Edinburgh Integration Joint Board

REPORT

Primary Care 2023/24 Summary Report

Edinburgh Integration Joint Board

22 April 2024

Executive Summary	The purpose of this report is to provide the Edinburgh Integration Joint Board with an overview of the ongoing Primary Care (GMS) 'Transformation' as at the end of March 2024.

Recommendations	It is recommended that the Edinburgh Integration Joint Board: 1. Recognises the progress being made to stabilise and transform Primary Care, despite the challenges. 2. Notes the continuing challenge of population increase to primary care stability across Edinburgh. 3. Notes the end of the substantive Primary Care Improvement Plan (PCIP) investment period and the national 'demonstrator' status awarded from April 2024 to December 2025. 4. Confirms the continuing role of the Edinburgh Leadership and Resources Group (chaired by the Clinical Director) in directing and overseeing all Primary Care investments. 5. To consider whether this report should become an annual expectation from the IJB, separately from any government PCIP specific reports which may be required.

Directions

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

1. This report has been submitted to the Edinburgh Primary Care Leadership and Resources Group on the 19 March 2024 and will be submitted to the Lothian GP Sub-Committee (date tbc).

Main Report

2. Primary Care provides a comprehensive General Medical Service to all Edinburgh citizens registered with a medical practice, including children and all residents of care homes. NHS Lothian holds the formal authority to issue or withdraw GMS practice contracts, whilst EHSCP is responsible for supporting the effective delivery.

3. Previously, an annual report on the implementation progress of the Primary Care Improvement Plan (PCIP 'tracker') was agreed by the IJB each year, prior to submission to Scottish Government. This was required to satisfy the governance requirements set by Scottish Government covering the implementation period 2018-23.

4. The 2019/20 PCIP report was more comprehensive in scope than the PCIP returns required by government and was well received by the IJB. Separately, Primary Care has also submitted Edinburgh vaccination program reports and updated assessments of the impact of population increase and the consequences for primary care premises. This 2023/24 report again takes the opportunity to report on the fuller Primary Care Transformation Program.

5. Primary Care has had a tumultuous decade. It is acknowledged that the public recognise the value of Primary Care services, which includes local access to highly skilled advice and care.

6. In 2023/24, GPs delivered two million patient appointments, with Practice Nurses providing an estimated 400,000 more. 70% of the Edinburgh public had at least one of

these appointments. Satisfaction with what is offered by our clinicians remains very high, despite all the pressures and mismatches of expectation around access.

7. In 2023 Scotland's Auditor General reported that 40% of public spend in Scotland is now on the NHS. This proportion will continue to increase unless resources can increasingly be focussed on the preventative potential of Primary Care.

8. The four main activities of the Edinburgh Primary Care Support Team are used to provide the structure to this report;
    a. Prescribing and the development of Pharmacotherapy
    b. Investment through PCIP and the Transformation and Stability Fund
    c. Population and Premises
    d. Health inequalities
    e. Vaccination is part of the PCIP implementation, but is given a fifth section, partly because of the profile of this activity and partly because the program is not yet established as a settled program of annual delivery.

9. Although this broad description of how the PCST organise support for our 69 GMS teams is useful, the team strives to respond to whatever circumstances are challenging at any given time.

Prescribing and the development of Pharmacotherapy

10. Edinburgh has a distinguished record of contribution to the development of prescribing excellence in Primary Care. This record is built on a sustained and constructive dialogue between employed pharmacist teams and the GP community, aided by support from community pharmacists, finance colleagues and a well-constructed network of NHS Lothian supported governance functions which have developed over at least 30 years.

11. On all available quality indicators, Edinburgh prescribing shows good, if not leading performance. These include adherence to the 'formulary' and excellent performance in national agreed prescribing indicators which monitor reduction in high risk prescribing for all Health and Social Care Partnerships (HSCP's) in Scotland. On the cost dimension, Edinburgh has long held a pre-eminent position in Scotland, with cost per head of population (c£145) substantially below the national average (c£190 pp). Part of this is of course demographic; it is known that Edinburgh medical practices with high deprivation will prescribe at c£180 pp, whereas high turnover inner-city practices prescribe on average at less than £100 pp. Nevertheless, after adjustment

for population weighting, Edinburgh remains considerably below the nearest other Scottish Health Board. (The prescribing costs pp of the other Lothian HSCPs are slightly below the Scottish average, and we are unable to identify any comparable healthcare system with lower costs). Edinburgh is a regular contributor to the pursuit of clinical excellence with numerous significant developments each year. In April 2024 for example, the team has been shortlisted as a Scottish Pharmacy Awards finalist (in the 'working in partnership' category).

12. The pharmacotherapy team has been developed considerably since 2018, with the injection of c£6m from the Primary Care Improvement Funds. The workforce has been quickly grown from c12wte to c100wte, with significant skill mix and the training of pharmacy technicians supported with a bespoke course run through Edinburgh College. The new pharmacist workforce has been embedded in practice teams with an understanding that c20% of their time is used on 'non-practice specific' duties such as efficiency projects, teaching and training.

13. Pharmacy technicians are shared between practice-based activity and 'pharmacotherapy hubs' where technicians can process significant parts of the everyday workload, notably 'medicines reconciliation'. Inevitably, the balance between contributing to practice workload and attending to wider cost and quality work causes tensions, particularly as the associated GMS workload is huge and the pharmacotherapy workforce is not yet able to give guaranteed daily workload support to practices.

14. Overwhelmingly however, the pharmacy team have been welcomed into primary care teams and our evaluations and informal feedback tell us that we are retaining staff and attracting new staff, despite the frustrating level of turnover experienced by many practices. The Partnership have predicted that this 'turbulence' would begin to settle but are now beginning to recognise that the pharmacotherapy workforce will always to be subject to relatively high turnover for a few (overwhelmingly positive) reasons. The workforce is however not yet fully established, and the Partnership has much to do in the reliable transference of routine daily work to 'hubs' outside individual practices. The anticipated consequential impact is that practice embedded pharmacists will be enabled to provide more bespoke support to clinical decision-making.

15. Pharmacotherapy workload was described in the 2018 GMS contract as consisting of Levels 1-3. Level 1 can generally be described as undertaken by qualified pharmacy technicians, whereas Level 3 requires a qualified pharmacist, usually with an

additional prescribing qualification. Despite the workload demand of 'level 1 and 2' pharmacotherapy, the pharmacy team have established 58 'Level 3' clinics covering 11 specialities. The team have also developed and validated a multimorbidity checklist to support the wider team and have assessed the impact of a pharmacist led diabetic clinic. Both pieces of research are being presented at a European Conference in poster format. Edinburgh wide quality improvement work led by the pharmacy team also won a national award. These are recent examples of why Edinburgh continues to be an attractive place for ambitious pharmacists who appreciate a supportive culture. The downside of this is of course, the turnover of staff described earlier.

Investment through PCIP and the Transformation and Stability Fund

16. The PCIP and its associated PCIF (Fund) was introduced by Scottish Government in mid-2018 to support the introduction of a new GP contract which was to introduce 'multi-disciplinary teams' across primary care. These MDTs were intended to augment a workforce which was increasingly unable to match clinical capacity with growing patient demand, and in Edinburgh's case, an expanding population.

17. As outlined above, a large part of our total PCIP fund (c£16.2m) was used for pharmacotherapy (c£6m). The investment in this area of the PCIP is in line with the rest of the country, partly because of widespread recognition of the potential contribution of pharmacotherapy and partly because of the perspicacity of Scottish Universities, who foresaw or responded quickly to the increased demand for pharmacists and increased the graduate output. When the PCIP funds became available, pharmacists were the single Multi-Disciplinary Team (MDT) group available to recruit in proportionate numbers. Despite this investment, the bulk of the pharmacotherapy workload remains with GPs, illustrating the size of the workload augmentation challenge.

18. The two tables below show the crude increase in all PCIP staff numbers to the end of March 2024 and how these posts are distributed across the 6 areas of the Scottish Government 'Memorandum of Understanding' (MOUs 1& 2) which directed the investment. In comparison with other areas, Edinburgh has invested less in Community Treatment and Care Services (CTACS) and more in the 'associated professions,' notably physiotherapists and Primary Care Mental Health nurses.

19. The original aim of the PCIP was to fill an estimated gap of c600 sessions of medical capacity missing from the Edinburgh primary care system each week. This is difficult to demonstrate unequivocally, but Edinburgh invested in, 'evaluation & insight'

resources which have subsequently proved an invaluable resource in demonstrating the correlation (if not always causal chain) between investment and workload impact. The Partnership called this whole process the 'transformation program' and have always managed this as a wider set of influences than solely the new PCIF investments.

20. From the beginning of the PCIP implementation, Edinburgh was concerned about being able to demonstrate the impact in a way which related to the workload of GPs. Accordingly, the Partnership choose 'equivalent medical sessions (EMS)'. Supported by ongoing evaluation, and as described more fully in earlier reports, we attached illustrative numbers of EMSs to each PCIP area. Edinburgh has subsequently used several representations of the combined impact of the PCIF investments, all of which remain illustrative. Table 1 below, shows the original estimation of the GMS 'workload gap' of c600 weekly medical sessions against an estimated weekly (baseline) provision of 2200 (2019). The established trend of a growing mismatch of capacity and demand has been partly countered by the investment of the PCIP. All these figures are open to interpretation. The 'informal consensus' is that the PCIP has been effective in managing the pressure on primary care, but has done little to address overall workload, due largely to the additional pressures of population increase and the long-term impact of covid on GMS workload.

Table 1 Capacity Impact of PCIP using estimated medical sessions (EMS) equivalence.

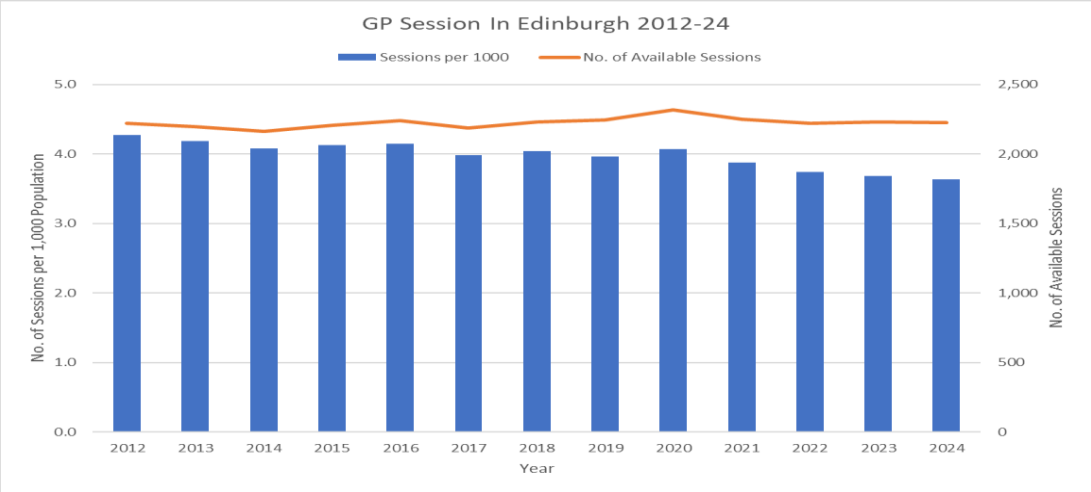
	Performer Provider	Total (1)	Practice List Size		Clinical Sessions per \ wte(2)	No. of Available Sessions	Weekly Clinical Sessions required by Population (4)	Weekly Sesssional Capacity gap (5)	PCIP WTE in Post (March) (6)	Clinical Session per WTE (7)	Estimated PCIP post input (8)	Remaining Weekly Sessional Capacity Gap (9)	Sessions per 1000
2012	316	427	519,837		6.5	2,220	2,599	-379	-	-	-	-	4.3
2013	313	429	524,837		6.4	2,196	2,624	-428	-	-	-	-	4.2
2014	315	429	529,799		6.3	2,162	2,649	-487	-	-	-	-	4.1
2015	308	445	534,634		6.2	2,207	2,673	-466	-	-	-	-	4.1
2016	310	459	540,790		6.1	2,240	2,704	-464	-	-	-	-	4.1
2017	310	455	548,834		6	2,184	2,744	-560	-	-	-	600	4.0
2018	310	465	552,552		6	2,232	2,763	-531	-	-	-	-	4.0
2019	297	475	565,743		5.9	2,242	2,829	-587	95	2.0	152	435	4.0
2020	300	499	569,399		5.8	2,315	2,847	-532	155	2.2	273	259	4.1
2021	300	493	579,930		5.7	2,248	2,900	-652	210	2.4	403	248	3.9
2022	301	496	594,763		5.6	2,222	2,974	-752	251	2.6	522	230	3.7
2023	297	507	605,252		5.5	2,231	3,026	-795	275	2.8	616	179	3.7
2024	295	515	612,252		5.4	2,225	3,061	-836	285	3	684	152	3.6

21. In summary, Table 1 illustrates the 'hypothesis' that from 2019 the PCIP impact has grown from 152 (equivelent medical sessions of capacity) to 616 in 2023.

22. In a stable population this impact would have been much more obvious, but has been diluted by population increase and additional workload. Figure 1 (below) shows the absolute sessions sligthly increasing as Edinburgh continues to be successful in attracting additional GPs, whilst the sessions per 1000 patients remains fairly consistent at 4 per 1000 patients. It is important to highlight that this picture is highly dependant on our predicted decline in the sessions available per GP, as shown in Table 1. If this is more than 5.4 in 2024 for example, then the picture improves. Sporadic information on the number of sessions worked by GPs starting with new practices, suggests this estimate is not far away.

23. Practices who cannot get enough GP sessions, inevitably ask more of their existing GPs, thereby gradually eroding sustainability. Whilst some Partners may be compensated adequately through additional income for a limited period, this can easily become exhausting and counterproductive, as GPs limit their exposure to intensive working conditions through reducing sessions. The original intention of the PCIP was to adjust this balance to allow a sustainable workload for all practices. Without the PCIP (& related) investments, it is clear that the system would have deteriorated further as we experienced up to 2019, and has been an effective buffer to further pressures. It has not however, significantly eroded the workload expected of GPs as was the original intention.

Figure 1 Growth in (estimated) Medical Sessions and impact on sessions in relation to population increase.



24. Table 2 (below) shows the total activity which is associated with each of the PCIP and vaccination workstreams. Much of this is directly relatable to impact on GMS workload, but the vaccination numbers combine flu, which was previously done by GMS, and Covid19 which has always been done by our vaccination service, although not as part of the PCIP. The table therefore summarises the workload which would have to have been undertaken by GMS, had PCIP and vaccination services not been developed.

25. **Table 2 Summary of Transformation workforce activity (estimated not actual)**

2023/24	Staff (WTE)	Weekly Appts per WTE	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
ANP	22	72	4,801	4,801	4,801	4,801	4,801	4,801	4,801	4,801	4,801	4,801	4,801	4,801	57,613
PA	5	70	1,061	1,061	1,061	1,061	1,061	1,061	1,061	1,061	1,061	1,061	1,061	1,061	12,730
SAS AP	5.5	30	500	500	500	500	500	500	500	500	500	500	500	500	6,001
MSK	22	40	2,667	2,667	2,667	2,667	2,667	2,667	2,667	2,667	2,667	2,667	2,667	2,667	32,007
CTAC	25.5	34	3,379	4,130	4,130	4,130	4,130	4,130	4,130	4,505	4,505	4,505	4,505	4,505	50,680
Mental Health	26	49	3,861	3,861	3,861	3,861	3,861	3,861	3,861	3,861	3,861	3,861	3,861	3,861	46,338
Link Working	21.9	12	794	794	794	794	794	794	794	794	794	794	794	794	9,529
Pharmacotherapy	115	36	12,557	12,557	12,557	12,557	12,557	12,557	12,557	12,557	12,557	12,557	12,557	12,557	150,686
Vaccination	50	180	20,833	4,167	4,167	4,167	4,167	54,167	54,167	54,167	54,167	54,167	20,833	20,833	350,000
Total	**292.9**		**50,454**	**34,538**	**34,538**	**34,538**	**34,538**	**84,538**	**84,538**	**84,914**	**84,914**	**84,914**	**51,580**	**51,580**	**715,586**

26. Table 2 shows c700,000 appointments, almost all of which would have been absorbed by GMS without these investments. It should be noted that almost 50% are vaccinations. Of the 350,000 vaccinations delivered, only c90,000 were removed from GMS (flu+), with the covid vaccinations being additional new workload.

27. Edinburgh has 'under-invested' in CTACS in comparison with many other HSCPs. The number of CTACS has now grown to 10, and they deliver c50,000 procedures per annum. This number is scheduled to increase with another site and further stability in the staff group. The Edinburgh CTACS are concentrated on relieving practices of a small batch of time-consuming procedures and allowing Practice Nurses to release capacity for other practice priorities.

28. It should also be noted that the 600+ EMS injected into the system, is offset by the medical time lost in supporting these staff, many of whom have not previously worked in Primary Care. No attempt has been made to quantify this, but this is likely to be in the region of 10% of the EMS gain.

    There is very little additional funding available and Scottish Government decided to distribute what additional funds were available through a competitive process.

Edinburgh emerged as one of the four successful HSCPs picked to 'demonstrate' the impact of further investment in two of the common PCIP service elements; CTACS and pharmacotherapy hubs. In the process of assessing the bids, Edinburgh successfully proposed that part of the intention of the new funding would be to demonstrate how further investment could help practices with increasing their list sizes. Investment of £1.2m is available in 2024/25, to be continued to the end of the calendar year 2025, and dependent on evaluation thereafter.

Population and Premises

29. Edinburgh's population is steadily growing and has been since before 2010. This is most obviously demonstrated through the growth in Edinburgh list sizes from 500,000 in 2012 to 600,000 by early 2023. (GP list sizes should always be adjusted down 6-8% to ascertain likely true population). This growth is reflected by the City development plans (ie housing), but not in the census figures which determine NRAC resources and appear to mask growth. GMS income relates to list sizes, but there is no direct link between list sizes and the availability of capital funding to build new premises, or to redevelop existing buildings. Edinburgh is now more than a decade behind a very modest expectation of the development of two new Primary Care premises per year. The impact of this lack of progress was first thoroughly assessed and presented in 2014, renewed in 2016/17 and then updated and re-presented in late 2022. In 2023 several practices Southeast Edinburgh were unable to further expand their lists and the decision by the Scottish Government in February 2023 to pause all capital developments not already committed to has exacerbated the situation. The impact of this was cushioned by a local 2C practice which had relatively recently stabilised and was able to increase its list at an unprecedented rate. Nevertheless, around 6 practices in one part of Southeast Edinburgh were 'closed' to new registrations at any given time during 2023.

30. Edinburgh has put forward a paper to Scottish Government, 'Fair Shares for a Growing Population (Background Reports 1)', highlighting the problem of the disconnect between growth in population defined by GMS lists and two elements of primary care funding: PCIF and premises capital.

31. Edinburgh are delighted at the support and flexibility shown by both CEC (City of Edinburgh Council) and NHS Lothian, in ensuring the Maybury Medical Practice (beside airport) premises could be developed together with a local primary school for this rapidly growing corner of Edinburgh. This was to be the first of several such developments driven by new population. Because of the pause on further capital builds it is anticipated that there will not be any further premises development in the

short or medium term that meets demand and developments as part of the Liberton Campus, Granton or the replacement for Brunton medical practice are no longer viable options.

32. It is acknowledged that there does continue to be a mismatch between GP provision and the growing population and whilst the GP community have been exceptional in their response to accommodating the increasing population, but this elasticity is now all but exhausted.

Health inequalities

33. Concern and responsiveness to health inequalities are fundamental to the effective delivery of GMS to the population of Edinburgh. Where possible and warranted, the Partnership will weight resources towards practices with the largest concentrations of people in SIMD categories 1&2 (most economically deprived). The Partnership understand the impact of poverty on access to health and healthcare is complex. More resources are used with less impact for individuals who are vulnerable. This is due to many factors, including barriers or delays to seeking help or people being unable to sustain the care and treatment recommended. Table 4 below highlights a few of the many statistics which illustrate the 'inverse care law'. Our more affluent populations certainly do not need less GMS resources and have intense challenges, but economic deprivation is not strongly enough supported in the allocation of available resources and poverty continues to have an enormous influence on the use of most public resources.

Table 3 Illustrative Comparison of Resource Use between two of Edinburgh's Demand Groupings.

Grouping	Population Size	A&E Attendances pe 1,000	GP OOHs Cases per 1,000	MH Admissions per 1,000	Direct Encounters rate per patient*	Prescribing Cost Per Patient 22/23	Global Sum per Patient 22/23
Low Deprivation/High Age (11)	103,533	220	118	2	1.15	£155.13	£111.65
High Deprivation/Low-Mid Age (8)	74,710	357	158	5	1.36	£174.44	£114.03
% difference		62%	34%	250%	18%	12%	2%

34. Table 3 shows an 18% increase on workload between the two Demand Groupings (of practices) matched by a 2% higher practice income.

35. Inequalities manifest in a variety of forms and over recent years we have welcomed refugees/asylum seekers from Syria, Ukraine and Saharan Africa to the city. Our ability to support their needs was hugely aided by the interest of one practice, which has

developed considerable expertise and understanding of people's health needs in these circumstances.

36. The Partnership continue to address social isolation through the Community Link Worker Network funded as part of the PCIP, and also invest in enhancing the access of selected practices to Welfare Rights Workers who help people in a variety of ways, but principally through ensuring maximisation of benefit entitlement.

37. The Minority Ethnic Health Improvement Team (MEHIS) team has now been established for many years. With a very modest resource base, they provide insight, linkage, and practical response, to our ever-changing mosaic of cultures and incoming people.

Vaccination

38. Edinburgh was the first Partnership in Scotland to deliver the winter flu program in 2019. This experience prepared us well for the COVID-19 vaccination program which dominated attention and capacity throughout 2020 and 2021. The success of these efforts was reported to the EIJB.

39. Edinburgh has developed a delivery model of three 'mini-mass' sites supported by both selected community pharmacists and clinics in areas which do not have easy access to the three main sites, or where uptake has been relatively low. The balance of delivery scale and access has proved successful in supporting continued high uptake and keeping costs low.

    The spring and winter programs were again successful in 2024/25 and reported the key results noted below in Table 4.

Table 4 Vaccinations Winter Program (2023) key outcomes

	Covid Booster Uptake		Flu Uptake	
	Number	**%**	**Number**	**%**
All Cohorts	95,498	58%	131,350	54%
5-11 At Risk	204	8%	35,220	43%
12-64 At Risk	23,956	36%		
65-74	34,750	73%	34,937	74%
74+	35,783	83%	35,845	83%
Care Home	2,285	85%	2,305	87%
Pregnant	860	22%	1,827	46%

40. Edinburgh's comparative performance is strong in relation to other areas of Scotland in the key % uptake of +65 years. This would be expected with a relatively affluent and mobile population, and the Partnership are confident that the arrangements in place provide flexible and accessible opportunity for all. In terms of cost, Edinburgh seems to provide a national benchmark with cost per vaccine delivered at under £10 per vaccination delivered as part of the winter program. It is much more difficult to maintain this level of efficiency out with the intense months of delivery and we are constantly adjusting our staffing to ensure capacity better reflects demand. Once again, the clinical safety of the vaccination program delivery was exemplary with 230,824 vaccinations delivered and only 32 reportable patient incidents (1 per 7000 patients).

2024/25 and beyond

41. Primary care continues to evolve, and patients continue to be highly satisfied with their care, but access to medical appointments is a constant challenge. Most practices release a proportion of medical appointments for advance booking, but some have such high patient demand that the morning telephone queue is the only realistic way to allocate available capacity.

42. As services gradually recover from the disruptive impact of the pandemic and its ongoing effect on demand, practices are trying to tilt their efforts back to the

preventative emphasis which was always at the heart of progressive primary care. Chronic Disease Management systems, serial prescribing, on-line mental health resources, polypharmacy, signposting to alternative providers, are all examples of how primary care teams are trying to manage demand. It is acknowledged that different things work for different populations and primary care teams make these judgements well on behalf of their patients. Patients have overwhelmingly welcomed their care being delivered by the new members of their local medical practice, and we have only rare examples of a patient insisting on seeing a doctor when alternative provision has been offered.

43. The greatest threat to primary care remains the balance between the immediate and the important. Most GPs now work fewer days, mainly because a fully committed clinical day in many practices can be exhausting. The survival pattern of work adopted by many needs to be gradually challenged and not acquiesced to over the next decade. An important dimension of this is the management of patient expectations and the application of 'Realistic Medicine.' This must be part of a national discourse and not left to clinicians to persuade patients that they will not benefit from particular treatment options. Delivering primary care remains as challenging, interesting, and inspirational as it ever was. Being part of an independent, motivated, and supportive team committed to making a fundamental contribution to local healthcare, is a vital foundation for our public services. 70% of people have at least one primary care appointment each year (excluding vaccinations!) and no other public service has this engagement with the public. 10% of our population have a much more intense relationship with their local medical practice and claim 40% of the available capacity. Many of this 10% (and several subsets) are very well known to Primary Care Teams and are also familiar to several other public services. Yet after decades of exhortation, the insight primary care can offer on how services really work for people, remains an opportunity.

44. Practices have begun to 'experiment' with running two practices or from two sites and to consider the advantages of becoming a larger organisation. This is likely to become a more prevalent model and may be key to addressing the workload and capacity challenge. Practice management (and managers) become increasingly significant in releasing the potential advantages of larger teams, but Edinburgh has a strong group to draw on.

Implications for Edinburgh Integration Joint Board

Financial

45. Edinburgh Primary Care expenditure comprises c£200m or c25% of the Partnership budget. The main categories are summarised below;
    a. Edinburgh share of national GMS allocation (through NHS Lothian) - £100m
    b. PCIP/T&S - £19m
    c. Vaccination – c£5m
    d. Prescribing – c£86m

46. Scottish Government confirmed the PCIP allocation as £16.2m in 2023/24. Alongside this sits the 'Transformation & Stability Fund' (c£3m), for application across Edinburgh Primary Care.

47. The funding for both GMS and PCIP is largely ring-fenced by government through a national GMS contract. There remains considerable discretion in how the PCIP/T&S funding is used. A national 'Memorandum of Understanding (MOU)' provides guidance on the investment of PCIP funds and agreement between the Partnership, the NHS Lothian GP Sub Committee and NHS Lothian is required.

48. Prescribing costs are a combined result of the actions of c1000 independent prescribers, accountable for their own clinical practice. Vaccination funds are confirmed each year, with no long term funding yet confirmed, despite Scottish Government guidance on required dedicated staffing levels.

49. The Edinburgh Leadership and Resources Group was established at the request of the Scottish Government, to oversee the investment of the PCIP fund. The group has gradually expanded its role into all areas of primary care investment and development, providing a single group with balanced membership and oversight of the whole sector. This role should be formally recognised, as well as noting that there are well developed and effective Lothian wide arrangements for prescribing management, which are not disturbed by this. The membership of the group would be adjusted to account for any subsequent development in responsibilities.

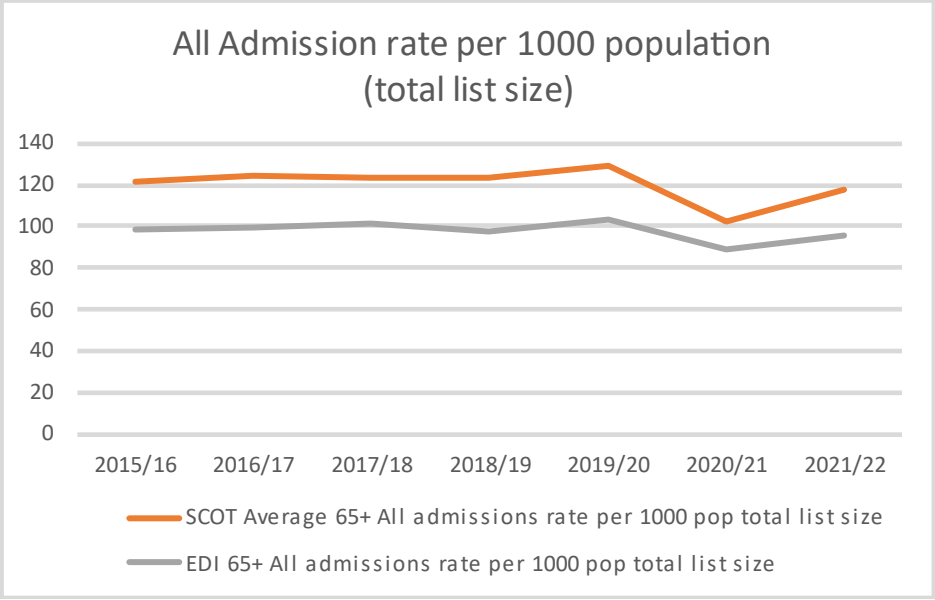
Legal / risk implications

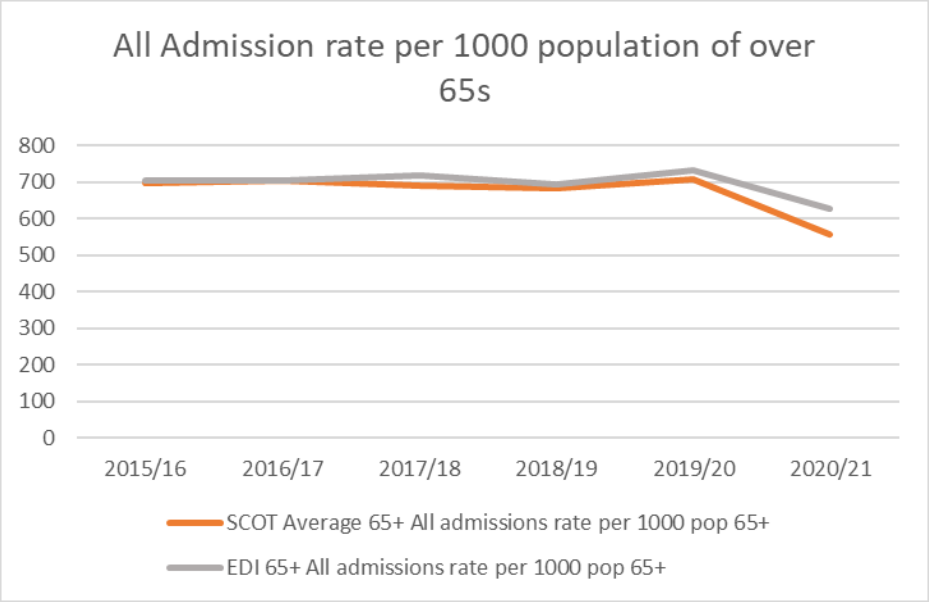
50. GP Partners who hold GMS contracts, are legally accountable for the delivery of the contract to their patients. The Edinburgh Primary Care Support Team (EPSCT)

recognises the inherent challenge in the maintenance of these contracts and sets out to help prevent instability and to build strengths and resilience.

51. GMS provides at least one medical appointment per year to 70% of the population and up to 10% of the population every week. A single average sized medical practice will provide some 500-600 medical appointments per week, increasingly augmented by a growing multi-disciplinary team. The average practice will also support the discharge of c40-50 patients per week from hospital. If a practice could not continue due to instability an increasing proportion of these patients would seek help from acute services (A&E) each week, and a growing number would be unable to be discharged from hospital without the support of their local practice team. In short, a single medical practice failure would significantly affect the equilibrium of a system already under increasing strain. Figure 2 (below) shows Edinburgh admissions as less than the Scottish average when using the total population and in line with the Scottish average when using the 65+ population. The risk is that all the efforts being made to avoid unneccesssary admissions could be undermined by additional admissions resulting from the failure of a single practice.

Figure 2 Edinburgh admission rates against Scottish average





52. The risk of instability of primary care remains as 'very high' on our risk register despite all the work across the Transformation Program. A recent illustration of this fragility is the current situation, where NHS Lothian is levying increased premises charges against practices premises costs. Several practices are reporting that this may cause another bout of instability and some to the point where they are considering returning their GMS contracts.

53. Similarly, although NHS Lothian holds the formal responsibility for ensuring all patients have access to GMS registration, the Partnership works with practices to ensure this capacity can support the steadily increasing population. For many of our practices new or renewed premises are vital to provide GMS to an expanded list, so the associated risk remains at least 'very high,' with South East Edinburgh possibly at 'severe.'

Equality and integrated impact assessment

54. This report does not require an Integrated Impact Assessment (IIA) as it is retrospective, however practices in areas with high deprivation generally have the highest workloads and greatest risks of instability.

Environment and sustainability impacts

55. There are no environmental or sustainability impacts arising from this report.

Quality of care

56. There are no quality-of-care issues arising from this report.

Consultation

57. This report was approved at the Edinburgh Leadership and Resources Group held on 26 March 2024.

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Background Reports

1. Fair Shares of PCIP for a growing population – version for Scotgov December 2023

Report

Fair Shares of PCIP for a growing population – version for Scotgov December 2023

1. Executive Summary

The financial value of the Edinburgh PCIP was determined in 2018, by calculating our proportionate share across Scotland using the NRAC formula for resource distribution across Health Board territories. The GMS population of Edinburgh grew by almost exactly 50,000 in the 5 years between April 2018 and April 2023. Despite this material growth, our PCIP allocation of the national resource remains constant. This paper quantifies the impact of this failure to link PCIP resource to population growth and considers what actions should be taken.

2.Recommendations

- That Scotgov commit to uplifting the overall PCIP allocation to reflect the growing Scottish population
- That Scotgov use GMS proportionate populations (not NRAC shares) to calculate PCIP allocations
- That EHSCP/EPCST consider what local action may be taken if either or both recommendations are unable to be met.

3. Background

3.1 In 2018, as the New GMS Contract was agreed, it was determined by Scotgov that Edinburgh HSCP would receive an 8.35% on average share of the national NRAC, population-based allocation; £12.9M

3.2 At the time, it was assumed that any population-based calculation would automatically be adjusted for population increase.

3.3 During the period of PCIP implementation (2018-2022) the annual PCIP funding and anticipated uplifts were only released to HSCPs following confirmation in the Annual Spending Review. In common with HSCPs

across the country, we built a substantial (unintentional) underspend which was then withdrawn/withheld nationally in 2022.

3.4 Until 2023 therefore, we had the increasing funding and in year flexibility (ie underspend) we needed to build the PCIP workforce which had been agreed for the City following the original allocation of £12.9M (subsequently uplifted for inflation to £14.2M).

3.5 Table 1: PCIP Allocations and relative NRAC shares

	Edinburgh	National	EDI NRAC Share
18/19	£3.8m	£45.7m	8.32%
19/20	£4.5m	£55m	8.34%
20/21	£9.2m	£110m	8.38%
21/22	£12.9m	£155m	8.37%
22/23	£14.2m	£170m	8.35%

Table 1 shows some marginal adjustments being made to Edinburgh's relative share, but nothing which matches the population increase which occurred over this period. Furthermore, the size of the Scottish population is steadily increasing, yet there is no adjustment to the national PCIP over the period, beyond the inflationary uplift given in 22/23.

3.6 Edinburgh had 9.65% of the Scottish population according to national GMS list size in 2018.The national workload assessment suggested we have 9% of the national workload,yet receive only 8.35% of the funding under NRAC. This difference of 0.65% of the national £170M PCIP fund is c£1.1M in PCIP allocation.

3.7 From 2023/24, the PCIP budget and spending commitments have become much more closely aligned and we therefore have less flexibility.

3.8 This reduction in PCIP financial flexibility was always anticipated from 23/24 onwards and is a symptom of the success of the Edinburgh PCIP in attracting and retaining staff.

3.9 With this inevitable tightening, many practices have responded by asking for their PCIP allocation to be adjusted upwards, as their practice list has increased.

3.10 Our response to date, has been firstly to resist any relatively minor adjustment ie below 0.5wte, which would normally require additional population of c1200-1500, or to assure practices that the top of their PCIP allocation range would be used as our 'target'.

3.11 Inevitably, as we make more of these assurances, we risk over-commitment of the PCIP budget, which remains unresponsive to GMS population growth.

3.12 In addition, Edinburgh has now commissioned a new medical practice for the west of the city, to respond to the growing population. We have advised for the moment that the new practice will have access to the PCIP. This is directly against the understanding of our GP Sub-LMC colleagues, who have said that the fixed PCIP fund should not be allocated to new practices or to help practices which grow, as this would reduce the agreed allocations made in 2018 (see appendix for 2019 agreed allocation methodology).

3.13 In tandem, the PCIP budget flexibility reduces partly because of growing stability in the workforce and partly because we have now deliberately over-committed on our PCIP workforce with an establishment of c300wte against an affordable establishment of c285wte. This carefully gauged action is designed to ensure we use all the PCIP available to support our practices and minimise underspend.

(3.13a It should be noted that we can be inconsistent in the way we refer to PCIP staffing. The original c211wte PCIP was the practice embedded workforce. To this, should be added the Community Link Workers, the 'top-sliced' CTAC workforce and the vaccination workforce. This brings the total PCIP staffing up to c300wte).

3.14 A rule of thumb calculation indicates an average allocation of 1.0wte PCIP resource per c2500 practice list patients. With an increase of c50,000 practice list people since 2018, this means Edinburgh now has c20.0wte fewer PCIP staff than the 2018 distribution intended.

3.15 The missing 20wte (c£1.2M) is now essential for 2 reasons;

- firstly, to support practices with list size increases over c1500 since 2018. There are currently 9 Edinburgh practices in this position, short of c£400K of PCIP.
- secondly, to support the additional requirements of the 'Capital Expansion Team' (CET) ie selected practices willing to register substantial additional patients. If the model proves safe and sustainable, these practices will be allocated additional PCIP staff, rather than strengthening the (pre-existing) medical team. An additional PCIP resource of c4.0 wte or £240K per year will be required for each enhanced team.

3.16 Table 2: NRAC and GMS population figures

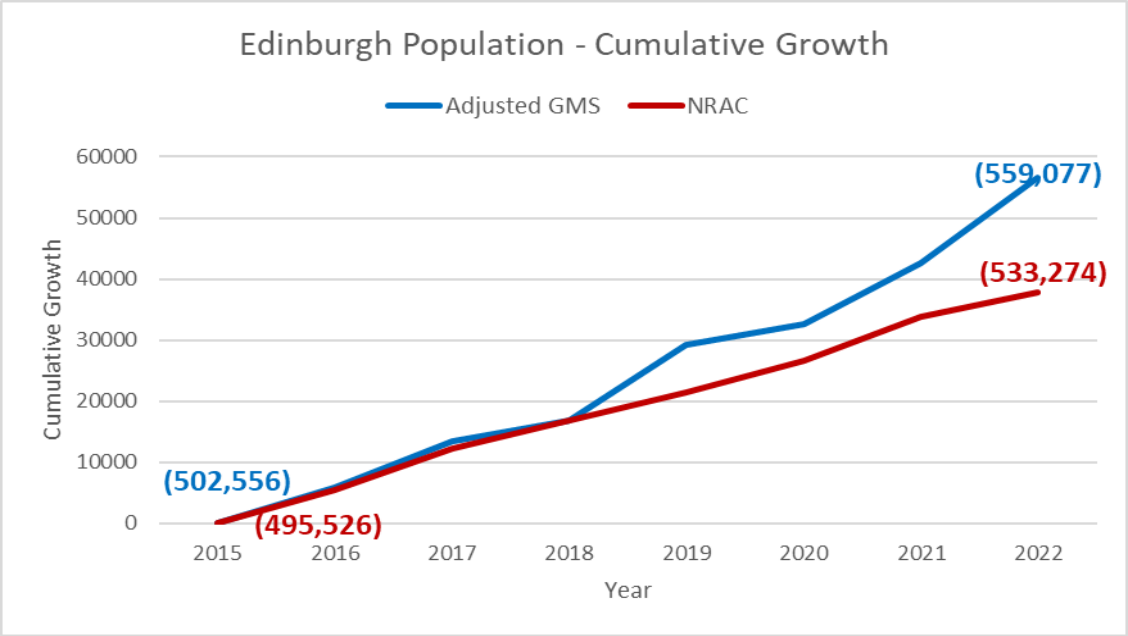
Source	2018	2022	Increase	%
NRAC	512k	533k	21k	4.10%
GMS (Reported)	552k	595k	43k	7.79%
GMS (Adjusted)	519k	559k	40k	7.71%

- NRAC population is the figure before being adjusted for demographics, but with Scottish Government weighting applied (appendix 2).

- GMS population shown as 'reported' and then adjusted down 6%.

3.17 The disparity between NRAC and GMS proportions is not inherently a problem as the two population sizes should track each other. This issue has arisen because of the increasing disparity between the two, with NRAC remaining relatively insensitive to population increase since 2018. (Figure 1 below). This is now having a material effect on Edinburgh's capacity to support its growing population with GMS.

Figure 1 GMS and NRAC Populations (2012 - 2022)



3.18 NRAC uses population **estimates** for each health board area based on the agreed Local Development Plans (housing) which support planned increases and decreases in population. These estimates are then periodically 'anchored' by census outcomes which report the true population each decade.

3.19 NRAC population figures are therefore relatively crude estimates, which are 'anchored' every decade by the census.

3.20 In mid 2023 the 2022 Census figures became available, and we anticipated a correction of the GMS list population (588K in April 2022) to between 540k (8% different) to 550K (6% different). Instead, the census reported the city population as 513K ie 13% different to the GMS figure.

3.21 GMS populations are reported using actual GP list sizes ie patients registered with a practice. These are known to normally be inflated by c6-8% for administrative reasons.

3.21 Our assertion is that following a 6-8% correction, GMS list sizes are and always have been, the most accurate barometer of population size and change available to the public sector. Consequently, we propose that PCIP allocation should be based on (adjusted) GMS not NRAC proportions.

3.22 The national distribution of GMS funds is already based on combined list sizes, so this proposal would bring consistency to the allocation of all GMS related Primary Care.

3.23 As outlined above, the implications of not uplifting PCIP along with GMS and prescribing budgets have been masked to date, by the availability of underspend and local flexibility.

3.24 We could recalculate the available PCIP across City practices using updated list sizes, thereby lowering the allocations to c20 Edinburgh practices. This would be an acceptance of the conscious withholding or diluting of PCIP resource to the City population, in comparison with other Scottish HSCPs.

3.25 If dilution of PCIP resource through redistribution is not acceptable, then we have no funding available to support increased PCIP allocation to City practices willing to consider growing their lists, nor can we support the agreed model of Capital Expansion Team in selected practices as a 'buffer' to help us accommodate population growth. The success of MOU2 Priorities; CTAC and Pharmacotherapy Hubs will be undermined, as they stetch the same resource over growing demand.

3.26 In these circumstances, we would have no option but to halt the development of the first agreed Capital Expansion Team and to inform practices growing their lists, that we have no prospect of increasing their PCIP allocation.

3.27 Over the last 10 years the City's GMS capacity has (uncomfortably) managed to accommodate increased population growth through a combination of premises related schemes and incentives (short term grants 'LEGUPs'). Consequently, the time between attempting to register with a medical practice and being registered, will have grown for the average patient and particularly new citizens. Whilst the total number of unregistered people at any given time will have grown, a 'tipping point' has not yet been reached where unregistered patients present to GMS 'out of hours' or A&E in problematic numbers.

3.28 With the certainty of 7000/8000 new people each year, we estimate that without this population sensitive support from GMS, citizens will wait longer to be registered, and this tipping point will be reached within a couple of years. Our unregistered population will build steadily, with an increasing proportion of additional citizens unregistered for growing periods. The implications of this should be clear, as can be seen in large

parts of the English NHS, with over reliance on emergency services as GMS falters.

3.29 In Southeast Edinburgh these pressures have already manifest in the formal closure of almost all medical practice lists, forcing patients out of their natural area or to rely on emergency services for their care. We understand that there may be a belief that the reported growth in the Edinburgh list size may be partly because of the failure of some practices to remove all relevant patients timeously. We have examined the pattern of removals and confirm that there is no slackening in removals, but a marked increase in additions. We can see no reason why Edinburgh should differ from other parts of the country. The proportion of students is sometimes cited, as more are thought to fail to re-register on leaving the city. This is not borne out by our experience with the (few) university dominated lists, where students re-register quickly on completion of their courses.

3.20 It should be noted that a parallel conversation about the need for increased premises investment due to population growth, has been running from the time of the first formal Edinburgh 'Population & Premises' impact assessment in 2014. To date, there has been no attempt to address this clear requirement with additional capital allocation to NHS Lothian.

4.Financial implications

4.1 As above, the annual rate of population growth over the last decade has averaged c7,500 which equates with c3.0wte additional PCIP staff per year @ c£180K pa.

4.3 As described in a separate paper, the consequences of supporting practice growth (selected practices) without access to the requisite medical staff, incurs additional PCIP expense of c£60K per 1000 people (on top of the baseline 1.0wte per 2500, which needs to be maintained).

4.5 It should be noted that the CET is an effective 'cost-avoidance' scheme. The alternative is to establish more new practices with both additional capital and development funding requirements. Edinburgh has tried to minimise the requirement for additional practice teams and has reduced the number of GMS practices over the last decade, despite an increase in population size of c80,000.

4.6 2023 marked a turning point in the reduction of GMS practice teams, with the dissolution of the last single-handed practice in June 2023. Thereafter, the smallest City practices will be 4000/4500, all with plans for list expansion.

4.6 Despite a population increase which would demand an additional team each year, Edinburgh only envisages 4 new practices over the next decade with continued absorption of population by existing teams. This

absorption will quickly be undermined without the support sought, leaving more expensive and much less feasible options to support access to GMS registration.

4.7 We need an agreed reconciliation over PCIP population uplift based on GMS list sizes. Without this, the disparity and associated financial gap will grow and the City population will be structurally disadvantaged by a national funding arrangement which was devised to ensure equity and transparency.

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Appendices

Appendix 1 - NRAC Formula and PCIF Allocation Summary (for 'Fair Shares' 2023 PCST Paper)
Distribution of Primary Care Improvement Plan and Transformation and Stability Funds

Appendix 1 NRAC Formula and PCIF Allocation Summary (for 'Fair Shares' 2023 PCST Paper)

The statement below reflects our 'best understanding' of the current situation.

The Scottish Resource Allocation Formula (RAF) is used by NHS Scotland Resource Allocation Committee (NRAC) to allocate around 70% of the NHS budget to the 14 NHS Boards in Scotland. The target share for each Board is calculated by weighting population figures against various demographics, namely:

- Age/sex
- Morbidity and life circumstances
- Excess costs (remoteness and rurality)

There are two "arms" to the NRAC formula with one assigning the share for Hospital and Community Health Services (HCHS) and the other for GP Prescribing. Both "arms" use different starting populations before applying the demographic weightings to create final adjusted populations for each Board/HSCP.

The HCHS formula uses National Records of Scotland (NRS) mid-year estimate and projection figures to calculate the **starting** population of the 'first arm'.

The second arm, used for GP Prescribing, uses a **starting** population figure taken from Community Health Index (CHI) data at the end of the most recent financial year. This figure is then adjusted based on the NRS figures to account for inflation in CHI figures. This adjustment produces a **third figure** for PCIP allocation, by weighting 89.1% of the HCHS population and 10.9% of the GP Prescribing population.

The Scottish Government (SG) uses this **third adjusted** population figure to determine Primary Care Improvement Plan allocations.

The disparity between the NRAC **starting** population and GMS List Size figures is readily reconciled. It is well understood that GMS List Sizes are generally inflated by 6-8%. For example, the current population of Scotland reported through GMS is 5.86M and the NRS figure is 5.5M; a c6% difference.

The continued use of the HCHS NRAC 'arm' to determine (c90%) PCIP shares, compounds differential population sizes with increasingly differential population growth rates to disadvantage the Edinburgh PCIP share.

Edinburgh received 8.32% of the NRAC allocation in 2018. This equated with c.10% of the national GMS population share and c.9% of the estimated national workload. The negative impact on Edinburgh PCIP allocation is c£1M in 2022.

Report

Distribution of Primary Care Improvement Plan and Transformation and Stability Funds

Edinburgh Primary Care Leadership and Resourcing Group (26.2.19)

(Recommendations agreed 26.2.19 for distribution to all practices for comment and feedback)

1. Executive Summary

1.1 In June 2018 Scottish Government began to invest resources over a 4 year period to April 2022 as required for the implementation of the 2018 General Medical Services Contract in Scotland

1.2 The resources are channelled through Health Boards to Health and Social Care Partnerships (HSCPs) and in Edinburgh the 'Leadership & Resources Group' (L&R) was established in September 2018 to ensure the resources were applied as effectively as possible.

1.3 This report recommends to all City Practices, a methodology for distribution which the Leadership and Resources Group have supported as a good balance of interests and considerations.

2. Recommendations

2.1 To approve the methodology proposed for the distribution of resources between individual GP Practices and GP Clusters. Table 1 below sets out the implications for all City practices (with exceptions)

2.2 Specifically, to approve the composition of the £11.3M total resource to be subject to this distribution and note the potential for this figure to be adjusted both up and down in accordance with new information available over costs of different elements of the contract: Transformation and Stability (T&S) funding might add to the total resource (see 2.7 below)

2.3 Specifically, to approve the distribution of 88% of the £11.3M (or adjusted figure) to be allocated to practices on the basis of their 'settled' global sum figure. This will be considered the 'final envelope'. Full use of the funds may be limited in the short term by staff availability. ***In line with the new Contract specifications, the money does not go directly to practices but rather represents the resource the practice can consider its share***. We have confirmed with Scottish Government that it will not allow practices to have new PCIP funding directly, and therefore GPs are not the employers of the new staff, but rather these are Health Board employed, and allocated to practices.

2.4 Specifically, to approve that 5% of the total resource is reserved and distributed according to the number of people on each practice list who are in the first (most deprived) quintile (20%) of the population.

2.5 Specifically, to approve that 5% of the total resource is reserved to give each GP cluster a modest financial platform to begin to develop shared services and incentivise practices to contribute part of their practice allocation to build this.

2.6 Specifically, to approve that an additional 2% of the total resource is distributed to practices related to the +85 year population. It is anticipated that practices may choose to add this (at least) to their cluster resource to develop shared services.

2.7 Specifically, to approve that the equivalent of a further 5% of the PCIP is reserved (in recurring terms) from the T&S Fund, to allow for a better understanding of workload to emerge. A further proposal for recurring commitment of these funds will be made through L&R.

2.8 To note that a significant proportion of the available resources which was originally made available as Transformation & Stability ('50/50') investments will be converted to New Contract investments from 1.4.19. No contributions will be sought from practices for staff in this category, as was previously agreed. This does not apply to non New GMS contract investments, such as A&C or local IT support.

Table 1: Proposed Distribution of PCIP Fund February 2019

Practice Address	List Size Jan 19	GS % Jan 19	1st Q %	Over 85%	WTE 88% + 5% + 2%
Baronscourt Surgery, 89 Northfield	7,357	1.5	20.3	2.19	3 - 3.5
Niddrie Medical Practice, Craigmillar	3,616	0.8	72.6	1.43	1.5 -2
Craigmillar Medical Group, Craigmill	9,390	2.1	72.9	0.79	5 - 5.5
Durham Road Medical Group, 25 Du	6,035	1.4	20.4	2.67	2.5 - 3
St Triduana's Medical Practice, 54 M	11,085	2.6	21.2	3.60	5.5 - 6
Milton Surgery, 132 Mountcastle Dr	7,792	1.9	30.5	3.26	4 - 4.5
Southfield Medical Practice, 132 Mc	3,849	0.9	25.2	3.54	1.5 - 2
The Hopetoun Practice, Bellevue Mc	7,078	1.2	2.9	0.81	2 - 2.5
Dr Gray & Partners, Bellevue Medic	6,433	1.1	4.1	0.86	2 - 2.5
Leith Surgery, 2 Duke Street, Edinbu	9,777	1.8	14.7	0.80	3.5 - 4
Brunton Place Surgery, 9 Brunton P	8,379	1.6	11	0.92	3 - 3.5
The Victoria Practice, Leith Commu	5,161	1.0	18.7	0.54	1.5 - 2
Leith Mount Surgery, 2 Lindsay Stre	11,126	2.2	25.1	0.92	4.5 - 5
Summerside Medical Practice, Sumr	6,344	1.4	29.9	1.49	2.5 - 3
Dr Shaw & Partners, Stockbridge He	9,079	1.8	1.2	1.92	3 - 3.5
The Group Practice - Eyre, 31 Eyre C	10,099	1.9	2.6	1.28	3.5 - 4
West End Medical Practice, 36 Manc	9,648	1.8	2.9	1.84	3.5 - 4
The Green Practice, Stockbridge Hea	8,702	1.7	2.6	2.32	3 - 3.5
The Long House Surgery, The Long H	7,985	1.7	11.5	2.31	3.5 - 4
Muirhouse Medical Group, Muirhou	15,982	3.4	68.3	0.99	7.5 - 8
Crewe Medical Centre, 135 Boswall	9,493	2.0	64.3	1.35	4.5 - 5
Dr Steve Allan & Partners, Bangholm	9,979	2.3	14.7	3.35	4 - 4.5
South Queensferry Medical Practice	12,581	2.4	4.9	1.30	4.5 - 5
Barclay Medical Practice East Craigs,	8,223	1.6	0	1.95	3 - 3.5
Davidson's Mains Medical Centre, 5	5,655	1.2	17	1.79	2 - 2.5
Ladywell Medical Centre (West), La	11,212	2.4	5.3	3.50	4.5 - 5
Ladywell Medical Centre (East), 26 I	11,058	2.3	7.1	3.08	4.5 - 5
Cramond Medical Practice, 2 Cramo	8,981	1.9	1.5	4.07	3.5 - 4
Blackhall Medical Centre, 51 Hillhou	6,353	1.4	4.6	4.18	2.5 - 3
Murrayfield Medical Practice, 13b R	7,173	1.6	3.2	4.78	3 - 3.5
Murrayfield Medical Centre, 35 Sau	7,675	1.7	11	3.79	3.5 - 4
Marchmont Medical Practice, 10 Wa	2,319	0.4	7.8	1.11	0.5 - 1
Bruntsfield Medical Practice, 11 For	12,105	2.2	0.1	2.19	4 - 4.5
Boroughloch Medical Practice, 1 Me	3,280	0.6	4.1	2.18	1 - 1.5
Meadows Medical Practice, 9 Broug	4,935	0.9	3.4	2.17	1.5 - 2
Morningside Medical Practice, 2 Mo	8,848	1.8	0.3	2.96	3 - 3.5
Grange Medical Group, 1 Beaufort R	7,724	1.6	0.4	4.05	3 -3.5
Hermitage Medical Practice, 5/6 He	7,094	1.4	0	3.75	2.5 - 3
St Leonard's Medical Centre, 145 Pl	7,604	1.5	23.4	0.90	2.5 - 3
Mackenzie Medical Centre, 20 West	8,262	1.7	23.9	0.96	3 - 3.5
Dalkeith Road Medical Practice, 145	3,818	0.8	12.9	2.42	1.5 - 2
Dr M Ferguson & Partners, Conan D	10,163	2.2	4.1	3.06	4 - 4.5
Gracemount Medical Practice, 24 Gr	7,739	1.7	54.2	1.67	3.5 - 4
Liberton Medical Group, 65 Liberto	7,116	1.6	31.1	2.19	3 - 3.5
The Southern Medical Group, 322 G	7,320	1.6	36.9	1.78	3.5 - 4
Inchpark Surgery, 10 Marmion Cres	5,685	1.3	34.4	2.60	2.5 - 3
Ferniehill Surgery, 8 Ferniehill Road	6,481	1.6	45.8	2.38	3 - 3.5
Gilmore Medical Practice, Tollcross I	7,627	1.3	2.5	0.36	2 - 2.5
Leven Medical Practice, Tollcross He	7,118	1.2	2.6	0.54	2 - 2.5
Springwell Medical Group, Springwe	10,703	1.9	9.9	0.80	3.5 - 4
Slateford Medical Practice, 27 Gorgi	10,239	2.0	13	1.52	4 - 4.5
Whinpark Medical Practice, Whinpa	11,071	2.5	43.8	1.62	5 - 5.5
Sighthill Green Medical Practice, Sig	9,362	2.1	47.5	1.77	4.5 - 5
Drs Sharpe, Putta & Burns Practice,	3,777	0.9	50	1.33	1.5 - 2
Braids Medical Practice, 6 Camus Av	9,668	1.9	1.2	3.06	3.5 - 4
Ratho Medical Practice, 14a Wilkies	2,647	0.5	0	1.16	1 - 1.5
Colinton Surgery, 296b Colinton Ro	11,511	2.4	2.5	3.38	4.5 - 5
The Pentlands Medical Practice, Per	13,476	2.8	0	2.83	5.5 - 6
Firrhill Medical Centre, Allermuir He	5,476	1.2	23.1	2.26	2 - 2.5
Craiglockhart Medical Group, Allerm	9,055	2.0	12.4	3.78	4 - 4.5
	485,523	100.0			c211

Cluster 5%	Population	WTE
NEE	49,124	1.1
NEL	54,298	1.2
NWB	80,967	1.9
NWT	78,911	1.8
SEN	46,305	1.1
SES	64,188	1.5
SWC	59,897	1.4
SWP	51,833	1.2
Clusters 5%	485,523	11.1

Practice	2Cs	Uni/Ricc
Population	37,974	35,280
1st Q	10,712	3,872
Over 85	605	36
WTE	14.8	4.7
Cluster	0.9	0.3
Fund	T&S	PCIP

WTE Distribution Summary	
88% (GS %)	c196
5% 1st Q Depr.	c11
2% Over 85	c5

- 1 WTE is the average of B5,B6,B7&B8a at £50.775 Annually - 2018 / 2019 Rate
- Clinical Management Cost will lead to reduce the overall WTE
- GS% will be updated in April 19

	Gross Charge18/19
Band 2	22,950
Band 3	24,669
Band 4	28,957
Band 5	39,915
Band 6	46,266
Band 7	54,142
Band 8A	62,777

3. Background

3.1 The funds available through the New Contract are shown in Appendix 1 with commitments and potential commitments for each of the contract areas.

3.2 In the first year the investments have been obvious and the Leadership and Resourcing Group (L&R) has been able to be confident in the actions taken to date.

3.3 The area of pharmacotherapy is a useful example. Scottish Government had made several previous investments into this area, but then decided these should be repackaged as part of the New Contract. As a result, of our total £12.9m resource we already had £1.1M invested in the strengthening of pharmacotherapy. There is widespread expectation that practices would benefit from an investment of c1.0wte (B7) pharmacist per 10,000. We asked that this was applied with some allowance for skill mix (B5 technicians) and the 'ideal' investment for the city would be c£3.7M. We are not yet in a position to judge whether investing such a large proportion of the £12.9M is optimal, but we were confident in the knowledge that is was highly unlikely that the City would invest less than £2m. Therefore, a decision was taken (October L&R) to commit a further £1M based on a paper which drew attention to the risks of Edinburgh losing out on a limited pool of available pharmacists, together with the knowledge that we had already invested (through T&S) in 5 dedicated posts which would test the efficacy of a concentrated pharmacy resource in 6 practices. The Evaluation Officer came into post in January and this will be an early assessment to provide feedback to L&R about the impact of these posts before further investment would be considered. In the meantime, we have indicated a figure of £2.85M as our best estimate of what will ultimately be invested in this area.

3.4 Throughout the consultation on the Primary Care Improvement Plan (PCIP) (March – May 2018) the issues of equity and equality were highlighted, with an intense interest in whether all practices would be supported and be seen to be treated fairly. The assurance of transparency was given repeatedly and the composition of the L&R group was reassuring to GPs.

3.5 A further dimension was the efficacy of shared resources in comparison with practice dedicated resources. In the early stages of supporting practices with current or foreseen stability challenges the 'injection' of resources directly into practices was both popular and effective, partly because of the speed at which this could be achieved. It also meant that practices could choose the health workers most suited to their needs and patient population. The view developed that this was the most realistic approach under duress, and that as more practices secured capacity the clusters would play a stronger role in developing ideas about how practices might collaborate.

3.6 This experience has influenced how we think about the new resources together with the issue of scale. We have 70 practices with widely differing challenges and orientation. Locality GP communication arrangements have been in place for 20 years or so and are well understood, now augmented by new GP cluster arrangements. It is not possible to have a consensual

agreement on the distribution of resources in the same way as is open to smaller populations. Our approach is to reassure all practices that the resources will come to them (with caveats) and they can then decide to what extent they collaborate with neighbouring practices to put agreed services into place. This also emphasises the dynamism of the arrangements in the longer term – clusters can invest and disinvest in shared services as experience is gained.

3.7 As part of the roll out of this resource we will clarify with practices who have already received additional resources, whether they are considered part of their new contract allocation. Practices with 17C funding and those who were allocated Primary Care Mental Health Nurses or pharmacists are obvious examples where this is the case.

3.8 Over time, practices and clusters may wish to change their investments as they gain experience in what is most effective. We will develop mechanisms for this to happen. All these investments are subject to evaluation and there is the potential for them to be withdrawn and reinvested elsewhere in primary care if it is apparent that they are not having the agreed or acceptable impact on workload. The experience to date is that close involvement of the practice team in introducing new roles is a prerequisite for success.

3.9 Practices are aware that the personnel to fulfil the New Contract are not all immediately available. They accept that we have had to support practices with immediate challenges first, in the knowledge that we will resource up to the level of the New Contract and that ultimately every practice will benefit to the level agreed for their population ie 'fair shares for all'.

4. Main report

4.1 Appendix 2 shows the 'topslices' ie answers the question why only £11.3M is available for distribution rather than the full £12.9M (subject to further adjustment). We currently anticipate the £12.9M being topped up by a yet to be confirmed £1M from 17C existing investments which will be merged with new contract resources.

4.2 Table 1 proposes that we take 88% of the available resource and distribute this according to Global Sum for each practice. The 2C group of practices and University and Riccarton Practices will be dealt with separately.

4.3 The Global Sum calculation is imperfect, but provides an objective and well recognised indication of the demand of a given list. The proposal is therefore that this is used as the key determinant of how 88% of the resource should be directed. It should be noted that we have removed the elements of Global Sum which are made up by New Patient Premium and Care Home weighting. This removes the distortion of practices which have recently grown their lists having a higher GS value than their population would normally attract and those practices with high care home numbers, already covered by both the age related GS weighting and enhanced services payments. We have checked the resulting adjusted GS figures against known directly comparable practices and

recommend this as the fairest methodology against which to allocate resources. This is referred to locally as the 'settled' GS figure for each practice.

4.4 Each practice will have a well-articulated view about why the Global Sum underestimates the 'weight' of their population. Many factors influence demand, but overwhelmingly the age and deprivation profiles determine workload. There is however a broad consensus that the recent adjustment to GS has benefitted practices with older populations rather than high deprivation, albeit that 'MPIGs' still benefit a minority of high deprivation practices.

4.5 On this basis a 5% allocation to be distributed to practices according to patients in the Q1 for deprivation is proposed. One of the declared intentions of the New Contract was to address inequalities and this is a relatively modest adjustment taking into account the relatively low levels of deprivation across the City as a whole.

4.6 The next adjustment to the available resource is that a further 5% allocation would be reserved specifically for joint investment by clusters. The average cluster would have a 'platform' of c£50k - £90k per cluster, depending on their (adjusted) population share. Participating practices could contribute, should they wish, to establish a Community Treatment And Care Centre (CTAC) or home visiting service, for example. Clusters can choose to combine resources or can focus available resources on a smaller group of practices willing to 'top – up' the platform contribution, using their allocated individual practice resource

4.7 The final proposed adjustment to the PCIP funding, is to weight the allocation to those practices which have the highest proportion of +85 populations. The total +85 population is around 11,000, of whom c3000 are resident in Care Homes where care is covered by an additional enhanced service payment. Where clusters (or sub clusters) agree, this 2% may be added to the Cluster 5% to create a stronger base for clusters to collaborate of services for their elderly populations

4.8 If agreed, the next steps are to inform each practice of their allocation of wte ('whole time equivalent'). This WTE refers to heath professional banding and is the average of B5, B6, B7& B8a at £50.775 p.a. (2018 / 2019 rate). This will encourage practices to debate what cluster wide (or locality or smaller group of practices') services they think would work best for them. The collective picture across the City will then be put together and we can share and provide further suggestions on this basis. For example, if each practice is determined to have an advanced nurse practitioner within the contract period, this would be unrealistic and the practices might have to agree to share or to consider another type of investment. Again, cluster-based discussions are envisaged about how best to mould local resources.

4.9 The 2C (directly managed) practices have been treated separately. The proposal is they do not access directly the New Contract funds (£11.7M), but access the Transformation & Stability Funds (currently £2.3M rising to £2.8M by 2021/22 tbc). There are two reasons for this. Firstly it is likely that when compared with their 17J counterparts, three of the 8 2C practices will already have levels of investment equivalent to the resources they would receive as a

17J practice plus the New Contract resources. The other 5 practices are still relatively new to 2C status, and we are confident of neither the reported budgets nor levels of expenditure to date. It is therefore difficult to judge whether they should have their capacity increased as they would if they had still been 17J – or that they keep all or part of the additional capacity injected from the Transformation & Stability Funds. This will become clear over the next few months and £800k of the T&S fund has been set aside to inject permanently into what is currently reporting as a c£1M overspend in the current financial year. Part of this overspend is that the reported budgets are not complete: part is recurring additional resource which we have allowed for (£800K) and part is a reflection of the transitional turbulence which has resulted in additional expenditure on medical sessions in particular (and is expected to settle in 2019/20). The undertaking of transparency of resource allocation and base funding to 2C practices has been emphasised, to ensure they are neither unfairly advantaged nor disadvantaged over 17J practices in access to new resources.

4.10 The other exceptional practices which have been treated separately are the two practices where the list is dominated by university students. To give these practices, which have quite different pressures, the same resource based on GS would not be proportionate. We have set aside PCIP funding to ensure both practices receive a fair allocation of additional resources. Direct discussion with the two practices concerned is outstanding.

4.11 A further stage in this process of allocation is to look not only at the impact of investment in the sustainability (workload) of general practice and secondary impacts on the wider health and social care system – but to consider the whole benefits to the population in the longer term and what specific expectations can be attached to these investments. We anticipate that this will develop over 2019/20 and have therefore 'ear-marked' the equivalent of a further 5% of PCIP funds to allow for this. This amount will not come from the PCIP funds, but from the T&S fund and any commitment of these funds on a recurring basis would need approval through L&R. The underspend accruing will be applied to non recurring primary care investments as approved by L&R.

5. Key risks

5.1 There is huge variation in workload challenges to practices across the City and consequently considerable diversity of opinion about the best way to distribute the resource. The proposed adjustments and setting aside a proportion of funding from the T&S to address this, is a significant mitigating factor. The risk remains however, that some practices will be generously treated by this allocation whilst others will continue to struggle.

5.2 A broad consensus across the GP community is essential for us to continue to benefit from the available resources. Without this, decision-making could be displaced elsewhere and a less locally responsive distribution imposed.

5.3 The risk of delays in decision-making remain. Many practices are potentially subject to destabilisation and if resources continue to be focussed

on crisis situations rather than in a more preventative fashion, further avoidable damage could be done to a sector only beginning to show the first signs of recovery.

6. Financial implications

6.1 This paper addresses the deployment of Government New Contract funding. There are no direct implications or requirements for additional funding for EHSCP.

7. Involving people

7.1 During March and early April this proposal will be discussed across primary care in Edinburgh with a view to agreeing a final version at the April L&R group.

7.2 The Edinburgh Integration Joint Board (IJB) has asked for a formal update on PCIP implementation progress for the May 2019 meeting. It is important that this next round of discussion is used to inform the IJB not only of the significant progress being made, but of the serious risks to stability which persist.

8. Impact on plans of other parties

8.1 The potential for effective investment to have a stabilising impact on the whole Partnership is profound. If the impact of some of the early investments on secondary care can be proven and sustained then the additional preventive capabilities of primary care will begin to emerge.

Background reading/references

Appendix 1 – Edinburgh PC PCIP Recurring Commitments Only (Financial Summary)
Appendix 2 - Proposed Recurring Topslices

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Appendix 1

Recurring Commitments Only (FYE)
Edinburgh Primary Care PCIP Implementation Plan
Update Summary for GPs (Issue 1 – Feb 2019)

	2018/2019	19/20	20/21	21/22	Estimated Workforce Projection by 21/22	FULL	Minimum
Funding Available(£M)	£3.8	£4.5	£9.1	£12.9		£17.1	£9.8
	(K)	**(K)**	**(K)**	**(K)**	**(WTE)**	**(K)**	**(K)**
1. Pharmacotherapy	£1000	£2000	£2850+	£2850+	63	£3700	£2000
2. Link working (20 practices)	£800	£900	£1100	£1100	24	£1100	£1100
3.Mental Health	£700	£1060+	£1220+	£1540+	34	£2250	£1220
4.Vaccination Expansion (All practices)	£150	£400+	£600+	£700+	17	£700	£700
5.ANP Expansion		£400+	£800+	£1200+	24	£2500	£1400
6.MSK	£30	£300	£600+	£900+	18	£2250	£1200
7.CTACS	£80	£320	£480	£640	16	£3000	£1200
8.Paramedics/Urgent Care		£150	£300	£600+	12	£1125	£300
9.Physicians Assistants		£100+	£200+	£400+	8		£200
Support*	£690	£690	£690	£690		£690	£690
TOTAL	**£3.45M**	**£6.32M**	**£8.85M**	**£10.6M**	**214**	**£17.3M**	**£10.0M**

*Top slices less Link working/Vaccs shown above

Appendix 2

Proposed Recurring Topslices
(As at Feb 19)

PCIP £12.9M by 2021/22

Proposed Recurring Topslices (As at Feb 19)	(£k)
Link working Network	1100K
ANP Training / Phlebotomy	420K
Vaccinations	700K
Designated Medical Practitioner Network	40K
Practice Management Network	20K
Primary Care Support Team	90K
Technology Development	100K
IT Additional Commitments	15+5K
Total	**£2.49M**