporting helpfully on each individual MOU area, the overall impact can be seen as an additional 15,000 patient appointments per week added to primary care capacity. If vaccination is removed and the remaining c6000 weekly appointments are adjusted for leave/training etc then the additional weekly capacity is reduced to c4500 appointments, reliably delivered by PCIP investment. The GP workforce is estimated to deliver c42,000 patient appointments per week, so we can reasonably estimate that we are augmenting GMS workload with c12% additional capacity. In addition, a considerable Covid Vaccination workload was deflected from Primary Care and we are using Transformation & Stability resources to promote clinical admin and to ensure the majority of phlebotomy is funded (amongst other investments).

36. As part of the tracker submission in mid-2022 we were asked what ‘full implementation’ would cost. We found this a very difficult question to establish consensus on. This is because the New GMS Contract (2018) ‘promised’ service and workload shifts which were out with either financial or operational reality. This is not a criticism of the New Contract, simply a reflection on what we have learnt during 4 years of implementation. We believe that without Edinburgh’s increasing population challenge, we could have credibly claimed to have effectively augmented more than c10-12% of workload. We assess that if

the resource were doubled, this could be increased to c20% and primary care would be re-stabilised, as well as being much more resilient into the future. This doubling would not however, deliver all of the New Contract potential, but would be an effective application of public funds.

37. The Government 'PCIP -Update and Next Steps' (31.3.23) proposes (Annex A) that we, 'make available sufficient staff to ensure that an adequate service continues to be available, including annual leave, sickness, parental leave etc.' This was specifically addressed in the 2019 Edinburgh consultation, where we highlighted the choice between putting as much resource out to practices as possible, or to retain c20% to provide cover. We have in place adequate non PCIP resource for our vaccination team to provide cover. In addition, partial cover is available for our pharmacotherapy hubs and CTACs. It is both financially out of reach and operationally almost impossible to provide cover provision for practice embedded staff. These staff work as an integrated (not discrete) and **embedded** part of the clinical team, and it is misleading to suggest that any arrangement can be put in place which allows their work to be regarded as separate. The risk is that work not undertaken by an absent PCIP staff member would not be picked up by the rest of the team, resulting in both backlogs and clinical risk. If more funding for MOU areas was available, it would remain difficult to deliver cover except for CTACs, vaccination and pharmacotherapy hubs.

<u>Where Next?</u>

38. The PCIP implementation process still has some way to go to reach a 'settled' picture where we assess that turnover is as low as it can be, the number of staff undergoing intense support and training is limited to c10%, and each of the services are well established and appropriately accessed.

39. The government has signalled the ultimate intention to issue enforceable directions for both CTACs and pharmacotherapy. We continue to voice our concerns over the associated risk of trying to impose a defined specification, on

service investments made at a point in the PCIP implementation where local variation was emphasised.

40. Whilst work on establishing a 'settled picture' continues, our evaluation focus has begun to turn attention to the benefits of certain PCIP staff offering an increasingly connected service between them. We have already seen elements of this with GPs/Mental Health Nurses/Pharmacists/Link Workers, co-ordinating their response to demand.

41. This work will inform our aspiration to develop 'enhanced Primary Care Expansion Teams (CETs)' attached to certain practices. CETs have been proposed to help us to absorb more population in the absence of any commensurate investment in the primary care premises required for our growing population. Like our 'LEGUPs' and extensive small and intermediate premises schemes, these should be seen as buying us more time, rather than solutions in themselves. At time of writing, we understand that the current 'pause' in capital investment available from government to support population expansion could last 3 years. A separate report (Edinburgh Population Growth and Primary Care Premises Assessment 2022-2030) made clear the requirement for urgent and substantial investment.

42. The additional outstanding investment into mental health remains a critical gap in capacity, which would make a huge difference to both medical workload and to the experience of those who need support. The foundations for this were laid in 2022 and not to capitalise on this momentum would be a huge opportunity missed.

Implications for Edinburgh Integration Joint Board

Financial

43. During 2022 an important issue was the application of the underspend. Early conversations with Scottish Government about whether a proportion of the underspend could be applied more widely to support primary care and over an

extended timescale, were abruptly stopped as the wider funding predicament facing public services became clearer. Edinburgh, like other HSCPs, was obliged to forfeit accumulated underspend (c£5M) which could have helped to support the continued transformation, allow us to develop further ways to cope with additional population and ensure stability. Nevertheless, subsequent conversations confirmed support for Distress Brief Intervention (DBI) to be developed over 2022/3 & 2023/4 with the expectation of PCMHWBT funding becoming available at some future date.

44. Appendix 1 reports our 2022/23 out-turn against the £14.7M available (Including 22/23 Pay Award); £13.5M giving a surplus of £1.2M. We have agreed that £680k of this will be carried into 2023/24 for investment currently ear marked for DBI. The remaining £520K will be retained for (non-recurring) core PCIP investment, on top of the full 2023/24 PCIP allocation.

    It should be noted that this £1.2M carry forward should be uplifted for 2023/24 costs in due course.

    This retained flexibility will be vital to allow us to support population increase in 2023/24, whilst recurring adjustments are agreed.

Risk implications

45. The risk associated with PCIP implementation is that it is insufficient to prevent the recurrence of instability in medical practices across the City, as experienced most acutely in the period 2015-18. This risk remains at ‘severe’ on the HSCP and NHS Lothian corporate risk registers. Previous experience of instability clearly showed the direct links between struggling practices and increased prescribing costs and increased admissions to hospital.

46. The issue of population increase has materially diluted the impact which the PCIP investment in Edinburgh would otherwise have made. A resource which was agreed for a population of c550,000 (GMS list size) is now spread across 600,000. This means a reduction of impact of almost 10%.

47. This reduction manifests in 2 obvious ways. Firstly, as a practice grows its list to try to accommodate all the patient demand in the area, they naturally wish to see their PCIP allocation grow at a rate of an additional 0.5wte per 1000-1500 more patients. Secondly, there are many practices which cannot grow their list and need to direct new people to the city to another practice with capacity. To establish 4 practices in the city with this extra capacity, we need to be able to establish strengthened PCIP teams for these practices.

48. A separate paper has been developed, 'Fair Shares for a Growing Population', which addresses the disconnect between population increase and our proportion of the national PCIP allocation.

49. The potential introduction of directions on two of the MOU areas; Pharmacotherapy and CTACs, risks the constructive relationship with local GPs being eroded from one which makes the best possible use of the resources available, to the HSCP being held accountable by GPs for the undeliverable.

Final Comment

50. The PCIP investment and associated transformation process is not yet over, and the Government has hinted at additional PCIP resources. The whole process has undoubtedly been successful and shown that the careful embedding of other clinicians into primary care teams can add both capacity and expertise, without adding the burden of direct management and responsibility of further employed staff. The starting point for the first PCIP plan in 2018 was one of crisis and widespread service risk. The implementation period then had to absorb the additional strains of the pandemic and is still absorbing the aftershocks. That could not be foreseen nor avoided. What can be foreseen and avoided, is that Edinburgh's population is growing steadily and both PCIP and premises resources are being diluted by funding arrangements which are not sufficiently sensitive to this context.

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Background Reports

1. EHSCP 2019 Consultation on equity of distribution of PCIP funds. EHSCP 2019 Consultation on equity of distribution of PCIP funds.pdf

Appendices

Appendix1 Edinburgh PCIP 6 Tracker (Password 171078)

Appendix 2 Edinburgh PCIP, TS & 17C Investment

Appendix 3 Acronyms

PCIP 6 - Local Implementation Tracker Guidance

Purpose of Tracker

We are collecting information about the primary care workforce funded through the Primary Care Improvement Fund (PCIF) and other funding streams, and the activity which is being delivered by these staff. We are also collecting financial information relating to your Primary Care Improvement Plan (PCIP). These trackers have been combined in order to simplify the process.

What information is manadatory/voluntary?

Please note that all information is mandatory at this time. We are using the following colour scheme:

Orange cells are required to be completed.

Grey cells are for guidance or are automatically populated

Returning the template

The template should be completed and returned via eRDM connect. Those requiring access to eRDM connect should email julia.vanaart@gov.scot and instructions will be provided on the site on how to download and return the template.

Trackers should be returned by **12th May.**

If you have any accessibility issues with filling out the tracker, please get in touch.

Guidance for completing the form - general

To help you fill out these trackers, we have scheduled support sessions on 13th April and 20th April. As part of these sessions we will talk you through the tracker, and you will be able to ask questions. We will circulate the slides for those who can't make it to these sessions.

Guidance for completing the form - definitions and detailed guidance

More detailed guidance is available in a word document also on eRDM connect. Please read this document before completing the tracker.

PCIP 6

Health Board Area:	NHS Lothian
Health & Social Care Partnership:	Edinburgh City
Total number of practices (overwrite if neccesary):	70

MOU PRIORITIES

2.1 Pharmacotherapy	**Practices with access to service by 31/3/23 (overwrite if neccesary)**
Level 1: Authorise/action acute prescribing requests	60
Level 1: Authorise/action repeat prescribing requests	50
Level 1: Authorise/action hospital discharge letters/outpatient requests	68
Level 1: Other	6
Level 2: Medication review (more than 5 medicines)	58
Level 2: other	50
Level 3: poly pharmacy reviews and specialist clinics	58
Level 3: other	0

What type of model are you running this service with? GP embedded or hub based etc.
Mixture of GP embedded and Hub
How many practices have no access to any of the subservices listed?
0
Please provide an estimate of the percentage of the population that has no access to any of the subservices listed.
0
Please provide a (rough) estimate of the percentage of Pharmacotherapy activity that is funded through PCIP.
1
If responded "other model" being used to run this service, please provide more details here.

2.2 Community Treatment and Care Services	**Practices with access to service by 31/3/23 (overwrite if neccesary)**	**Total weekly appointment capacity (based on your current workforce), PCIF and non-PCIF funded.**	**Total current number of appointments taken up (activity) in a typical week, PCIF and non-PCIF funded.**	**Standard/average appointment time (in minutes), on which activity numbers are based.**
General Practice phlebotomy	70	4500	4500	10
Chronic Disease Monitoring	0			
CTAC treatment services including but not limited to ear syringing, suture removal etc	56	925	825	20

What type of model are you running this service with? GP embedded or hub based etc.
Mixture of GP embedded and Hub
How many practices have no access to any of the subservices listed?
0
Please provide an estimate of the percentage of the population that has no access to any of the subservices listed.
>0% - 25%
Please provide a (rough) estimate of the percentage of Community Treatment and Care Services that are funded through PCIP.
>50% - 75%
What adjustment factor did you use to calculate your appointment capacity? (The adjustment factor is the percentage of capacity at 100% workforce availability anticipated to be lost through leave.)
22%
Please provide further details on the source and methodology used for capacity and activity data - see guidance document for more information.
CTAC capacity and activity data captured via local activity dashboard.

2.3 Vaccine Transformation Program	**Practices with access to service by 31/3/23 (overwrite if neccesary)**
Pre School - Practices covered by service	70
School age - Practices covered by service	70
Out of Schedule - Practices covered by service	70
Adult imms - Practices covered by service	70
Adult flu - Practices covered by service	70
Pregnancy - Practices covered by service	70
Travel - Practices covered by service	70

What type of model are you running this service with? GP embedded or hub based etc.
Hub
How many practices have no access to any of the subservices listed?
0
Please provide an estimate of the percentage of the population that has no access to any of the subservices listed.
0
Please provide a (rough) estimate of the percentage of the Vaccine Transformation Program that is funded through PCIP.
>0% - 25%
If responded "other model" being used to run this service, please provide more details here.

2.4 Urgent Care Services	**Practices with access to service by 31/3/23 (overwrite if neccesary)**	**Weekly appointment capacity (based on your current workforce), PCIF and non-PCIF funded.**	**Current weekly appointment activity, PCIF and non-PCIF funded.**	**Standard/average appointment time (in minutes), on which activity numbers are based.**
In-practice	32	1600	1310	15
External appointments e.g. house visits or care homes	10	180	150	30

What type of model are you running this service with? GP embedded or hub based etc.
GP embedded
How many practices have no access to any of the subservices listed?
38
Please provide an estimate of the percentage of the population that has no access to any of the subservices listed.
>50% - 75%
Please provide a (rough) estimate of the percentage of Urgent Care Services that are funded through PCIP.
1
What adjustment factor did you use to calculate your appointment capacity? (The adjustment factor is the percentage of capacity at 100% workforce availability anticipated to be lost through leave.)
22%
Please provide further details on the source and methodology used for capacity and activity data - see guidance document for more information.
Urgent Care represents ANPs, NPs, Physician Associate and Paramedic. Capacity and activity data captured through local, multi-source evaluation conducted in 2022. Data was collated via manual audit as well as Practice Data Systems, with approach tailored based on the

Additional professional services

2.5 Physiotherapy / MSK	**Practices with access to service by 31/3/23 (overwrite if neccesary)**	**Weekly appointment capacity (based on your current workforce), PCIF and non-PCIF funded.**	**Current weekly appointment activity, PCIF and non-PCIF funded.**	**Standard/average appointment time (in minutes), on which activity numbers are based.**
Practices accessing APP	32	650	550	20

What type of model are you running this service with? GP embedded or hub based etc.
GP embedded
Please provide an estimate of the percentage of the population that has no access to APP.
>50% - 75%
Please provide a (rough) estimate of the percentage of Physiotherapy/MSK that is funded through PCIP.
1
What adjustment factor did you use to calculate your appointment capacity? (The adjustment factor is the percentage of capacity at 100% workforce availability anticipated to be lost through leave.)
22%
Please provide further details on the source and methodology used for capacity and activity data - see guidance document for more information.
Capcity and activity data collected via monthly activity audit returns from APPs.

2.6 Mental health workers	**Practices with access to service by 31/3/23 (overwrite if neccesary)**	**Weekly appointment capacity (based on your current workforce), PCIF and non-PCIF funded.**	**Current weekly appointment activity, PCIF and non-PCIF funded.**	**Standard/average appointment time (in minutes), on which activity numbers are based.**
Practices accessing MH workers / support	23	1134	1000	20

What type of model are you running this service with? GP embedded or hub based etc.
GP embedded
Please provide an estimate of the percentage of the population that has no access to MH workers / support through PCIP.
>50% - 75%
Please provide a (rough) estimate of the percentage of Mental Health Workers that are funded through PCIP.
1
What adjustment factor did you use to calculate your appointment capacity? (The adjustment factor is the percentage of capacity at 100% workforce availability anticipated to be lost through leave.)
22%
Please provide further details on the source and methodology used for capacity and activity data - see guidance document for more information.
Capacity based on standardised rotas used by MH staff, adjusted for leave. Activity based on capacity, adjusted for DNA, cancellation etc.

2.7 Community Links Workers	**Practices with access to service by 31/3/23 (overwrite if neccesary)**	**Weekly appointment capacity (based on your current workforce), PCIF and non-PCIF funded.**	**Current weekly appointment activity, PCIF and non-PCIF funded.**	**Standard/average appointment time (in minutes), on which activity numbers are based.**
Practices accessing Link workers	44	334	250	60

What type of model are you running this service with? GP embedded or hub based etc.
GP embedded
Please provide an estimate of the percentage of the population that has no access to Link workers.
>25% - 50%
Please provide a (rough) estimate of the percentage of Community Links Workers that are funded through PCIP.
1
What adjustment factor did you use to calculate your appointment capacity? (The adjustment factor is the percentage of capacity at 100% workforce availability anticipated to be lost through leave.)
22%
Please provide further details on the source and methodology used for capacity and activity data - see guidance document for more information.
Data taken from CLW Annual Report - data collated via audit returns from CLWs.

2.8 Other - please provide details in the description box below	**Practices with access to service by 31/3/23 (overwrite if neccesary)**	**Weekly appointment capacity (based on your current workforce), PCIF and non-PCIF funded.**	**Current weekly appointment activity, PCIF and non-PCIF funded.**	**Standard/average appointment time (in minutes), on which activity numbers are based.**
Other	70			

Please provide a (rough) estimate of the percentage of Other services that are funded through PCIP.
0
What adjustment factor did you use to calculate your appointment capacity? (The adjustment factor is the percentage of capacity at 100% workforce availability anticipated to be lost through leave.)
Please provide further details on the source and methodology used for capacity and activity data - see guidance document for more information.
Clinical Admin c20wte

Workforce profile

Health Board Area:	NHS Lothian
Health & Social Care Partnership:	Edinburgh City

Table x: Workforce profile (WTE)

Funding category	Financial Year - **Please overwrite data if neccesary**	Service 2: Pharmacotherapy			Service 1: Vaccinations			Service 3: Community Treatment and Care Services			Service 4: Urgent Care (advanced practitioners)			Service 5: Additional professional roles			Service 6: Community link workers
		Pharmacist	Pharmacy Technician	Pharmacotherapy Assistant / Other Pharmacy Support Staff	Nursing	Healthcare Assistants	Other [a]	Nursing	Healthcare Assistants	Other [a]	ANPs	Advanced Paramedics	Other [a]	Mental Health workers	MSK Physios	Other [a]	
WTE staff funded through PCIF	**In post at 31 March 2022**	73.9	31.1	0	9	0	0	14.6	5.3	4.5	26.3	5	6	23	16	0	22.4
	In post at 31 March 2023	71.65	33	2	9	0	0	24	4.29	5.2	24.49	5	5	26.09	21.77	0	24.7
	FORECAST: In post at 31 March 2024 [b]	72.6	37	2	9	0	0	25.5	16.29	6.2	26.99	5.46	6	28.09	21.77		24.7
WTE staff <u>not funded through PCIF</u>	**In post at 31 March 2022**	1	0	0	16	23	20	0	0.6	0	2.7	1	0	0	0	0	0
	In post at 31 March 2023	2	0	0	15	23	17	0	0.6	0	3.12	1	0	0	0	0	0
	FOPRECAST: In post at 31 March 2024 [b]	2	0	0	21.5	23	16	0	0.6	0	3.12	1	0	0	1	0	0

[a] please specify workforce types in the comment field
[b] If planned number cannot be estimated, add n/a
[c] please provide more details in the comment field

Comment:Vaccination workforce supported with an extra c20wte in peak time. Vaccinations Programme is delivered via Edinburgh Primary Care Support Team Management (Scottish Government funding for the Vaccination programme, CTAC Team, NHS Lothian Travel Clinic, Practice Nurses through Staff Bank, Midwives, School Nurses & Health visitors).

Key:	IAs need to input to all orange shaded cells	These are Cells D17:E30, G17:G30, G36, F43:F56
	Grey cells are calculated cells - no input required	

Integration Authority:	Edinburgh City
NHS Board Area:	Lothian
Total PCIF 2022-23 (£000):	£14,192

1. Expenditure Forecast 2022-23

All values are in £000s

PCIF programme:	Category	Actual YTD Spend £000s at 31 October 2022 — Total YTD costs (1)	Actual Spend to the year-end £000s 1 November 2022 to 31 March 2023 — Total Actual Costs (2) - Overwrite if neccesary	Total Spend 2022-23 £000s — Total Costs 2022-23	PCIF AfC uplift costs agreed with Health Boards (3)	Brief Description of Funded Activities (4):
Vaccination Transfer Programme	Staff costs	467	23	490	0	(pre-school programme, school-based programme, travel vaccinations and travel health advice, influenza programme cohort as at 2018, at risk and age group
	Non-staff costs	0	0	0	0	0
Pharmacotherapy services	Staff costs	2,598	2,305	4,903	237,908	The PCIP share of the fund will only allow for 79wte but Edinburgh will recruit up to 112wte relying on at least 10% staff turnover so Pharmacotherapy budget c£6.75m.
	Non-staff costs	0	0	0	0	0
Community Treatment and Care Services	Staff costs	547	659	1,206	49,951	36wte CTAC + 12 HCA Domiciliary Phlebotomy + £775k (c25wte) Phlebotomy; Edinburgh will have a multi CTACs to support the City practices with 1. Complex
	Non-staff costs	0	0	0	0	0
Urgent care services	Staff costs	775	1,021	1,796	68,502	c42.50wte ANPs, SPP or Physician Associate (Includes 4wte Vacancies). Responsible for providing a level of support to practices on urgent care.
	Non-staff costs	0	0	0	0	0
Additional Professional Roles (including MSK physiotherapists and mental health)	Staff costs	1,196	1,252	2,448	113,690	MSK 21.77wte & Mental Health 28.09wte (Includes 2wte Vacancies). Responsible for providing a level of support to practices.
	Non-staff costs	0	0	0	0	0
Community Link Workers	Staff costs	720	648	1,368	8,188	16.90wte National Programme & 7.80wte PCIP. Responsible for providing a level of support to practices.
	Non-staff costs	0	0	0	0	0
Other - **please provide detail in Description box**	Staff costs	141	586	727	0	Support: £690,000 per annum: ANP Training / Phlebotomy, Technology, Practice Support and Clinical Management & Evaluation. 2018/2019: £540,907, 2019/2020:
	Non-staff costs	0	0	0	0	0
Total Expenditure		6,444	6,494	12,938		

2. Legal commitments and reserve position	Value in £000s
Forecast PCIF reserve position at 31 March 2023 (5)	£1,198
Actual spend on legal commitments agreed with SG in 2022/23 (6)	£156,000
Forecast spend on legal commitments agreed with SG for future years (7)	£680,000

3. Three year spend summary

All figures in £000s

PCIF programme:	Category	2021-22 outturn — Total	2022-23 outturn — Total	2023-24 forecast (8) — Total
Vaccination Transfer Programme	Staff costs	401	490	**1,000**
Pharmacotherapy services	Staff costs	3,290	4,903	**4,700**
	Non-staff costs	100	0	**0**
Community Treatment and Care Services	Staff costs	600	1,206	**2,004**
	Non-staff costs	91	0	**340**
Urgent care services	Staff costs	1,301	1,796	**2,552**
	Non-staff costs	37	0	**0**
Additional Professional Roles (including MSK physiotherapists and mental health)	Staff costs	1,550	2,448	**3,115**
	Non-staff costs	46	0	**0**
Community Link Workers	Staff costs	1,158	1,368	**1,336**
	Non-staff costs	100	0	**0**
Other - **please provide detail in Description box**	Staff costs	N/A	727	**350**
	Non-staff costs	N/A	0	
Total Expenditure		**8,709**	**12,938**	**15,397**

NB: Figures shown for Ayrshire and Arran, and Forth Valley are aggregated by Board and not broken down by HSCP.

Please provide any additional comments on your forecast 2023-24 spend below (9);

The 2023/24 Budget is based on Edinburgh share of the national £170m and as of 2022/23 staff cost. The above budget is not to deliver the MOU2 100%. For example, Edinburgh PCIP share of the fund and after committing c 45% on non MOU2. Edinburgh can only afford for 79wte in Pharmacotherapy however will recruit up to 112wte relying on at least 10% staff turnover across the workforce and other funding streams, by this Pharmacotherapy budget c£6.75m. The latter will only support the Management of 33% of the acute and repeat prescriptions, medicines reconciliation, performing polypharmacy reviews and serial prescribing.
The Scottish Government Vaccination Programme Fund will support the PCIF and ensure at least 90% of the Vaccination & agreed local CTAC services to be delivered
Please note that all costing based on 2022/23 Pay scale

MoU implementation profile

Health Board Area:	NHS Lothian
Health & Social Care Partnership:	Edinburgh City

Table x: Intended workforce (WTE)
Service intentions (based on staffing complement required to deliver against each of the MoU services as defined in section 7 the guidance).

Funding category	Service 2: Pharmacotherapy			Service 1: Vaccinations			Service 3: Community Treatment and Care		
	Pharmacist	Pharmacy Technician	Pharmacotherapy Assistant / Other Pharmacy Support Staff	Nursing	Healthcare Assistants	Other [a]	Nursing	Healthcare Assistants	Other [a]
WTE Service intentions funded through PCIF	97	92	2	9	0	0	34	21	11
WTE Service intentions not funded through PCIF	0	0	0	41.5	23	16	0	0	0

[a] please specify workforce types in the comment field

Comment:

Cost to deliver service intentions (based on staffing complement required to deliver against each of the MoU services as defined in section 7 the guidance).
All figures in £000s

PCIF programme:	**Category**	**Total - Overwrite if neccesary**
Vaccination Transfer Programme	Staff costs	**1,200**
	Non-staff costs	**0**
Pharmacotherapy services	Staff costs	**12,500**
	Non-staff costs	**0**
Community Treatment and Care Services	Staff costs	**2,700**
	Non-staff costs	**0**

NB: Figures shown for Ayrshire and Arran, and Forth Valley are aggregated by Board and not broken down by HSCP.

Please provide any additional comments on your service delivery spend below;

We have tabled above what we (Edinburgh HSCP Primary Care Support Team) believe would be an 'ideal' PCIP investment modelled on Edinburgh's population, which will shortly reach 600,000 (combined GP list size). This ideal MoU2 investment would be just:
Pharma: 95.0 B6/7/8a: 1.25wte per 10,000 (Includes 20% Cover & c5% management) & 95.0 B4/5/6: 1.25wte Per 10,000 (includes 20% Cover & c5% management).
Vaccination Travel, Child, Maternity & Flu (65+ & 18-64 At Risk) (excludes Gov vaccination funds, Gov vaccination fund c£4.6m; c60wte)

P Code	Practice	Locality	PCIP WTE	PCIP WTE	Jan-23	T&S	17C	Pharmacotherapy	ANP	NP	PA	SPP	MSK	Mental Health	DBI	HCA	CTAC	Phleb.	Vacc.	LW PCIP	LW NP	C Admin	e Consult
70658	Baronscourt Surgery, 89 Northfield	NEE	3 - 3.5	3.3	2.3			0.98					0.50				0.47	0.33	0.30		0.50	0.29	
70198	Niddrie Medical Practice, Craigmill	NEE	1.5 -2	1.9	2.7	0.64		0.65						1.00			0.27	0.24	0.17		1.00	0.16	
70215	Craigmillar Medical Group, Craigm	NEE	5 - 5.5	5.1	6.5			1.20	1.00	0.61			0.50	2.00			0.74	0.63	0.46		1.00	0.41	
70605	Durham Road Medical Group, 25 D	NEE	2.5 - 3	2.9	3.6			1.13	0.80	1.00							0.42	0.29	0.26		0.20	0.27	
70785	St Triduana's Medical Practice, 54	NEE	5.5 - 6	5.6	6.5	0.60		1.40	0.55		1.00		0.50	0.91			0.81	0.54	0.51	0.20	0.50	0.51	
70427*	Milton Surgery, 132 Mountcastle D	NEE	4 - 4.5	4.1	3.9		*2.50*	0.40									0.60	0.39	0.37		0.60	0.36	
70639*	Dr Comiskey & Partners, Conan D	NEE	4 - 4.5	4.5	5.3		*2.40*	0.88		1.00					√		0.65	0.47	0.40			0.41	
70126	Southfield Medical Practice, 132 M	NEE	1.5 - 2	2.0	1.5			0.60					0.40				0.29	0.22	0.18		0.20	0.17	
70521	The Hopetoun Practice, Bellevue M	NEL	2 - 2.5	2.4	2.5			0.85					0.40	0.50			0.35	0.26	0.22	0.20		0.23	
70499	Annandale Medical Practice, Belle	NEL	2 - 2.5	2.3	2.5			1.10					0.40	0.50			0.33	0.29	0.21			0.21	Jun-21
70179	Leith Surgery, 2 Duke Street, Edinb	NEL	3.5 - 4	3.8	4.6			1.20	0.69				0.50	1.00			0.54	0.40	0.34	0.30		0.35	
70268	Brunton Place Surgery, 9 Brunton	NEL	3 - 3.5	3.3	4.0			1.20			2.00						0.48	0.34	0.30			0.32	Jan-21
70982	The Victoria Practice, Leith Commu	NEL	1.5 - 2	2.0	1.8			0.98					0.40		√		0.29	0.22	0.18			0.20	
71114	Leith Mount Surgery, 2 Lindsay Str	NEL	4.5 - 5	4.7	4.2			1.08					1.00	1.00			0.68	0.48	0.42		0.40	0.43	Apr-20
70747	Summerside Medical Practice, Sun	NEL	2.5 - 3	2.9	3.2			0.83	1.00							0.69	0.42	0.29	0.26			0.27	
71364	Mill Lane Surgery, 4 Mill Lane, Edir	NEL	-	-	2.0			0.50						1.00			0.32	0.26	0.20			-	
71398	Links Medical Centre, 4 Hermitage	NEL	-	-	1.9			0.33						1.00			0.33	0.28	0.21			-	
70569	Restalrig Park Medical Centre, 40 A	NEL	-	-	1.7			1.00									0.42	0.29	0.26		0.50	-	
70408	Dr Thyne & Partners, Stockbridge H	NWB	3 - 3.5	3.5	3.2		0.50	1.00					0.55		√		0.50	0.38	0.31	0.30		0.33	May-22
71326*	The Group Practice - Eyre, 31 Eyre	NWB	3.5 - 4	3.8	3.4		0.50	1.00					0.50				0.55	0.41	0.34	0.50		0.36	
70319*	West End Medical Practice, 36 Ma	NWB	3.5 - 4	3.7	3.0		*0.50*	1.10					0.50				0.54	0.44	0.33			0.35	
70094	The Green Practice, Stockbridge He	NWB	3 - 3.5	3.5	3.5		0.50	0.95					0.76				0.50	0.41	0.31	0.50		0.35	Jan-21
70234	The Long House Surgery, The Long	NWB	3.5 - 4	3.6	3.3			0.70	1.00			0.40					0.52	0.36	0.32	0.40		0.32	
70662*	Muirhouse Medical Group, Muirho	NWB	7.5 - 8	8.0	7.6		0.50	1.70	1.00				0.50	2.00			1.15	0.97	0.72		1.60	0.65	
70573*	Crewe Medical Centre, 135 Boswa	NWB	4.5 - 5	4.9	5.1		0.50	0.70			1.00		0.75	1.00	√		0.70	0.54	0.44		1.00	0.40	
70272	Dr Steve Allan & Partners, Bangho	NWB	4 - 4.5	4.5	5.9			1.25	0.80	1.00	1.00					0.25	0.65	0.46	0.41	0.50		0.44	
71401	Parkgrove Medical Practice, 22B P	NWT	-	-	1.1			0.10						0.40			0.25	0.15	0.15	0.20		-	
78171	South Queensferry Medical Practic	NWT	4.5 - 5	5.0	5.3		1.00	0.80	1.00				0.33	1.00			0.72	0.53	0.45			0.47	
71434	Barclay Medical Practice East Craig	NWT	3 - 3.5	3.4	3.9	2.80		0.25									0.50	0.37	0.31			0.31	
70709*	Davidson's Mains Medical Centre,	NWT	2 - 2.5	2.5	1.8		0.20	0.50					0.50				0.36	0.26	0.22			0.23	
70220	Ladywell Medical Centre (West), L	NWT	4.5 - 5	5.0	4.1	0.20		1.35				1.38					0.73	0.47	0.45			0.45	
70361	Ladywell Medical Centre (East), 26	NWT	4.5 - 5	4.9	5.3			1.35	1.00			1.38					0.71	0.48	0.45	0.40		0.45	
71129	Cramond Medical Practice, 2 Cram	NWT	3.5 - 4	4.0	4.3		0.50	0.90	1.00					1.00			0.58	0.40	0.36			0.37	
70535	Blackhall Medical Centre, 51 Hillho	NWT	2.5 - 3	3.0	3.0		0.50	0.95	0.84								0.43	0.31	0.27			0.27	
70501	Murrayfield Medical Practice, 13b	NWT	3 - 3.5	3.2	4.0		0.50	1.40	0.80			0.23					0.47	0.33	0.29	0.30		0.31	
71025*	Murrayfield Medical Centre, 35 Sa	NWT	3.5 - 4	3.6	2.5		0.50	1.20									0.52	0.35	0.32			0.33	
70766	Marchmont Medical Practice, 10 W	SEN	-	0.8	0.4			0.20									0.11	0.07	0.07			0.08	
70323	Bruntsfield Medical Practice, 11 Fo	SEN	4 - 4.5	4.5	4.5			1.20	0.85				1.00				0.66	0.49	0.41	0.40		0.43	
71379	Boroughloch Medical Practice, 1 M	SEN	2.5 - 3	1.2	3.6	1.00		1.20					1.13				0.17	0.28	0.11			0.12	
70451	Meadows Medical Practice, 9 Brou	SEN	1.5 - 2	1.8	1.4			1.00							√		0.27	0.19	0.17			0.17	
70790	Morningside Medical Practice, 2 M	SEN	3 - 3.5	3.5	1.8			1.00									0.51	0.37	0.32			0.35	
70412	Grange Medical Group, 1 Beaufort	SEN	3 -3.5	3.2	3.5			1.15	1.00				0.60				0.46	0.34	0.29			0.31	May-21
71449	Hermitage Medical Practice, 5/6 H	SEN	2.5 - 3	3.0	2.2			1.55									0.43	0.31	0.27			0.28	
70592	University Health Service, 6 Bristo	SES	3 - 3.5	3.5	1.9			0.60					0.50				0.51	0.70	0.32			0.32	Jan-21
70893	Braefoot Medical Practice , Conan	SES	-	-	1.4			0.65									0.29	0.22	0.18	0.30		-	
70963	Edinburgh Access Practice, The Spi	SES	-	-	1.2			1.20									0.00	0.03	0.00		1.00	-	
70841	St Leonard's Medical Centre, 145 P	SES	2.5 - 3	3.0	2.9			1.05	0.45				0.50				0.44	0.28	0.27	0.20		0.28	
70381	Mackenzie Medical Centre, 20 We	SES	3 - 3.5	3.4	3.1			1.60					0.50				0.50	0.32	0.31	0.20		0.32	
70470	Dalkeith Road Medical Practice, 14	SES	1.5 - 2	1.6	1.3			0.50									0.23	0.16	0.15	0.40		0.16	
70516	Gracemount Medical Practice, 24 C	SES	3.5 - 4	3.9	3.5			1.55						1.00			0.57	0.44	0.36		0.50	0.32	
70376	Liberton Medical Group, 65 Liberto	SES	3 - 3.5	3.5	3.1			1.30								1.00	0.51	0.38	0.32		0.30	0.31	
70588	The Southern Medical Group, 322	SES	3.5 - 4	3.6	3.3	0.08		0.90					0.50	1.00			0.52	0.38	0.32		0.50	0.31	Jul-20
70291	Inchpark Surgery, 10 Marmion Cre	SES	2.5 - 3	2.9	2.3			1.15					0.50				0.42	0.28	0.26		0.20	0.25	
70164	Ferniehill Surgery, 8 Ferniehill Roa	SES	3 - 3.5	3.5	3.2			1.00	1.00					0.40			0.51	0.36	0.32		0.30	0.31	
71222	Gilmore Medical Practice, Tollcros	SWC	2 - 2.5	2.4	3.3			1.43	1.00								0.35	0.26	0.22	0.30		0.24	
70107	Leven Medical Practice, Tollcross H	SWC	2 - 2.5	2.3	2.6			1.15	0.50						√		0.34	0.22	0.21	0.40		0.23	Apr-20
71082	Springwell Medical Group, Springw	SWC	3.5 - 4	3.9	3.0			1.33					0.50		√		0.57	0.40	0.35	0.30		0.37	
70997	Slateford Medical Practice, 27 Gor	SWC	4 - 4.5	4.2	5.0			1.45	1.00				0.61	1.00			0.61	0.43	0.38			0.39	
70253	Whinpark Medical Practice, Whinp	SWC	5 - 5.5	5.5	6.3			2.00			1.00	1.38	0.64				0.80	0.55	0.50		0.60	0.48	
70911	Sighthill Green Medical Practice, S	SWC	4.5 - 5	4.9	4.5			1.55	0.80					1.00			0.70	0.52	0.44		0.70	0.40	Feb-21
70906	Drs Sharpe, Putta & Burns Practice	SWC	1.5 - 2	1.9	2.5			0.60	1.00					0.40			0.28	0.20	0.17		0.30	0.17	
71011	Polwarth Medical Practice, Tollcro	SWC	-	-	1.5			0.73							√		0.28	0.17	0.17	0.30		-	
70978	Wester Hailes Medical Practice, W	SWC	-	-	2.8			1.05						1.00			0.43	0.41	0.27		1.00	-	Y
70075	Braids Medical Practice, 6 Camus A	SWP	3.5 - 4	3.9	3.6	0.90		0.95					0.50				0.57	0.43	0.35	0.30		0.36	
71420	Ratho Medical Practice, 14a Wilkie	SWP	1 - 1.5	1.1	1.2			0.35		0.50							0.16	0.12	0.10	0.10		0.09	
70131	Colinton Surgery, 296b Colinton Ro	SWP	4.5 - 5	4.8	5.2	0.50		1.75	1.00					0.80			0.70	0.51	0.44			0.45	
70930	The Pentlands Medical Practice, Pe	SWP	5.5 - 6	5.7	5.5			2.70				0.46	1.00				0.83	0.60	0.52			0.53	
71097	Firrhill Medical Centre, Allermuir H	SWP	2 - 2.5	2.5	2.2			0.80	0.80						√		0.36	0.26	0.22			0.23	Sep-20
70610	Craiglockhart Medical Group, Aller	SWP	4 - 4.5	4.2	3.8			1.30					1.00		√		0.61	0.43	0.38	0.50		0.39	
70925	Riccarton General Practice, Heriot-	SWP	1 - 1.5	1.5	1.0			0.35									0.22	0.29	0.14	0.30		0.25	
	North East							10.40															
	North West							10.80															
	North West							9.40															
	South West							9.10															
													0.50	0.6									
													1.00	0.7									
							5.00	-16.90	1.00			0.23	0.66	2.00			6.20						
	EPCST							1.60	1.00				1.14	3.88			27.50				4.00		
						6.72	16.10	96.20	22.88	4.11	6.00	5.46	21.77	28.09		1.94	33.70	25.23	21.00	7.80	16.90	19.87	

PCIP	265.85
T&S	6.72
17C	16.10
LW NP	16.90
	305.57
To be allocated	22.10

AA

Acronyms Used in PCIP 6.0 Tracker Submission Report

ANP	Advanced Nurse Practitioner
APP	Advanced Physiotherapy Practitioner
ASE	Adjusted Sessional Equivalent
CET	Primary Care Expansion Teams
CTAC	Community Treatment and Care
DBI	Distress Brief Intervention
EHSCP	Edinburgh Health & Social Care Partnership
EIJB	Edinburgh Integration Joint Board
EMT	Executive Management Team
GMS	General Medical Services
GP	General Practitioner
HSCP	Health & Social Care Partnership
L&R	Primary Care Leadership and Resources Group
LMC	Local Medical Committee
MDT	Multidisciplinary Team
MOU	Memorandum of Understanding
MSK	Musculoskeletal
NHS	National Health Service
PA	Physician Associates
PCIP	Primary Care Improvement Plan
PCMHWBT	Primary Care Mental Health & Wellbeing Teams
Phlebotomy	Blood taking (to test)
PN	Practice Nurse
SAS AP	Scottish Ambulance Service Advanced Practitioner
T&S	Transformation & Stability Fund