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A meeting of the **Scottish Borders Health & Social Care Integration Joint Board** will be held on **Wednesday, 2nd March, 2022** at **9.00 am** via Microsoft Teams

AGENDA

Time	No		Lead	Paper
09:00	**1**	**ANNOUNCEMENTS & APOLOGIES**	**Chair**	Verbal
09:02	**2**	**DECLARATIONS OF INTEREST**	**Chair**	Verbal
09:05	**3**	**MINUTES OF PREVIOUS MEETING - 15.12.2021**	**Chair**	Attached
09:10	**4**	**MATTERS ARISING**		
	4.1	Action Tracker	**Chair**	Attached
	4.2	Health, Social Care and Adult Social Work pressures and levels of risk	Director of Nursing, Midwifery & AHPs and CSWO - Verbal	Verbal
	4.3	Communities Mental Health and Wellbeing Fund update -	Chief Executive Third Sector Dumfries & Galloway	Verbal
09:25	**5**	**FOR DECISION**		
	5.1	2022/23 Joint Financial Plan	Chief Financial Officer	Presentation
	5.2	Needs Assessment : Oral Health and Dental Health	Locum Consultant in	Appendix-2022-1

			Dental Public Health	
	5.3	Millar House	General Manager MH & LD	Appendix-2022-2
	5.4	Directions 15 December 2021: • HSCP Integrated Workforce Plan • Strategic Commissioning Plan • Care Village Provision 2 March 2022: • Oral Health Plan • Millar House • 2022/23 Budget	Chief Officer	Appendix-2022-3 A B C D E to follow F to follow
10:30	**6**	**FOR NOTING**		
	6.1	Monitoring and Forecast of the Health and Social Care Partnership Budget 2021/22 at 31 December 2021	Chief Financial Officer	Appendix-2022-4
	6.2	Update on impact of Integration Joint Board requirements as category 1 responders under the civil contingencies act 2004	Chief Officer	Appendix-2022-5
	6.3	Chief Social Work Officer Annual Report	CSWO	Appendix-2022-6
	6.4	Strategic Planning Group Minutes 3.11.2021	Board Secretary	Appendix-2022-7
10:55	**7**	**ANY OTHER BUSINESS - DEVELOPMENT SESSION TO BE HELD 11 AM - 12 NOON (WITH SPG AND HSCP LEADERSHIP TEAM)**	Chair	
11:00	**8**	**DATE AND TIME OF NEXT MEETING: WED 20 APRIL 2022, 10 AM - 12 NOON VIA TEAMS**	Chair	Verbal

Minutes of a meeting of the **Scottish Borders Health & Social Care Integration Joint Board held** on **Wednesday 15 December 2021** at **10am** via Microsoft Teams

Present:
(v) Cllr S Haslam
(v) Cllr J Linehan
(v) Cllr T Weatherston
(v) Cllr E Thornton-Nicol
(v) Mrs L O'Leary, Non Executive (Chair)
(v) Mrs K Hamilton, Non Executive
(v) Mr J McLaren, Non Executive
(v) Mr T Taylor, Non Executive
Mr C Myers, Chief Officer
Mrs J Smith, Borders Care Voice
Ms L Gallacher, Borders Carers Centre
Ms G Russell, Partnership Representative NHS
Mr N Istephan, Chief Executive Eildon Housing
Mr S Easingwood, Chief Social Work and Public Protection Officer

In Attendance: Miss I Bishop, Board Secretary
Mrs J Stacey, Internal Auditor
Mr R Roberts, Chief Executive NHS
Mrs N Meadows, Chief Executive, SBC
Mr G McMurdo, Programme Manager SBC
Ms J Holland, Director of Strategic Commissioning and Partnerships SBC
Ms S Bell, Communications Manager SBC
Mrs L Lang, Communications Officer NHS
Mr A Bone, Director of Finance, NHS Borders
Ms H Jacks, Planning & Performance Officer, NHS
Mr G Samson, Audit Scotland
Dr T Patterson, Director of Public Health
Ms S Henderson, Planning & Development Officer, NHS
Mr S Burt, General Manager MH&LD
Ms S Brown, Public Member

1. APOLOGIES AND ANNOUNCEMENTS

1.1 Apologies had been received from Cllr David Parker, Mrs Harriet Campbell, Non Executive, Mr David Robertson, Chief Financial Officer, SBC, Mrs Sarah Horan, Director of Nursing, Midwifery & AHPs, NHS, Dr Lynn McCallum, Medical Director, NHS, Dr Kevin Buchan GP, Ms Linda Jackson, LGBT+, Mr David Bell, Staff Side, SBC and Ms Juliana Amaral, BAVs.

1.2 The Chair advised that there would be a slight change to the running order of the agenda, with item 5.5 being taken ahead of item 5.4.

1.3 The Chair confirmed the meeting was quorate.

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1.4 The Chair welcomed guest speakers and members of the press to the meeting.

2. DECLARATIONS OF INTEREST

2.1 The Chair sought any verbal declarations of interest pertaining to items on the agenda.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted there were none.

3. MINUTES OF THE PREVIOUS MEETING

3.1 The minutes of the extraordinary meeting of the Health & Social Care Integration Joint Board held on 20 October 2021 were approved.

4. MATTERS ARISING

4.1 **Action 4:** Mr Chris Myers suggested he meet with Cllr Shona Haslam to clarify the data available before bringing it forward to a future meeting. Cllr Haslam agreed to that approach.

4.2 **Action 2020-3:** Mr Tris Taylor commented the action had been marked as complete by 31.03.21. Miss Iris Bishop apologised for the inaccurate sentence and advised that it should have been marked as in progress as the Scheme of Integration light touch review consultation would commence shortly.

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the action tracker.

5. FORMAL APPOINTMENT OF CHIEF OFFICER HEALTH & SOCIAL CARE

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** formally appointed Mr Chris Myers as Chief Officer Health & Social Care.

6. IJB BUSINESS PLAN AND MEETING CYCLE 2022

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** approved the business plan and meeting cycle for 2022.

7. SELF ASSESSMENT

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** approved the format of the self assessment form template.

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** approved roll out to the Board and its Committees and Groups to undertake an annual self assessment in the autumn each year with a six week turnaround.

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8. IJB STRATEGIC COMMISSIONING APPROACH

8.1 Mr Chris Myers provided an overview of the content of the paper. He suggested the next IJB Development session be used to further discuss the strategic commissioning approach. He noted that the paper had been developed based on discussion at the IJB's Strategic Planning Group.

8.2 Further discussion focused on: assurance that staff governance standards would be adhered too; visibility of unmet need and ensuring planning was taken forward in coproduction with people; directions formulated in coproduction and if necessary resolution pathways followed before directions are issued; planning for success through the alignment of NHS Borders and SBC strategies with the IJB Strategic Commissioning Plan; and adequacy of joint needs assessment resourcing.

8.3 Mrs Jenny Smith welcomed the robust and thorough approach and asked that the membership of the Future Strategy Group included third sector and independent sector representation.

8.4 Mrs Karen Hamilton commented that the IJB Audit Committee had discussed the paper at its meeting the previous week and had been supportive of it. The Audit Committee had also acknowledged the issue of updating the Terms of Reference and were content to take on a monitoring role to provide the IJB with assurance.

8.5 Mr Myers welcomed the discussion and commented that broad engagement with all stakeholders is key, and as a result that the Future Strategy Group (FSG) would support and report into the Strategic Planning Group which contained service users and other experts from the community, third sector, staffside and independent sector representatives. The output from the FSG would be submitted to the Strategic Planning Group (SPG) to assess the plans and directions, and if supportive recommend them to the IJB for approval and issue. However the SPG could also return plans and directions back to the FSG for further consideration by other groups.

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** considered and approved the following recommendations:

- That the work of the SIP Oversight Board is realigned to the Audit Committee rather than directly reporting to the IJB.

- That the IJB hold a series of development sessions in partnership with key operational and functional stakeholders to appropriately consider and undertake the planning process.

- That a 'Future Strategy Group' is developed that reports into the Strategic Planning Group to develop Directions and to manage the work associated with the delivery of the new Strategic Developments over the next 12-14 months.

- That the IJB endorse the approach of undertaking a comprehensive Joint Needs Assessment to inform the Strategic Commissioning Plan that will be concluded towards

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the end of 2022/23 to support the development of a 3 year Strategic Commissioning Plan for 2023-26.

- That whilst the Strategic Commissioning Plan is focused on the period up to the implementation of the National Care Service, that a series of strategic commissioning assumptions are developed over the longer term to support the business planning processes and sustainability of the IJB's key strategic and operational partners.

- That the Audit Committee oversee a rapid review of the Terms of Reference and a self-assessment of the IJB Committees to ensure that the IJB and these Committees are able to continue to effectively function in the context of the significant level of work required, in line with the IJB's duties outlined in the Act.

- That an additional development session be held to progress the Strategic Commissioning Approach work.

9. DIRECTIONS POLICY AND PROCEDURE

9.1 Mr Chris Myers provided an overview of the content of the report and commented that by providing a more formalised approach to directions a monitoring and review of progress could be undertaken. The IJB Audit Committee had agreed to take on the role of monitoring and reviewing implementation to provide assurance to the IJB that directions were being delivered. The process was based on best practice guidance and national expectations for issuing of directions. The process would also allow all parties to understand the planning assumptions of the IJB and all associated parties.

9.2 Mrs Netta Meadows sought assurance that the process had been checked against the standing orders of the respective organisations especially in regard to budgetary decisions and delegated decisions.

9.3 Mr Myers commented that the standing orders of the partners had not been consulted. He advised that the process was aligned to the Scheme of Integration and the IJB's Standing Orders which were not incompatible with the partners standing orders.

9.4 As the IJB is the commissioning body and the new Future Strategy Group and SPG would produce plans in coproduction with the parties, which the SPG would review and potentially recommend to the IJB, there would be no surprises for either organisation when a direction was issued, as all parties were involved through each stage of the process.

9.5 Operational decisions would remain with the partners and directions would be strategic in nature and at times may reference some operational decisions taken. He assured the IJB that partners would be involved in the decision making process when developing directions.

9.6 Mr Ralph Roberts commented that it was important that in the development of directions at a strategic level, the engagement process was robust and included, service providers as well as the public and service users. He suggested once any organisation received a direction from the IJB it would have the right to advise the IJB

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that the direction could not be fulfilled and ask the IJB to reconsider and adjust the direction.

9.7 The Chair welcomed the improved level of transparency that would be achieved through the process.

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the content of this report, the requirements of the Public Bodies (Joint Working) (Scotland) Act 2014 and the statutory guidance issued by the Scottish Government in January 2020 in relation to Directions.

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** approved the IJB Directions Policy and Procedure and IJB Directions template set out in Appendices 1 and 2 of this report.

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** approved the associated addition to the SBIJB Audit Committee Terms of Reference: The oversight and scrutiny of the implementation of the Strategic Commissioning Plan and the application of the Directions Policy. Monitor and review progress with the implementation of Directions made to partners to ensure that clarity and transparency can be demonstrated and aligned to performance and financial reporting, and escalate key delivery issues to the IJB. Maintain independent oversight of progress against the Strategic Commissioning Plan, and provide assurance to the IJB thereon.

10. DAY SERVICES PETITION AND FUTURE PROVISION

10.1 Mr Stuart Easingwood provided an overview of the content of the report and highlighted that the intention was to design day services with a focus on early intervention and in line with self-directed support requirements.

10.2 Mrs Netta Meadows sought clarification of the scope of the action plan.

10.3 Cllr Tom Weatherston supported the proposal and referenced earlier discussion on coproduction, advising that the public had been unsupportive of the direction of travel, however mechanisms were in place to reach a resolution.

10.4 Mr Tris Taylor enquired if carers were involved in the proposal at a sufficient level to influence the direction of travel initially, especially given there had been a public reaction.

10.5 The Chair commented that in moving forward the Carers Workstream would be asked to undertaken the work, and she enquired if there was a mechanism of engagement with the end users themselves in addition to carers.

10.6 Mrs Lynn Gallacher commented that there were lessons to be learned on the engagement and consultation process for day services . The original transformation of day services had not engaged well to provide an informed direction of travel and that would be remedied through the engagement of the Carers Workstream. She welcomed the recommendation from the SBC Audit and Scrutiny Committee.

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10.7 Mr John McLaren commented that previously work had focused on buildings and services provided from buildings, when it would have been more beneficial to have known the needs of carers and service users as the first focus of any transformation.

10.8 Cllr Elaine Thornton-Nicol supported the intention of assisting people in their communities instead of it buildings and suggested the pathway to progress the matter would sit within the Older Peoples pathway group. She commented that the world had changed since 2019 and what might have been right then might not be right as matters were progressed.

10.9 Mr Easingwood, provided reassurance in terms of individuals circumstances, commenting that the first stage of the process was coproduction and the mapping of individuals needs as a starting point and then matching the services to the individuals needs.

10.10 In regard to scope Mr Easingwood commented that the approach was for carers to be supported to access flexible support and information to best meet their needs and choices going forward. The scope was within the remit of the Carers Workstream and would ensure there was clear and transparent engagement.

10.11 Mr Easingwood commented that in regard to buildings, 4 of the 5 locality areas had now moved away from buildings based services, and there were some individuals without the right packages in place that were being reviewed. He commented that as a consequence of the pandemic it was essential to look at the current and future landscape for service delivery moving forward. The needs of individuals and the open and honest conversations with carers and service users about their individual circumstances and what they needed would inform service provision moving forward.

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** considered and agreed to the request made by the Scottish Borders Council Audit and Scrutiny Committee

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the contents of the petition papers and Audit and Scrutiny meeting minute

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** agreed to task the existing Carers Workstream with the task of undertaking this piece of work, as part of the workstream's new work to develop an Action Plan for Carers in the Scottish Borders. Progress of this work should be reviewed in the first instance by the Integration Joint Board's Audit Committee prior to reporting to the Integration Joint Board.

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted that a future Integration Joint Board Direction for day services is likely to be required as a result

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** sought a timeline for the work to be taken forward.

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11. MEMBERSHIP OF THE IJB

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the change in voting membership.

12. MONITORING AND FORECAST OF THE HEALTH AND SOCIAL CARE PARTNERSHIP BUDGET 2021/22 AT 30 SEPTEMBER 2021

12.1 Mr Andrew Bone provided an overview on the content of the report and drew the attention of the Board to the £6.2m deficit for the year end forecast. He further referred to the supporting appendices, breakdown of savings and gap in projections.

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the combined forecast adverse variance of (£6.186m) for the Partnership for the year to 31 March 2022 based on available information and arrangements in place to partially mitigate this position;

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted that whilst the forecast position includes direct costs relating to mobilising and remobilising in respect of Covid-19, it also assumes that all such costs will again be funded by the Scottish Government in 2021/22;

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted that the position includes additional funding vired to the Health and Social Care Partnership during the first half of the financial year by Scottish Borders Council to meet reported pressures across social care functions from managed forecast efficiency savings within other non-delegated local authority services and funding brought forward in respect of Covid-19 expenditure;

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted that any residual expenditure in excess of the delegated budgets at the end of 2021/22 will require to be funded by additional contributions from the partners in line with the approved Scheme of Integration.

13. STRATEGIC RISK REGISTER UPDATE

13.1 Mr Chris Myers provided an overview of the content of the report and advised that he had met with the Auditors and the Risk Management Team separately.

13.2 The Chair commented that in regard to escalating risks with the external environment it was good to know that something could be done to reduce their risk level a little.

13.3 Mr Tris Taylor welcomed the news that it would be rewritten and suggested it did not provide a systematic overview of the actions being taken to manage risks.

13.4 He commented that in regard to Risk 1 on cultural change it was hard to assess if it had been appropriately managed as it did not have a definition of what was required to be done or by when. He further commented that it did not reflect that low compliance with the Choices Policy remained a key barrier to the discharge strategy. He enquired

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if the risk was a feature of the partners risk registers. He further suggested it did not seem a sufficient approach if it was confined to partners to manage risks with stakeholder engagement.

13.5 In regard to Risk 9, Mr Taylor suggested evidence was required on progress and project management and for Risk 10 he commented that the year 2021 was probably a typo and should read 2022.

13.6 The Chair welcomed the comments and suggested members provide feedback to Mr Myers on how to make the report stronger in the future.

13.7 Mrs Jill Stacey commented that the intention was to have a more fundamental review of the IJB strategic risk register, especially in light of the reviews of the Strategic Commissioning Plan and Scheme of Integration. She welcomed Mr Taylor's comments and advised that they would be captured as part of that fuller review. In terms of the appendix she advised that it was a summary report and a fuller report was provided to the Chief Officer with all of the linked actions in terms of mitigating actions and controls. She advised that the format of the report could be expanded for the Board to highlight some of the key mitigating actions being undertaken.

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** considered the IJB Strategic Risk Register to ensure it covers the key risks of the IJB;

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the actions in progress to manage the risks; and

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted that a further risk update will be provided in June 2022.

14. QUARTERLY PERFORMANCE REPORT

14.1 Mr Chris Myers commented that the report had been updated in line with the principles of 'Active Governance' to try and ensure the narrative and the way in which data was presented was more helpful to the IJB members and he thanked Mrs Meriel Carter and her team for enabling the change. Mr Myers commented that in future a key focus on outcomes and delivery would be made more explicit through the performance reports.

14.2 Mr Myers drew the attention of the Board to the key concern of the number of delayed discharges in the system. He advised that there had been an increase in demand and need across the whole system with more people with a greater level of frailty and dependence being requiring support both in hospitals and our communities. He added that the Health and Social Care Partnership teams were continuing to work across the whole system to address the increased demand.

14.3 The Chair noted the huge pressures being felt by all sectors as a consequence of the pandemic and welcomed the partnership approach to addressing increased demand on all services.

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The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the quarterly performance report.

15. INTEGRATED WORKFORCE PLAN

15.1 Mr Chris Myers commented that an interim workforce plan had been formulated and would continue to be further developed by the HR Directors in both SBC and NHS Borders.

15.2 Mr Nile Istephan commented that it was an important piece of work and suggested the independent sector might be included given the continuing recruitment difficulties in all sectors. Mr Myers commented that he would welcome the input of independent providers, third sector and primary care independent providers to ensure a more coordinated approach to recruitment in future.

15.3 Mr Tris Taylor enquired if as the workforce plan developed it would provide a view of the entire workforce that was producing health and care and wellbeing in the Borders including unpaid carers. Mr Myers commented that in terms of unpaid carers they often provided the bulk of care and the Carers Workstream would need to map out the needs of people who were provided unpaid care, to form the basis of the IJB's Strategic Commissioning Plan..

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted that Scottish Government DL(2020)28 outlines the requirement for:

- Integration Authorities to ensure a 3 year workforce plan is developed no later than 31 March 2022.
  - This plan should cover the period 1 April 2022 to 31 March 2025.
  - Integration Authorities' Workforce Plans should be published on organisations' websites by 31st March 2022, and a link to each Plan should be forwarded to the Scottish Government's National Health and Social Care Workforce Planning Programme Office by that date

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted that HR Directors have been advised that recognising the impact of COVID-19, this deadline may be postponed to a later date in 2022.

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted that an Interim (integrated) Workforce Plan was submitted to the Scottish Government at the end of April 2021

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** recommended that the Health and Social Care Partnership should continue to develop an Integrated Workforce Plan over the coming months, and report this back to the IJB prior to submission to the Scottish Government.

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16. TWEEDBANK CARE VILLAGE

16.1 Mrs Jen Holland spoke to the content of the report and highlighted that it set out the case for change and care needs across the Scottish Borders, especially for older people requiring a provision of care to be given at the right time, in the right place with a focus on possibility rather than disability.

16.2 Mrs Holland advised that SBC had approved the capital allocation for residential care provision and owners and designers of a similar scheme in the Netherlands had met with some IJB members and officials to look at the possibility of replicating facilities in the Scottish Borders on the Tweedbank site. The proposal was for 60 units including outdoor community space and the site would include rehabilitation, assessment, nursing care, palliative care, and dementia care.

16.3 The Chair enquired about the role of the IJB in terms of commissioning for the care to be delivered in the proposed Care Village.

16.4 Mrs Jenny Smith commented that the Impact Assessment was incorrect, which was important in terms of due process, given under item 6 on page 127 it listed Borders Carers Voice. She advised that there had been one workshop in early 2020 which involved Borders Carers Voice and the proposal discussed at that time was not the same proposal presented to the IJB, so very limited discussion had taken place without further engagement and consultation.

16.5 Mrs Lynn Gallacher advised that Borders Carers were also referenced in the report and were at the same session in early 2020 which had been more of an information shared session as opposed to a consultation session and had not had any further engagement on the proposal as it had been progressed. She commented that she was concerned that there was not enough detail in the report to be able to understand the implications of the closure of Garden View and Waverley on staffing, given the model would have more carers than residents and might not meet the care that was required to enable people to stay in their own homes. She sought further information about filling the gap of enabling people to stay in their own homes and how that would impact on the demand for residential care.

16.6 Mr Tris Taylor advised that he was mindful about the role of the IJB in the project and that it was for SBC to provide the buildings and the services were to be commissioned by the IJB. He suggested the outline business case detailed the involvement of carers and third sector in the project but that was not actually the case and it did not mention the engagement of service users. He suggested an options analysis was required given the only other option was the current status quo. He further commented that it was difficult to understand the rationale for moving from a desire to keep people in their own communities and homes where possible, to moving them from their homes and communities to a purpose built facility. It was also not obvious from the outline business case that it would meet the kinds of needs against which the IJB would want to commission. He was concerned that SBC might expose itself to that risk without genuine coproduction having taken place and clear accountability being given to address the actual needs of older people instead of potentially consolidating supply to meet a number of other broader SBC objectives.

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16.7 Mrs Netta Meadows assured the Board that people were not removed from their homes, any relocation was done as part of a social work assessment and decisions to provide people with residential care settings were taken carefully, based upon their level of need. In regard to delivering care, the proposal was fundamentally about delivering residential care services to meet the increasing need identified. It would meet the need for older people to be supported to grow old well with the delivery of high quality residential care in better fit for purpose settings. The IJB were responsible for commissioning the provision of residential and nursing care and the new facility would provide a higher quality standard environment.

16.8 Mrs Holland commented that in regard to consultation as the project moved towards the full business case, there would be consultation with key users, carers, families and potential users. She advised that the intention was always to keep people as independent as possible, although some people required 24 hour care and the model was designed to be able to provide that care within a homely environment with social community aspects. An additional 11 beds had been included in the plan to accommodate the closure of Garden View and Waverley. A year ago there had been a need for 180 beds, and a lot of work had been put into discharge to assess and conversations with carers about what was needed for individuals to help people live independently at home.

16.9 The Chair commented that in the longer term the IJB would issue a direction to commission the provision of care within the care village.

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the paper presented to Scottish Borders Council on 25th November 2021 and approval of its recommendations.

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the capital and revenue decision taken by Scottish Borders Council.

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the expected growth in demand and current planned mitigations.

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted that it would issue a direction to commission the provision of care within the care village which would clarify the role and requirements of the IJB from a governance perspective.

17. REVIEW OF LEARNING DISABILITY (LD) DAY SUPPORT SERVICES – MARKET TESTING

17.1 Mr Simon Burt provided an overview of the content of the paper.

17.2 The Chair welcomed the approach to balancing the needs of service users and carers.

17.3 Ms Lynn Gallagher congratulated Mr Burt on the approach that had been taken and suggested there was learning for other services to be taken from it.

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The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the progress of the learning disability day support review

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted that the LD service will, on completion of the market testing, seek a commissioning decision from the IJB in the spring of 2022.

18. THE ALLIANCE – HEALTH & SOCIAL CARE IN THE SCOTTISH BORDERS

18.1 Mr Chris Myers referred to the significant work that had been taken forward with the Alliance and other partners and that a number of sessions had been held. The key themes from the sessions had been formulated into a report for the partnership to consider and he advised that the partnership would be working with communities on the outputs of the report.

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the Alliance Report.

19. ALCOHOL AND DRUGS PARTNERSHIP ANNUAL REPORT 2020-21

19.1 Dr Tim Patterson provided an overview of the content of the annual report.

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the Annual Review and highlight Annual Report

20. STRATEGIC PLANNING GROUP MINUTES: 04.08.21

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the minutes.

21. ANY OTHER BUSINESS

21.1 The Chair advised that there had been no notification of any other business.

22. DATE AND TIME OF NEXT MEETING

22.1 The Chair confirmed that the next meeting of the Scottish Borders Health & Social Care Integration Joint Board would be held on Wednesday 16 February 2022, from 10am to 12noon, via Microsoft Teams.

The meeting concluded at 12.15.

Signature: ……………………………
Chair

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SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD

ACTION TRACKER

Meeting held 19 August 2020

Agenda Item: Primary Care Improvement Plan: Update

Action Number	Reference in Minutes	Action	Action by:	Timescale	Progress	RAG Status
2020 - 2	7	Evaluation report of new Primary Care Mental Health Service, funded through PCIP.	Rob McCulloch-Graham Kevin Buchan	~~August 2021~~ April 2022	**In Progress:** **Update 22.09.21:** Mr Rob McCulloch-Graham confirmed that the "Renew" service was being evaluated and regular reports were received by the PCIP Executive. He confirmed that a full evaluation would be shared with the IJB at a later date (2022). **Update 23.02.22:** Paper on "Renew" scheduled for the IJB meeting on 20 April 2022.	G

Agenda Item: Strategic Implementation Plan & Priorities

Action Number	Reference in Minutes	Action	Action by:	Timescale	Progress	RAG Status
2020 - 3	11	Undertake a review of the Scheme of Integration.	Rob McCulloch-Graham Iris Bishop	~~March 2021~~ April 2022	**23.09.20 Update:** Mrs Karen Hamilton enquired if the timescale for Action 3 was for the review to have been completed by the end of March 20201. Mr McCulloch-Graham confirmed that it was. **09.10.20: Update:** An initial review of the scheme is currently being	G

					taken forward and a timeline for completion is being worked up. **16.12.20: Update:** We intend to undertake a number of development sessions/workshops with board members and other stakeholders regarding the review of the Strategic Commissioning Plan. This work will inform any required amendments to the scheme of integration. The date for changes to the scheme will need to be determined after the review of the plan. **Update 26.05.21:** Mr Tris Taylor sought a timeline for the review of the Scheme of Integration. Mr Rob McCulloch-Graham confirmed that the Strategic Commissioning Plan (SCP) would be reviewed by April 2022 and the Scheme of Integration (SoI) target date would be after that date. He explained that the review of the SCP may impact on the SoI and therefore it would make sense to complete the SoI after the SCP review had completed. He further commented that there may be changes to the SoI required as a consequence of the Derek Feeley recommendations being accepted by the Scottish Government. To date those recommendations remained with the Scottish Government for consideration.	

					Update 22.09.21: A timeline for the Scheme of Integration refresh was a substantive item on the agenda. **In Progress:** Review in progress with an end date of 31.03.21. The light touch review consultation concludes on 28.02.22 and the results will be submitted to NHS Borders on 3 March and SBC on 31 March for agreement and then submitted to Scottish Ministers for formal approval. Any comments received as part of the consultation of a broader nature than the light touch review will be studied and if appropriate taken forward as part of a wider review of the SoI over the following 12 months.	

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Meeting held 22 September 2021 *(26 May 2021 minute refers)*

Agenda Item: Quarterly Performance Report

Action Number	Reference in Minutes	Action	Action by:	Timescale	Progress	RAG Status
4	7	Cllr Shona Haslam requested that the data and evaluation of discharge to assess as mentioned in the minutes of 26 May 2021 be formally recorded as an action on the action tracker and the data and	Rob McCulloch-Graham	December 2021	**Update 15.12.21:** Mr Chris Myers suggested he meet with Cllr Shona Haslam to clarify the data available before bringing it forward to a future meeting. Cllr Haslam agreed to that approach.	A

		evaluation be submitted to the IJB. *(26.05.21 Minute extract: Cllr Haslam agreed that the data was not inclusive of social care. She further commented that it appeared to be hospital admission focussed and not about improving the health of the population. She suggested including data on oncology, diabetes and obesity would give the Board a broad view of how population health could be improved. She further sought data on Discharge to Assess.)*			**In Progress:** It has been agreed with Cllr Haslam that high-level performance data for Discharge Programme services will be reported in the IJB performance report. In addition, a briefing meeting with Cllr Haslam and HSCP Officers will occur on Home First. The IJB Development session on 02.03.22 will be the opportunity for IJB members to define what areas of focus IJB members would like for the needs assessment, and this will inform the development of priorities for the new IJB Strategic Commissioning Plan to be developed over 2022-23	

Meeting held 15 December 2021

Agenda Item: IJB Strategic Commissioning Approach

Action Number	Reference in Minutes	Action	Action by:	Timescale	Progress	RAG Status
5	8	The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** considered and approved the following recommendations: That an additional development session be held to progress the Strategic Commissioning Approach work.	Chris Myers	April 2022	**In Progress:** First IJB Development Session is timetabled for the 02.03.2022. This session will focus on the approach to be taken for the Joint Needs Assessment which will underpin the Strategic Commissioning Plan. A further session on the development of the Strategic Commissioning Plan will occur in Autumn once the Joint Needs Assessment has been	G

					completed.	

Agenda Item: Day Services Petition and Future Provision

Action Number	Reference in Minutes	Action	Action by:	Timescale	Progress	RAG Status
6	10	The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** sought a timeline for the work to be taken forward.	Stuart Easingwood	April 2022	**In Progress:** Work to define the Carers Needs Assessment has commenced with the IJB Carers Workstream. The needs assessment and planning will be incorporated into the updated IJB Strategic Commissioning Plan, however an update on day services will be provided in advance of the conclusion to the development of the full Strategic Commissioning Plan	A

Agenda Item: Integrated Workforce Plan

Action Number	Reference in Minutes	Action	Action by:	Timescale	Progress	RAG Status
7	15	The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** recommended that the Health and Social Care Partnership should continue to develop an Integrated Workforce Plan over the coming months, and report this back to the IJB prior to submission to the Scottish Government.	Chris Myers	April 2022	**In Progress:** A Direction to the Scottish Borders Council and NHS Borders is included in the agenda	G

Agenda Item: Tweedbank Care Village

Action Number	Reference in Minutes	Action	Action by:	Timescale	Progress	RAG Status
8	16	The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted that it would issue a direction to commission the provision of care within the care village which would clarify the role and requirements of the IJB from a governance perspective	Chris Myers	April 2022	**In Progress:** A Direction to the Scottish Borders Council is included in the agenda	G

KEY:	
Grayscale = complete:	
R	Overdue / timescale TBA
A	Over 2 weeks to timescale
G	Within 2 weeks to timescale

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Scottish Government
Riaghaltas na h-Alba
gov.scot

HSCP Chief Finance Officers
NHS Board Directors of Finance
Cc:
HSCP Chief Officers
Local Government Directors of Finance
NHS Chief Executives

via email

25th February 2022

Colleagues

Further Covid funding 2021-22

Following the recent submission of your Quarter 3 financial returns, I am writing to confirm further funding of £981 million for NHS Boards and Integration Authorities to meet Covid-19 costs and to support the continuing impact of the pandemic. This funding is being provided on a non-repayable basis and includes provision for under-delivery of savings. While I anticipate that funding will be allocated in line with **Annexes A and B**, it will be a matter for NHS Boards and Integration Authorities to agree any revisions where appropriate to take account of local circumstances.

Within the overall funding outlined above, £619 million is being provided for Integration Authorities, which includes funding for a range of Covid-19 measures. The significant disruption to services has created a backlog of demand as well as increasing unmet need and frailty of service users. Investment is needed across day care services, care at home and to support unscheduled care, to keep people within the community, where possible and safe to do so, to avoid unplanned admissions and impacts on delayed discharges. Alongside this is the impact on mental health and services have been stepped up through, for example, Mental Health Assessment Units. This funding will also cover sustainability payments to social care providers and additional staff costs across Health & Social Care.

Where funding remains at year end 2021-22, this must be carried in an earmarked reserve for Covid-19 purposes in line with usual accounting arrangements for Integration Authorities, and I expect that this funding to be used before further allocations are made through the Local Mobilisation Planning process. This can be used to support continuation of costs which were funded in 2021-22 as a direct result of Covid-19. Use of these allocations to meet Covid-19 expenditure should be agreed by the IJB Chief Finance Officer and the NHS Board Director of Finance. The funding should be targeted at meeting all additional costs of responding to the Covid pandemic in the Integration Authority as well as the NHS Board.

/cont'd

Any proposed utilisation of the earmarked reserves to meet new expenditure that had not been funded in 2021-22 will require agreement from the Scottish Government, and it will remain important that reserves are not used to fund recurring expenditure, given the non-recurring nature of Covid funding.

Thank you for your support and engagement during 2021-22 and I look forward to continued close work with you as we take forward plans for 2022-23 and beyond.

Yours sincerely

Richard McCallum
<u>Director of Health Finance and Governance</u>

Annex A Funding by Board Area

Further Covid-19 Funding (£000s)	Health Board	HSCP	Total
NHS Ayrshire & Arran	14,420	42,765	57,185
NHS Borders	7,471	17,575	25,046
NHS Dumfries & Galloway	13,997	16,146	30,143
NHS Fife	20,947	43,961	64,908
NHS Forth Valley	7,531	32,355	39,886
NHS Grampian	7,533	55,697	63,230
NHS Greater Glasgow & Clyde	88,484	132,917	221,401
NHS Highland	10,947	37,604	48,551
NHS Lanarkshire	15,121	68,810	83,931
NHS Lothian	31,641	114,566	146,207
NHS Orkney	2,575	3,746	6,321
NHS Shetland	999	3,620	4,619
NHS Tayside	2,441	45,355	47,796
NHS Western Isles	1,608	3,887	5,495
NHS National Services Scotland	118,110	-	118,110
Scottish Ambulance Service	11,326	-	11,326
NHS Education for Scotland	- 1,909	-	- 1,909
NHS 24	-	-	-
NHS National Waiting Times Centre	5,436	-	5,436
The State Hospital	-	-	-
Public Health Scotland	3,071	-	3,071
Healthcare Improvement Scotland	- 176	-	- 176
Total	**361,573**	**619,004**	**980,577**

Please note these figures represent the total funding across several allocations (PPE, Test & Protect, Vaccinations and General Covid Funding). A detailed analysis will be provided to each NHS Territorial Board setting out the split across Board and Integration Authorities.

Annex B Total Funding by Integration Authority

Integration Authority	Further Covid-19 Funding £000s
East Ayrshire	14,143
North Ayrshire	15,891
South Ayrshire	12,731
Scottish Borders	17,575
Dumfries and Galloway	16,146
Fife	43,961
Clackmannanshire & Stirling	16,819
Falkirk	15,536
Aberdeen City	24,317
Aberdeenshire	19,675
Moray	11,705
East Dunbartonshire	9,930
East Renfrewshire	14,781
Glasgow City	73,130
Inverclyde	10,370
Renfrewshire	16,964
West Dunbartonshire	7,741
Argyll & Bute	11,881
North Highland	25,724
North Lanarkshire	32,102
South Lanarkshire	36,708
East Lothian	13,537
Edinburgh City	70,314
Midlothian	9,506
West Lothian	21,209
Orkney	3,746
Shetland	3,620
Angus	11,843
Dundee	16,784
Perth & Kinross	16,728
Western Isles	3,887
Total	**619,004**

Please note these figures represent the total funding across several allocations (PPE, Test & Protect, Vaccinations and General Covid Funding). A detailed analysis will be provided to each NHS Territorial Board setting out the split across Board and Integration Authorities.

Scottish Borders Health & Social Care
Integrated Joint Board

Report By:	Morag Muir, Locum Consultant in Dental Public Health
Contact:	Morag Muir
Telephone:	07866 102 757
NEEDS ASSESSMENT: ORAL HEALTH AND DENTAL SERVICES	
Purpose of Report:	To present the findings of the oral health needs assessment, setting out priorities for action and recommendations to inform a strategic plan for oral health
Recommendations:	The Health & Social Care Integration Joint Board is asked to: a) Ratify the report for publication and wider dissemination b) Include oral health in their strategic commissioning plan c) Agree to commission the Health Board/Public Health Directorate to develop a strategic plan for oral health and dental services
Personnel:	No direct implications at this stage
Carers:	Consultation/engagement with carers will be undertaken as recommendations from the report are taken forward to develop a strategic plan
Equalities:	EQIA will be carried out as part of the strategic plan development.
Financial:	No direct impacts as majority of dental funding received direct from SG
Legal:	N/A
Risk Implications:	The needs assessment highlights 10 priorities for action. Many of these have become more acute as a result of the pandemic, for example increased inequalities and disruption to oral health improvement activity are expected to have had a negative impact on oral health and increased service pressures have exacerbated issues around recruitment and retention and access to dental care. A new strategic plan is urgently required to implement the recommendations of the report and support effective remobilisation.

SBAR: NHS Borders Oral Health Needs Assessment

Author: Morag Muir, Locum Consultant in Dental Public Health, November 2021

SITUATION

An Oral Health Needs Assessment (OHNA) was undertaken to review oral health and dental services in the Borders. The resulting report identified ten priorities for action and included recommendations to inform a strategic plan for oral health.

BACKGROUND

The South East and Tayside Dental Public Health Network were approached in early 2018 with a request to undertake an OHNA with a view to developing a new strategic plan for oral health.

The needs assessment drew on data gathered at local and national levels and included engagement with members of the public and dental professionals working across hospital, general and public dental services and oral health improvement team.

The report was completed in early 2020, however emergence of the COVID-19 pandemic has delayed progress towards the next steps, including development of the strategic plan.

ASSESSMENT

The OHNA provides a benchmark against which impacts of the pandemic on oral health and dental services in the Borders can be assessed. As services remobilise, intelligence from the report will be of value in informing the recovery efforts.

The ten priorities for action identified in the report have been reviewed and remain equally important, if not more so, as we emerge from the pandemic. While there are as yet limited data to assess the specific impacts of the pandemic on oral health, we are aware that inequalities, a key determinant of oral health, have widened and issues surrounding access to dental care have become more acute.

There is now an increased urgency to develop a strategic plan which, in addition to addressing the priorities identified in the needs assessment, will inform and support the remobilisation of oral health improvement and dental services to overcome the additional challenges arising from the pandemic.

RECOMMENDATIONS

It should be noted that the Strategic Planning Group supported the approach outlined at their meeting held on Wednesday 02 February 2022 and that, as a result, an associated draft direction has also been drafted for consideration for approval at the IJB.

- The IJB are asked to ratify the OHNA report for publication and wider dissemination
- The IJB are asked to include oral health in their strategic commissioning plan
- The IJB are asked to commission the Health Board/Public Health to develop a comprehensive strategic plan for oral health and dental services to take forward the recommendations of the OHNA

Oral Health and Dental Services

Oral Health Needs Assessment 2020

Authors and Acknowledgements

Authors

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Morag McQuade *Director of Dentistry, Clinical Director, NHS Borders Public Dental Service*

Keith Allan *Consultant in Public Health, NHS Borders*

Helen Brand *Oral Health Improvement Manager, NHS Borders*

Adelle McElrath *Dental Practice Adviser, NHS Borders*

Susan Hogg *Public Involvement Officer, NHS Borders*

Heidi Goodship *Scottish Borders Council*

Members of NHS Borders Area Dental Committee

Members of dental teams in the general, hospital and public dental services

NHS Borders Oral Health Improvement Team

Executive Summary

Oral health is an important aspect of general health and wellbeing. While oral diseases are mostly preventable, they remain common and share risk factors with a number of general health problems. Promoting good oral health is closely linked to wider public health priorities and can help reduce the need for treatment and demands on dental services.

Changing demographics in the Borders and developments in dental service delivery and approaches to oral health promotion over a number of years have brought new pressures on services.

This needs assessment report describes the oral health status of the population of the Borders and the availability and use of dental services in the area.

Findings from a review of available data sources and engagement with dental teams and members of the public has led to identification of a number of priorities and the development of recommended actions to take these forward. These are summarised in the section which follows.

Priorities for Action

These priorities are not presented in order of importance. It is recognised that it will not be possible to take forward all actions immediately and that several of them will require gradual change over a number of years.

These recommendations will be used to inform a strategic plan for oral health and dental services in the Borders. Development of the strategic plan will allow for prioritisation and will inform timelines for implementing the changes suggested in this report.

PRIORITY: Raising the Profile of Oral Health

1. In line with the Health in All Policies approach already adopted across Borders HSCP, oral health should be included during development of any strategies/policies which could have an impact on health or oral health
2. Routes for oral health issues and information to be fed up to Board level and through the Integrated Joint Board should be explored

PRIORITY: Maintaining and Improving Oral Health

3. Oral health improvement should incorporate action to address wider determinants of health and take a common risk factor approach, working alongside general health improvement teams
4. Continue to focus on maximising child oral health as the foundation for good oral health throughout life
5. Action should be taken to improve oral health for the whole population with a particular focus on groups recognised to be at greatest risk of poor oral health
6. Awareness of the role of the oral health improvement team and ability to make referrals to them should be raised among dental professionals and wider health and social care partners

PRIORITY: Maintaining Access to Primary Care Dental Services

7. Continue to monitor and highlight issues relating to access to dental care.
8. Maintain emergency dental services at level required to meet needs for urgent dental care

PRIORITY: Encouraging Recruitment and Retention of Dental Professionals

9. Promote the Borders as an attractive place to work as a dental professional
10. Continue to develop high quality dental services with opportunities for career progression and job satisfaction to retain dental professionals in the area

PRIORITY: Meeting the Needs of Ageing Patients

11. Deliver support through expansion of the national Caring for Smiles oral health improvement programme for dependent older people for those in residential care and receiving care at home services
12. Oral health should be actively considered and included in individuals' care plans across all health and social care services
13. Continue to implement and support further roll out of the eGDP model for domiciliary dental care

PRIORITY: Meeting the Needs of Dental Priority Groups

14. Expand engagement with priority groups (adults with additional care needs, those with physical and cognitive disabilities, poor mental health, addictions and the homeless)
15. Consider a more flexible approach to delivery of dental services for those who may have difficulty accessing traditional models of care
16. Increase support offered to those who have difficulty attending dental appointments and raise awareness of the availability of translation services, including British Sign Language interpreters

PRIORITY: Developing the Role of the Public Dental Service

17. It remains necessary to retain the access function of the PDS to ensure sufficient provision of dental services for the general population. The main focus should however be on providing support to patients who have special care requirements
18. PDS referral criteria should be updated and self-referrals for routine dental care only accepted from patients who are unable to access a general dental practice
19. Awareness of the function of PDS should be raised to facilitate referrals from health and social care partners and others working with priority groups
20. Options for input from Specialists in Paediatric Dentistry and Special Care Dentistry should be explored including the possibility of establishing networks with neighbouring Boards

PRIORITY: Developing the PDS Workforce to Provide a More Specialised Service

21. Continue to support and maximise opportunities for training and development of PDS staff

PRIORITY: Developing Patient Pathways to Dental Services

22. Interprofessional links should be promoted across GDS, PDS and HDS through shared professional development and quality improvement activities
23. Consideration should be given to wider use of eGDP models to support delivery of more complex dental treatments in primary care and reduce pressure on secondary care dental services
24. Demand management work which has been undertaken with oral surgery services should be supported

25. All dental services delivered in BGH, including specialist services, should be reviewed to identify those which could be safely transferred out with a hospital environment to primary care settings

PRIORITY: Promoting Networking and Engagement of Dental Teams and Wider Partners

26. Dental teams from across the Borders should be brought together through existing professional groups and organisations and CPD events
27. The format of the Area Dental Committee and its lines of communication with the Board and the wider dental profession should be reviewed to encourage engagement with the Committee
28. Use of the internet and social media should be promoted to enhance communication with the dental profession locally
29. Links between dental services, other health and social care services and wider partners should be developed and strengthened

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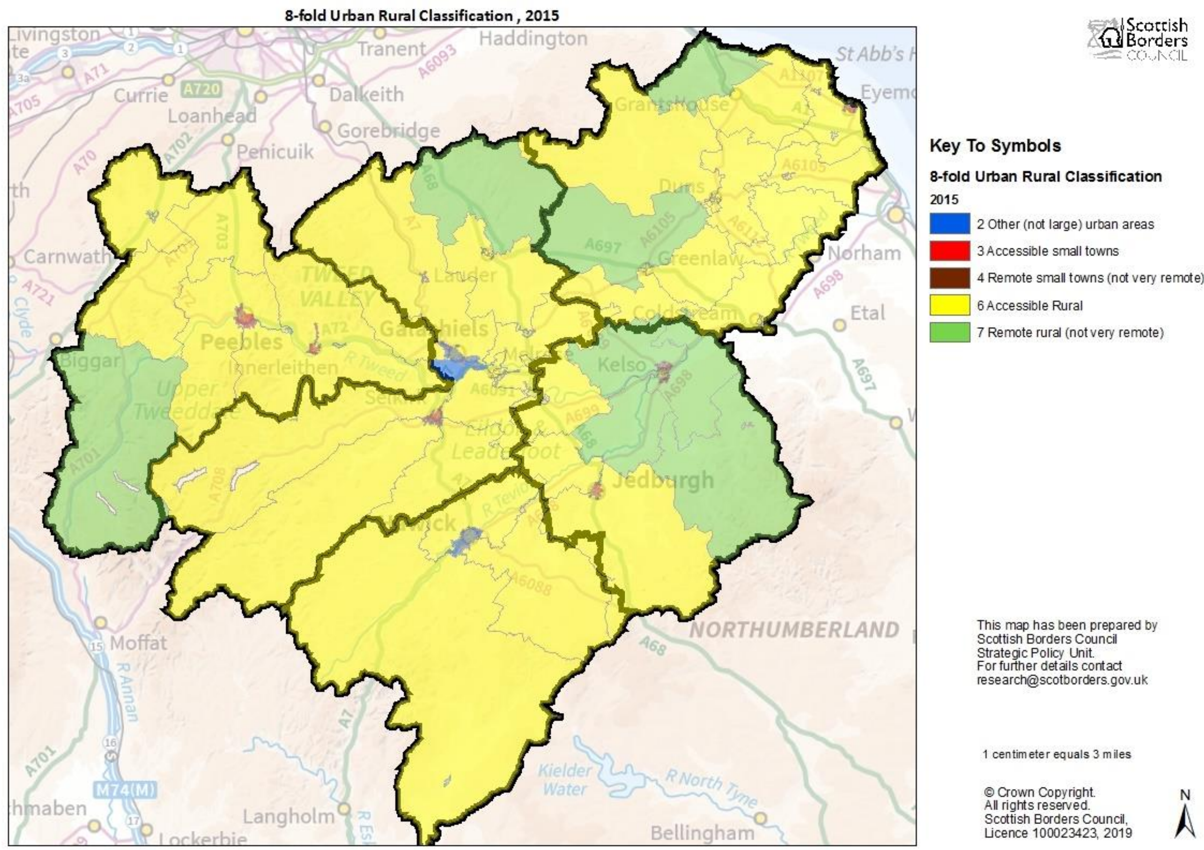
1. Background

The Borders

The Borders is a rural area in the South East of Scotland with a population of around 115 000. The Borders is the 4th most sparsely populated mainland area in Scotland, with a population density of 24 per km^2, and 30% of residents living in settlements of less than 500 people.

The Scottish Government's Urban Rural Classification[1] differentiates between urban areas, small towns, rural and remote areas based on settlement size and drive time to major settlements. Figure 1 shows the breakdown of Urban Rural Classification within the Borders. The majority of the Borders is classified as "Accessible Rural" – settlements with a population of less than 3 000 and within 30 minutes drive time of a settlement of 10 000 or more, or "Remote Rural (not very remote)" – settlements of less than 3 000 within 30-60 minutes drive of a settlement of 10 000 or more. Two areas are "Other (not large) Urban Areas" – settlements with a population of 10 000 – 124999, these include the towns of Galashiels (population 12 600) and Hawick (population 13 300). The Borders has a number of "Accessible small towns" – settlements with a population of 3 000-9 999 within 30 minutes drive of a settlement of 10 000 or more.

Figure 1 – Map of Scottish Borders 8 Fold Urban Rural Classification



The Borders is served by a single Health Board (NHS Borders) and Local Authority (Scottish Borders Council). Borders Health and Social Care Partnership (HSPC) brings together NHS primary and community services, and social care functions provided by the

Council and the Independent and Voluntary Sector. Primary care dental services are hosted by the HSPC and are provided by General Dental Practitioners (GDPs) and the Public Dental Service (PDS).Secondary care dental services are provided in the Borders General Hospital covering the specialties of oral surgery and orthodontics.

Oral Health

Oral health is defined as:

> *A standard of health in the oral and related tissues without active disease. That state should enable the individual to eat, speak and socialise without discomfort or embarrassment, and contribute to general wellbeing.*

Department of Health, 2004

The impact of poor oral health on general health is well established and it could be argued that there is "no health without oral health".

In general oral health in Scotland is improving, however dental caries (tooth decay) and periodontal disease (gum disease) remain common. A third condition, oral cancer, though rare, remains a concern due to the significant impact it has on individuals affected.

Determinants of Oral Health

Most oral health problems are preventable and many of the risk factors are common to other health conditions, including a diet high in sugar and low in fruit and vegetables, tobacco use and drinking alcohol over the recommended weekly limits.

Oral health has a strong association with the social determinants of health, with individuals from more deprived backgrounds experiencing poorer oral health than the more affluent. Some population groups are also known to be at risk of poorer oral health, including those with additional care needs, certain medical conditions and the socially excluded.

Policy Context

In January 2018, the Scottish Government's Oral Health Improvement Plan (OHIP)[2] was published. The plan includes 41 actions outlining their vision for oral health and dental services in Scotland. It encourages a focus on prevention and has a strong emphasis on meeting the needs of an ageing population.

The OHIP follows on from the 2005 Action Plan for Improving Oral Health and Modernising Dental Services in Scotland[3]. The 2005 plan had a significant impact on improving access to NHS dental services and in establishing national Oral Health Improvement Programmes. These initially focused on children (Childsmile) and, following publication of the National Oral Health Improvement Strategy for Priority Groups in 2012[4], Caring for Smiles for dependent older people, Smile 4 Life for people experiencing homelessness,

Mouth Matters for prisoners and, most recently, Open Wide for adults with additional care needs.

More generally, new Public Health Priorities for Scotland[5] were published in June 2018, setting out ambitions to achieve:

1. **A Scotland where we live in vibrant, healthy and safe places and communities**
2. **A Scotland where we flourish in our early years**
3. **A Scotland where we have good mental wellbeing**
4. **A Scotland where we reduce the use of and harm from alcohol, tobacco and drugs**
5. **A Scotland where we have a sustainable inclusive economy with equality of outcomes for all**
6. **A Scotland where we eat well, have a healthy weight and are physically active**

These priorities have been accepted by NHS Borders and Scottish Borders Council as the Scottish Borders Public Health Priorities. Actions to improve oral health link closely with these priorities (Table 1).

Table 1 - Public Health Priorities and links to oral health

Public Health Priority	Oral Health
PRIORITY 1 A Scotland where we live in vibrant, healthy and safe places and communities	Access to dental services and oral health improvement programmes for all
PRIORITY 2 A Scotland where we flourish in our early years	Childsmile Oral Health Improvement Programme
PRIORITY 3 A Scotland where we have good mental wellbeing	Reciprocal relationship between poor oral health and poor mental health
PRIORITY 4 A Scotland where we reduce the use of and harm from alcohol, tobacco and drugs	Reducing use of alcohol, tobacco and drugs improves oral health
PRIORITY 5 A Scotland where we have a sustainable inclusive economy with equality of outcomes for all	Inequalities closely linked to oral health. Oral health improvement programmes focus on priority groups
PRIORITY 6 A Scotland where we eat well, have a healthy weight and are physically active	Diet (particularly sugar reduction) is key to oral health

Locally an Oral Health Improvement Strategy for Borders 2007-2012 was developed following publication of the 2005 Scottish Government Dental Action Plan. While much of its content has remained relevant beyond 2012, there have been changes in oral health and dental services in the Borders during this time.

In the current financial climate it can be challenging to continue to deliver high quality care and meet increasing demands and expectations on services. A statement of intent for financial turnaround is being developed by NHS Borders to guide how services should be delivered to maximise efficiency and effectiveness with an overall aim of achieving financial balance. It is recognised that any recommendations from this needs assessment should align with actions in the statement.

This oral health needs assessment provides an opportunity to review the current oral health status and needs of the population of the Borders. It also addresses how well current services are able to meet these needs and will inform a new strategic plan for oral health in the Borders.

2. Scope of Needs Assessment

This needs assessment will review oral health needs of the population in NHS Borders and services available to meet the needs identified and improve oral health.

The needs assessment includes:

- General Dental Services
- Public Dental Service
- Specialist/Hospital Dental Services
- Oral Health Improvement Activity
- Dental Workforce
- Access to dental services
- Cross Border dental attendance

The needs assessment will not include:

- In depth analysis of Special Care Dentistry provision
- e-Dental and e-Health

SECTION 1:
DEMOGRAPHICS, HEALTH AND ORAL HEALTH

3. Population Profile

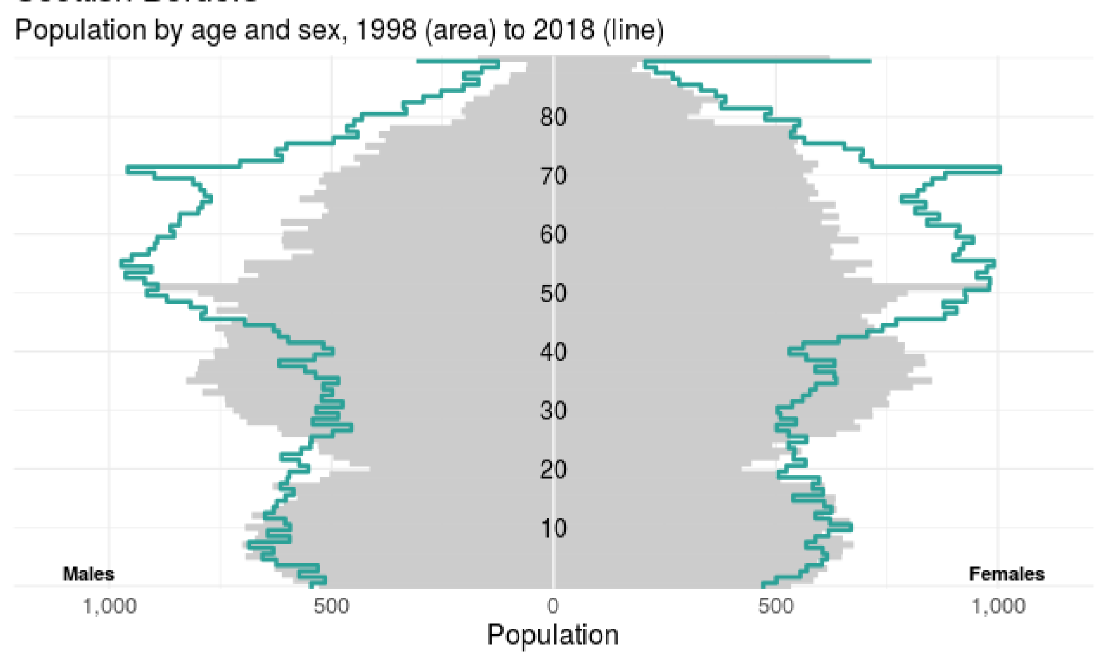
Profile

The population of the Borders was estimated to be 115 270 in mid 2018. This has been gradually increasing in recent years, and is projected to continue to grow. The main driver of population change is migration with more people moving in to the area than leaving. A higher number of deaths than births in the area means that natural change (number of births minus number of deaths) currently results in a net reduction in population size. The majority of in migrants to the Borders are from other areas of Scotland (57%) or the rest of the UK (37%), with only 6% coming from overseas. The largest net migration in to the Borders is seen in age groups between 30-39 years old, with a second peak for age groups between 55 and 69 years old. Out migration from the Borders follows a similar pattern in terms of destination with the majority of those who leave moving to other areas of Scotland. The most common age to leave the area is between 15 and 19 years old.[6]

The proportion of the population who are aged 65 or older (24%) is higher in the Borders than in Scotland as a whole (19%), with a smaller working age population (59%), than Scotland (64%). The proportion of children aged 0-16 years is similar to that of the Scottish population at 17%.[6]

Increased life expectancy and a growing ageing population has resulted in a changing pattern of age distribution in recent years. Figure 2 shows the change in age structure of the population in the Borders between 1998 and 2018.

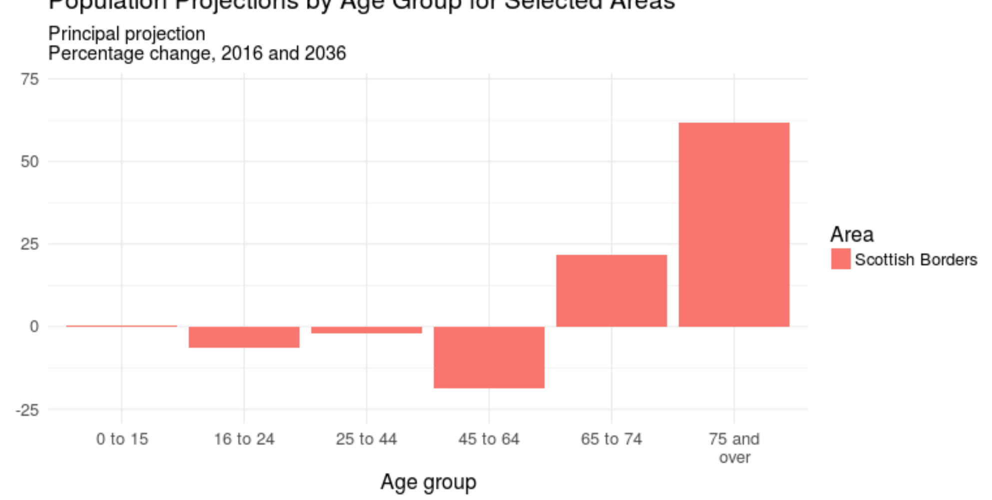
Figure 2 - Change in Age Structure of Population in the Borders 1998 (shaded) and 2018 (line)



https://scotland.shinyapps.io/nrs-population-projection-variants-scotland-uk/

Projections suggest that demographic changes will further reduce the proportion of working age adults in the area and increase the proportion of older adults, particularly those aged 75 or older. The projected percentage change by age group in the Borders between 2016 and 2036 is shown in Figure 3.

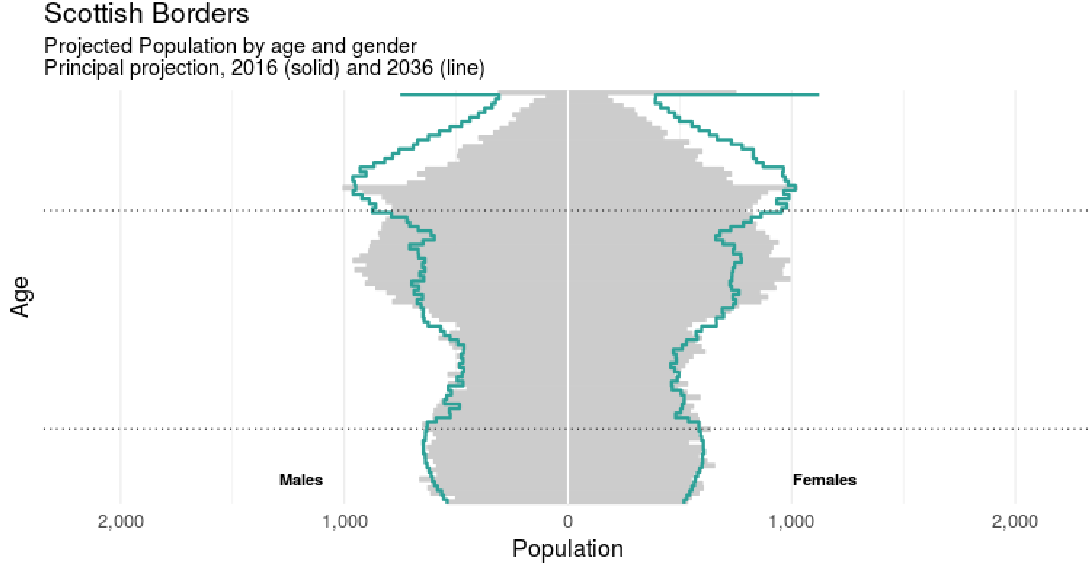
Figure 3 - Projected population change (%) by age group 2016-36 in the Borders



https://scotland.shinyapps.io/nrs-population-projection-variants-scotland-uk/

Between 2016 and 2036 this is likely to have a further effect on population structure as illustrated in Figure 4.

Figure 4 - Scottish Borders population by age and gender, 2016 (shaded) and projection for 2036 (line)

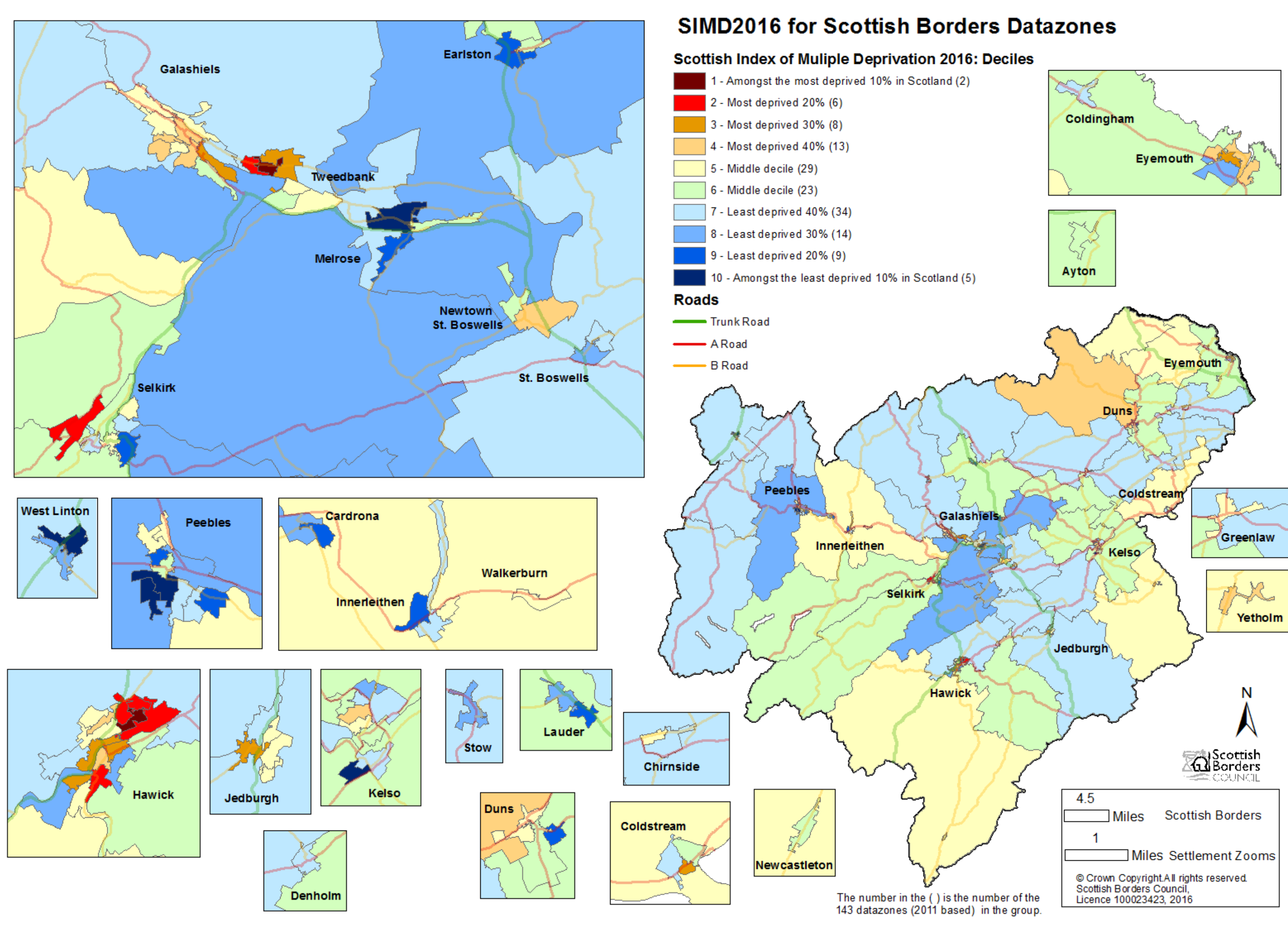


https://scotland.shinyapps.io/nrs-population-projection-variants-scotland-uk/

The Borders has higher levels of employment than the Scottish average, although wages tend to be lower. The Borders comprises 143 SIMD* datazones, of which two (Burnfoot in Hawick and Langlee in Galashiels) are in the most deprived 10% in Scotland (SIMD 1) and five are in the least deprived (SIMD 10). Figure 5 show the relative levels of deprivation for datazones within the Borders.

*The Scottish Index of Multiple Deprivation (SIMD) is an area based tool which ranks datazones of between 500-1000 people by indicators of multiple deprivation.

Figure 5 - SIMD (2016) Levels of Deprivation of Datazones in the Borders



While area SIMD can be useful for making comparisons between communities by level of deprivation, the lower population density in the Borders means that area level measures may mask pockets of deprivation within communities. It is therefore difficult to quantify the extent of oral health inequalities affecting Borders residents and factors other than area of residence require to be considered when examining socio-economic influences.

The rural nature of the Borders, with a significant proportion of the population living out with the main towns, often with limited public transport available, can make accessing services, including dental care, challenging. This geographic isolation may impact on oral health, though quantifying its effects is complex.

Priority Groups

Three specific groups who are recognised to be at increased risk of poor oral health were mentioned in the 2012 National Oral Health Improvement Strategy for Priority Groups[4]:

- Dependent older people
- People with additional care needs
- People experiencing homelessness

Dependent Older People

As already identified, the Borders has a higher proportion of older people than other areas of Scotland and the number of older people is projected to increase. As an individual ages, their level of dependency often increases. Within the Borders 20.9% of adults provided unpaid care to family, friends or neighbours during 2017, compared to 17.4% across Scotland as a whole[7]. Reasons for providing unpaid care can include physical or mental ill health or disabilities in addition to old age, however the increased level of unpaid care provision in the Borders may reflect the higher proportion of older people in the area.

There are currently 21 care homes in the Borders which provide accommodation for older people who require support. It is recognised that a significant number of older people out with the care home sector also require support with day to day life. In the Borders 1190 people were in receipt of Home Care provided by the local authority during 2017 with an average of 6.8 hours of support per day provided to each client and 200 people over the age of 65 years receiving 10 or more hours of support.[8]

Additional Care Needs

Additional care needs is a broad category, encompassing a variety of challenges arising in a range of circumstances including physical, cognitive or sensory disabilities and a number of health conditions including poor mental health.

Within the Borders 647 individuals were known to the Local Authority during 2017-18 to have a diagnosis of learning disability, equating to 6.7 per 1 000 population, slightly higher than the Scottish rate of 5.2 per 1 000. One hundred individuals, 15.5% of the population in the Borders, are known to have a diagnosis of Autism Spectrum Disorder, compared to 18.7% of the population of Scotland.[9]

Data are not available to quantify the prevalence or severity of physical or sensory disabilities in the Borders or of people living with specific disabling conditions.

People Experiencing Homelessness

There were 735 homeless applications in the Borders during 2018-19.Thirty applicants had slept rough at least once in the previous three months and 15 the previous night. While rough sleeping is not common in the Borders, on 31st March 2019 81 households were living in temporary accommodation in the Borders.[10]

Other Priority Groups

In addition to those mentioned in the Priority Groups Strategy[4], a number of other population groups are recognised to be at increased risk of poor oral health, including care experienced children, those in the criminal justice system, and those with addictions.

In 2017-18 2% of children in Scotland were looked after or on the Child Protection Register[11]. Local data describing the number of care experienced children and young people in the Borders are not available.

There are no prison services in the Borders, however support is available through the local Criminal Justice Service including supervision of probation orders, supervision of community payback or community service, through-care services, supervised release orders and supervision on parole. During 2017-18, 384 Criminal Justice Social Work Reports were submitted in the Borders, of whom 223 were subject to Community Payback Orders, 10 to Drug Treatment and Testing Orders and 6 were Diversion from Prosecution cases[12].

The most recent national drug prevalence study for years 2015-1613 estimated problem drug use in the Borders to be the lowest of any mainland Local Authority area in Scotland at 0.73%. During 2018-19 approximately 120 individuals accessed drug and alcohol addiction services each quarter, around 2/3 of whom sought help for addiction to alcohol and the remainder for drug addiction.[14]

The availability of data is limited for many of the priority groups and most of the categories highlighted comprise small number of individuals, however it is important that these groups are not overlooked as their specific needs require to be identified and addressed.

4. Health Status

General Health

General health is closely related to oral health, with many common health conditions impacting on oral health, either as a direct consequence of the condition, a side effect of medication or by influencing an individual's ability to maintain their oral hygiene. In general, health in the Borders appears to be slightly better than the national average.

Pooled data from the 2014-17 Scottish Health Surveys[15] indicate that 77% of adults in the Borders rated their general health as good or very good and 6% rated their health as bad or very bad, compared to the national averages of 74% and 8% respectively. Over the same time period 52% of people in the Borders and 54% in Scotland as a whole reported having no long term illnesses. Twenty percent of Borders residents reported having a long term illness which limited their day to day life, and 20% reported having a long term illness which was not limiting, compared to a Scottish average of 32% and 14%.

Many systemic diseases have been linked to oral health. Diabetes is associated with an increased risk of periodontal (gum) disease and is known to affect susceptibility to infection and impact on healing following surgery. Improved diabetic control has been demonstrated following treatment of periodontal disease. In the Borders around 6% of the population have been diagnosed with diabetes, slightly higher than the national average of 5.6%[16]. Links between cardiovascular disease and oral health have also been suggested.

Approximately 16% of the population of the Borders have a cardiovascular condition, compared to the national average of 15%.[15] The slightly higher prevalence of each of these conditions is likely to reflect the age structure of the population as the conditions are more common in older age groups which make up a larger proportion of the local population.

Obesity is becoming increasingly common and is recognised to be a growing public health concern in Scotland and the UK as a whole. Obesity and dental caries share the common risk factor of a diet high in sugar. Medical issues associated with obesity can affect safe provision of dental care and the fact that standard dental chairs accommodate patients up to a maximum weight limit of around 21 stones have important implications for dental services. The proportion of adults in the Borders who are classed as overweight or obese ($BMI \geq 25$) is slightly higher than the national average at 66% (compared to 65%), though the proportion who are obese ($BMI \geq 30$) is 25%, slightly below the national average of 29%.[15]

Mental Health

Mental health has a reciprocal relationship with oral health. Poor oral health has the potential to negatively impact on mental wellbeing and mental ill health often makes it more difficult for an individual to maintain good oral health. Many medications used in the

treatment of mental health conditions can lead to dry mouth, with loss of the protective effects of saliva putting the oral tissues at risk.

Two measures of mental health are included in the Scottish Health Survey, the Warwick Edinburgh Mental Wellbeing Scale (WEMBS) which measures mental wellbeing and the 12 point General Health Questionnaire (GHQ-12) which measures risk of developing mental ill health.

In the Borders the average WEMBS score was 50.2, slightly higher than the Scottish average of 49.9. The proportion of people scoring 4 or above in the GHQ-12, an indicator of probable mental ill-health, was however slightly higher in the Borders (18%) than in Scotland as a whole (16%). A slightly higher proportion of Borders residents (62%) recorded a GHQ-12 score of zero than across Scotland as a whole (61%).[15] Residents of the Borders therefore appear to be more likely to experience good mental health, though those who do have a mental health condition seem to be more severely affected.

5. Oral Health

Children

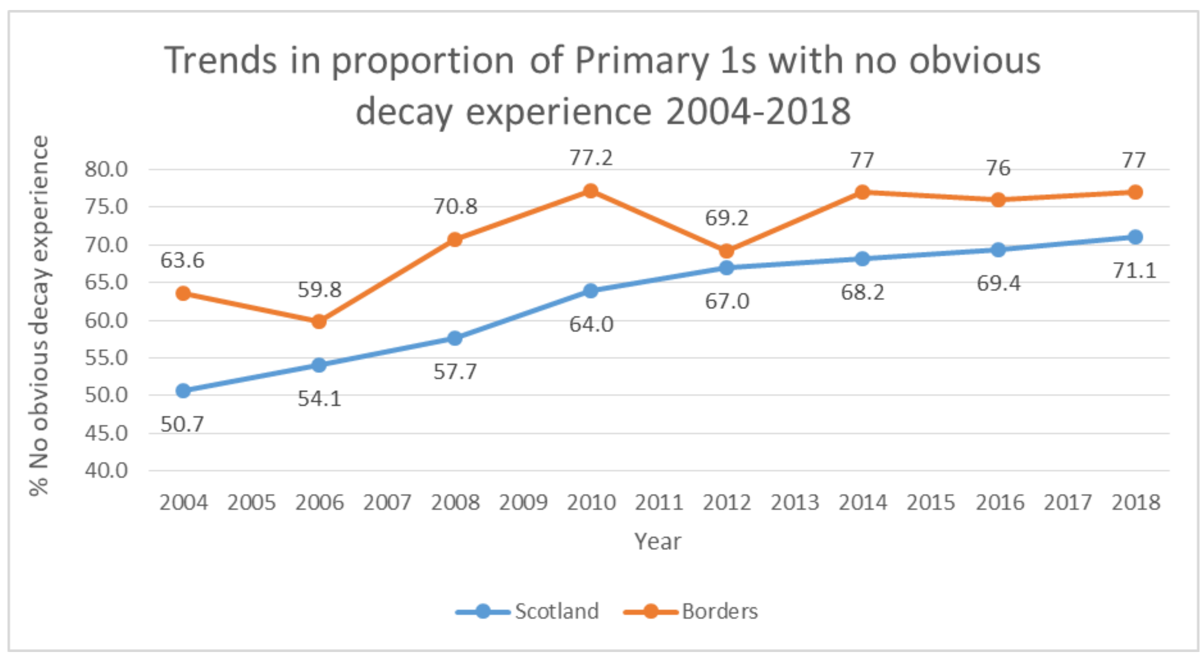
Robust data on children's oral health is gathered through the National Dental Inspection Programme (NDIP). On an annual basis, all children in Primary 1 and Primary 7 attending Local Authority schools are offered a Basic Inspection to provide monitoring data and inform parents/carers of their child's oral health status. In addition, in alternating years, a sample of children in P1 or P7 undergo a Detailed Inspection by trained and calibrated examiners which provides reliable information on prevalence of dental caries (decay) for use by Scottish Government, NHS Boards and other organisations concerned with children's health.

In general, children in the Borders enjoy good oral health. The most recent Detailed Inspection of Primary 1 children, during the academic year 2017-18 shows that 79% of those inspected in the Borders had no obvious decayed, missing or filled primary teeth[17]. The Detailed Inspection of Primary 7 children during 2018-19 reported that 78.6% of those inspected had no obvious decayed, missing or filled permanent teeth[18].

Nationally the proportion of children with no obvious decay experience has increased significantly since NDIP was introduced in 2004 and improvements have also been evident in the oral health of children in the Borders, as shown in Figures 6 and 7. The most recent data suggest that the rate of improvement in child oral health is slowing at both the local and national levels.

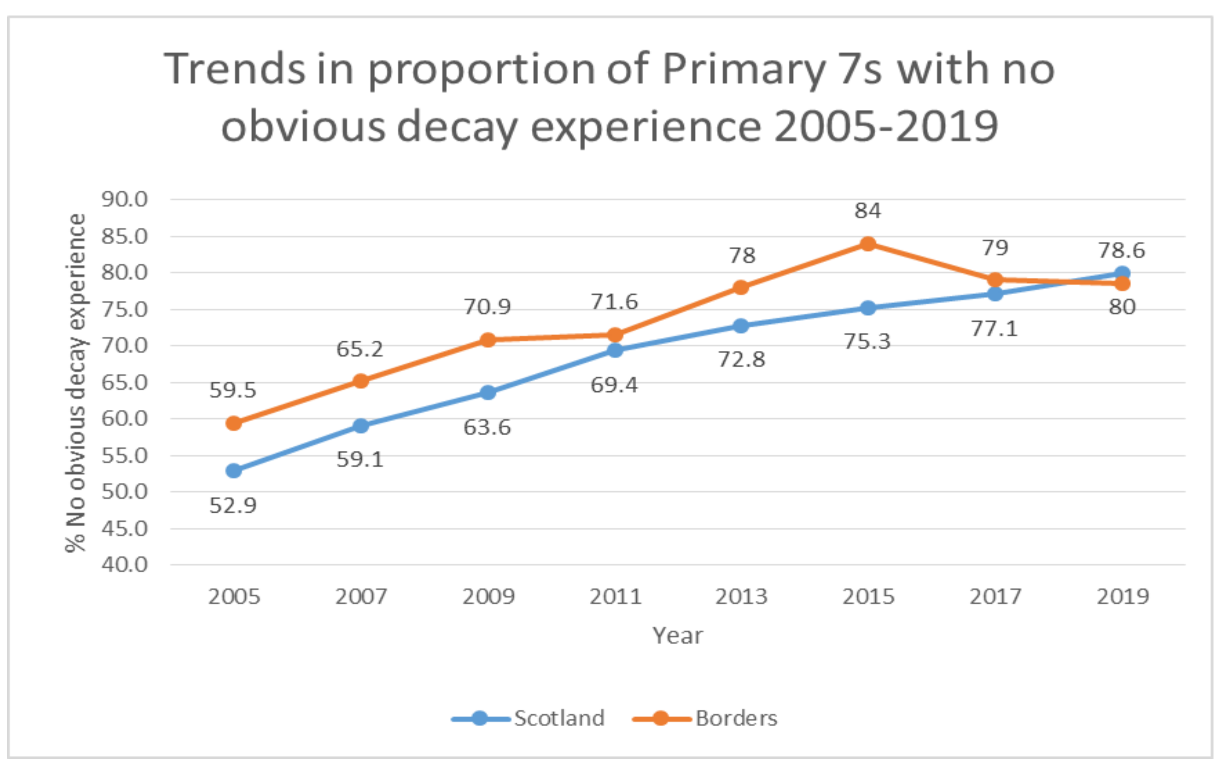
Caution is required in interpreting trends in obvious caries experience over time within the Borders due to the relatively small sample size. Sampling for the Detailed NDIP inspection is at class level, aiming to include a minimum of 250 children or 8% of the population of the year group (P1 or P7 depending on year). In the Borders during 2018-19 317 children (27.3% of the P7 population) received a detailed inspection and in 2017-18 338 pupils (27.9% of the P1 population) were inspected. As a result, small variations in obvious caries experience of children inspected may over-estimate any increase or decrease in the overall proportions of children with no obvious decay experience.

Figure 6 - Trends in proportion of Primary 1s with no obvious decay experience in Scotland and Borders



https://www.isdscotland.org/Health-Topics/Dental-Care/Publications/2018-10-23/2018-10-23-NDIP-Report.pdf

Figure 7- Trends in proportion of Primary 7s with no obvious decay experience in Scotland and Borders



https://www.isdscotland.org/Health-Topics/Dental-Care/Publications/2019-10-22/2019-10-22-NDIP-Report.pdf

The Scottish Government has set national targets for 75% of P1s and 80% of P7s to be free of obvious decay experience by 2022. The target has been achieved in the Borders for P1s since 2014.The target was exceeded for P7s in 2015, though has dropped slightly below 80% in the two subsequent inspection years. Further local targets have been set for each Health Board to deliver an improvement of 10% in the proportion of children with no

obvious decay experience which was recorded in 2014 for P1s and 2015 for P7s. For NHS Borders this has resulted in ambitious targets of 84.5% of P1s and 92% of P7s to be free from obvious decay by 2022 which will be challenging to achieve.

Nationally it is evident that inequalities in oral health have persisted despite the overall improvements, with children from more deprived areas continuing to experience more dental decay. Caries data are not reported by deprivation category at Board level and as previously discussed it is likely that area level measures of deprivation may not be sensitive enough to capture the extent of inequalities in the Borders where pockets of deprivation are often masked within smaller communities.

Adults

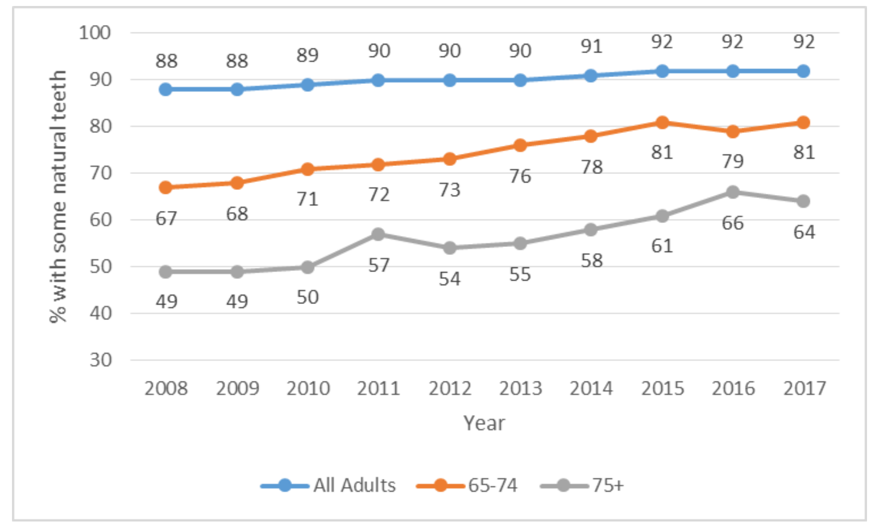
Less data are available to describe the oral health of adults, with most only reported at national level. As childhood oral health is known to predict future oral health it would be hoped that the good oral health observed in children in the Borders would also translate to older age groups.

The annual Scottish Health Survey[19] includes self-reported presence of natural teeth as a measure of oral health for a representative sample of adults aged 16 years and older reported at national level. In 2017 92% of respondents reported having some natural teeth with 76% reporting that they had 20 or more natural teeth*. Some measures within this survey are aggregated for the previous four years to enable reporting at Health Board level. Unfortunately measures of oral health have not been included in aggregated reports to date.

*The presence of 20 or more natural teeth, known as the functional dentition, is regarded as the minimum number of teeth required for an individual to eat what they like without requiring a partial denture

The proportion of individuals in Scotland with one or more natural teeth has been increasing over time, particularly amongst older age groups as shown in Figure 8.

Figure 8 - Trends in proportion of Scottish adults with at least 1 natural tooth 2008-2017 for all adults (age 16+ years), 65-74 years and 75+ years



https://www.gov.scot/publications/scottish-health-survey-2017-volume-1-main-report/

The greater proportions of older adults retaining some natural teeth is expected to continue as those with improved oral health increase in age. This is likely to result in greater demand for dental services.

During 2015-16, a pilot Scottish Adult Oral Health Survey[20] (SAOHS) was undertaken to test the feasibility of collecting adult oral health data during routine dental examinations, with a further “boost sample” added in 2018. In future it is hoped that a SAOHS programme can be introduced to record adults’ oral health in Scotland.

The 2019 report[21] pools data for 3114 dental patients aged 45 years and above examined during the course of the two data collection periods, 201 of whom (6.5%) were from the Borders. Due to the nature of the pilot it was not possible to report results at Health Board level. Nationally it was found that 96% of those examined had at least one natural tooth.

The survey demonstrated inequalities in adult oral health, with those from more deprived areas being less likely to have any natural teeth or, where teeth were present, less likely to have a functional dentition and more likely to have untreated decay. Oral health was also noted to vary with age, with older adults more likely to have fewer teeth, less likely to have teeth which were sound (not decayed or filled) and more likely to wear dentures. Those over 75 years old tended to have poorer oral hygiene. Untreated decay reduced with age, being lowest amongst those aged 64-75 years, before increasing again in those over the age of 75.

Although known to be the most common oral diseases, no data are available to describe the prevalence of dental caries or periodontal (gum) disease amongst adults in the Borders. The third major oral disease, oral cancer, is much rarer, but is important as it has a significant impact on those affected. In the Borders in 2016, the most recent year for which data are available, 8 new cases of oral cavity cancer (ICD 10, C01-06) were diagnosed and one individual from the Borders died as a result of the condition during 2016[22].

Determinants of Oral Health

There are a number of factors known to influence oral health. Diet, particularly the frequency and amount of sugar consumed, increases the risk of dental decay. No data are available to quantify sugar consumption in the population of the Borders, however measures of fruit and vegetable consumption reported in the Scottish Health Survey provide some indication of dietary practices. Aggregated data from 2014-17 show that 70% of adults in the Borders eat fewer than the recommended 5 portions of fruit and vegetables per day, with 8% reporting that they do not eat fruit or vegetables on a daily basis. These figures compare favourably with the Scottish average of 79% eating less than 5 portions of fruit and vegetables per day and 11% not eating fruit and vegetables on a daily basis[15].

Smoking is associated with poorer periodontal (gum) health and is known to increase the risk of developing oral cancer. Smoking rates have been declining in recent years and currently around 18% of the population of the Borders report that they are regular smokers, which is slightly lower than the national average of 21%[15]. Alcohol is also associated with oral cancer, with a synergistic effect observed where there is exposure to

both alcohol and tobacco. Alcohol may also increase the risks of oro-facial trauma and excessive toothwear. In the Borders around 21% of adults are described as having harmful/hazardous drinking habits (drinking above the recommended limit of 14 units per week), in comparison to 25% across Scotland as a whole[15].

Fluoride is known to protect against dental caries. Fluoride can be delivered in a number of formats, including toothpastes, professionally applied gels and varnishes and fluoridation of domestic water supplies. People living in fluoridated areas tend to experience less dental decay than those in non-fluoridated areas and there is evidence that water fluoridation can narrow oral health inequalities[23]. In the Borders, as with the rest of Scotland, supplemental fluoride is not added the water supply. The Scottish Government have made it clear that water fluoridation is not being considered at the present time, stating in the Oral Health Improvement Plan that: “Although we recognise that water fluoridation could make a positive contribution to improvements in oral health, the practicalities of implementing this means we have taken the view that alternative solutions are more achievable”. Currently, the national direction is to focus on delivery of topical fluoride through twice daily brushing with fluoride toothpaste, supplemented by professional application of fluoride varnish to those at greatest risk of decay.

As noted earlier, both adults and children from deprived areas are at greater risk of poor oral health though it is difficult to quantify the extent to which this is the case in the Borders. It has been suggested that in the Borders, geographic isolation may also impact on the oral health of those affected. Lack of data also limits our ability to describe the oral health of particular population groups in the Borders who are likely to be at increased risk of poorer oral health, including people experiencing homelessness, care experienced children, those with additional care needs and those with poor mental health.

Main Findings Section 1: Demographics, Health and Oral Health

- **There is a large and growing proportion of older people in the Borders**
- **Inequalities in the Borders are often masked by area measures of deprivation**
- **General health in the Borders is relatively good. Increased prevalence of some conditions may reflect the age structure of the population**
- **Oral health of children is good, though the rate of improvement appears to be slowing**
- **There is a lack of data to describe the oral health status of adults or “priority groups”**
- **Health behaviours including fruit and vegetable intake, smoking and hazardous drinking are more favourable in the Borders than the rest of Scotland though there is still room for improvement**

Key Discussion Points

Ageing Population

The large, and growing, proportion of older adults in the Borders has important implications for dental services in the area. In combination with increased numbers of people reaching older age, the fact that more people are retaining natural teeth will place increasing demands on dental services. In the Borders where the proportion of older people is higher than the national average this is likely to present particular pressures to dental services in the future.

While improvements in oral health have led to more teeth being retained, past dental disease means that many of these teeth will have been subject to dental treatment, often with large restorations or crown and bridge work which can be complex to maintain and which will require replacement over time.

In addition to increased requirements for treatment, there are challenges associated with providing dental care for an ageing population. Increasing prevalence of health conditions and co-morbidities with advancing age, cognitive decline and increasing frailty introduce complexities into treatment provision. Many of the medications required for these conditions can also impact on oral health and dental care, for example through side effects of dry mouth, effects of immuno-suppression or anticoagulants.

Advancing age may also make it more difficult for patients to access dental care as mobility declines and presents barriers to attending dental appointments. The ability of individuals to maintain high standards of daily oral care may also reduce, either due to physical limitations or with cognitive decline. Dependence on care providers to support oral

hygiene and mouth care is an important aspect to be considered in any packages of personal care. Daily oral care is essential to reduce the risk of dental problems and requirement for dental interventions which would be complex to provide.

Migration

While the increasing proportion of older people in the Borders is likely to have the greatest impact on dental services in the future, the main driver of population growth is net migration into the area. A small proportion, around 6%, of those arriving in the Borders are from overseas, however it is recognised that there are specific considerations for dental services, including the requirement for translation services to support provision of dental care. During financial year 2017-18 114 requests for translators were made by the Public Dental Service, incurring a cost of £13 626. This was an increase on the previous year when 84 requests were made and the cost was £6 798. The increases over this time were most likely due to new arrivals in the area, including a number of Syrian families with refugee status, which is supported by the fact that the most commonly requested language was Arabic. Greater consideration of the reasons for requesting interpreters and an increased use of telephone interpretation reduced costs of providing translation services to £3 626 in 2018-19.

No data were available for costs of translators supporting patients attending General Dental Practices and it is unclear whether this is because the services are not used or their use is under recorded. Patients who have English as a second language should not automatically be directed or referred to PDS, though groups with particular needs such as refugees may be identified as requiring the additional input which can be offered by the PDS.

Aside from challenges and costs associated with providing dental care to individuals whose first language is not English, oral health needs of those arriving from other countries can be expected to differ from the local population. The relatively good oral health in the Borders makes it likely that oral health of new arrivals will be poorer and this is particularly the case for people arriving from areas of high caries prevalence such as Eastern Europe or refugees who often have high health needs. The specific needs which may differ from the general population of the Borders require to be taken into account when planning and delivering oral health services, including preventive interventions.

Priority Groups and Health Conditions

While data to describe individuals likely to be at increased risk of poor oral health, including priority groups and those with additional care needs or specific health conditions, are limited it is known that many such individuals are resident in the Borders. It is important to ensure that the oral health of these groups is not over looked and the specific oral health needs (which are likely to be greater than those of the general population) must be identified and taken into consideration to ensure they are met.

Child Oral Health

The oral health of children in the Borders is good and for a number of years has been consistently better than the national average. The small population in the Borders requires a degree of caution in interpreting local trends in results of school dental inspections. Locally the rate of improvement which has been observed in child oral health has been slowing. This has also been observed in other areas of Scotland and is felt to reflect that

fact that while oral health improvement programmes have been successful for the majority of children further action is required to reach children who have not fully benefited from the interventions to date. To continue to reduce levels of dental disease it will be necessary to place greater emphasis on those children who continue to be at risk of experiencing dental decay. This will require an increased emphasis on community based approaches to reach out to families of children who need increased support to maximise their oral health.

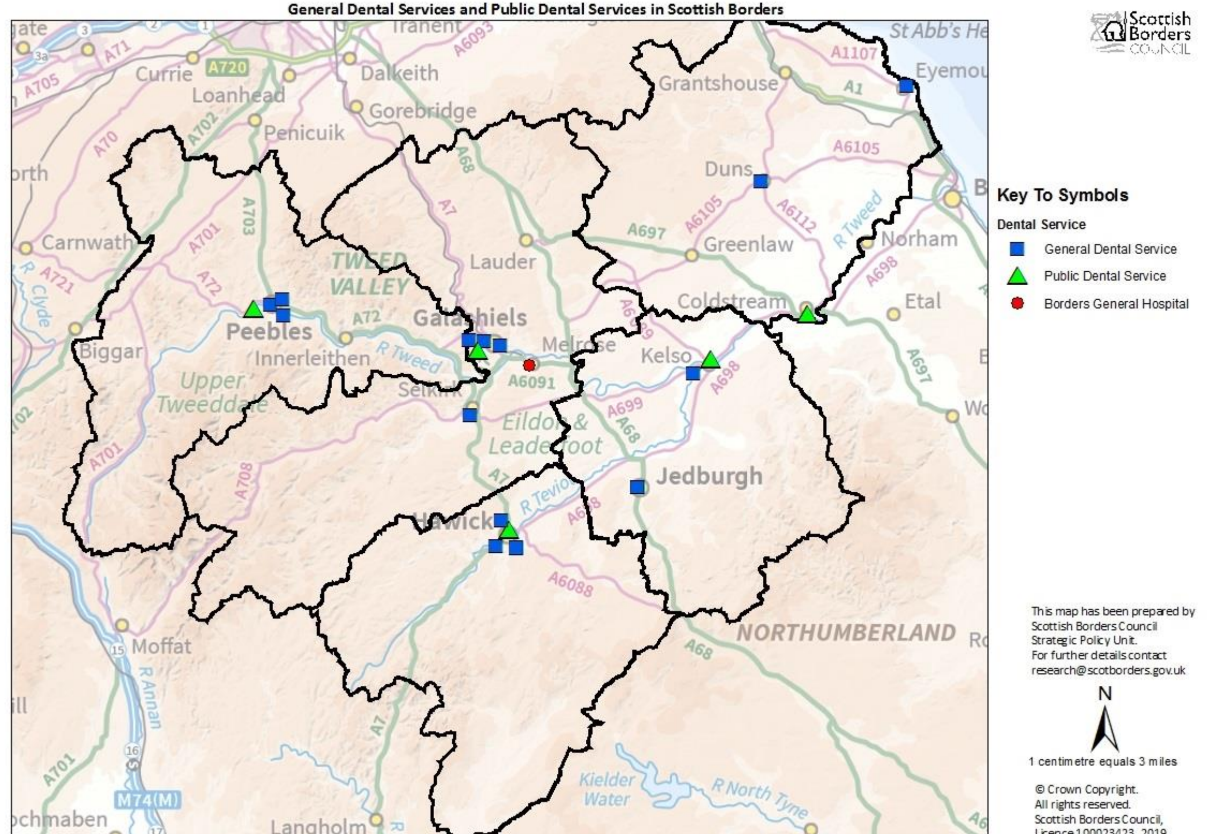
SECTION 2:
DENTAL SERVICES IN THE BORDERS

6. Provision of Dental Services

Primary Care Dental Services

Primary Care dental services are available in a number of locations across the Borders, provided for the NHS by either the General Dental Service (GDS) or Public Dental Service (PDS). Figure 9 shows the distribution of GDS and PDS clinics in the Borders. Clinics are generally available in the areas of greatest population density, though it is evident that residents in some areas may have to travel significant distances to access a dental clinic in the Borders.

Figure 9 – Map showing distribution of GDS and PDS Dental Services in the Borders



Funding of Primary Care Dental Services

Primary care dental services are funded by Scottish Government. GDPs receive payments via Practitioner Services Division as item of service payments, (minus patient contribution), continuing care / capitation payments for registered patients plus allowances. The GDS budget is non cash limited. The PDS is hosted by the HSCP and is funded via an allocation from Scottish Government with some additional funding from the Health Board. In addition NHS Borders receives funding through the “Superbundle” for delivery of the national oral health improvement programmes e.g. Childsmile, the emergency dental service and clinical waste for all primary care dental services.

Dental Registration

The proportion of the Borders population registered with an NHS dentist has increased significantly in recent years. On 30th September 2018, 81.6% of adults and 89.7% of children were registered with an NHS dentist in the Borders, in contrast to 2003/4 when less than 40% of adults in the Borders were registered. NHS dental registration in the Borders is slightly below the national average of 94.3% of adults and 94.1% of children.[24] It is worth highlighting that some individuals attend for dental care on a private basis and are therefore not included in this figure, though they do access dental services. Information is not available to describe the number of individuals currently accessing private dental care, though it is known that this is offered by a number of local practices. The proportion of the population who are currently not accessing dental care is therefore difficult to quantify but likely to be well below 20%.

Until 2006 registration with an NHS dentist was time limited and would lapse if the patient had not attended within the previous 15 months. From 2006 the registration period was extended to 36 months, then 48 months in 2009. Following further changes to the Regulations, lifelong registration was introduced in 2010. Anyone who has been registered with an NHS dentist since this time remains registered unless the dentist actively chooses to de-register a patient or the patient opts to attend a different NHS dentist at which point their registration will transfer to the new dentist.

Figures 10 and 11 show trends in dental registration for children and adults with NHS dentists since 2000 for Scotland and the Borders.

Figure 10 - Trends in dental registration for children in Scotland and the Borders 2000-2018

Proportion of children (aged 0-17 years) registered with an NHS dentist 2000-2018

https://www.isdscotland.org/Health-Topics/Dental-Care/Publications/2019-01-22/2019-01-22-Dental-Report.pdf

The pattern of registration rates has been similar for children in the Borders as in other parts of the country, though in 2000 there were fewer children registered with an NHS dentists in the Borders than in Scotland as a whole. As registration rates increased, this

occurred more rapidly for children in the Borders, though it appears that the registration rate for children is levelling off at around 90%.

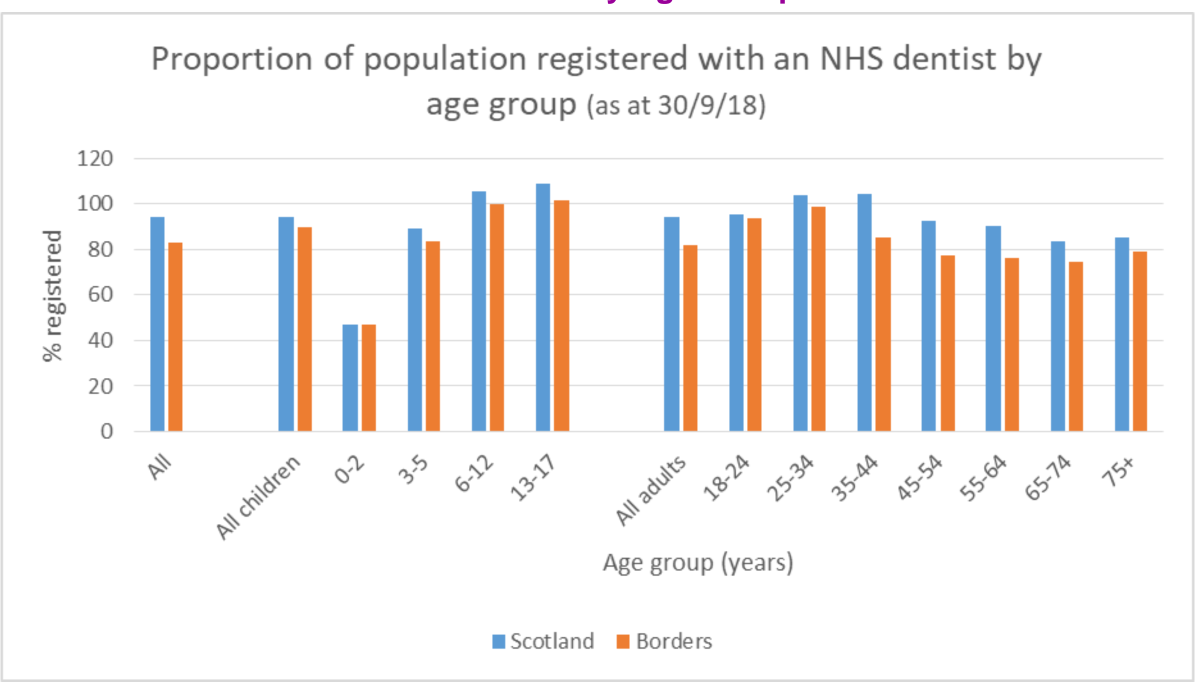
Figure 11 - Trends in dental registration for adults in Scotland and the Borders 2000-2018

https://www.isdscotland.org/Health-Topics/Dental-Care/Publications/2019-01-22/2019-01-22-Dental-Report.pdf

Trends in dental registration for adults in the Borders have varied slightly from the national picture. In 2000 a greater proportion of adults in the Borders were registered with an NHS dentist than in Scotland as a whole. Registration rates declined sharply around 2003-4, when a number of local dentists reduced their NHS commitment and the balance shifted towards increased provision of private dental care. As registration rates have increased, this has happened more slowly in the Borders than in other parts of Scotland and while the current level of 89.6% of adults being registered is a significant improvement on 49% in 2003, it remains below the national level.

Registration rates tend to vary with age, with highest registration amongst children and the 25-34 age group. Levels of registration by age group in the Borders and Scotland are presented in Figure 12. In general registration by age follows a similar pattern in the Borders as the rest of Scotland, with lowest registration amongst the youngest age group where only 46.7% of those aged 0-2 years are registered with a dentist. The Borders is slightly unusual in having a higher proportion of the 75+ age group (79.1%) registered with a dentist than any other group from 45 and above.

Figure 12 – Proportion of Population in the Borders and Scotland Registered with an NHS Dentist by Age Group



https://www.isdscotland.org/Health-Topics/Dental-Care/Publications/2019-01-22/2019-01-22-Dental-Report.pdf

Participation with Dental Services

Since the introduction of lifelong registration in 2010, being registered with a dentist no longer represents continuing active engagement with dental services and a new measure of participation has been introduced as a measure of those who regularly attend dental services. Participation is defined as having attended an NHS dentist for examination or treatment within the previous two years. In the Borders in September 2018 77.1% of adults and 91.7% of children registered with an NHS dentist had participated with NHS dental services during this time period. This is higher than the national average of 66.6% of registered adults and 84.1% of registered children across Scotland.[23] Borders patients who are registered with an NHS dentist are more likely to attend the dentist regularly than in other parts of Scotland.

Like registration participation rates vary with age, being highest amongst children and lowest among young adults and the oldest age groups. Participation rates by age group for NHS Borders and Scotland are shown in Figure 13. In the Borders the proportion of older adults participating with dental services is higher than in other parts of the country.

Figure13 - NHS Dental participation rates by age group in Scotland and the Borders

Proportion of registered patients attending for NHS dental care within previous 2 years (as at 30/9/18)

Participation rate

Age group (years)

Scotland, Borders

All ages, All children, 0-2, 3-5, 6-12, 13-17, All adults, 18-24, 25-34, 35-44, 45-54, 55-64, 65-74, 75+

https://www.isdscotland.org/Health-Topics/Dental-Care/Publications/2019-01-22/2019-01-22-Dental-Report.pdf

Cross-Boundary Dental Attendance

Unlike General Medical Services which have strict geographical boundaries for registration, patients can choose to register with a General Dental Practitioner in any location, including in other Health Board areas. Data from NHS National Services Scotland Information Services Division (ISD) show that during financial year 2018-19 274 patients from the Borders received NHS dental care in Dumfries & Galloway and 6186 Borders residents attended NHS dentists in Lothian. It is possible that some people accessing dental care out with the Borders do so because they are unable to register with a dentist locally, though this is unlikely to be the only explanation. Reasons for accessing dental services out with the Borders could be varied, including patients who have moved from another area opting to remain registered with the dentist they have previously seen, a dental practice in a neighbouring area being closer to a patient's home or having more direct transport links than the nearest service within the Borders, or for an individual who works in the neighbouring Board area it may be more convenient to attend a dentist close to their place of employment. Registration and participation figures are based on the patient's home postcode and as such, the figures above include residents of the Borders regardless of where in Scotland they are accessing dental care.

The proximity of the Border with England means that some residents of the Borders may choose to access dental services in England for reasons similar to those outlined above. Due to the different model of delivery of primary care dental services in England, there are no equivalent figures for registration and participation with an NHS dentist. A request was made to the English NHS Business Services Authority (NHSBSA) for information regarding the number of Scottish patients known to be accessing dental care in England.

Between August 2017 and July 2019 (a standard 2 year period which NHSBSA works to) around 6 000 patients seen in England were identified as having a Scottish home postcode. Of these, 2 810 were residents of the Borders, making up 46.7% of all Scottish people who received dental care in England over this time. Perhaps unsurprisingly, the

next most frequent area from which Scottish patients were accessing care in England was Dumfries & Galloway, however this accounted for only 13.4% of Scottish residents seen in England over this time.

Reasons for Scottish patients accessing dental care in England may include requiring emergency dental care for an acute problem while on holiday. Analysis of the number of claims for urgent treatments for Scottish patients showed that while the majority (37.2%) of these were submitted in the North of England, claims for urgent dental treatments were made across most areas of England and were noted to be higher in areas recognised to be holiday destinations such as Blackpool and Cornwall.

Band 1 FP17 claims (claims for basic items of treatment including a dental examination) could be considered a proxy for patients receiving regular dental care. A significant proportion (81.2%) of all Band 1 FP17 claims for Scottish residents were submitted in the North of England (Cumbria, Northumberland and Tyne & Wear). Contract analysis also revealed that the area where most claims for Scottish residents were submitted per contract was Berwick upon Tweed (3 299 claims), with the majority of these patients being resident in the Borders. It should be noted that this does not equate to the number of individual patients seen, as it would be expected that patients receiving regular dental care would have received more than one course of dental treatment (hence generating more than one claim) during the 2 year reporting period.

While some patients from the Borders opt to access dental care in England, it is known that some English residents travel to attend dental practices in the Borders. During financial year 2018-19, information from ISD shows that 777 patients from England were treated by NHS dentists in the Borders, with a total of 1146 courses of treatment provided over this time period.

General Dental Services

The majority of dental care in the Borders is provided in Primary Care by independent contractor General Dental Practitioners (GDPs). GDPs providing NHS dental services are required to meet criteria for listing by the NHS Board and are registered to work in a practice which is subject to a 3 yearly rolling programme of practice inspections. GDPs listed to provide NHS services are obliged to offer the full range of NHS dental treatments as set out in the Statement of Dental Remuneration[24] to patients registered with them for NHS care.

Treatment provided in NHS dental practices is funded mainly on a fee-per-item basis with patients paying 80% of the cost of treatment unless they fall into an exemption category (under 18, aged 18 and in full time education, pregnant or have had a baby in the previous 12 months or in receipt of certain benefits). NHS dental examination is free of charge for all patients. Treatment fee income is supplemented by additional payments and allowances, for example continuing care payments for registered patients, payment for participating in continuing professional development and reimbursement of some business expenses. A Remote Areas Allowance is payable to dentists working in an area with less than 0.5 people per hectare, or those who have retained a list number in a practice 90 minutes or more from the closest Postgraduate Dental Education Centre, which made them eligible for the Remote Areas Allowance prior to 2006. During 2018-19 a total of £188 100 was paid by Scottish Government in Remote Areas Allowances to dentists in the Borders[26].

A Recruitment and Retention Allowance is available to encourage dentists to take up posts providing NHS dental care in Designated and non-Designated Areas of Scotland where it is recognised that there is a shortage of dentists. This allowance is payable to dentists on completion of training or in applying to join a dental list in the area, having not been listed there in the previous 5 years. To qualify for the allowance they must undertake to provide at least four sessions of NHS dentistry per week in the three subsequent weeks, with NHS earnings accounting for not less than 80% of their total income over this time. One area in the Borders is classed as a non-Designated area, which is Coldstream. As the only dental practice in Coldstream is a PDS clinic, this allowance may help to encourage recruitment to a PDS post were it to become available but would be unlikely to bring new GDPs to the Borders.

GDPs may also offer additional private treatments to their NHS patients, for example where a treatment is not available in the SDR. Many also opt to provide private care to patients who are not registered as NHS patients. The level of commitment to the NHS varies between individual practitioners and between dental practices.

There are 15 dental practices in the Borders who provide NHS dental care, most of which also offer private treatment to a greater or lesser extent. Details of NHS dental practices and dentists in the Borders are presented in Table 2. Forty six dentists are listed to provide NHS dental services in the Borders (as at December 2019). The majority are self-employed independent contractors to the Health Board. Two dentists are employed by dental practices as assistants. An assistant is a qualified dentist who is employed by the dental practice usually on a salaried basis and works alongside a principal dentist. During their first year in General Dental Practice, recently qualified dentists will take up a post as a Vocational Dental Practitioner (VDP). A VDP is a fully qualified, registered dentist who works alongside an experienced GDP who can provide support during this first year. There is currently one VDP in the Borders.

Table 2 – Dental Practices in the Borders

Town	Dental Practice	Number of dentists listed	NHS/ Private*
Duns	Duns Dental Practice	2	Predominantly Private
Eyemouth	The Eyemouth Dental Practice	5	NHS & Private
Galashiels	Roxburgh Dental Practice	5	NHS & Private
	Bank Street Dental Practice	7	NHS & Private
	Albert Place	3	NHS & Private
Hawick	GK Dental	2	NHS & Private
	North Bridge Dental Practice	3	Adults Private, Children NHS
	Teviot Dental Practice	2	Predominantly Private
Jedburgh	EM&B Dental Practice	1	NHS
	Jedburgh Family Dental Practice	7	NHS & Private
Kelso	The Gentle Touch	4	Predominantly Private
Peebles	Peebles Dental Practice	3	NHS & Private
	Rosalind Kerr Dental Practice	3	NHS & Private
	Kingsmeadows Dental Practice	1	Adults Private, Children NHS
Selkirk	Selkirk Dental Practice	4	NHS

*Based on practices status as “NHS committed” and whether accepting new patients as at December 2019. This does not directly reflect the number of NHS patients registered with each practice.

Traditionally General Dental Practices were owned by a principal dentist, or partnership of dentists within the practice who took on responsibility for running the practice in addition to providing clinical care. Self-employed associate dentists work in dental practices and pay a proportion of their income to the practice owner(s) to cover practice overheads. While this remains the most common model of delivery of General Dental Practices in Scotland, in recent years there has been an increase in the number of practices owned by Dental Bodies Corporate (DBC), commercial companies who own a number of dental practices staffed by associate or assistant dentists. Three of the fifteen NHS dental practices in the Borders are currently owned by DBCs. In addition there is one specialist NHS dental practice providing orthodontic treatment. A referral pathway has been established for orthodontic services in the Borders to support GDPs to refer patients to either the specialist orthodontic practice or Borders General Hospital as appropriate (Appendix 1). In line with the Scottish Government’s Health and Social Care Delivery Plan[27], this ensures that patients who can be managed in a Primary Care setting are treated in the community, and only those with more complex orthodontic needs are directed to the hospital based consultant orthodontist. Staff in the orthodontic practice comprise a specialist orthodontist, a dentist who is employed by the practice to provide orthodontic treatment and an orthodontic therapist.

There are two dental practices in the Borders which only offer private dental care. Private practices which do not have any dentists listed to provide NHS dental care are not subject to Health Board dental practice inspections. Non-NHS dental practices are regulated by Healthcare Improvement Scotland (HIS). Requirements of the NHS practice inspection checklist are included in the HIS inspection process, though these inspections do not follow the same three yearly rolling programme. Reports of HIS inspections of independent hospitals and clinics, including private dental practices, are published on the HIS website.

Public Dental Service

The Public Dental Service (PDS) offers a complementary Primary Care dental service for patients who are unable to access care from a GDP. The primary purpose of the Public Dental Service is to provide care to patients with additional needs which make providing dental care more complex, for example those with disabilities, medically compromised patients, pre-cooperative children, socially excluded groups and those with severe dental anxiety or phobia. In addition PDS teams provide care to inpatients in acute and community hospitals requiring dental treatment. The PDS also has a role in providing routine dental care to the general population in areas where they are unable to register with a dentist due to lack of service availability. The PDS provides dental care under the same GDS terms and conditions as GDPs, with patients who are not exempt from NHS charges paying the same fees as they would for care by a General Dental Practitioner. As Health Board employees, PDS dentists are not permitted to offer additional private treatments.

The 2005 Dental Action Plan sought to improve access to NHS dental services, with substantial investment in Salaried Dental Services in areas where there were fewer NHS GDPs. Due to the acute shortage of NHS dentists in the area at this time, the Borders benefited from this through the creation of new dental centres in Hawick and Coldstream, and recruitment of additional staff members to the PDS.

Nationally access is no longer considered to be a political priority and there is increasing emphasis on encouraging patients to attend a GDP where possible. PDS main focus will then be on the care of more complex patients for whom treatment in a GDS setting would not be possible. In the Borders the access function, providing regular dental care for routine patients, remains a significant proportion of the PDS workload when compared to other parts of the country as shown in Figures 14 and 15 for children and adults respectively.

Figure 14 – Proportion of Children Registered with GDS or PDS by Health Board

Proportion of children (0-17 years old) registered with GDS or PDS by Health Board

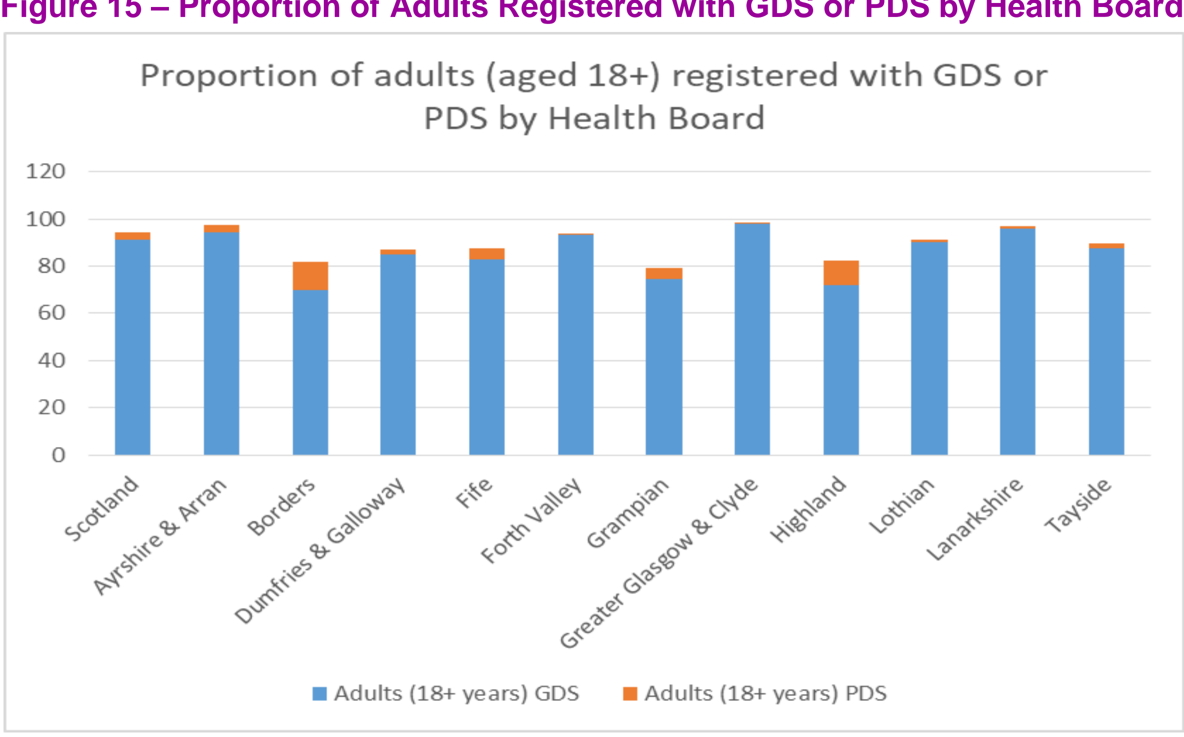
100
90
80
70
60
50
40
30
20
10
0

Scotland
Ayrshire & Arran
Borders
Dumfries & Galloway
Fife
Forth Valley
Grampian
Greater Glasgow & Clyde
Highland
Lothian
Lanarkshire
Tayside

Children (0-17 years) GDS
Children (0-17 years) PDS

https://www.isdscotland.org/Health-Topics/Dental-Care/Publications/2019-01-22/2019-01-22-Dental-Report.pdf

Figure 15 – Proportion of Adults Registered with GDS or PDS by Health Board



https://www.isdscotland.org/Health-Topics/Dental-Care/Publications/2019-01-22/2019-01-22-Dental-Report.pdf

There are currently six PDS clinics in the Borders. All but one clinic (Peebles) operate five days per week. Most clinics provide care for a mixture of routine (GDS) patients and those requiring special care dentistry. The clinic within Borders General Hospital only accepts patients who have been referred for treatment. Table 3 outlines the number of dental chairs and staffing level in each clinic. Table 4 outlines the number of staff employed in each role within the PDS.

Table 3 – PDS Clinic size, staffing levels and categories of patients seen (December 2019)

Clinic	Chairs	Staff*	Days	Patient types
BGH	1 PDS chair in dept with 3 surgeries	2 dentists 3 dental nurses	4 days	Referral only Special Care General Anaesthetic IV sedation Inhalation Sedation Anxiety management
Peebles	1	1 dentist 1 dental nurse	1 day/ fortnight	Doms Special Care only
Galashiels	3	2 dentists 1 hygienist-therapist 3 dental nurses	5 days	Routine Special Care
Kelso	2	3 dentists 1 hygienist-therapist 5 dental nurses	5 days	Routine (GDS) Special care
Coldstream	5	3 dentists 2 hygienist-therapists 7 dental nurses	5 days	Special care Routine (GDS)
Hawick	8	5 dentists 2 hygienist-therapists 10 dental nurses	5 days	Routine Special care

*Staff may work across a number of sites on different days. Staffing levels correct as at December 2019, but will vary depending on service requirements.

Table 4 - Staff in NHS Borders Public Dental Service as at December 2019

	Headcount	WTE
Clinical Director	1	0.85
Specialist Dentist	0	0
Senior Dentists	3	2.87
Dentists	9	7.27
Hygienist-Therapists	4	3.85
Hygienists	0	0
Dental Nurses	31	26.64
Reception/Admin	10	9.92
Local Decontamination Unit	6	5.6

The Bateman Casemix tool[27] is used by PDS to quantify the complexity of patient treatment by scoring six categories:

- Ability to communicate
- Ability to co-operate
- Medical status
- Oral risk factors
- Access to care
- Legal and ethical barriers to care

The breakdown of patient complexity as assessed by the Casemix model recorded for PDS patients attending clinics in the Borders during 2019 is shown in Table 5.

Table 5 - Level of complexity of patients seen in NHS Borders PDS (2019) Classified according to Bateman Casemix Tool

Level of complexity	Proportion of patients
1: No complexity	49.6%
2: Mild complexity	34.6%
3: Moderate complexity	11.6%
4: Severe complexity	2.8%
5. Extreme complexity	1.4%

The high proportion of patients recorded as having no or mild complexity may reflect the fact that many patients attend the service for its dental access function, however as a Casemix score was not recorded for every patient, it may not accurately reflect the proportions of patients within each category. In addition, the Casemix tool is scored in relation to the specific course of treatment, therefore a patient who may score high complexity for active clinical interventions would receive a lower score if the assessment has been based on a simple treatment plan such as a routine recall appointment with no other more invasive treatment required.

While a number of patients are registered with the PDS in the Borders for routine general dental care, treatments are provided to PDS patients which are less frequently provided by GDPs, for example as at August 2018 approximately 492 residents in care homes in the Borders were registered with PDS dentists for domiciliary dental care, equating to provision of dental care for around 70% of the total number of residential spaces available in care homes for older people in the region. It is anticipated that the balance of domiciliary dental care provision will shift from PDS to GDS in the future as the new enhanced skills GDP (eGDP) model becomes established, though this will depend on sufficient uptake of the role by GDPs.

Patients who attend PDS may be unable to tolerate routine treatment due to dental anxiety or other additional needs. During 2019 a total of 86 children had dental extractions under general anaesthetic. Providing dental treatment under general anaesthetic is considered to be a last resort for patients who cannot receive their treatment in any other way.

For some individuals sedation can help them to cope with treatment without the requirement for a general anaesthetic. During 2019, 73 patients were treated under inhalation sedation with nitrous oxide and 49 with intra-venous sedation (25 midazolam (dentist led), 24 propofol (anaesthetist led)).

Patients can access PDS services via self-referral, or on referral from a GDP or another professional involved in their care. The majority of new patients seen in PDS have self-referred, with GDPs being the most frequent source of professional referrals. Referrals to PDS are triaged centrally at Borders General Hospital and allocated to PDS, oral surgery or orthodontics based on the request of the referring dentist. The most common type of referral received by PDS is for children requiring sedation or general anaesthetic to enable them to accept dental treatment. Other referrals are for adults requiring sedation, those with special care needs and inpatients in acute and community hospitals.

Table 6 - Number of referrals to PDS by age group and category (January 2018 – December 2018)

Reason for referral	Age at referral					Total Number of Referrals
	0-18	19-44	45-64	64-75	75+	
Sedation	13	68	43	7	3	134
Special Care Dentistry	2	9	14	8	7	40
Paediatric Dentistry	231					231

Patients who self-refer are directed to their nearest GDP practice in the first instance. Priority group patients will be offered an appointment at the clinic closest to their home. Other patients requesting treatment with PDS are placed on a waiting list but encouraged to register with a GDP practice. A recent review of the waiting list for an appointment to register with the PDS at Coldstream Dental Centre identified that of the 324 on the list, around half had some access to dental care, though this was often not NHS care. Patients who are formally referred are prioritised and fitted in to appointment books where spaces are available.

Emergency Dental Care and Dental Enquiry Line

Emergency Dental Care is provided through the Borders Emergency Dental Service (BEDS). During practice opening times GDPs are responsible for providing emergency cover for their registered patients. Unregistered patients can access emergency care during weekdays by calling the Dental Enquiry Line. On a rota basis, all local dental practices and PDS clinics take a turn to hold predetermined emergency slots each day for treatment of unregistered patients who have contacted the enquiry line with an urgent dental problem.

Out of hours triage of dental emergencies for both registered and unregistered patients is provided by NHS 24, with emergency dental sessions available at weekends from the clinic at BGH between 1-4pm on Saturdays, Sundays and bank holidays. All GDPs providing NHS care and PDS dentists participate in the out of hours rota and are required to work approximately two out of hours sessions each year. During 2018 776 patients attended the out of hours dental service. The number of attendances at out of hours has remained relatively static since 2016 with 765 patients attending in 2016 and 753 patients in 2017.

In addition to being the contact number for unregistered patients who have dental problems or pain, the Dental Enquiry Line provides general advice about dental services, can provide up to date details of practices currently accepting new NHS patients and helps support unregistered patients who wish to find a dentist. During 2018 the enquiry line received over 2700 calls, a slight increase on 2017 when 2203 calls were received.

Secondary Care Dental Services

Specialist NHS dental care is provided for two dental specialities (oral surgery and orthodontics) from hospital dental clinics based in the acute sector in Borders General Hospital (BGH).

Orthodontics

One consultant orthodontist is based in BGH six sessions per week, with one additional session in Edinburgh Dental Institute (EDI), where it is possible to provide joint clinics with the Restorative and Paediatric Dentistry Departments, for Borders patients requiring more complex or multi-disciplinary care. Specialty trainees in orthodontics usually based in EDI also provide clinical input to the service in the BGH on a regular basis.

The orthodontic referral pathway which has been established in the Borders enables the consultant to focus on treating the more complex cases, while those suitable for treatment in primary care are managed in specialist practice out with the hospital setting.

During 2018 there were a total of 1792 attendances for orthodontic treatment in BGH, 151 of which were new patients and 1641 reviews and ongoing treatment. Waiting times for orthodontic assessment are within the 12 week referral to treatment target.

Oral Surgery

A total of 12 sessions of oral surgery are provided by two consultant oral surgeons, who are joined by a specialty trainee in oral surgery from EDI 1 day per week.

The oral surgeons accept referrals for a full range of oral surgery treatments from simple extractions on patients with complex medical histories, including those on anticoagulant medications, to surgical extractions and removal of impacted teeth. The oral surgeons also accept referrals relating to the specialty of oral medicine. Treatments are provided under local anaesthetic, intravenous sedation or general anaesthetic depending on the nature of the surgery and patient's ability to tolerate treatment.

During 2018 there were approximately 840 out-patient attendances at the oral surgery department (SMR00 data) and 141 patients were treated as day cases (SMR01 data). The oral surgery service has been under pressure with waiting times reaching 20 weeks. Waiting list initiative clinics have been provided to help reduce the backlog and reduce waiting times to around 12 weeks. Once assessed, patients requiring treatment under local anaesthetic can be treated fairly soon, however those requiring general anaesthetic may wait several months.

Other Dental Specialties

Patients requiring other aspects of specialist dental care may be referred on to Edinburgh Dental Institute. Treatment of Borders patients in EDI is managed via a Service Level Agreement (SLA). Prior to referring any patient to the Dental Institute, approval is required from NHS Borders and any referrals received in EDI without this approval in place will be

rejected. There are no arrangements in place between NHS Lothian and NHS England for cross-charging treatment costs and as a result EDI are unable to accept patients who live in England. Referrals for patients resident in England, even if referred by a GDP based in Scotland, are returned to the referrer who is advised to refer the patient to Newcastle.

There is an expectation that patients requiring orthodontic or oral surgery treatments will be referred to local services in the Borders in the first instance, however there are no restrictions on patients from the Borders being referred to the paediatric dentistry, restorative dentistry or oral medicine departments. Formal referral and acceptance criteria apply universally to all referrals received by EDI, whether from local dentists within NHS Lothian or neighbouring Boards served by the Dental Institute (Borders, Forth Valley and Fife). Decisions on acceptance of patients by EDI are based on the following considerations:

- Specialist review of the clinical information contained in the referral
- Core referral/acceptance criteria
- Recognition of the skill set within and across GDPs
- Recognition of available training capacity requirements (referrals falling out with the acceptance criteria may be accepted on occasion as training cases based on individual requirements)

Patients requiring treatment for oral cancer or head and neck trauma are transferred to the regional Oral and Maxillo-Facial Surgery (OMFS) unit in St Johns Hospital, Livingston.

Oral Health Improvement

There is an active oral health improvement team based within NHS Borders PDS whose main workload is delivery of the national oral health improvement programmes for children (Childsmile) and dependent older people (Caring for Smiles).

The Childsmile programme is well established in Borders nurseries and schools. Childsmile toothbrushing programmes are in place in all nurseries and the majority of Primary Schools and fluoride varnish application is offered in 40% of Primary Schools in the Borders, with Childsmile offered in most of these schools up to and including Primary 7, which exceeds the requirements of the programme. Childsmile is also delivered in additional support units in mainstream schools and Leadervalley School for children with complex additional needs.

The Childsmile practice arm includes oral health support workers (OHSW) who provide advice to families to promote good oral health and support them to access dental care for their child. During financial year 2018-19 545 families were contacted by an OSHW including 444 who were referred to an OHSW with a requirement for additional input to maintain their oral health and support dental attendance[29]. These referrals include children who have been referred to PDS for dental treatment under general anaesthetic all of whom are offered additional support by the Childsmile team.

Since 2011 Childsmile has been incorporated into the Statement of Dental Remuneration so that a fee can be claimed by dental practices for providing Childsmile interventions: diet advice and toothbrushing instruction for children aged 0-2 and 3-5 years and fluoride

varnish application for children between 2 and 5 years old. This enables monitoring of delivery of “Childsmile Practice”. Table 7 shows the proportion of children registered with NHS dental services who received Childsmile interventions during 2018-19 compared to the national average. The oral health improvement team offer support to GDPs to encourage delivery of Childsmile interventions.

Table 7 - Proportions of children registered with GDS receiving Childsmile Interventions

Childsmile intervention	Proportion of children registered with a GDP receiving intervention (%)	
	Borders	Scotland
0-2 years diet advice	79.9	74.4
0-2 years toothbrushing instruction	79.8	76.7
3-5 years diet advice	58.1	46.3
3-5 years toothbrushing instruction	57.5	46.2
2-5 years fluoride varnish application (1 or more)	55.7	41.4
2-5 years fluoride varnish application (2 or more)	30.9	20.1

http://www.healthscotland.com/uploads/documents/36660-Childsmile%20National%20Headline%20Data%20-%20Nov2019.pdf

In PDS and some GDS practices dedicated Childsmile clinics are delivered by extended duties dental nurses (EDDNs) who offer preventive interventions including oral hygiene advice, diet advice and fluoride varnish application. One full time EDDN is directly based within the oral health improvement team in NHS Borders, with a further six dental nurses currently working in PDS available to provide sessions for Childsmile when required.

The Caring for Smiles programme aims to improve oral health of dependent older people by training staff in care homes to provide and document daily oral care, including toothbrushing and denture care. Within the Borders 71% of care homes currently have a staff member trained as an oral health champion, with plans to increase the number of care home staff who have received training.

There is one dental health support worker based in the Caring for Smiles team who works closely with clinical services in the PDS, providing a link between the care home and clinicians to support the delivery of domiciliary dental care when it is required.

The Caring for Smiles team have expanded beyond the care home setting and also offer training in oral health to home care teams in the private sector and from Scottish Borders Council.

The oral health improvement team recognise the value of joint working with colleagues in wider health improvement and have links with drug and alcohol services, smoking cessation services, the family nurse partnership, pre-diabetes groups and learning disability teams. They work in partnership with wider teams to promote good nutrition and oral health in schools.

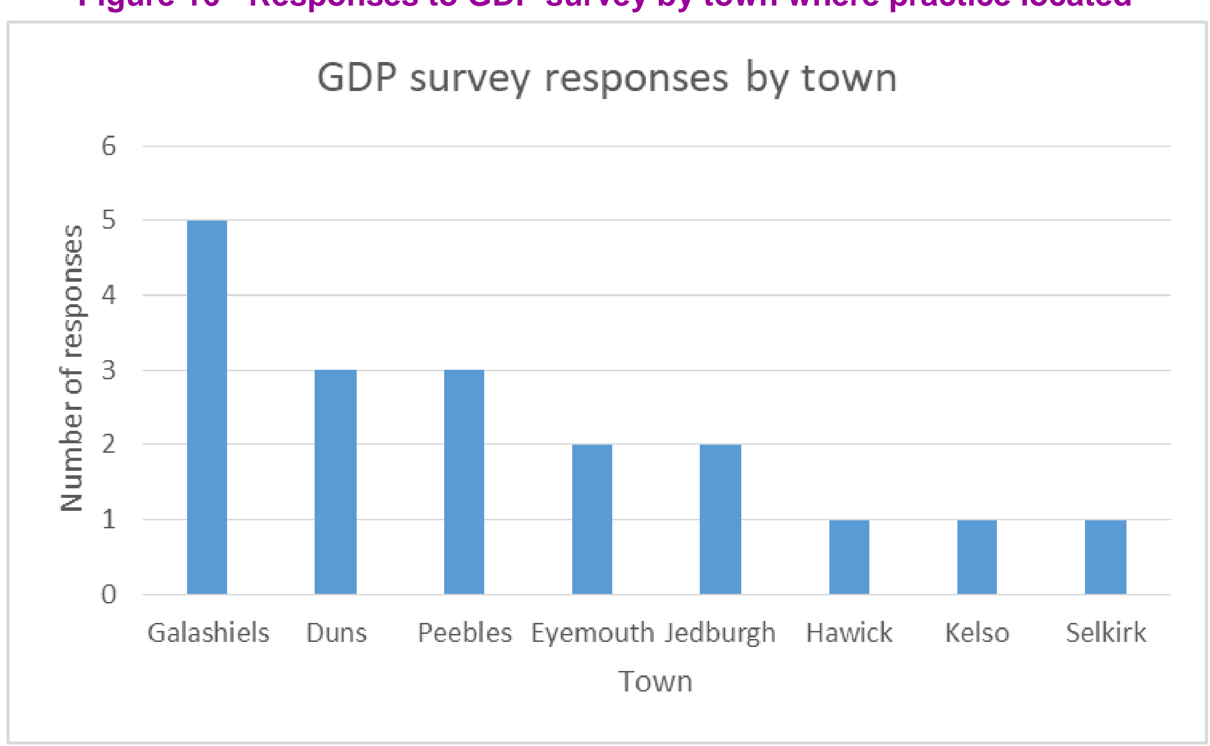
7. Reported Current Primary Care Dental Provision and Future Possibilities

General Dental Services

Between July and September 2019 an online survey was undertaken, with individual GDPs in the Borders invited to provide details of current service provision, staffing levels, utilisation of referral services and anticipated changes.

A weblink to the survey was sent by email by the local Dental Practice Adviser using the distribution list for GDPs who participate in the Borders Emergency Dental Service. Seventeen responses were received (37% response rate). The majority of respondents were practice principals (8), or associates (6). Two respondents were non-clinical practice owners who were not asked questions relating to clinical care, being directed to those regarding staffing. One respondent to the clinical section was a practice manager. The practice manager's responses relating to individual demographics were excluded from analysis, however to ensure that details of service provision for the practice were captured, responses relating to this were included on the assumption that responses reflected the practice as a whole. Responses were received from owners or principal dentists of nine practices (75% of practices in the Borders). All towns with General Dental Practices were represented (Figure16)

Figure 16 - Responses to GDP survey by town where practice located



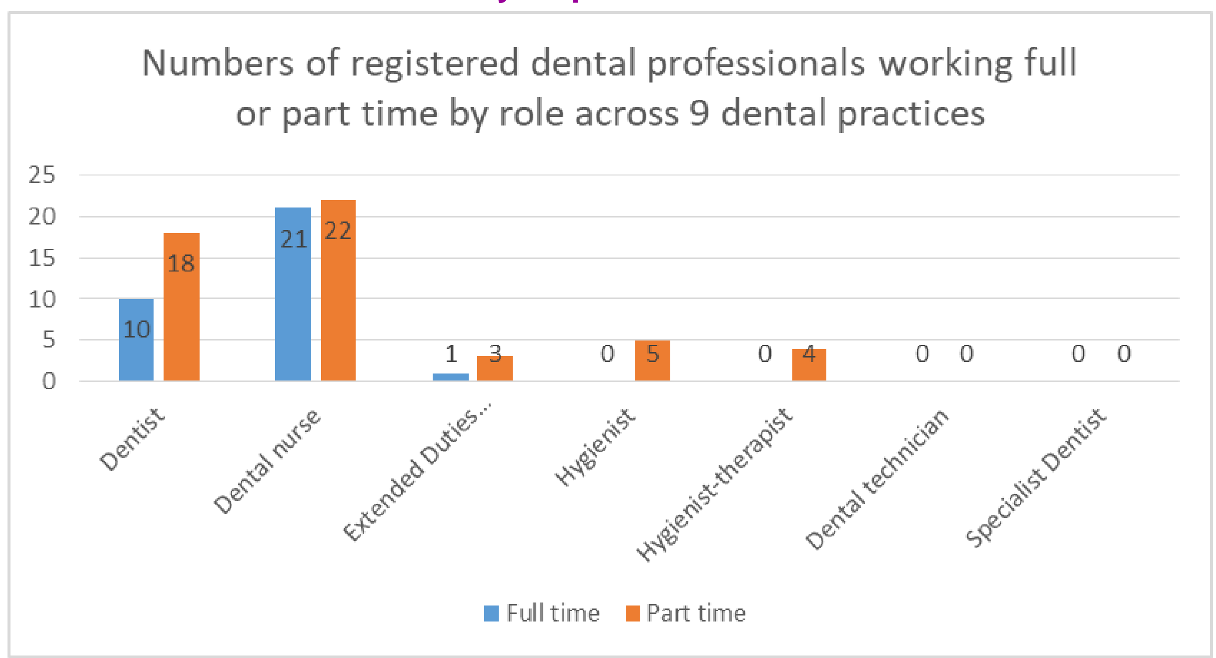
Survey Respondents

Given the response rate of 17 of the 46 GDPs invited to participate in the survey, it is unlikely that respondents are representative of the overall GDP workforce in the Borders. Of those who responded there were an equal proportion of males and females and 60% fell into the 41-50 years age bracket. Seventy nine percent of respondents were British and the remaining 21% EU nationals. The vast majority (86.7%) reported that they commuted less than ten miles to work and none commuted more than 40 miles.

Dental Practice Staff

Practice owners/principals of nine (from the total of fifteen) practices provided details of the numbers dental professionals working either full or part time in their practices. As would be expected the largest professional group was dental nurses, followed by dentists. Similar numbers of dental nurses worked full and part time (21 and 22). The majority of dentists worked part time (18), compared with ten working full time. None of the practices employed dental technicians or dental specialists on either a full time or part time basis. None of the practices for whom responses were provided employed full time dental hygienists or hygienist-therapists, though a number did employ either a part time hygienist or hygienist-therapist.

Figure 17 - Numbers of registered dental practitioners across the nine practices for which survey responses were received

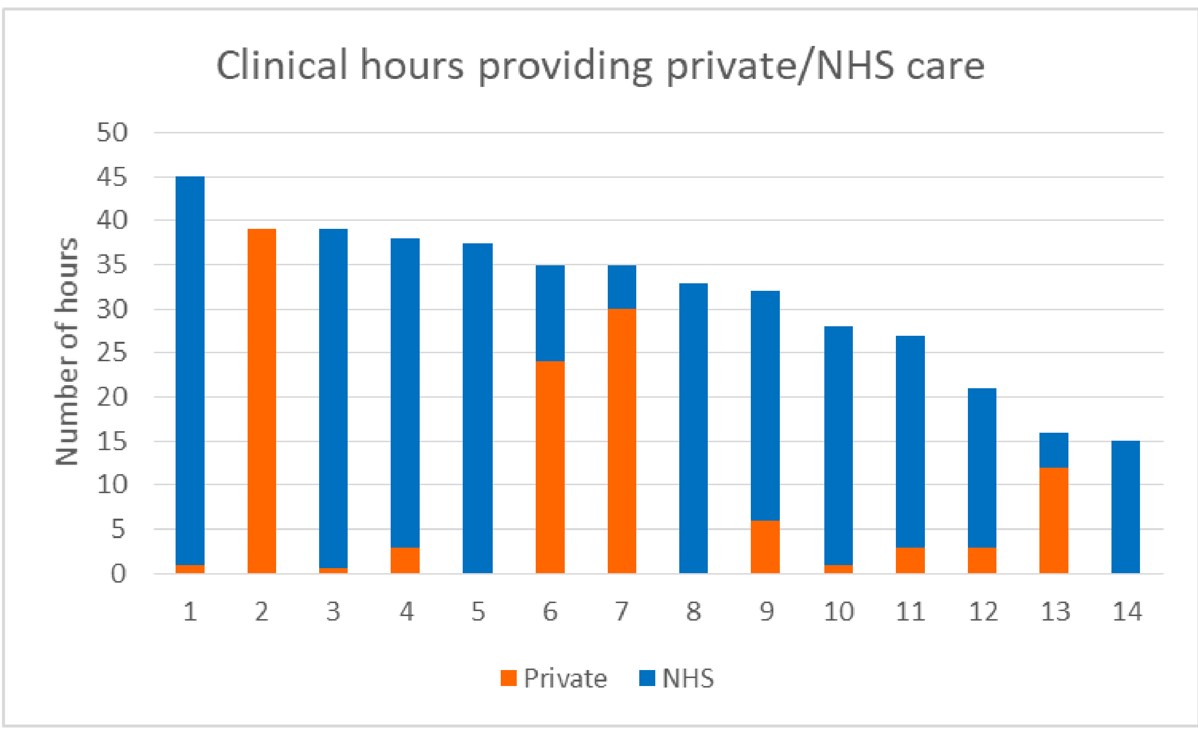


Two practices (22%) reported that they currently had at least one vacant post within their practice. Both of the vacancies were for associate dentists. One practice had no current vacancies but reported that they had advertised for an associate dentist the previous year and were unable to fill the post. They reported that they had plans to re-advertise but were concerned that they may again be unable to recruit to the post. Further pressures included nurse shortages due to illness and maternity leave. Seven of the nine practices reported that they had encountered difficulties with recruitment and retention of staff over the past five years.

Dental Care Provision

The total number of clinical hours worked by each respondent ranged from 15 to 45 hours per week. The split between private and NHS dental care is illustrated in Figure 18. While four respondents provided predominantly private dental care, the majority of those who responded to the survey spent most of their clinical time providing NHS care.

Figure 18 - Hours providing private or NHS dental care per dentist



All respondents provided NHS dental care for child patients, though one reported that children were only accepted for NHS care if their parents were registered with the practice as private patients. All but one respondent reported that they provide NHS dental care for adults. Five respondents (33%) were currently accepting new adults as NHS patients and eight (53%) were accepting new child patients. No distinction was made between adults who were exempt from NHS charges in terms of which adult patients were currently seen, or would be accepted as new patients.

20% of respondents do not currently register child patients from birth. One respondent reported that this was due to their list being closed to new patients. Another reported that this was partly due to the requirement to see a patient for them to become registered with the practice, when in the past it had been possible to submit a form to register a new patient prior to their attendance for examination. It was also felt that parents were not aware they could bring a child to the dentist before teeth are present, with most children not being brought to the practice until they are around a year old.

Capacity to See Patients

To gain an idea of the level of demand on NHS dental services, respondents were asked to give an indication of how soon existing registered patients and new patients wishing to register could be offered an appointment. Most respondents (69%), could offer existing patients an appointment within one month, with the remainder all able to offer an appointment within three months. New patients wishing to register with a practice were

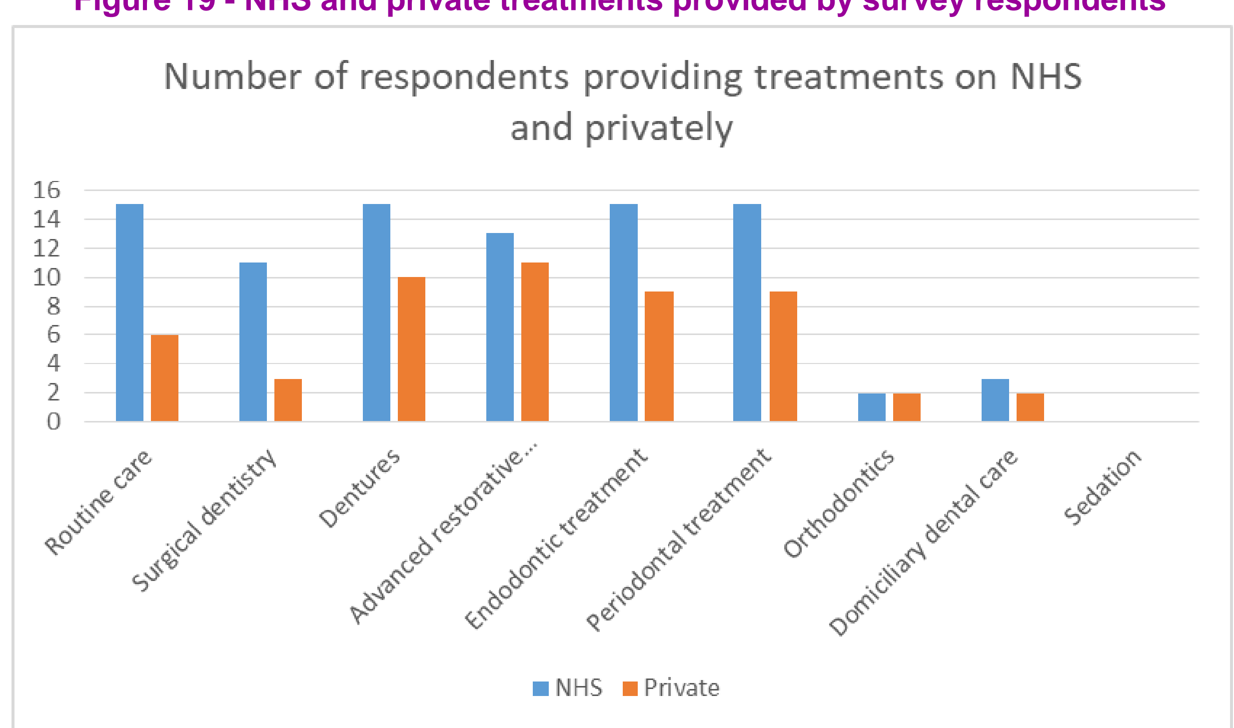
likely to wait longer for an appointment, with only one respondent able to offer an appointment within a month, and the majority (44%) reporting that a new patient would be seen within 6 months to a year.

Treatments Provided

Respondents were asked to indicate which types of treatment they provided on the NHS and privately. Treatments provided on the NHS and privately are presented in Figure 19.

All fifteen respondents offered routine dental care (including examinations, simple restorative treatments and routine extractions), dentures, endodontic treatment and periodontal treatment on the NHS. The most common treatments provided privately were restorative treatments, including advanced restorations (crowns and bridges) (11 respondents), dentures (10 respondents) and endodontic and periodontal treatment (9 respondents for each). None of the dentists who responded to the survey offer dental treatment under sedation either privately or on the NHS, though it is known that one local practice does offer intravenous sedation.

Figure 19 - NHS and private treatments provided by survey respondents



Dentists were asked how many domiciliary visits they had provided within the past year. The vast majority (9 respondents) had not provided any domiciliary dental care, 2 had provided one visit each, 2 had provided two visits and 1 had provided four. The remaining dentist had provided six domiciliary visits.

Referral Services

The survey asked respondents to indicate how frequently they referred patients to a range of specialist dental services. All of the dentists who responded indicated that they referred to oral surgery, orthodontic practice and private dental practice. Frequency of referral to different specialist services is presented in Table 8.The most frequently referred to service appeared to be the orthodontic practice.

Table 8 – Frequency of referral to specialist dental services by GDPs

Referral service	Never	Rarely (up to 1-2 referrals per year)	Occasionally (up to 1 referral per month)	Regularly (approx. 2 referrals per month)	Often (more than 3 referrals per month)	Not answered
BGH Oral Surgery	0	5	5	4	1	-
BGH Orthodontics	2	8	2	1	0	2
Orthodontic practice	0	0	6	4	5	-
Edinburgh Dental Institute	1	12	1	1	0	-
Private practice	0	4	6	3	1	1
Other/out of Board referral	8	5	0	0	0	2

Respondents were asked to specify which private practices and "other" services they referred to. Within the Borders referrals were made to a private endodontist and a recently opened private specialist referral practice. Patients were referred out with the Borders to an orthodontic practice in East Lothian and two private dental practices in Edinburgh. One respondent reported referring patients to St Johns Hospital for Oral Medicine, while another stated that they referred patients to Newcastle Dental Hospital though did not specify to which specialties.

Future Service Provision

The survey asked dentists whether they expected to continue to be providing dental care within the same town in the future. The majority (79.6%) of respondents anticipated that they would still work in their current town in 5 years time, and 60% expected to still be there in 10 years time. Of those who did not expect to still be providing care in the same town the most common reason given was retirement.

Dentists were also asked whether they expected to continue to accept the same categories of NHS patients as they do currently. Around two thirds of respondents stated that they were likely to continue to accept NHS patients on the same basis as they do currently. Four respondents (27%) reported that they were likely to either stop accepting NHS patients or reduce which categories of patients they would take on in future. Reasons given for reducing the number of NHS patients taken on included the fact that their lists were reaching capacity. Two respondents reported a desire to expand their practices or move to larger premises to enable them to continue to accept patients, however they were concerned that it may not be possible to recruit an additional dentist if their practice was to expand. None of the respondents felt it was likely that they would increase which categories of patient they would accept for NHS treatment in the future.

At the time the survey was conducted, a new model of delivery for domiciliary dental care was in the process of being introduced. The new model is based on “enhanced skills GDPs” (eGDP) providing dental care to care home residents. At the time of the survey one local dentist was undergoing training and mentoring towards accreditation as an eGDP. Respondents were asked whether they were likely to consider becoming an enhanced skills GDP for domiciliary dental care in the future. Only one respondent said this was something they would consider, with all others saying they would not.

Although currently limited to domiciliary dental care, the Scottish Government’s Oral Health Improvement Plan also includes a proposal to increase access to dental services “on the high street” through enhanced skills GDPs offering other more specialised dental treatments within practice. Six respondents stated that they would consider becoming an enhanced skills GDP in the future. Four of the respondents who expressed an interest in providing this service stated that they would wish to provide oral surgery under this model. One respondent would be interested in becoming an enhanced skills GDP providing orthodontics.

Public Dental Services

To gauge the current skill mix of staff working within the PDS, all PDS staff were invited to provide a list of recognised courses and qualifications they had undertaken in addition to their primary dental qualification. There was also an opportunity to undertake a “skills and preferences exercise”. Separate questionnaires were devised for each of the professional groups – dentists, dental hygienist-therapists and dental nurses, based on their scope of practice and responsibilities. Members of PDS staff were asked to rate their level of skill or confidence to treat specific patient groups, work in particular settings, provide a range of different treatments and to undertake additional non-clinical duties which may be expected within their role. Level of skill or confidence was rated on a five point scale:

I am confident and can perform independently	I am fairly confident but may need occasional support	I am familiar but would need support	I understand the theory but have no experience	I have little or no knowledge

In addition to rating their confidence or skill level, for each item on the list staff were also asked to rate their preferences, or how they would feel about undertaking them. Preferences were rated on a four point scale:

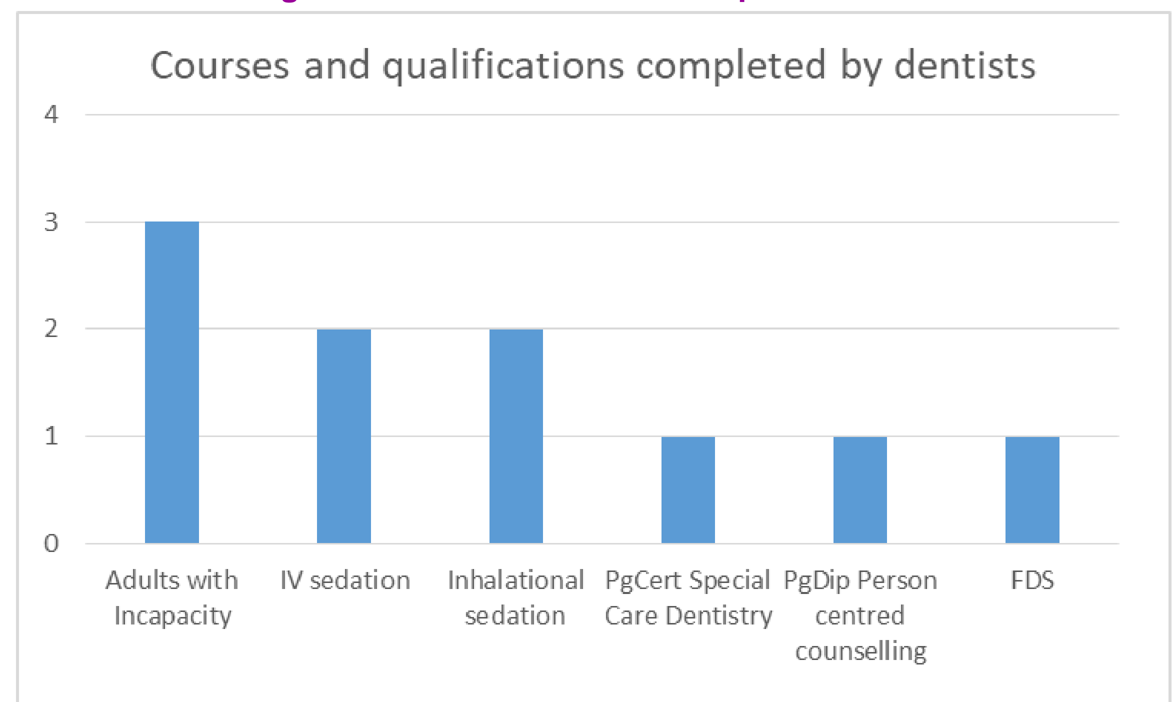
I am happy and get satisfaction	I don’t mind	I have little or no experience but willing to learn	I would prefer not to do this

Dentists

Eleven dentists responded to the questionnaire (response rate 100%).

Additional courses and qualifications which dentists had completed are outlined in Figure 20.

Figure 20 - Dentists' additional qualifications



*It has been highlighted that there may have been some misinterpretation of the survey relating to dentists completing training in Adults with Incapacity as the majority of dentists within PDS have completed this training but only three responses indicated that this was the case.

Two further dentists were undertaking the Certificate in Special Care Dentistry at the time the survey was completed and were due to complete their qualification in September 2019.

Dentists' skills

The patient group which dentists were most comfortable to treat was children, with all but one rating themselves as confident to treat them independently. The majority of dentists were also comfortable treating older people, adults and children who are anxious and those with mild or moderate learning disabilities. Fewer dentists felt they would be confident to treat adults or children with more severe learning disabilities or physical disabilities. Only two dentists would feel confident to manage patients experiencing homelessness or those with addiction problems, while five dentists reported that they would require support to treat these patient groups.

In terms of settings, around half of the dentists would be comfortable to provide treatment on a domiciliary basis or in a hospital. Levels of confidence to manage patients within a mental health unit were lower which is likely to reflect that this type of service is currently only provided by the PDS team working within the BGH.

The majority of dentists were confident providing items considered routine dental care, including restorations, extractions, dentures and unscheduled (or emergency) dental care. Most were also comfortable to provide crown and bridge work, endodontic treatment and periodontal treatment. Dentists were less confident providing more complex or specialised items of treatment including minor oral surgery, preformed metal crowns for children and taking a neutral zone impression.

Only some dentists had experience of providing treatment under sedation or under general anaesthetic, which was reflected in the fact that dentists tended to either feel confident or said they had little or no experience, with no middle ground. There was an even spread among dentists relating to their skills in behaviour management of adults and children.

Most dentists were comfortable to liaise with colleagues in other areas of health and social care or with health improvement teams. While the majority of dentists felt able to mentor new or less experienced members of staff, they were less confident with their ability to deliver a presentation or in public speaking.

One dentist commented that it can take time to develop confidence, knowledge and independence due to different systems, documentation and protocols in place. Others highlighted that levels of confidence vary depending on opportunities to undertake different aspects of care, for example as more special care patients are seen a dentist may upskill in some areas relating to specific treatments being provided, but will at the same time de-skill in other areas for example more advanced restorative procedures which are less likely to be undertaken. It was acknowledged that to maintain confidence in more complex treatment items, such as minor oral surgery, these procedures need to be undertaken regularly. This can be hard to achieve in primary care where there are time pressures and there is an ability to refer on to the consultant led oral surgery service. Another dentist stated that although they had completed training in intravenous sedation, there had subsequently been an insufficient number of cases requiring sedation to maintain skills or confidence in the procedure.

Dentists' preferences

In general the dentists' preferences were in line with the skills ratings – where they were most confident they were more likely to report being happy and getting satisfaction. Generally for the more complex patient groups – severe learning disabilities, physically disabled and medically complex, more dentists reported that they would prefer not to work with them. The exception was with people experiencing homelessness and those with addictions, where none of the dentists opted for "prefer not to" and almost half stated that they had little experience but would be willing to learn.

Preferences for working in different settings were divided. There was a fairly even spread of ratings for domiciliary dental care, with some being happy, others who didn't mind or were keen to learn and a few who would prefer not to provide domiciliary care. Working in a hospital environment was more polarised with dentists tending to either be happy to work there or preferring not to. There was a relatively even split between dentists who were happy to provide care in a mental health unit, would be happy to learn about providing care in this setting or would prefer not to, with no one reporting that they "didn't mind".

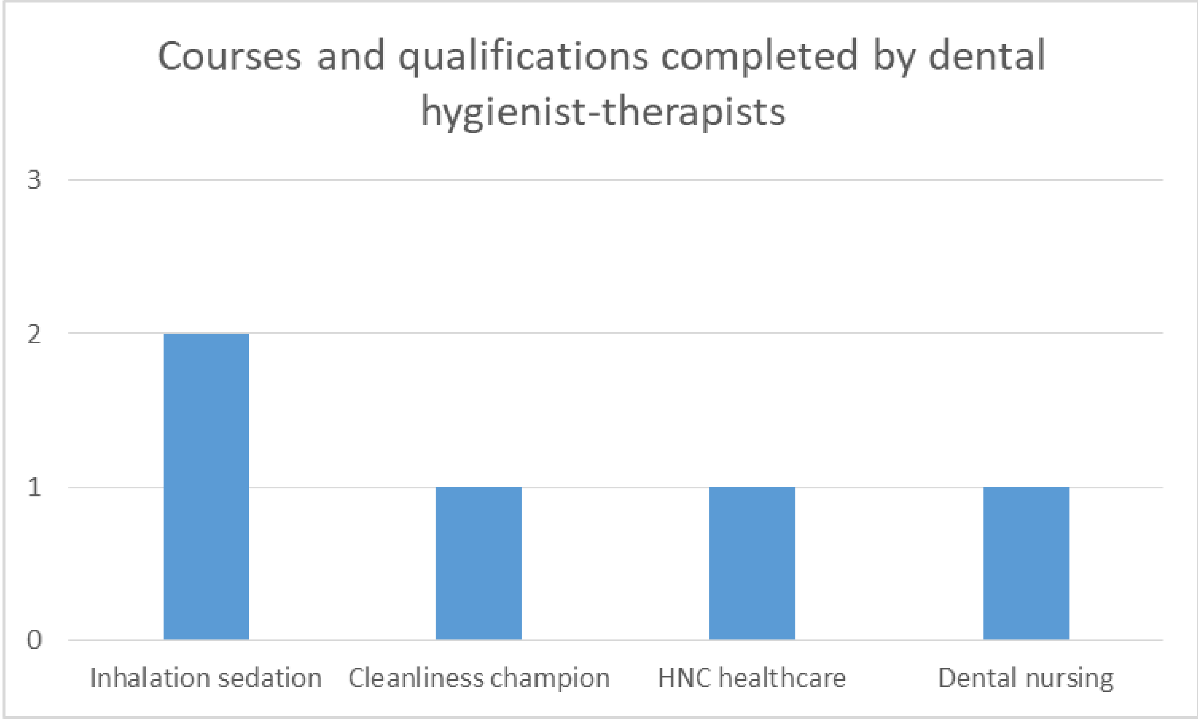
Dentists were either happy or didn't mind providing most types of treatment. The only procedure which the majority would prefer not to do was minor oral surgery. Dentists were either happy to provide treatment under general anaesthetic or sedation or not. No one "didn't mind", they were either happy, willing to learn or would prefer not to provide sedation or treatment under general anaesthetic. Preferences regarding additional non-clinical duties were also broadly in line with the dentists' confidence levels regarding teaching, public speaking and liaising with other professionals.

Hygienist-Therapists

All three hygienist-therapists responded to the questionnaire.

Additional courses and qualifications which hygienist-therapists had completed are outlined in Figure 21.

Figure 21 - Hygienist-therapists' additional qualifications



One hygienist-therapist was in the process of completing supervised inhalation sedation sessions.

Hygienist-therapists' skills

In general the hygienist-therapists were confident in their ability to provide care for most patient groups, though it was indicated that more support may be required by them when treating patients experiencing homelessness and addictions and children with severe learning disabilities. The aspect where hygienist-therapists appeared to be least confident was providing care in different settings, with a range of confidence from independent to requiring support for domiciliary dental care, and greater levels of support required or lower knowledge and experience working within a hospital setting or in a mental health unit.

The hygienist-therapists were confident to provide the majority of treatments, with the majority of items of treatment being rated as "confident to provide independently" and none scoring less than "familiar but would need support".

One of the hygienist-therapists had not undertaken training in inhalation sedation and, as would be expected, rated this as being an area of limited knowledge. One hygienist was experienced and confident to undertake school dental inspections, with another planning to become involved in the inspections in the coming school year. Since the survey was

undertaken the third hygienist-therapist has also completed training and calibration required to participate in school dental inspections.

Hygienist-therapists' preferences

Like dentists, ratings for preferences were broadly in line with self-rated skills or confidence. The hygienist-therapists were either happy or didn't mind treating the majority of patient groups listed and were willing to learn more about treating those experiencing homelessness or addictions and children with severe learning disabilities.

The hygienist-therapists were either happy or didn't mind providing all of the items of treatment listed. While only two hygienist-therapists had undertaken training in inhalation sedation, the third indicated a willingness to learn.

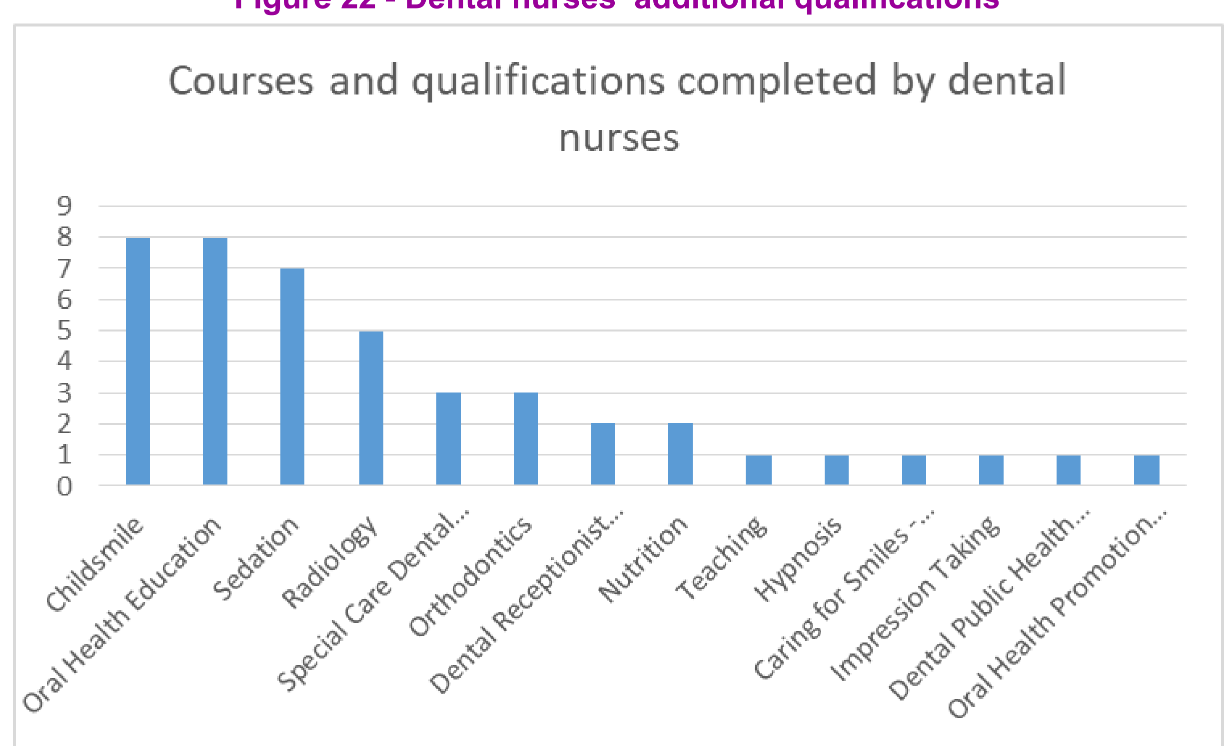
One of the hygienist-therapists indicated through additional comments a preference for treating anxious children and enjoyment of undertaking acclimatisation with adults with learning disabilities. Another felt that they would enjoy working in the hospital environment with complex adults and children and general anaesthetic cases.

Dental Nurses

Thirty dental nurses responded to the questionnaire.

Additional courses and qualifications which dental nurses had completed are outlined in Figure 22.

Figure 22 - Dental nurses' additional qualifications



PDS Staff Skills and Preferences

Overall, for all staff groups, levels of confidence and experience reflected the staff member's role and workload. While a greater number of staff members were confident with some patients, settings or treatments than others, there were no areas where no one felt comfortable to provide care. It is recognised that as a role becomes more specialised, the individual in that role is likely to provide more of some types of treatment and less of others and that their confidence and skill level will grow to reflect this. It may be beneficial to encourage some staff members to develop specific skills, particularly in providing treatments which are less common to maximise their exposure to these procedures and further develop their experience providing these treatments to build their skills and confidence.

The preference rating "I would prefer not to do this" was not commonly used and often related to more specific areas which it would be reasonably expected that some people would be happier to provide than others. Very small numbers of people said they would prefer not to do any single item and across the service it is evident that there are sufficient numbers of people in all roles willing to undertake each item to deliver the full range of services.

Main Findings Section 2 - Dental Services

- **There are 15 General Dental Practices and 6 Public Dental Service Clinics in the Borders**
- **81.6% of adults and 89.7% of children in the Borders are registered with an NHS dentist (slightly lower than the national average)**
- **77.1% of adults and 91.7% of children in the Borders who are registered with an NHS dentist have attended in the past 2 years (slightly higher than the national average)**
- **NHS Specialist dental services in the Borders are provided for Oral Surgery and Orthodontics by Consultants in Borders General Hospital and a Specialist Practice in Orthodontics**
- **The PDS in the Borders provides a greater proportion of the routine general dental care in the area than PDS services in other Scottish Health Boards**
- **Many General Dental Practices are at or near full capacity in terms of patient numbers**
- **Seven out of nine practices reported having experienced difficulties in recruitment and retention of staff in the past 5 years**

Key Discussion Points

Access to Primary Care Dental Services

The proportion of the population registered with an NHS dentist is slightly lower in the Borders than in other parts of Scotland, however the figures do not include patients who access private dental care, or those who attend an NHS dentist in England. The vast majority of residents in the Borders do therefore have access to dental care. As the population continues to increase, an anticipated growth in demand for dental services makes it important to retain capacity within primary care dental services to meet future oral health care needs.

Currently most General Dental Practices in the area suggest they are operating at or near capacity in terms of the number of patients seen. Twenty seven percent of GDPs who responded to the survey reported that they were likely to stop accepting new NHS patients or reduce the categories of NHS patients they would take on in future. To continue to meet demand and ensure services are available to those not currently accessing dental care in the area, it will be necessary for dental services to take on additional patients which is likely to require additional GDPs.

Unfortunately difficulties with recruitment and retention of staff, particularly associate dentists are common. Seven of the nine practices who responded to the survey reporting that they have experienced difficulties with recruitment and retention of staff over the past five years. Concerns about the ability to attract new dentists to the area have been

identified as barriers to expansion of existing dental practices. This has the potential to have a negative impact on access for those looking to register with a dentist.

Role of PDS

Currently the PDS in the Borders sees a higher proportion of the overall number of patients registered with an NHS dentist than their counterpart PDS services in other mainland Health Boards. While providing dental access services is no longer a core activity of the PDS, it is evident that at the present time there is no spare capacity within GDS. Withdrawing provision of routine dental care by the PDS would have a significant negative impact on dental access in the region and would therefore not be advisable.

Supporting access to routine dental care should however not come at the expense of providing care to priority group patients who are unable or would face challenges to accessing care in a General Dental Practice. These patients should continue to be offered preferential access to PDS care. Over the longer term the main emphasis within PDS should be to expand the provision of special care dentistry services and focus on the delivery of dental care to the more vulnerable patients who require additional support to access and receive dental care.

This shift in emphasis should be a gradual process to reduce the impact on General Dental Services and to allow staff working in PDS, many of whom have provided predominantly an access function in the past, to develop their knowledge and skills as they continue to adapt to treating more complex patient groups.

PDS Staff Development

The PDS skills and preferences exercise indicated that across all staff groups, there was a willingness to learn a number of new skills and develop their roles into new areas. This should be encouraged and capitalised on through the existing appraisal and PDP systems and dentists' job planning.

There has been a strong history of staff development within the PDS, including the employment of trainee dental nurses, support for dental nurses within the service to take on additional post-registration qualifications and facilitating dental nurses to train to become hygiene-therapists. Hygiene-therapists are also encouraged to maximise their potential, having been provided with opportunities to complete training in provision of inhalation sedation and to become calibrated examiners for school dental inspections. The service has also been involved in VDP training in the past, with one current member of staff having been a previous VDP. Over the past two years there has been an increase in training to support provision of care to more complex special care patients with a number of dentists embarking on postgraduate qualifications in special care dentistry and one of the senior dentists attending study days with the NHS Lothian special care dentistry team. Another dentist has recently enrolled on a Masters degree in Oral Surgery which will develop skills of benefit to the service as a whole.

One issue identified was the challenge of retaining skills and confidence in providing treatments which are not required in large volumes such as intravenous sedation or the management of patients with rare conditions. While training a single clinician to provide such types of treatment would maximise that individual's exposure to the treatment and enable them to build their personal expertise, it is important to ensure that there is

sufficient cover for those providing more specialised aspects of care should that individual be unavailable or on leave. Building resilience within the service will be important to succession planning to protect future provision in the event of an experienced staff member or one with a specific skill set or area of expertise moving on. As greater emphasis is placed on building the special care patient base it is likely that more opportunities will present for staff to be exposed to a wider range of patient groups and to build their skills and confidence in providing care and treatment for these individuals.

Referral Pathways

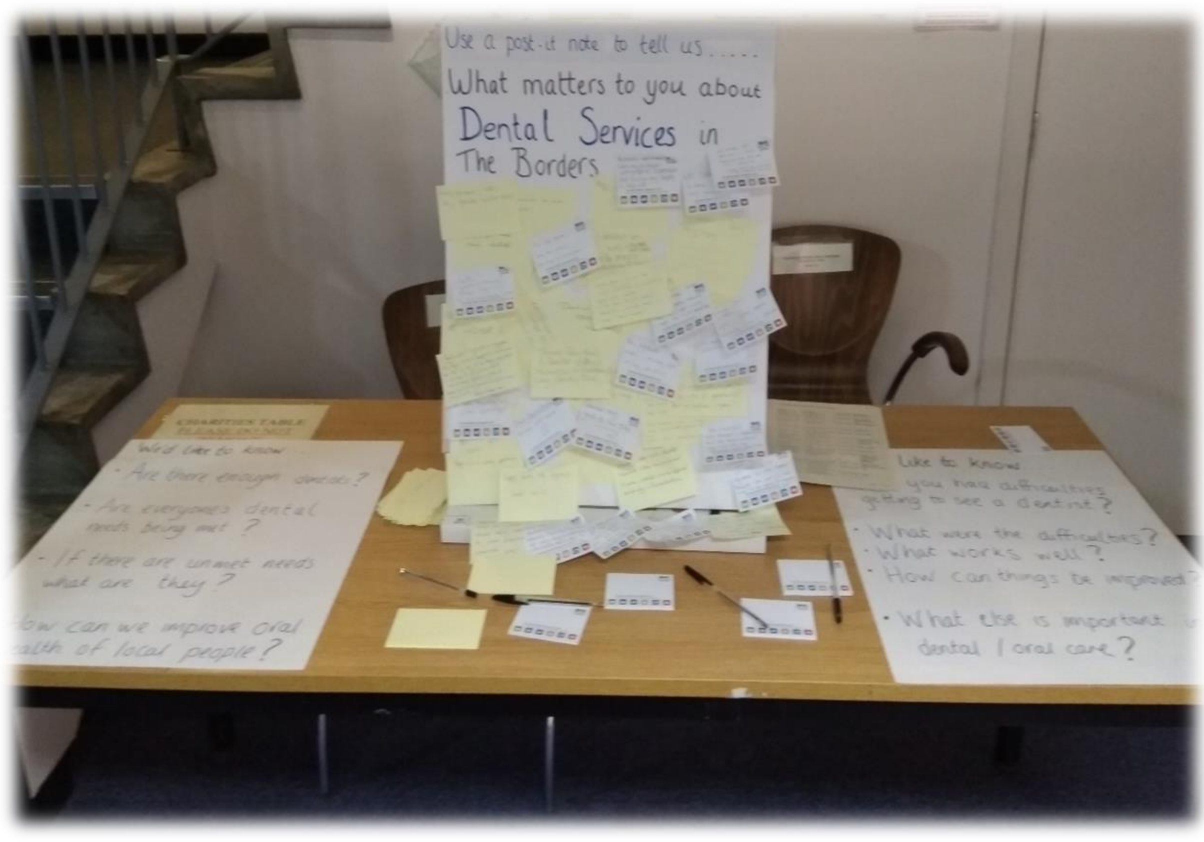
Referrals into the PDS and dental specialties based in BGH are received through SCI-Gateway and processed through the TRAK care system. Interpreting data extracted from TRAK in the context of this needs assessment presented some challenges as it was not immediately clear which specialty patients were referred to and in the case of PDS patients it was not possible to identify the reasons for referral or to break down which types of PDS services were requested – whether for example patients were referred for anxiety management, domicilliary care, additional needs or medical complexities. Patients referred to PDS are triaged by a senior dentist based on PDS acceptance criteria. PDS referral criteria are being updated at present and consultation is underway with representatives and local dentists to agree the final version.

Clear referral criteria have been agreed for orthodontic care which have been made available to referring dentists and appear to facilitate the patient journey to the most appropriate care provider. There are no specific criteria for Oral Surgery and no intermediate tier between primary care dentists and consultant oral surgeons. This may contribute to the large volume of patients being seen as all referred patients are currently accepted and offered treatment.

The new referral criteria for PDS will be made available to local dentists to increase their awareness of the role of PDS and range of services available on referral. In future the offer of shared care should be explored, with PDS providing support for specific items of treatment on referral while the patient remains registered with the GDP who provides ongoing routine examinations and maintenance which can be provided in general dental practice. As many of the patients in greatest need of PDS care may find it difficult to access GDPs, referral criteria should also be publicised among services working with priority group and vulnerable patients to raise awareness of the additional support which is available to facilitate dental attendance and to encourage referral of those who currently may not be accessing dental care.

SECTION 3

ENGAGEMENT WITH DENTAL TEAMS AND THE PUBLIC



8. Dental Staff Perceptions

General Dental Services

As the majority of dental care in the Borders is provided by GDPs, it is essential that this needs assessment takes account of their views. Engagement with this independent contractor group was anticipated to be challenging as there tends not to be a single forum where they will all come together. GDP engagement began with the local Area Dental Committee (ADC), with more in depth follow up with individual dental practitioners through an online questionnaire.

Area Dental Committee

On 20th March 2019, an overview of the needs assessment process and reasons for conducting it was presented to those in attendance at the ADC meeting. Attendees were then asked what they felt the priorities and challenges facing GDPs in the Borders were at that time. Topics of discussion included:

1. Recruitment of staff,
2. Patient access to dental care,
3. Dental referral services,
4. Aspects of the Scottish Government's Oral Health Improvement Plan,
5. Health tourism.

The committee also provided valuable input into the format and content of the questionnaire being developed to gather information on services provided by GDPs and the views of NHS GDPs across the Health Board area.

Recruitment of practice staff

Recruitment of staff was a concern shared by all present with comparisons drawn between the relative ease of recruitment in cities such as Glasgow and difficulties in a rural area like the Borders. Despite financial incentives and higher rates of remuneration being offered in the Borders than in other areas, practices locally struggle to recruit dentists to the area. It was highlighted that even in Galashiels where there is direct access to Edinburgh by train, two practices have recently struggled to attract new staff members. It was also noted that practices who do successfully recruit, often take on a dentist from another practice within the Borders, resulting in the vacancy being passed to another practice, as opposed to bringing a new practitioner to the area. In addition to difficulties recruiting dentists, some of those present had also found it difficult to recruit dental nurses, with access to dental nurse training courses described as challenging.

There were concerns that recent changes to regulations, requiring dentists coming to work in Scotland for the first time to attend a mandatory training course could increase difficulties with recruitment and introduce delays in new recruits taking up posts. Practice owners were also anxious about the potential impact of Brexit on dentist numbers. Currently there are a number of EU nationals working as GDPs in the area, with the risk that they may opt to leave the UK. It was also felt that in future it is less likely that EU

nationals would take up posts in the UK, potentially further reducing the availability of dentists in the area.

Patient access to dental care

GDPs reported that there still seems to be a large demand from patients wishing to register for NHS dental care, and that this does not seem to be reflected in the high proportion of the population reported to be registered with an NHS dentist in national figures. It was queried whether many of the patients seeking to join a new practice perhaps don't realise that if they have been registered since 2010, they have lifelong registration with that practice, assuming that their registration will have lapsed as was previously the case. It was also suggested that some patients may be keen to move practice as it is known that it is common for patients to travel to different towns for dental care based on where they were originally able to register at the time when dental services were less readily available.

The GDPs were aware of disparities in access to services and the challenge some patients face in travelling to appointments. It was highlighted that there is limited public transport serving some communities and for those reliant on bus services it may require a full day for them to travel to a single dental appointment. Travel difficulties were acknowledged to be a particular challenge for older people. It was also recognised that as there are more older people living in their own homes, many of them may become unable to attend a dental appointment as their level of dependence increases. The group also discussed the fact that a GDP is unlikely to know if a patient is struggling to attend and that there is a need for follow up of patients whose attendance pattern drops off. They also felt that there would be benefits in strengthening links between the GDS and PDS, perhaps using oral health support workers to engage with older people at home who may be struggling to attend appointments.

GDPs valued input from Childsmile, both in school and supporting attendance at dental practices. They described dental health support workers as very proactive and valued their input in following up children who had missed appointments in practices.

Dental referral services

Locally GDPs are able to refer to oral surgery and orthodontic services in the BGH as well as to the Public Dental Service. They felt there was a need for more support with complex periodontal cases, particularly with an increasingly dentate older population. Referrals for restorative dental care to Edinburgh Dental Institute were described as often being "bounced back". GDPs reported that when a patient is referred to the Dental Institute they will often be provided with a treatment plan and returned to the referring dentist to provide treatment, which can be challenging to deliver. The general feeling was that for restorative care, including endodontics, referrals tended to be made to private dental services due to lack of availability of specialist support on the NHS.

Oral surgery services were described as being "good when the patient gets there", with long waiting times for treatment not being ideal. There was a feeling that there has been some improvement recently with waiting times now beginning to reduce.

Waiting times for paediatric dental general anaesthetic were noted to have increased and practitioners described a changing demographic of child patients, with more children from

other countries presenting with extensive caries which often requires referral for general anaesthetic.

Oral Health Improvement Plan

In general there was support for the Oral Health Improvement Plan, though it was stressed that Scottish Government need to be mindful of the business needs of practices and patients already being seen. Comment was made that roadshows during the consultation phase prior to publication of the plan were not well attended and there was no roadshow event held in the Borders.

GDPs were in agreement with the proposed increased focus on prevention and suggested that there may be opportunities presented with the new Galashiels Academy to promote healthy food choices. There was a strong feeling that it would be beneficial to take a joined up, common risk factor approach to improving diet, by linking with the diabetes and obesity agendas. There was some disappointment with the Government stance regarding water fluoridation, with some dentists feeling that there should be a focus on promoting the benefits of fluoridated water.

The proposal to introduce an oral health risk assessment and dental recall intervals based on oral health status was discussed and generally supported. There was a suggestion that certain points in the life course could be identified as times when the oral health risk status may change, for example as teenagers gain increased independence.

The committee also recognised the value of focussing on the ageing population and there was discussion of the new model for delivering domiciliary dentistry. There was a suggestion that it may be cheaper to make arrangements for patients to be transported to dental surgeries to receive care, than to remunerate GDPs for providing domiciliary care. The group was also keen to highlight the benefits of providing treatment in a surgery environment where the full range of treatment is available and a higher standard of care is possible. The PDS was described as having tight criteria for domiciliary referrals. There was a feeling that as patients gained more understanding that a wider range of treatment is possible in the surgery environment, there seem to be more patients willing to attend clinics.

Health tourism

One concern raised by GDPs, which had not previously been considered, was the impact of health tourism, with patients travelling abroad for dental care. Dental implants and dentures had been reported to be cheaper in Poland than the UK, and patients were also described as having received treatment in Turkey amongst other countries. In some instances patients have presented for their regular check-up appointment having undergone extensive cosmetic restorative treatments, which the GDPs do not always feel are beneficial to the general oral health of the patient. GDPs expressed anxiety regarding their ongoing duty of care to a patient who has undergone treatment out with their practice and which they would often have advised against. These patients leave the GDP in a position where there is a distinct possibility of having to manage complications of treatment or failure of complex restorations.

GDP Questionnaire

In addition to gathering information on general dental services, the questionnaire referred to in Chapter 7 provided an opportunity to gather GDPs' thoughts on what is good about being a GDP in the Borders, what they feel the main challenges facing oral health and dental services in the Borders are and what changes they would like to make to improve oral health and dental services in the area. The questionnaire also captured their opinions on other aspects of providing general dental services, including reasons for decisions around taking on NHS patients, considerations relating to working as an enhanced skills GDP, referral services and issues surrounding recruitment and retention of dental practice staff.

What is good about being a GDP in the Borders?

Almost all GDPs were positive about the Borders as a location, which they felt was a good place to live and to bring up a family. They referred to the Borders as a beautiful area and enjoyed the lifestyle on offer, including a good work-life balance and short commute to work. They were also very positive about their patient base, with a number of GDPs describing their patients as "lovely people". They enjoyed having a mixed patient base from all walks of life and the fact that patient lists were relatively stable, enabling them to provide continuing care and get to know their patients over time.

GDPs in the Borders also appreciate their working relationships, including "good support staff in the practice", well organised systems and opportunities for networking with colleagues. The Dental Practice Adviser was described as being knowledgeable and approachable.

Factors influencing decisions to take on NHS patients

For many dentists taking on NHS patients was just something they do, either because they or their practice has always had a high commitment to providing NHS dental care, or because they have been recruited by the practice to provide NHS dentistry. Other dentists reported providing NHS care as patients in the area were unable to afford private dental care.

Their ability to take on new NHS patients depended on capacity within the practice, with several reporting their lists were already either at, or near, full capacity. Judgements depended on the waiting times for existing patients to be seen and, in some cases, staffing levels within the practice. Practices with current vacancies for clinicians stated they would only be able to take on new patients once these posts were filled.

In practices where capacity to accept new patients was limited, priority was given to family members of existing patients, with one practice only accepting patients under the age of 21 years and only if their parents were registered with the practice as private patients.

Three respondents reported that their decision on whether to take on NHS patients depended on factors relating to remuneration and support available from the NHS, including a consideration of whether they felt able to provide "adequately funded, quality care in a well-equipped, well-run environment". One dentist was concerned about patient expectations and limitations on what can be provided as NHS dental care, while the other described "Bureaucratic and often outmoded treatment choices".

Enhanced skills GDP (domiciliary care) considerations

Only one dentist who responded to the survey stated that they would consider becoming an enhanced skills GDP for domiciliary dental care. Those who were not interested in taking on such a role provided a number of reasons for this, ranging from not being interested in providing this type of care and being concerned about spending time away from an already busy list in the surgery to concerns about the administrative burden and potential inadequate remuneration.

One dentist reported that they had provided domiciliary dental care in the past but had been put off by new requirements to undertake risk assessments and carry emergency equipment. Dentists highlighted the increased time taken to travel to a patient's home, set up and treat a patient in a domiciliary setting compared to providing care in the clinic. They noted additional challenges faced in the provision of domiciliary care, including locating the address, communicating with carers and arranging for payment to be made. A number of dentists felt that there would be insufficient patients to make providing domiciliary care worthwhile and that remuneration was inadequate to make it financially viable. It was not clear whether the remuneration referred to related to current regulations for non-enhanced skills practitioners, or whether this also applied to the new arrangements published in July 2019 which apply to designated enhanced skills practitioners.

One GDP felt that the new arrangements included "too many hoops to jump through" in relation to the requirement to complete training which includes a portfolio and period of mentoring as well as ensuring the practice is able to provide cover for registered domiciliary patients who have a dental emergency.

Referral services

Around 33% (5 respondents) reported that they felt the referral services currently available met their needs, 2 respondents reported that they did not meet their needs, and 53% (8 respondents) felt that their needs were partially met.

Oral surgery services at BGH were regarded as providing good quality care, though several GDPs mentioned long waiting times for patients to be seen. There was also a feeling that patients referred to oral surgery requiring urgent treatment (due to pain) should be able to be seen more quickly than they currently are.

A number of dentists highlighted that there is no access to NHS specialists in periodontics or endodontics in the area, with one dentist reporting a feeling that restorative support from EDI was "not fit for purpose". Another described many referrals being rejected and a further dentist stated that "my patients are hardly seen at EDI". One GDP reported that they tend to refer patients privately as they have had "limited success getting patients seen or treated at EDI".

Long waiting times were also reported to be an issue for adults and children with additional needs and that parents were unhappy with the "lack of care" available.

GDPs were also asked which services they would like to be able to refer to which are not currently available to them. The majority (8 respondents) would like to be able to refer patients for periodontal care, followed by restorative care (3) and endodontic care (3). Others mentioned an oral surgery emergency service, prosthodontic service, oral medicine

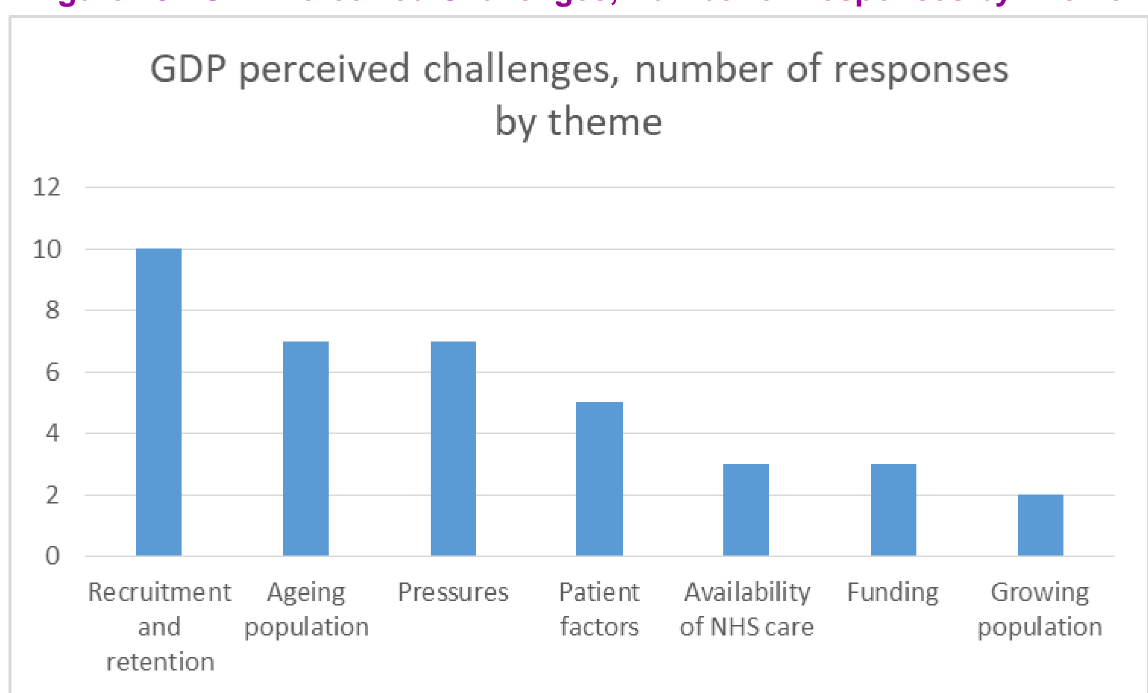
and a paediatric trauma clinic. One dentist would like to see services available to provide complex treatments such as post removal, endodontics and oral and maxillo-facial surgery, while another would like a local service providing "everything that EDI offers"

One of the respondents stated that they would rather see investment in improving the currently available services than spreading the resource more thinly in an attempt to offer additional services.

What are the challenges for GDPs in the Borders?

GDPs identified a number of challenges which fell into seven main themes as outlined in Figure 23.

Figure 23 - GDP Perceived Challenges, Number of Responses by Theme



Recruitment and retention

The most common challenges mentioned related to recruitment and retention, being raised by around two thirds of respondents. One respondent indicated that they would like to expand their practice to meet demand from patients wishing to register, however they felt unable to commit to this as they were not confident it would be possible to find an associate dentist who would want to work in the area.

Ageing population

Around half of the respondents highlighted their ageing patient base and the fact that many more older people have retained their natural teeth. They noted that older patients can face challenges accessing the dental clinic and mentioned the additional complexity of providing care for older patients.

Pressures

A range of pressures facing dental practices were highlighted. In addition to insufficient numbers of clinicians, these included ensuring the availability of accessible care, waiting

times for patients referred to hospital clinics and delays in processing of Prior Approvals*. Pressure was also felt to arise from a number of obligations on dental practitioners including requirements to follow standards, have policies and protocols in place and comply with continuing professional development requirements and mandatory audit and quality improvement activity. Other non-clinical pressures relating to employment of staff were also mentioned, including managing pensions, sick leave and requirement to use agency staff to cover absences.

*NHS dentists are required to apply to Practitioner Services Division of NHS National Services Scotland for Prior Approval before providing treatment for patients where the total cost of the course of treatment will exceed £410, and for a small number of specific items of treatment. A new electronic system for processing Prior Approval was introduced with all dentists required to use the electronic system from 1st October 2018.

Patient factors

There was a feeling that there are "too many patients" with a large demand for care resulting in high numbers of patients registered with each dentist, and that patient expectations are increasing. It was felt that some patients "lack accountability and self-ownership" of their oral health and that there was a requirement for better education for patients and transparency around costs of treatment to the NHS.

Patient demographics and oral health risk factors were also noted to present challenges. Specific aspects of patient care which can present challenges were also mentioned, including poor periodontal health and management of anxious dental patients.

Availability of NHS care

It was felt that it was a challenge to maintain sufficient NHS dental services to meet demand for them. There was felt to be a lack of availability of dental centres accepting new NHS patients and a lack of availability of NHS dental appointments. There was also a concern that unregistered patients are unable to gain access to regular dental care.

Funding

In the past grants were available to support GDPs to set up a practice, with funding available for items such as dental chairs or dental handpieces. Respondents were disappointed that "those days are gone" with reduced availability of financial support. Remuneration for NHS dental treatment was also mentioned, with a specific comment that fees are insufficient to cover costs of treatment requiring lab work (dentures, crowns and bridges). Lab work was described by some as being "expensive or poor quality".

Growing population

It was also felt that as the population in the Borders is increasing in size this places additional pressure on existing dental services which are already seeing large numbers of patients.

Difficulties with recruitment and retention

As recruitment and retention had been highlighted as being of significant concern by members of the Area Dental Committee, the survey included specific questions for practice principals and owners relating to their experiences of staff recruitment.

All practice principals and owners who responded to the questionnaire had recruited staff within the past five years, amounting to: six dentists, two hygienists, four hygienist-therapists and nine dental nurses across the nine practices.

Of the staff who had been recruited over this time, around two thirds of practices reported that new members of staff who had joined the practice had already left their posts. One practice had recruited a dentist, hygienist-therapist, nurse and receptionist, all of whom had left. Others had lost dentists who had stayed for between one or two years. Reasons for dentists having left their posts (where given) were varied. Several described dental nurses leaving, some after being in post for as little as one month.

Four of the practices reported that vacancies had been advertised but remained unfilled. Not all respondents provided detail of which roles had been unfilled, however all who did reported that these were for associate dentists. One respondent noted that they had had a vacancy for an associate for six months, while another reported that they currently had a post which had been unfilled for one month “so far”. There was also a comment that when there has been a gap between a dentist leaving and being able to recruit to the post this places additional stress on the whole practice team in managing a larger quota of patients and dealing with more emergency appointments. Another commented that as a result of difficulties with recruitment there have been times when they have had to close a surgery within the practice or use agency staff, bringing additional financial pressures and reducing the number of appointments available to patients.

Three of the practices reported having to change the nature of posts due to an inability to recruit. Measures had included offering part-time working or altered working hours. One practice had recruited a dedicated dental receptionist as a result of being unable to recruit a dental nurse. It was noted that having a dedicated receptionist had reduced flexibility within the practice as previously all nurses had worked both in surgery and on reception and had been able to provide cross cover for each other. Another practice reported that they offered a retention package to their associates and had increased wages for dental nurses, however this has had a financial impact on the practice.

Seven of the nine responses (78%) indicated that they had experienced difficulties with recruitment and retention. One dentist reported that very few, if any, dentists respond to advertisements for posts and that dentists do not seem keen to move to take up an NHS post. Another noted that they had had to increase wages of all staff to aid recruitment and retention. In general it was reported to be easier to recruit dental care professionals (DCPs) than dentists, though it was noted that there can be a high turnover of dental nurses.

Many of the respondents felt that recruitment difficulties were due to the rural nature of the area, reporting that dentists, and particularly younger dentists were not interested in working outside cities. There was also a suggestion that for those who live in cities, commuting to many Borders towns can be difficult by public transport if they do not own a car.

There was a feeling that Brexit has had a compounding effect on recruitment issues. It was noted that while in the past Borders practices have been successful in recruiting dentists from the EU, more recently there have been no European applicants for posts. This was

highlighted as a significant concern as "UK graduates nearly all want to work in or close to a city and there is rarely any interest from UK graduates [for posts in the Borders]".

The requirement for dentists who have not worked in Scotland within the previous five years to undertake Mandatory Training before being eligible to work as an NHS GDP was also felt to be an additional hurdle. While the benefits of the training were acknowledged, it was suggested that the cost of the course and requirement to complete it may have an impact on the number of applicants for posts.

Suggested changes

Dentists were asked what changes they would like to see made. Many of the comments related to the challenges which had been highlighted around recruitment and retention and access to specialist referral services. It was suggested that there should be more support with recruitment and retention and efforts made to promote the Borders as a good area to work, with a view to attracting more dentists to the area.

It was suggested that there should be more specialist clinics, with shorter waiting lists and support available for more complex aspects of treatment including periodontics and endodontics and an increase in the availability of sedation services. There was also a feeling that services should be more accessible geographically, making it easier for patients living further from BGH to access services.

GDPs were keen that access should be improved for unregistered patients and that they should be offered more than just emergency care. Dentists also suggested changes which would help to promote good oral health, including training for carers to promote dental care and targeting school leavers to encourage them to maintain regular dental attendance. There was also a request for more local delivery of CPD sessions.

Although not possible to change at the local level, there were several GDPs who would like to change the current system for remuneration of NHS dental care. It was suggested that the number of NHS dentists in the area could be increased by offering "realistic remuneration", while another dentist felt than increasing payments would enable dentists to spend more time with their patients leading to increased job satisfaction. Others focussed on the payment system as a whole, suggesting that it should be more fluid to allow treatment to be tailored to patients' individual needs. It was also suggested that there was a need to alter fee scales to reflect changes in dentistry such as availability of new dental materials. The Oral Health Improvement Plan includes a commitment to simplify the Statement of Dental Remuneration and a number of working groups led by Scottish Government are currently working to develop a "new model of care" which is expected to result in changes to the payment structure for NHS dental practitioners.

Further thoughts

The questionnaire closed with a final question asking dentists to provide any further information which they felt the oral health needs assessment should capture. One respondent reported that they felt oral health needs are high in the area. Another described oral health in the area as declining and stated that "without proper remuneration and an increased number of NHS dentists the cliff edge is rapidly approaching".

Many of the dentists mentioned concerns about the increasing proportion of older patients, highlighting difficulties they can have accessing dental care. There was a feeling that older people are less able to travel to dental clinics, especially if treatment in BGH is required and concerns were raised around managing the complex medical needs of many older patients. One GDP felt that it would be good for older people to be able to be seen in a setting which was appropriate for them “like a health centre”.

Transport to dental appointments was also highlighted as a challenge, particularly for patients who rely on public transport. Access to the BGH for patients requiring specialist treatment was noted to be challenging from some parts of the Borders and this had become more of an issue since the referral criteria have been tightened.

It was also noted that children may be looked after by a range of family members. This could mean that messages regarding positive oral health behaviours are not always passed on to everyone involved in a child’s care, making it difficult to maintain consistent messages.

GDP Study Day

In September 2019 an NHS Education for Scotland study day for dental teams was hosted in the Borders. This provided an opportunity for further engagement with GDPs. On the day, of a total of 57 delegates, 15 GDPs were in attendance, with the majority of attendees being dental nurses and a number of PDS staff in attendance. The event was used to promote the GDP questionnaire which was active at the time, encouraging those present to respond to it and to encourage colleagues in their practices to do so too. GDPs were also give an opportunity to share further thoughts on what matters to them about dental services in the Borders.

Opinions shared at the study day were similar to those which had been discussed at the Area Dental Committee and findings from the questionnaire responses, including the need for additional specialist services, particularly for restorative dentistry and financial pressures facing dental practices. There were also requests for more training to be delivered locally, with a suggestion that increasing the availability of training in the area may bring dentists in to the area.

Public Dental Services

Staff Meetings

Staff working in PDS meet on a regular basis within their main hub area. Time was allocated during these meetings in Coldstream (24 staff members based in Coldstream and Kelso) and Hawick (27 staff members from Hawick, Galashiels and Borders General Hospital) in December 2018 to give PDS staff the opportunity to feed their views in to the needs assessment. Staff were asked four questions:

1. What are the main challenges for oral health and dental services in the Borders?
2. What works well?
3. What doesn’t work so well?

4. What changes would you like to see to improve oral health and dental services in the Borders?

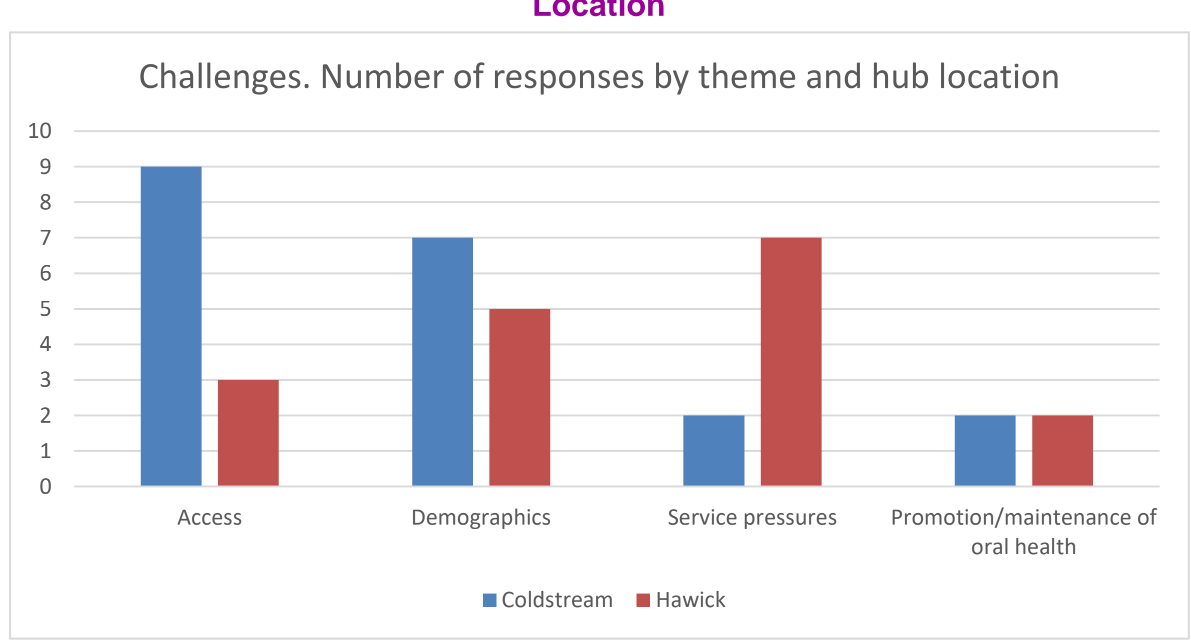
Participants discussed their answers to each question in small groups before feeding back to the wider meeting. Responses from each small group were collated and common themes identified.

For all questions, similar themes were identified in both hub locations, though emphasis differed slightly and there were some points which were only raised in one of the sites.

Challenges

As an introduction to the meeting, staff were asked for their thoughts on the biggest challenges they faced in providing dental care and promoting good oral health. The main themes identified at each location are presented in Figure 24.

Figure 24 – PDS Perceived Challenges, Number of Responses by Theme and Hub Location



Access

The most commonly reported challenge overall was access to dental care, which received particularly strong emphasis in Coldstream. The main difficulty was felt to be in relation to the distribution of services and difficulties faced by those in more remote areas where there is a requirement to travel and public transport can be limited. Teams in Coldstream highlighted that although General Dental Services may be available, not all offer NHS care, particularly for new patients. In Hawick it was noted that patients with special care needs may find it particularly difficult to access services.

Demographics

Demographic issues were also mentioned in both areas, including the challenges faced in providing care for an ageing population, with complexities associated with multi-morbidities and frail older people. In addition to recognising the challenges of providing dental

treatment for older people, maintaining daily oral care was also highlighted and ensuring oral hygiene is maintained in care homes was recognised as a challenge.

There was recognition that inequalities and deprivation have a significant impact on oral health and may be linked to unemployment, poor housing, mental health status and motivation to take on board oral health advice. While teams described some patients as lacking "motivation", there may be a number of factors which contribute to the ability of an individual to act on advice given which will also be important to consider.

Promoting/Maintaining Oral Health

Lifestyle factors, including diet, sugary drinks, tobacco and alcohol were mentioned in both areas as being difficult to address. It was suggested that this may be due to lack of education or knowledge of the negative effects on oral health, but it was also acknowledged that when advice is provided it can be difficult for individuals to make the changes being recommended.

Service Issues

Lack of staffing was the biggest concern affecting services in both areas. There was a feeling that staffing levels were insufficient for the geographic area being covered. Difficulties recruiting staff (particularly dentists) to the area was strongly highlighted.

In common with many other services, it was recognised that the current financial climate may have an impact on what can be delivered and how care is provided.

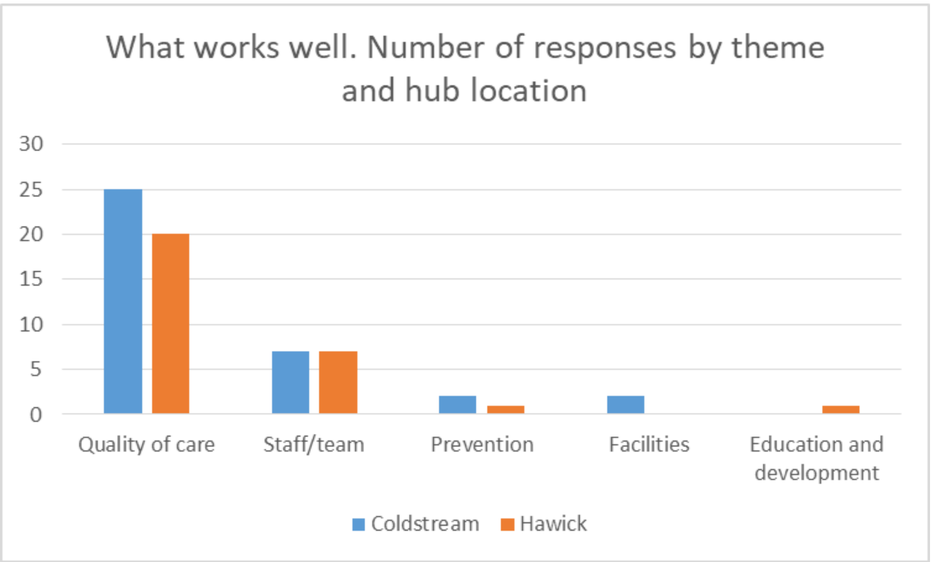
In the Hawick hub, it was suggested that there was a lack of capacity for dental access patients. It was also noted that there had been an increase in the number of children requiring dental treatment under general anaesthetic, and that there seemed to have been an increase in the complexity of the children referred to this service which placed additional pressure on the service. This is likely to have been more apparent at this hub as the team providing the general anaesthetic service, being based at BGH were in attendance at this meeting.

In both sites, patients missing appointments were mentioned, and the challenge of following up patients who had failed to attend. In Coldstream this was particularly in relation to child patients who were not brought to their appointments. Since these meetings took place a new Child Not Brought policy has been introduced and an adult Did Not Attend policy has been developed and will be implemented in the near future.

What Works Well?

Teams were asked for their views on the positive aspects of service provision by the PDS. Their responses are presented in Figure 25.

Figure 25 - PDS Perceptions of What Works Well, Number of Responses by Theme and Hub Location



Quality of Care

Teams felt that the care provided to patients of the service is of a high standard in terms of treatment provided and interpersonal relationships. The teams were pleased to offer prompt access to emergency dental care when required and the dental emergency line for unregistered patients was also recognised as a service which works well.

Staff were particularly positive about the care provided to children and spoke highly of the support provided by Childsmile teams in terms of delivery of toothbrushing in schools and within PDS clinics. Support from the Childsmile and oral health improvement team in following up vulnerable children and those who had not attended appointments was highlighted as a very valuable part of their care. Staff recognised that the good oral health observed in children in the area is down to the combined efforts of Childsmile, oral health support workers and extended duties dental nurses working with clinical teams providing dental care and treatment.

The PDS was felt to provide a good service to vulnerable patients, including those with learning disabilities, older people, those with special and complex needs and patients whose first language is not English (though a language barrier would not in itself be a reason for a patient to attend PDS). One of the main benefits of the service provided by PDS for these patients was felt to be the ability to take time to provide the additional support which these patients require. Input to improve oral care for older people from the Caring for Smiles team and the introduction of oral care training for care workers was valued by clinical teams.

The ability to provide domiciliary dental care to patients who are housebound was also recognised and the fact that urgent visits can be arranged to prioritise patients who have an acute dental problem but are unable to attend a clinic. Care for anxious patients and those with dental phobias was also highlighted to be a strength by teams in Coldstream.

The availability of secondary care services for oral surgery and orthodontics were also described as being valuable.

Staffing/Teamwork

Staff in both areas were very positive about their colleagues and teamwork within clinics. Although recruitment of staff had been highlighted as challenging, retention of staff was noted to be high. Input from support staff, including admin teams was recognised as a positive and it was felt that teams had demonstrated their ability to work positively through challenging times.

The contribution made by dental care professionals was recognised, with trainee dental nurses being mentioned specifically. The role of hygienist-therapists was also highly valued in providing care to patients across both locations.

Prevention

As well as recognising the contribution of oral health improvement teams, in particular Childsmile and Caring for Smiles, prevention was felt to be an aspect which worked well. Staff were confident with the oral health messages being provided around sugar, tobacco, alcohol and oral cancer and valued the availability of resources to promote oral health.

Facilities

Clinic facilities were felt to be of a good standard and staff highlighted that there were no physical barriers, with all clinics being accessible to patients with disabilities. The service provided by the Local Decontamination Units in each area were also valued and felt to work well.

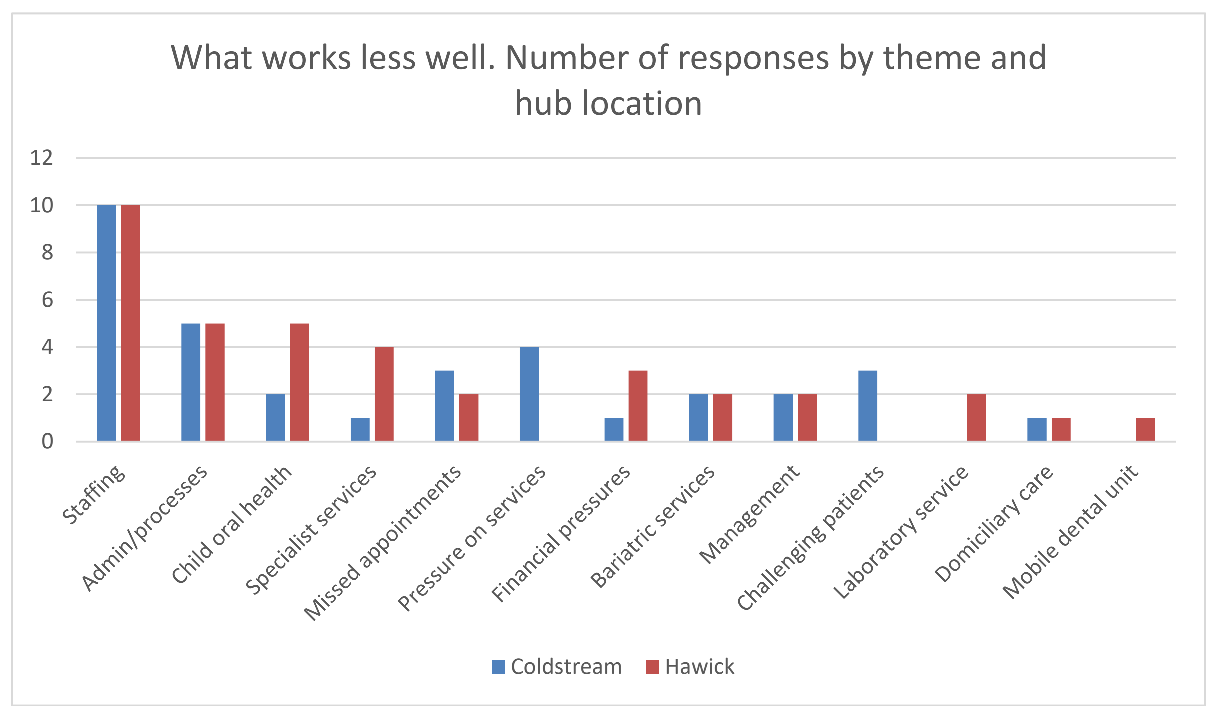
Education and Development

Staff in Hawick valued study days for dental teams and being able to participate in continuing professional development.

What Works Less Well?

Teams were then asked about aspects which they felt did not work so well. Aspects which were felt to work less well are presented in Figure 26.

Figure 26 – PDS Perceptions of What Works Less Well, Number of Responses by Theme and Hub Location



Staffing

Although team working and positive staff relationships were recognised as a significant strength within PDS, there was a strong message that staff numbers were too low. Lack of dentists was the major concern, though issues with nurse cover were also raised. Staff absence due to sickness was mentioned frequently and appears to be the main reason for staff shortages, in combination with difficulties in recruiting new members of staff. It was suggested that there may be an over reliance on hygienist-therapists to cover the shortfall in dentists and there was a feeling that greater flexibility around working patterns for dentists and streamlined working hours could be helpful in providing cover for those on sick leave.

While the overriding staff issue was pressure due to low numbers, there was also a suggestion of some dissatisfaction from some members of staff, with mention of a lack of opportunities for career progression and a need for staff to feel more valued.

Management

Management structures for dental services had changed over the previous year, with loss of the dental service manager post in 2018 and practice manager post in 2019. These posts have not been backfilled due to financial constraints by the Board and it was felt that it has been challenging to provide the level of support the staff have been used to. Staff in both hubs reported feeling that lack of managerial support was having a negative impact on communication and motivation.

Pressure on Services

In Coldstream in particular, the service seemed to be under particular pressure. It was highlighted that there are only two GDP practices within Berwickshire, one of which provides predominantly private dental care. Demands on the clinic in Coldstream seem to

be particularly high and it was felt that an insufficient number of appointments are available for the number of patients which can impact on the timing of care provision.

There was also a feeling that an increasing number of referrals are being received from GDPs in the area, and it was questioned whether dentists may be less confident to provide certain aspects of care.

Missed Appointments

An additional frustration, adding to the pressure on services, is high numbers of patients failing to attend appointments. This was an issue highlighted in both hubs, with concerns about the time required to follow up patients who have missed appointments and a worry that some children who have missed appointments may miss out on treatment they require if follow up is not successful. The nature of PDS patients means that more broken appointments are to be expected and the focus requires to be on supporting patients to maximise attendance as far as possible. Since the meetings a new Child Not Brought policy has been developed (Appendix 2) which aims to address this and a policy for adults is in development.

Challenging Patients

A particular concern in Coldstream related to challenging patients, with a feeling that reception staff were faced with managing disgruntled patients on a daily basis. Patients attending the clinic in Coldstream were described as having high expectations on both the clinical care being provided and having a service available "on the doorstep". There was a feeling that many of the patients expressing dissatisfaction were not necessarily the core group of patients for whom PDS services were primarily made available. One member of staff described the clinic as having "opened ourselves to a patient group who *can* access GDP services". Others described patients who opt to attend the PDS clinic for routine check-ups, but when they require treatment choose to visit a private dentist to access more complex or aesthetic treatments which are not available on the NHS. There was a feeling from staff that this did not represent best use of the service and that their primary purpose as a PDS service should be to focus on more vulnerable patients who require additional input or support and would find it challenging to access general dental care.

Specialist Services

While the treatment provided by the consultant led oral surgery service in BGH was valued, staff reported that patients who were referred faced long waits to receive treatment. It was also highlighted that there was a lack of secondary care facilities for other dental specialties, including periodontal treatment and endodontics.

Domiciliary Dental Care

Despite highlighting domiciliary dental care as one of the areas which works well, it was felt that provision from Coldstream may be insufficient to meet the levels of demand in the area. Dentists were also keen to highlight that although they aim to provide the highest standard of care possible, it is not feasible to provide all treatments in a domiciliary setting in comparison to the level of care which could be provided within a clinic.

Bariatric Dental Services

Staff highlighted that there are currently no dental facilities within the Borders which can accommodate bariatric patients. With increasing prevalence of obesity, staff had concerns that more patients will present who are unable to access care in a standard dental clinic as their weight exceeds the safe working limit of the dental chair. Currently these patients require to attend BGH to be treated in the operating theatre on a hospital trolley, though there are a small number of dental chairs in the PDS which can accommodate patients weighing up to 28 stones.

Children (GA, Prevention)

Members of staff were concerned that some vulnerable children who require dental care may be being missed, and that there may be a misconception by some parents that Childsmile input in schools is equivalent to them having a "school dentist". While Childsmile is seen as very valuable, it was suggested that delivery of Childsmile interventions in General Dental Practices may not happen consistently in all practices. There was also a worry that school input from Childsmile does not continue beyond primary school and once a child reaches secondary school, there is no further follow up to ensure oral health is being maintained.

Admin/Processes

Staff were frustrated with the volume of administrative tasks impacting on clinicians' time, this was particularly related to the recent introduction of electronic submission of prior approval (for treatment involving particular individual items requiring approval, or where the cost of treatment exceeds £410). Staff also felt that there could be better use of information technology, pointing out that it would be beneficial for systems to link with those of other health services.

There was also a feeling that the requirement to follow processes and pathways could be challenging and there were restrictions on what treatments they are able to offer, particularly in relation to regulations set out in the Statement of Dental Remuneration, with restrictions on the timing of when some items can be provided.

Finances

There was a feeling that financial pressures had led to a restriction in the availability of some dental materials within PDS, however there was also a feeling that money was being lost through wastage of materials.

Removal of Mobile Dental Unit

Staff in Hawick were unhappy that the mobile dental unit which had been in use until 2016/17 had been withdrawn. There was a feeling that there was still a demand for this service.

Changes

Suggestions for changes which staff felt would improve the services delivered included introducing measures to deal with staff absences and make cover available, which was mentioned in both hubs. Other suggestions took a different focus in each area.

In Coldstream it was felt that there was a need to focus the service on patients most in need of PDS care, with less time being spent on patients who could access GDS services. They were keen to improve communication with the public to highlight the shift in emphasis from Salaried General Dental Services to a Public Dental Service and to increase awareness of what treatments are available to NHS patients. There was a feeling that a simplified Statement of Dental Remuneration would be helpful, though it was acknowledged that this would require substantial change at a national level.

In Hawick there was a stronger focus on children's oral health, with a desire for input in the early years to follow up patients through maternal health groups, and expansion of oral health improvement activities into secondary schools.

Specialist Dental Services

Orthodontics

Orthodontic services

Discussions were held with both the hospital based consultant in orthodontics and specialist practitioner. Both were positive about the interface between each of their services and felt that the level of orthodontic provision in the area seems to be about right. The specialist practice has no waiting list for new patients and the waiting list for orthodontic assessment within the hospital is consistently within the 12 week target. In addition to orthodontic services provided through the NHS, there was an awareness that a recently opened private dental practice provides orthodontic treatment and approximately 8-10 local dentists also offer orthodontic treatment, mainly to adult patients on a private basis. The orthodontic specialist practice provides predominantly NHS treatment for child patients, though does receive some referrals for adult patients who may have declined private treatment. Adult patients are triaged by the practice, with the specialist practitioner only accepting patients where treatment will be of benefit to them. Overall it was felt by both orthodontists that the balance between supply and demand for orthodontic treatment is well met and there was no requirement to increase the level of service currently being provided.

The interface between the hospital and primary care orthodontic services was felt by both to work well, with clear referral criteria (Appendix 1) available to support dentists to direct patients to the most appropriate clinic. It was reported that some dentists may be unclear of the criteria or have a preference to refer to a particular service, but where referrals are repeatedly directed inappropriately, a copy of the referral criteria will be sent out to that practitioner as a reminder. The hospital consultant reported that a few referrals had to be "bounced back", usually to request additional information. Both orthodontists reported that it was more likely that patients would be seen in the specialist practice and require to be transferred to the hospital clinic than the other way round, which was felt to be as it should be.

Orthodontic referrals

The specialist practitioner felt that most, around 60% of, referrals were appropriate and were made at the right time. Both services reported receiving some late referrals, most commonly for impacted canine teeth, where problems could have been identified at an earlier stage. They also described receiving some referrals at too early a stage. It was acknowledged that you "can't expect referrers to be orthodontists", however there was a

concern that there may be a lack of knowledge of normal dental development among some dental practitioners. The orthodontic consultant described some referrals which state the problem to be crowding (a relatively common and straight forward problem), then on assessment patients are found to have complex orthodontic problems which will require orthognathic surgery (a joint orthodontic and surgical approach to realign the jaws).

Oral health/hygiene

The orthodontists acknowledged that oral health of children in the Borders is generally very good, describing seeing very few patients with untreated dental decay and reported that there appear to be only a few small "hot-spots" where caries rates appear to be higher. The specialist practitioner did describe often seeing patients with poor oral hygiene, though reported that once they have been given oral hygiene instruction, the vast majority of patients take this on board and manage to make improvements. It was unclear whether these patients have not received advice on improving their oral hygiene from the referring dentists, or whether patients don't adhere to advice from their usual dentist but will pay more attention to that from the orthodontist.

Interfaces with other specialties

Some orthodontic treatment plans will require input from other dental specialties, most commonly oral surgery or restorative dentistry. Generally those requiring multi-disciplinary care have more complex orthodontic needs and will be treated by the hospital based orthodontic consultant. Patients who require joint restorative-orthodontic care, for example for hypodontia (missing teeth as a result of failure of some teeth to develop) are referred to Edinburgh Dental Institute (EDI) where they are seen by the orthodontist from the Borders, jointly with the other specialists required for their care. This system is felt to work reasonably well and in general, patients from the Borders accept the requirement to travel to receive this level of specialist care. Patients seen in the specialist practice who require the input of a restorative dentist will be referred on to the hospital orthodontist who will make arrangements for them to be referred on to EDI.

The hospital orthodontic consultant holds a joint orthodontic-oral surgery clinic every two months in the BGH for patients who require surgical dentistry as part of their orthodontic treatment. Surgical interventions required will then be provided by the oral surgeons within the BGH. While most patients requiring multi-disciplinary input receive their orthodontic care within the hospital, the specialist practitioner does provide treatment for some patients who require surgical interventions, for example for exposure of impacted canine teeth. Patients from the specialist orthodontic practice are referred to an NHS oral surgery specialist practice in Edinburgh, where they can be seen more promptly than if they were referred to the oral surgery department at the BGH. Patients requiring more complex orthognathic surgery will be referred via the hospital orthodontist to her clinic in EDI, for input from oral and maxillo-facial surgeons.

In the past PDS clinics for paediatric patients were scheduled to coincide with orthodontic clinics in the BGH, though the orthodontist described this as joint time, with patients being passed between each other rather than a true joint clinic where both clinicians would see the patient together. The hospital orthodontist felt that having input from a specialist in paediatric dentistry would bring significant benefits, enabling her to provide a better service to her patients, through for example joint planning regarding long term prognosis for first permanent molar teeth (it was noted that although an orthodontist can advise on long term planning following extraction of teeth, they are not the most appropriate person to judge

the quality of teeth to advise on whether they should be extracted) and the ability to offer more advanced restorative care to young patients.

Local need for additional dental specialists

It was felt that local input from a specialist in paediatric dentistry would bring benefits not only through opportunities to link with orthodontic care, but that specialist input to the Public Dental Service would provide support to staff, bringing opportunities for them to develop their skills and enhance the service currently being provided, reducing the need for paediatric patients to travel to EDI for specialist care for example in the event of dental trauma.

In addition to input from a paediatric dentist, it was also suggested that specialist special care dentistry input could bring similar benefits in terms of supporting and upskilling PDS staff to provide care for more complex patients, helping to develop the service from providing access for routine patients to focussing on more vulnerable patient groups.

The orthodontists highlighted that the only dental specialties available at specialist level in the area are oral surgery and orthodontics, with patients requiring restorative care, including prosthodontics or periodontics to either opt for private dental care or be referred to EDI. Periodontal care was also highlighted as being particularly needed, with many of the adult patients referred for an orthodontic opinion requiring periodontal treatment.

Networks/interaction with colleagues

The hospital orthodontist highlighted the additional benefits of also working within EDI where there is the opportunity to link in with colleagues and gain exposure to different ideas and ways of working. This helps to avoid isolation which they feel could be a risk for people working exclusively in the Borders where there are limited opportunities to interact with others.

Oral Surgery

Oral surgery services

Discussions were held with each of the part time oral surgery consultants. The overriding concern raised by both was the workload and pressures on the service. The consultants described long waiting times for initial assessment and to receive treatment, particularly where general anaesthetic or sedation was required. They reported that recent additional sessions and locum provision of treatment out of hours and at weekends had helped to reduce waiting times, though there was a concern that when these additional measures cease, waiting times will grow again.

Sessions delivered

The oral surgeons were keen to increase the number of sessions the visiting oral surgery specialty trainees could provide within the department. In addition to addressing waiting times this would also allow further access to training opportunities. It had not been possible to take this forward due to lack of available surgery space. They suggested that it would be beneficial to review clinic utilisation within the department with a view to transferring some treatments and services currently provided in the department into a primary care setting, thus freeing up space in the hospital for additional oral surgery clinics.

Demand / nature of referrals

One of the reasons for the long waiting lists was the high volume of referrals into the service. The oral surgeons felt that this most likely reflects a lack of experience or confidence in managing oral surgery and oral medicine amongst primary care dentists. There was also perceived to be an element of “risk aversion” with dentists preferring to refer extractions rather than being comfortable to provide the treatment themselves. They stressed that they did not wish to put pressure on primary care dentists to work out with their comfort zone or level of skill, and indicated that they would be willing to provide support and training to primary care colleagues who wished to develop their knowledge and skills.

Treatments provided

The consultants highlighted that a number of the referrals they received were for treatment which they considered to be routine and which does not require the expertise of a consultant. At present there is no threshold for the level of complexity of treatment to be provided. The consultants feel that for a patient who has been referred for an oral surgery procedure, regardless of the complexity, the most appropriate person to provide their care is an oral surgeon. They acknowledged that surgical procedures can go from easy to difficult very quickly, and that it can be challenging for a primary care dentist to predict which treatments are within their level of competency. It was also highlighted that complexity was not solely related to the nature of the procedure but also patient factors, including medical conditions which require to be taken into consideration in provision of care.

Need for additional dental specialists

The consultants felt that input of a specialist in special care dentistry based in PDS would be valuable as treatment could be provided by a specialist in special care dentistry (or experienced dentists working within a specialist led service) for patients who require their care to be provided in a hospital setting as a result of medical complexity rather than the need for an advanced surgical dentistry procedure. This is also true for patients requiring routine oral surgery under sedation. Currently a Senior PDS dentist provides dental treatment under sedation for patients with dental anxiety. It is possible that more of the patients referred to oral surgery for sedation could be directed to PDS where sedation is required due to patient factors rather than an advanced surgical procedure.

It was also suggested that having a specialist in special care dentistry on the team would bring further benefits through an ability to provide support to other members of staff, encouraging development of more specialised skills amongst their PDS colleagues. It was however recognised that it can be difficult to recruit specialist expertise to a rural area and there was a suggestion that building links to special care dental services in Lothian could help strengthen the service within the Borders.

Oral surgery/EDI interface

Current links with the oral surgery department at EDI were viewed as a valuable asset, enabling the oral surgery team to join monthly clinical governance meetings, including continuing professional development, audit and incident reporting. In the past oral surgeons from BGH would deliver clinical sessions in EDI and those from EDI would come down to provide treatment in BGH. The oral surgeons felt that this previously well-

established clinical link, was valuable and should be re-visited for peer review and support purposes.

In contrast there was reported to be no direct link to oral and maxillo-facial surgery (OMFS) services, other than when oral cancer cases are referred on for management. Patients presenting with a facial swelling may also require to be transferred to OMFS due to lack of out of hours cover for these patients within BGH. The oral surgeons felt they work well with medical colleagues within BGH and while they would welcome OMFS input if it were offered were comfortable with the current arrangements.

Networks / interaction with colleagues

It was highlighted that as the two oral surgeons work part time and are present in the department on different days, there are limited opportunities for them to meet with each other or undertake peer review, which can be isolating. Issues can also arise if one person is unavailable or on leave as they are unable to provide cross-cover for each other. This is another instance where a more formal network with EDI clinics could be beneficial.

Being the only oral surgeon present can also provide challenges fitting in emergency patients should they arise, with one person managing a clinical session, patients on the ward and having to fit in any additional patients. Having the specialty trainee around was noted to help ease these challenges by facilitating a team approach to managing the multiple demands.

Oral surgery in primary care

The oral surgeons were asked for their views on the proposal in the Scottish Government's Oral Health Improvement Plan[2] for more dentists on the high street, to include oral surgery services in a primary care setting. The oral surgeons felt that a suitably trained primary care practitioner could form part of a managed clinical network to provide some oral surgery in primary care. If this was a non-specialist, they believe it would need to be made very clear to patients that they were not seeing a specialist oral surgeon. It was felt that increasing training opportunities for oral surgery specialty trainees within the hospital would hopefully help to deliver more suitably trained specialists to work in primary care.

There was also a feeling that an NHS specialist practice model could be helpful, but that this would require careful management, clear agreed referral criteria, appropriate regulation and would have to be adequately funded.

If the enhanced practitioner model were to be introduced for oral surgery, it was felt that there was not currently anyone working in the Borders who would be in a position to provide oral surgery in primary care. It was acknowledged that there may be a practitioner who is unknown to the department as they manage their own oral surgery cases and have not required to make many referrals to the department.

Oral Health Improvement

A general discussion was held with members of the Oral Health Improvement Team, giving them the opportunity to describe their roles and work being undertaken particularly in relation to the Childsmile and Caring for Smiles programmes. Conversations were

structured around what worked well, what they felt they main challenges were and what changes they would like to make to maximise opportunities to improve oral health.

Childsmile

Staff working with the Childsmile team were happy that the programme works well, highlighting the fact that they now see fewer children with caries than they did in previous years. They also described seeing fewer children who were not registered with a dentist – mentioning that while working in nurseries and schools earlier that day they had seen two unregistered children, where a few years ago it would have been usual to see around 20-25.

In the past Oral Health Support Workers had been allocated to a specific area and provided support to both practices and educational establishments in that area. More recently their roles have focussed on either working with Childsmile practice (encouraging dental registration and attendance) or Childsmile nursery and school (supporting the toothbrusing and fluoride varnish programmes). The teams felt that these new arrangements were more effective.

Teams described positive and longstanding relationships with Health Visitors, though they do find that some tend to refer more children to them than others. The decision on whether a child requires referral to Childsmile depends on the Health Visitor's individual judgement and once referred the Health Visitor and Oral Health Support Worker will tailor the level of support provided to the needs of the individual child.

The team described their process for following up children who have been referred to a dental practice by Childsmile, by making contact four months after the referral to ensure the child has attended and all is well. They felt this was beneficial and provided an opportunity to identify children who had not engaged with dental services and who required further support to do so. Participation with dental services among children was felt to be good and the teams believed that this was due to the support offered by the Oral Health Support Worker.

Childsmile clinics within the PDS were seen as a valuable means of delivering preventive care and advice and were described as working best when the Extended Duties Dental Nurse takes ownership for delivering them. They were felt to work particularly well in some clinics, however there were inconsistencies in others where clinics were either irregular or seldom delivered.

The teams described positive relationships between Childsmile and clinical teams within the PDS and reported that over time they felt Childsmile oral health improvement teams and the clinical teams had developed to a stage where they work well together.

Childsmile is generally well accepted by schools and nurseries in the area and positive relationships have been built, with the majority of staff in these establishments welcoming Childsmile teams. In the past schools had been prioritised for Childsmile input based on SIMD quintiles, however more recently there has been recognition that in the Borders SIMD may not be sensitive enough to identify the schools or children where caries risk is highest. As the number of schools receiving Childsmile interventions have increased,

factors such as free school meals, attainment money and obesity level have also been used to guide which schools receive most input.

The team described the strong relationships that Oral Health Support Workers have developed with nurseries and schools and the benefits of both parents and staff knowing the Childsmile teams. They also noted the benefits of working in a small Board area where people know each other, which facilitates communication between education and health services, allowing for information to be shared appropriately without the barriers faced by some of their colleagues in other Health Board areas.

Childsmile input to Leadervalley School for children with complex additional support needs was described as "fantastic". One Extended Duties Dental Nurse is allocated to the school and to the additional support units in other schools across the region and was very positive about her role there, feeling that it was good to have the opportunity to concentrate on children with additional needs. She reported that there was a requirement to "tweak" the way Childsmile is delivered to children with additional support needs in comparison to mainstream schools, dependent on the unit or class and needs of individual children. For some children specific toothbrushes may be required, and consideration needs to be given to timing of toothbrushing and visits from the team. She reported that not all children are able to accept fluoride varnish application, though around half of the children she sees do manage to have varnish applied. The EDDN reported that she is recognised by the children and has also developed good relationships with parents through attending parents nights and has received "nice feedback" about the input of the Childsmile team.

Challenges described by the Childsmile team included a feeling that, despite the success to date, it will be very difficult to achieve the government target for 2022 of 84.5% of Primary 1s and 92% of Primary 7s having no obvious decay experience.

The teams also identified the lower rates of dental registration among very young children (aged 0-2 years). In an attempt to address this a pilot was being undertaken in one area where registration was known to be an issue in which Health Visitors had agreed to refer all children to the Childsmile team at their 6-8 week visit through the Universal Health Visiting Pathway. It was hoped that through all families having contact with an Oral Health Support Worker at this early stage that more parents would be encouraged to register their baby with a dentist. The teams were keen to see the outcomes of this pilot, but also explore what impact the increased number of referrals would have on their workload.

Relationships with GDP practices were described as variable and going through "peaks and troughs", varying over time and being more positive with some practices than others. Teams felt that twice yearly fluoride varnish applications in dental practices, as recommended by the Childsmile programme, were not always being delivered and that promoting this among GDPs was another challenge they faced.

The teams felt that it could be difficult to balance the roles of Extended Duties Dental Nurses who spend part of their working week delivering Childsmile and part working in clinics. At times this dual role could make it difficult to deliver what they had planned as clinical sessions were given higher priority and Childsmile clinics may be cancelled if the nurse was required to work with a clinician. They felt that Childsmile clinics should be viewed as a higher priority than they perhaps appeared to be at the time.

Broken appointments within PDS clinics were also discussed, with a feeling that children who have not been brought to appointments are not always followed up. The teams felt that there was a need for greater understanding of factors which may have contributed to a missed appointment. They felt that clinicians may not always see beyond the wasted clinical time and that there should be a greater focus on the more vulnerable patients and appreciation that PDS has an important role in ensuring patients who may have complex life circumstances are given the support necessary to receive dental care. The team felt that there was a need for dentists to "adjust to see what else was going on" rather than "write off" a patient as a poor attender. The introduction of a "Child Not Brought" policy since this discussion was held aims to help to address this issue.

A further challenge had come about through the discontinuation of the Mobile Dental Unit which had previously offered a local dental service in areas where there was no dental clinic. The team reported doing a lot of work to engage with families who had previously used this service to encourage them to come in to clinics. This work was ongoing despite it being over a year since the mobile service had ceased.

At times the teams face challenges following up consents for children to participate in Childsmile fluoride varnish application, reporting that it is necessary to follow up with parents who have not returned forms and that despite their efforts parents do not always respond. Within nurseries and schools, although relationships were good with most establishments, others remained more difficult to engage with. The teams felt that as Childsmile has become well established over the years, positive relationships have developed, though there is still a need to "keep selling" the programme. They valued the "PR work" done by Oral Health Support Workers to continue promoting the programme and suggested that it may be beneficial to have a "Childsmile relaunch" where the benefits and positive impacts of the programme could be highlighted.

Caring for Smiles

The Caring for Smiles programme was described as evolving all the time. To date no care homes in the area have declined the offer of Caring for Smiles training, though promoting uptake by care home staff was described as a challenge. Positive relationships are being developed between the Oral Health Improvement team and care homes and it was felt to be beneficial that the Caring for Smiles coordinator attended monthly care home managers' meetings, though this has ceased since the discussion took place as meetings were not always well attended and frequently cancelled at short notice.

One Oral Health Support Worker is allocated to the Caring for Smiles team and this role was viewed as valuable in bringing together the Oral Health Improvement and clinical PDS teams. In addition to supporting the delivery of the Caring for Smiles, the delivery of domiciliary dental visits by PDS staff is supported, through liaison with the care homes to ensure that necessary arrangements and paperwork are in place prior to the dentist's visit.

While Caring for Smiles and PDS staff work well together, there was a feeling that there was still room to strengthen links with GDPs, PDS and Caring for Smiles to enable them to work more effectively together.

Adults with Learning Disabilities

At the time of the conversation with the Oral Health Improvement team the Open Wide, national oral health improvement programme for adults with additional care needs had not been launched, however work was already underway to build links to support adults with learning disabilities in the Borders. The Caring for Smiles Oral Health Support Worker was already working with Social Workers who would notify him of anyone requiring support to register with a dentist. The Oral Health Support Worker felt that this was a positive piece of work, though it could be challenging and there was a need to persevere to successfully facilitate access to dental care. It was also acknowledged that working with adults with learning disabilities is “not for everyone”.

9. Public Perceptions

To gain an insight into the oral health needs perceived by residents of the Borders and their priorities in relation to oral health, groups representing the population were consulted. In addition a number of direct public facing engagement events were arranged to gather views of Borders people first-hand.

Patient Representative Group

Patient representatives were consulted via the NHS Borders Patient Representative Group (PRG) meeting in February 2019. The PRG is chaired by the NHS Borders Public Involvement Officer and consists of volunteer members of the public, including a representative for people who use mental health services and a representative of people who are deaf and hard of hearing. The meeting on 18th February also included a local secondary school pupil with a view to encouraging representation of younger people. Points raised by the group related to:

1. Access to dental services
2. Requirement to travel
3. Treatment costs
4. Prevention
5. Relationships with other health services

Access to Dental Services

It was reported that people moving in to the area can find it difficult to register with a dentist. One member stated that it could take between 12-18 months to find a dentist in the area. Another member referred to a wait of around one year to register with the [PDS] dental clinic in Coldstream.

Requirement to Travel

It was recognised that access to dental care can be more problematic in some areas than others, with limited availability of public transport adding to the issue. The burden of travelling to access care was felt to be particularly challenging for older people. Travelling was noted to be a common difficulty shared with other medical services including, for example, opticians. It was also highlighted that the out of hours dental service is based in the Borders General Hospital, which may not be easily accessible for some people.

Treatment Costs

Costs of dental treatment were also discussed. Members were positive about the clear breakdown of charges on the NHS, and highlighted that private costs were often significantly more. The group also discussed “mixing and matching of NHS and private treatment” and the fact that dentists will at times advise of private options to provide particular types of treatment.

Prevention

Members of the group commended the good standard of oral health of children in the area and the positive impact of the Childsmile programme in nurseries and schools. They did however question why Childsmile input does not continue beyond primary school and felt pupils would benefit from the continuation of the toothbrushing programme through secondary school.

Relationships with Other Health Services

There was a feeling among the group that they would like to see a better "tie up" between doctors and dentists, suggesting that there should be greater communication and more ability for referral between the services.

Public Engagement Events

Between February and September 2019, a variety of opportunities were provided for members of the public to help inform the needs assessment by asking them

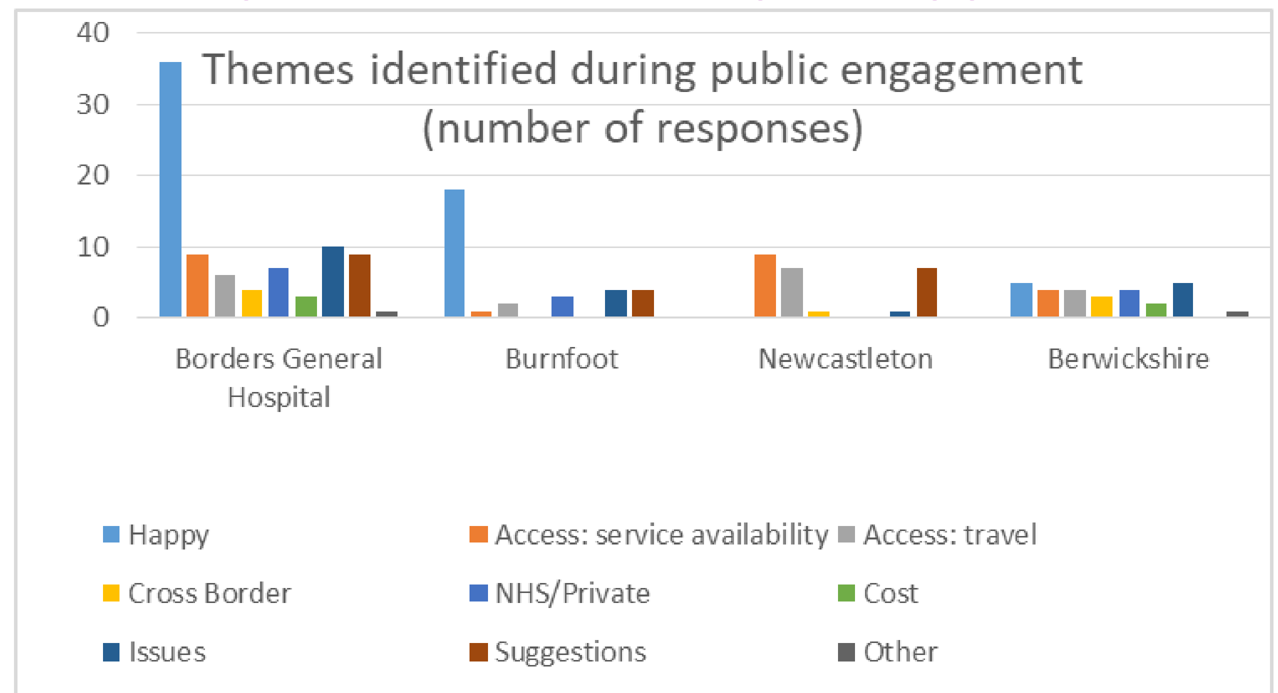
What matters to you about oral health and dental services in the Borders?

The first and largest event was held in Borders General Hospital, however in recognition of the fact that this was a central location with good access to dental services nearby, follow up events were arranged in three health centres in more remote areas of the Borders: Eyemouth, Chirnside and Newcastleton. Two further events were also held in Burnfoot Community Hub, an area of high deprivation in Hawick and with employees of Farne Salmon, a fish processing plant in Duns. Stands were set up in each location, with passers-by asked to provide feedback on post-it notes, which were collated and analysed for common themes.

In the Borders General Hospital around 80 responses were received from patients, visitors and members of hospital staff. Twenty nine responses were received in Burnfoot, 23 in Newcastleton and 25 from the three events in Berwickshire (10 in Chirnside, 4 in Eyemouth and 11 in Duns). Due to the smaller number of responses in each of the Berwickshire events, these have been collated to provide a summary of feedback from Berwickshire as a whole.

Figure 27 provides a summary of responses by theme for each location.

Figure 27 – Themes Identified During Public Engagement



Happy

Around half of the responses in the BGH and Burnfoot were very positive about dental care.

- *"Having an NHS dentist in the Borders has been great. Out of hours was also fantastic when I needed it." (BGH)*
- *"Attend NHS dentist. Happy with service. Children love their dentist and attend regularly as a family" (BGH)*
- *"I hope they continue to benefit the community, doing a great job" (Burnfoot)*
- *"Think the service is excellent – great in schools, excellent Childsmile, great service" (Burnfoot)*
- *"Access and quality of service is much better than down South – we are very lucky" (Chirnside)*
- *"Efficient out of hours care over weekend" (Chirnside)*

It is noteable that Newcastleton was the only location where none of the responses expressed satisfaction with dental services, with the majority of feedback there highlighting difficulties accessing dental services.

Access - Availability of Dental Care

The most common issue raised across all of the locations was around access to dental care, and lack of availability of dentists. This was a particularly strong feeling in Newcastleton and mirrors staff concerns.

- *"All Borders towns lacking NHS dentists" (BGH)*
- *"Too few dentists take NHS patients. Not enough NHS dentists/places" (BGH)*
- *"Dental services in the village would be so much more accessible" (Newcastleton)*
- *"Why is there a doctor in Newcastleton and not a dentist? Dental health is very important" (Newcastleton)*

Most comments about availability of services in Berwickshire tended to focus specifically on low availability of NHS dentists in the area.

- *"Not enough and very few and far between dentists on the NHS" (Duns)*

One person at the BGH event felt there was good availability of dentists, though this view did not appear to be widely shared.

- *"Gala practice was advertising for patients recently. Not sure why people complain they can't get a dentist" (BGH)*

Access: Travel

A number of respondents reported that they travelled several miles to access dental care.

- *"I live in Jedburgh but have to travel to Gala for dentist" (BGH)*
- *"Not enough dentists in local area. My dentist is in Edinburgh" (BGH)*
- *"I previously had to travel to Glasgow" (BGH)*

The distance to the nearest dental practice, and issues with transport were raised frequently in Newcastleton.

- *"At present it is difficult to access dental services. 30 minute drive to nearest which only has one dentist at any one time. Local service would be a huge help" (Newcastleton)*

Within Berwickshire, the need to travel to receive dental care seemed to be most of an issue for people in Chirnside. Difficulties for people who rely on public transport to get to appointments were also highlighted.

- *"Need to travel quite a distance for NHS treatment" (Chirnside)*
- *"Travel distances and costs. Lack of public transport at good times" (Chirnside)*

Whilst travelling to dental appointments was noted as an inconvenience by some, it was highlighted that for some individuals the requirement to travel posed more of a barrier.

- *"Difficult for people with learning disabilities – difficult to travel" (BGH)*
- *"As an elderly person, transport is very limited and bus stop too far to walk from to dental centre" (Newcastleton)*

Cross-Border Care

Some respondents, particularly those living in the East of Berwickshire, reported accessing dental care in England, despite living North of the Border.

- *"Lack of access to NHS dentist in local town" (Peebles).*
- *Still attending dentist in Newcastle where I moved from" (BGH)*
- *"Travel to Northumberland for dental care as I used to live there" (BGH)*
- *"So… my dentist is in Berwick because originally I could not register with a dentist in Duns. I think that would no longer be the case. I do wonder would the service be different if I was in the 'Scottish System'" (BGH)*
- *"Registered in Berwick – had to for NHS dentist" (Eyemouth)*
- *"Had to register in England as couldn't get in anywhere here" (Eyemouth)*

There was little mention of people travelling to England for dental care from more western parts of the Borders, though one respondent in Newcastleton did describe travelling to Newcastle for dental care.

NHS vs. Private Dental Care

A number of patients reported having "had to" change from NHS to private dental care, particularly when a previously NHS dentist has switched to providing private care.

- *"Need to keep NHS dentist availability. Too many going private. Otherwise very good" (BGH)*
- *"My dentist went private. I didn't have an option" (BGH)*
- *"Family dentist is private and very good but we changed to NHS in same practice. Have now been told that they may not be taking NHS patients so will need to look for new dentist. We all cannot afford to go private. Borders dentists are good but a lot are going private." (BGH)*
- *"In Duns I need to go private to get a dentist" (Duns)*

Some respondents in Burnfoot did mention receiving private care, all of whom expressed a preference to receive NHS care if it was available.

- *"Currently registered with a private dentist but would rather be with an NHS dentist" (Burnfoot)*

Private dental care was not mentioned in any responses in Newcastleton.

While some patients would prefer to continue to receive NHS dental care, others reported being happy with private care.

- *"Now registered privately (previously NHS) but happy with dentist" (BGH)*
- *"Happy to pay for private if get good service" (BGH)*
- *"Registered privately but easy to get an appointment when needed (expensive though)" (Eyemouth)*

Costs

In BGH, some patients mentioned finding dental treatment expensive, though it was not always clear whether this referred to private or NHS charges. The cost of dental care was not mentioned in either Newcastleton or Burnfoot and in Berwickshire the only mention of cost was to highlight that private dental treatment is more expensive than NHS.

Problems and Queries

Some patients provided feedback on specific problems they had faced, including lack of continuity of dentists through frequent changes of personnel and appointments being cancelled or rearranged at short notice.

- *"Four different dentists in 1 year. No continuity – each had differing opinions" (BGH)*
- *"Always changing your dentist without telling you" (Berwickshire)*

In one area, a number of patients expressed dissatisfaction with the service they received from their dental practice. Many of the comments related to the same practice, though it should be noted that there were also positive comments recorded relating to the same practice.

Others mentioned having to wait long periods of time to get an appointment, or being removed from a dentist's list for missing an appointment and unable to pay fees charged for the missed appointment.

One respondent raised the issue of lack of disabled access to the local dental practice. Under the Equality Act (2010) service providers are required to make "reasonable adjustments" to ensure people with disabilities are not disadvantaged. Arrangements are in place for any dental practice where it is not feasible to provide disabled access to refer patients on for dental care in PDS, where all clinics support wheelchair access.

Questions were raised about referral pathways and there was a feeling that these are not always clear, which can result in delay for patients if they are not referred to the correct place in the first instance. Another asked about thresholds for making referrals as there was a feeling that some dentists seem to make more referrals than others.

A member of hospital staff asked about cover for inpatients who may have a dental problem and was unaware that this is available through the PDS.

Suggestions

Some respondents provided suggestions to improve oral health and services. These included increasing the focus on preventing poor oral health with more publicity for oral care and encouragement for workplaces to support good oral health.

Respondents felt it would be beneficial if dental services were easier to contact, for example for advice between appointments, and they would like dental practices to make more contact with them. There was also a request for practices to offer later appointment times to accommodate work and commuting. It was suggested that patients should be reregistered with the dentist closest to their home to address the fact that many patients travel to an alternative town to attend the dentist.

All of the suggestions made in both Newcastleton and Burnfoot related to improving access to dental services. The vast majority of these related to reinstating the mobile dental service which had previously visited both locations.

- "Mobile dental should be reinstated" (Newcastleton)
- "Mobile dental service very good at the time. Needs to come back" (Burnfoot)
- "Bring back the mobile dental service to Burnfoot. It was well used and an asset to our community" (Burnfoot)

Others suggested introducing a part time dental service in Newcastleton, or reinstating the dental clinic within the school.

- "Need dentist in village, even once a week" (Newcastleton)

The strength of feeling about providing a local dental service was evident among the community in Newcastleton, with an offer to contribute financially towards making a service available.

- "I would be happy to pay £5 per week to improve services" (Newcastleton)

Specific Population Groups

It is recognised that some members of the population can experience particular difficulties accessing dental care, including those with physical or cognitive disabilities, mental health problems, people experiencing homelessness and those with addiction problems. Representatives for the deaf and hard of hearing and people with mental health conditions on the PRG were able to provide feedback relating to these specific groups.

The main concern raised relating to patients who are deaf was around availability of British Sign Language interpreters to support communication between patients and dental teams and it was identified that there was a need to make dentists aware that they have the facility to book a sign language interpreter through translation services. It was also suggested that it would be helpful to let patients who may require an interpreter know that this is something which can be arranged and that they should feel able to request.

A number of challenges were described relating to dental attendance for patients with poor mental health and it was reported that many patients with mental health problems do not go to the dentist. Problems accessing care include high levels of anxiety among this patient group, and that when having a “bad day” patients may find themselves unable to bring themselves to attend a dental appointment which had been arranged previously. Memory problems were also highlighted as these may result in non-attendance for appointments. The representative felt there was a need for a flexible approach to providing dental care for these individuals and for mental health support workers to play a role in supporting patients to attend dental appointments. A need for dental input to East Brig Rehabilitation Unit was also highlighted

It was recognised that information relating to wider priority group populations had not been captured through the PRG meeting or the wider public engagement events. A number of local organisations and groups working with people who may be at increased risk of poor oral health, or who may find it more difficult to access care were contacted to explore whether they were aware of problems with oral health and access to dental care amongst their clients.

Responses were received from two organisations, both of which provide addiction services. Representatives from both services reported that their clients did struggle to access dental care. They described difficulties registering with a dentist due to limited availability of NHS dental services in the area. It was highlighted that their clients often rely on emergency dental services, however they may be offered an emergency appointment anywhere in the Borders and transport can present a challenge to attending. For patients who have managed to register with a dentist, it is recognised that attendance patterns may be erratic, either due to memory problems which are common amongst this group, or the fact that support is required when clients are at their most chaotic and attending appointments tends not to be prioritised when patients are at this point. It is common for GDPs to charge a fee for appointments which have been missed which must be paid prior to a new appointment being arranged and this was reported to be a barrier to attending for dental care.

Staff working in addiction services indicated a desire to improve the situation through preventive actions to improve oral health and facilitating access to dental services and attendance at appointments. Addiction services already work closely with other health

services, for example the sexual health service and suggested that it would also be beneficial to build links with oral health and dental services. It was also suggested that an open access or drop in dental service may be helpful to this client group and it was highlighted that if positive experiences and early interaction with dental care can be encouraged this would help to better meet the oral health needs of this client group.

No information was received from organisations working with other groups likely to be at increased risk of oral disease or facing challenges to access dental care. Further engagement with relevant organisations and patient groups will be necessary to ensure the needs of these individuals are not overlooked.

Main Findings Section 3 – Engagement and Dental Teams and the Public

- **Access to dental care was the main concern for dental staff in both PDS and GDS and for members of the public**
- **The vast majority of dental patients were happy with the care they receive**
- **GDS and PDS staff both described feeling under pressure**
- **Low staffing levels and issues with recruitment and retention were major concerns in both GDS and PDS**
- **53% of GDPs described their needs as being "partially met" by currently available specialist dental services**
- **Dental teams and the public were positive about preventive services, particularly Childsmile, but all felt that input should continue into the secondary school stage**

Key Discussion Points

Access to Dental Care

Feedback from both patients and members of primary care dental teams indicates that access to dental services is a much greater concern than registration and participation figures would suggest.

Several reasons were suggested for the level of demand for dental services being experienced at present despite high registration levels, including the possibility that a number of those seeking to register as new patients may already be registered with an NHS dentist, either looking to move to a different practice, or through lack of awareness of lifelong registration.

The main sources of new NHS dental registrations in the area are likely to be from patients moving in to the area, patients currently accessing private dental care looking to switch to NHS and patients who have accessed care in England looking to register in Scotland for the first time. Through the engagement events it was apparent that long term residents of the Borders who had been registered with a dentist for a number of years were happy with the care they received and that the main difficulties were faced by new residents moving into the area and seeking to register for the first time as a new NHS patient, or patients who had been attending an NHS dentist which had switched to offering only private dental care.

While some members of the public reported that they were happy to opt for private dentistry, it was clear that others currently receiving care on a private basis would prefer to receive NHS care. There were also a number of reports of dentists "going private" with patients facing a choice of continuing to attend their current dentist or seeking a new NHS dentist. The possibility of a shift in care provision with more dentists making a decision to

focus on providing private dental care cannot be ruled out and could be expected to result in a significant increase in demand for those continuing to provide NHS dental services.

The PDS experience a high demand from individuals seeking to register as NHS patients. It was suggested by staff that some of the patients seeking PDS care would be able to register with a GDP and that some may in fact already be registered. There is felt to be a lack of awareness among the general public of the difference between GDS and PDS and the purpose of PDS as a “safety net” service for those unable to receive care in GDS. They identified a need to raise awareness that being registered with the PDS clinic closest to a patient’s home was not equivalent to being registered with their local medical practice. One suggestion made during patient engagement was that patients should be reregistered with the dental practice closest to their home to reduce numbers travelling between towns for dental care. Under current arrangements this is not something which could be implemented as patients are free to choose which dental practice they wish to register with regardless of its location.

Alongside the reported lack of availability of NHS dental care, it was also highlighted that those living in the more remote parts of the Borders may face difficulties travelling to dental clinics, particularly if they rely on public transport. This issue was particularly strongly expressed in the Newcastleton area by patients who were previously able to access care via a mobile dental unit (MDU) which had visited the town until 2017. Despite requests for this service to be reinstated, providing care from a mobile unit is no longer considered viable as the unit would not have met requirements to pass a dental practice inspection. In addition the vehicle used was unlikely to pass an MOT test and the necessary parts to maintain the roadworthiness were not available. At the present time there is no additional financial resource available to replace the mobile unit, however new domiciliary dental equipment has been purchased to enable treatment to be provided at home for patients who are unable to travel to a clinic.

The Oral Health Improvement Team have also provided, and continue to provide support to residents previously served by the MDU to help them register with a dentist and encourage them to continue to access regular dental care. While it is recognised that there are areas in the Borders which would benefit from a dental practice being set up locally, areas with a small population are unlikely to be viewed as a viable business opportunity by GDPs and the Health Board has no authority to request that a dentist opens a new practice in a particular location. In the past grants have been available to encourage practices to open in areas of high need, however such funding is no longer available and would not address concerns regarding longer term financial viability.

Staffing Levels

Issues with access to dental services are likely to be compounded if staffing levels within dental services cannot be maintained. Significant concerns were also raised around the recruitment and retention of staff in both general dental practice and the PDS. Despite a number of benefits described by GDPs working in the Borders including higher remuneration, well established dental lists, lower costs of living and pleasant surroundings, dentists seem reluctant to consider a post in a more rural area.

One of the measures to increase the availability of dentists following publication of the 2005 Dental Action Plan[3] was a recruitment drive to encourage dentists from other EU countries to relocate to Scotland. This proved successful at the time and GDPs reported

that while there are often no applicants from within Scotland for associate posts, in the past there have usually been dentists from other parts of the EU who have shown an interest in applying. A marked reduction in applications for posts from EU dentists has been observed since 2016, with significant uncertainties relating to the UK's departure from the EU and its future implications. The ability to recruit dental professionals and measures which can be taken to attract new practitioners to the area will require careful consideration to maintain and build the dental workforce.

Staffing levels can also be challenging where there are high rates of absence or sickness within a team. In GDS this can have a significant financial impact as practices require to take on agency staff to enable them to continue to provide a service. Within PDS, the small size of the team means that absence of one staff member can have a significant impact on the workloads of other members of the team. Robust processes for maintaining resilience and managing absences are necessary to enable services to continue to meet the needs of their patients.

Engagement with GDPs

As independent contractors who are not employed by the Health Board, there was no single forum through which to engage with GDPs to ensure their views were considered as part of the needs assessment. The online questionnaire was felt to be the best option to gather feedback from as wide a range of GDPs as possible, however not all GDPs invited to participate responded and the profile of dentists who did respond does not appear to be representative of the entire GDP workforce in the area.

To ensure that decisions which affect GDPs are acceptable to them it is important to maximise engagement with this group who are the main providers of dental services in the Borders. Opportunities for GDPs to have their voices heard should be made available and they should be encouraged to participate in local networks and to link in with wider groups. Attendance at meetings such as the Area Dental Committee has been noted to have declined in recent years and there is a need to reinvigorate these groups and encourage GDPs to become more involved in shaping decisions which affect their practices.

It was highlighted that during the consultation phase prior to publication of the Scottish Government's Oral Health Improvement Plan[2] that none of the roadshows took place within the Borders. With increasing use of technology, it may be worth considering the possibility of arranging for dental teams in the Borders to link in to such national events via video-conference to ensure that those working in more remote areas are able to feed in their perspective, which may differ from that of a dentist working in a city centre practice, thus ensuring that a full range of views is considered.

Specialist Services

Dental teams were positive about the specialist services available to them in the Borders, though it is clear that the waiting times for oral surgery are an issue. One of the challenges faced by the oral surgeons appears to be the volume and range of referrals being accepted in the department. Clear referral criteria and the possibility of a primary care based oral surgery service, similar to the model for orthodontic care currently in place in the Borders could be considered to help address some of these difficulties. In parallel with this needs assessment a demand management process has been conducted to review the

workload of the oral surgery department and it is hoped that the findings of this needs assessment can help to inform decisions on the future direction for oral surgery services.

Dentists in both PDS and GDS highlighted the lack of NHS specialist restorative dentistry services in the Borders. Although it is possible to refer patients to Edinburgh Dental Institute for restorative care, there was a feeling that referrals are often “bounced back” or that patients are provided with a treatment plan to be delivered by the referring dentist which they do not always feel confident to deliver. There may be a perception that referrals are less likely to be accepted from dentists in the Borders than those working more locally to EDI in NHS Lothian, which is however not the case. The same referral and acceptance criteria apply to all patients whether they are referred from within NHS Lothian or a neighbouring Health Board.

The restorative department in EDI has 3 whole time equivalent consultants serving a population of close to 1.5 million and as a result there are significant demands on the service. Consultants therefore focus on their core responsibilities which include restorative management of trauma, head and neck cancer, cleft lip and palate and patients requiring restorative treatment as part of orthognathic provision. They have a secondary focus on things which can only be provided on the NHS in a secondary care hospital setting such as implant supported prostheses in line with guidelines from the Royal College of Surgeons. Capacity to provide assistance with more general restorative cases is limited, requiring strict referral criteria for the department and while the most complex periodontal, prosthodontic and endodontic cases will be accepted where possible, treatment cannot be offered to all patients referred to the department. There is recognition that GDPs do not always feel confident to deliver treatment plans which have been provided following referral and consultation.

NHS provision of restorative dentistry is under similar pressure across Scotland and to some extent there may be a need to manage expectations of primary care dentists in relation to what treatments can be offered by these services. It is clear however that dentists in the Borders do feel a need for more support and alternative options to support provision of more complex restorative care in the Borders should be explored. The possibility of a local service or network for restorative dentistry could be considered including a potential eGDP model in the future. Lessons can be learned from other areas where local services have been introduced and a key factor will be ensuring that there is clarity around what treatments will and will not be provided with formal referral criteria to manage patient flows.

Surgery Utilisation in BGH

The dental department in BGH consists of three dental surgeries, which are used by oral surgery, orthodontics and the PDS. Space within the department is at a premium with a desire by some services to increase their clinical sessions limited by lack of surgery space. It was identified that some items of treatment currently provided by dental teams in BGH could be safely and effectively delivered in a primary care setting. One solution could be a facilities utilisation review, with appropriate staff engagement, to look at innovative approaches to take some services into a primary care setting, thus reducing pressure within the department.

This is in line with the NHS Borders Clinical Strategy[30] which aims to ensure care is provided out with hospital and in settings closer to patients’ homes. It is also recognised

that delivery of services in a primary care setting can reduce costs and, in the case of dental care, patients receiving treatment will, unless exempt, make a contribution to treatment costs promoting greater equity between patients who have been referred for treatment and those who are offered equivalent treatments by their usual GDP.

Care will be required not to withdraw PDS services completely from BGH as a presence will still be necessary to provide care which cannot be delivered in primary care and to provide adequate cover for inpatients who may develop a dental problem. The ageing population and fact that more people are living longer with chronic conditions should also be taken into consideration as the number of patients who may in future require treatment within a secondary care setting is likely to continue to increase.

Specialist Input to PDS

The consultant orthodontist and both oral surgeons highlighted benefits which a specialist in special care dentistry and in paediatric dentistry could bring to the PDS in terms of expertise in managing more complex patients and items of treatment and in sharing their experience with the wider team to support upskilling across the service. These benefits are also recognised by the PDS leads, however previous attempts to recruit a specialist to PDS in the Borders have been unsuccessful in attracting applicants. Alternative opportunities to link PDS with specialist input may be possible through enhancing existing links with the special care and paediatric dentistry teams in PDS in NHS Lothian.

Prevention

Members of dental teams and members of the public recognise the benefits of promoting good oral health and were positive about current oral health improvement activity, particularly the Childsmile programme. All did however suggest that it would be beneficial for this input to continue beyond primary school age. The oral health improvement team do currently have some input in to health promotion activities in the secondary school setting, usually around the time of P7 transition, however it would be worth exploring opportunities for additional input, while being mindful of the finite resource available to deliver additional oral health improvement activities.

While discussion with clinical teams tended to focus on individual chairside prevention and oral health education, it is recognised that the ability to take action and make the changes which have been recommended depends on the patient's wider circumstances. Oral health promotion has an important role in developing environments which support individuals to take positive steps to improve their oral health. Clinical teams should also be encouraged to recognise challenges which may limit an individual's capacity to take on board preventive advice and aim to offer realistic goals which can be agreed with the patient.

10. Conclusion

Ongoing work is required to ensure all members of the population in the Borders benefit from the best possible standard of oral health.

The high and growing proportion of older adults is expected to introduce new challenges for oral health, both through meeting daily oral care needs and managing additional complexities of providing dental treatment.

Registration and participation with dental services is high, though there remains a significant demand from those wishing to register for NHS dental care. Access to NHS dentistry, particularly in the more remote areas is a concern both to members of the public and to dental professionals. Challenges in recruiting dentists and DCPs has the potential to further impact on availability of dental services and will require careful monitoring.

New models for providing specialist dental care are being developed and have the potential to reduce pressure on current services and increase availability of the range of specialist care offered.

A strategic plan for oral health services in the Borders will be developed to take forward recommendations from this needs assessment to continue to promote and improve oral health and to develop dental services to meet the needs of the local population.

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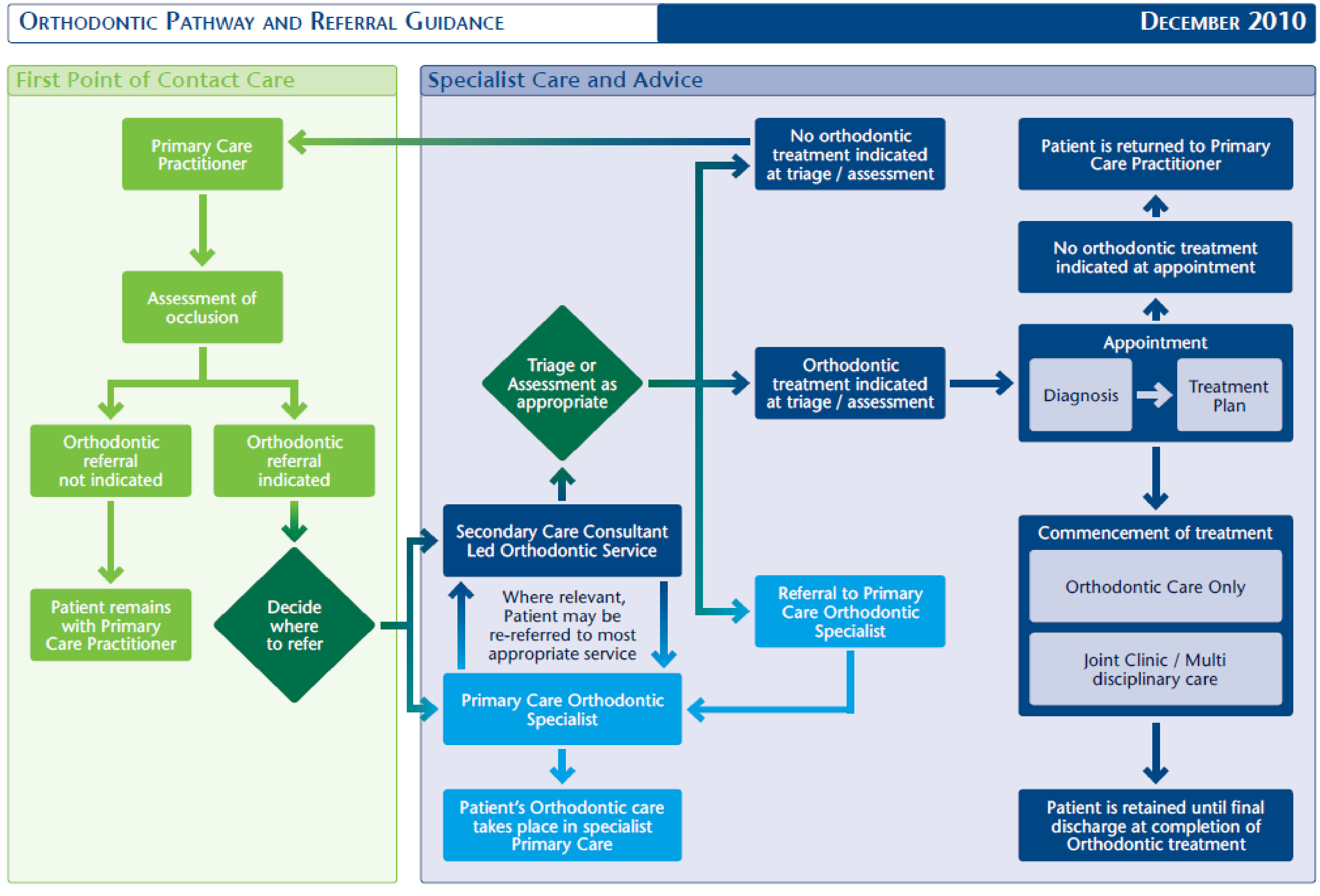
Glossary

ADC	Area Dental Committee
BEDS	Borders Emergency Dental Service
BGH	Borders General Hospital
Caring for Smiles	National oral health improvement programme for dependent older people
Childsmile	National oral health improvement programme for children
CPD	Continuing Professional Development
DBC	Dental Body Corporate
DCP	Dental Care Professional, includes dental nurses, dental hygienists, hygienist therapists and dental technicians
DEL	Dental Enquiry Line
Dental caries	Tooth decay
Dental registration rate	Proportion of the population registered with an NHS dentist
Domiciliary dental care	Dental care provided in a patient's place of residence including a private dwelling or care home setting
EDDN	Extended Duties Dental Nurse
eGDP	Enhanced Skills General Dental Practitioner
EDI	Edinburgh Dental Institute
Endodontic	Involving root canals within teeth
GDP	General Dental Practitioner
GDS	General Dental Service
GHQ-12	General Health Questionnaire – A 12 question tool to screen for potential mental health conditions
HIS	Healthcare Improvement Scotland
HSCP	Health and Social Care Partnership
Hygienist-therapist	Dental Care Professional who provides items of clinical care including periodontal treatments, fillings and extraction of deciduous teeth
ISD	Information Services Division
NDIP	National Dental Inspection Programme
NHSBSA	NHS England Business Services Agency
OHIP	Oral Health Improvement Plan
OHSW	Oral Health Support Worker (also known as Dental Health Support Workers)
OMFS	Oral and Maxillo-Facial Surgery
Open Wide	National oral health improvement programme for adults with additional care needs
PDS	Public Dental Service
Participation	Proportion of patients registered with an NHS dentist who have attended within the previous 2 years
Periodontal	Relating to gums and supporting tissues around the tooth
PRG	Patient Representative Group
Prosthodontic	Relating to replacement of teeth by dentures or dental implants
Restorative Dentistry	Dental Specialty concerned with restoring teeth to function, includes periodontal, prosthodontic and endodontic treatment
SIMD	Scottish Index of Multiple Deprivation
WEMBS	Warwick Edinburgh Mental Wellbeing Scale
VDP	Vocational Dental Practitioner

Appendix 1 – Orthodontic Referral Pathway



ORTHODONTIC REFERRAL MANAGEMENT TABLE

This referral management table can be used as a basis for discussions for agreement at local level.

Presenting Condition	Main presenting problem	Referral not indicated	Refer to Specialist Practice	Refer to Hospital
Canines	Not palpable buccally 10+ years		*	
	Palatally placed on radiographs		*	*
	Cs retained, not mobile 11+ years		*	*
Cleft lip and palate and syndromes				*
Crowding	Crowding in mixed dentition	*		
Crowding in permanent dentition	Mild crowding, little significant aesthetic detriment	*		
	Mild crowding, significant aesthetic detriment		*	
	Moderate or severe crowding		*	
Hypodontia (ignore 8's)	One buccal tooth missing per quadrant		*	
	More than one tooth missing per quadrant			*
Incisor Crossbite	1 or 2 permanent incisor teeth in crossbite		*	
	3 or 4 permanent incisor teeth in crossbite		*	*
	Posterior crossbites		*	
Increased Overjet	Overjet under 6mm at any age	*		
	Overjet 6-9mm 10+ years		*	
	Overjet over 9mm 10+ years		*	*
Medical history or management issues complicating treatment		*		*
Overbite	Overbite traumatic to tissues, or open bite >3mm		*	
Problems likely to need specialist surgical or restorative care				*

This table is based on work originally developed by NHS Grampian (2009) (Modified NHS Borders, 2013)

Appendix 2 – Child Was Not Brought Policy

Title	CNB - Child Not brought
Document Type	Policy
Issue no	*DEN002/001*
Issue date	30.05.13 (DNA policy) 20.12.16 (revised)
Updated	14.07.19
Review date	14.07.21
Distribution	Dental Staff Team
Prepared by	Children's Dental Needs Steering Group
Developed by	Children's Dental Needs Steering Group
Equality & Diversity Impact Assessed	Completed 21 April 2015 Reviewed and updated 14 March 2016

Children and Young People aged 0-18 years
CNB (Child Not Brought) Policy for NHS Borders Public Dental Service

The GIRFEC values and principles must be at the forefront of all interactions regarding the wellbeing of a child. While this CNB policy is designed as guidance for administration staff, it must be remembered that it is the whole dental team's responsibility to work together in the best interests of each child.

The R4 Marker system must be used for all children and young people registered within PDS in addition to text messaging, which indicates who needs a phone call reminder on the day or day before the appointment. All communication must be documented in Comms (Communications tab in R4).

Marker 2+1: All children and young people with a history of vulnerability and or poor dental attendance who should receive a call on day before or day of appointment. Any barriers to access should be noted and a referral made to Childsmile Practice if additional support needed to ensure future attendance.

Marker 2: All other children and young people.

0-5 year olds and primary school age children

If Child is not brought for 1st exam appointment a member of the admin team will attempt to make contact with parent/guardian by phone during the working day. If no contact is made with this first call, a first CNB letter will be sent out, if no response to first CNB letter, a second CNB letter will be sent 2 weeks later and the child put on a 6 month recall.

On the day of the first missed appointment for treatment a member of the admin team will attempt to make contact with parent/guardian by phone during the working day. If no contact is made with this first call, a first CNB letter will be sent out, if no response to first CNB letter, a second CNB letter will be sent 2 weeks later indicating that all future appointments will be cancelled and a referral made to Childsmile via the generic e-mail box.

If a child does not attend for 2 appointments, whether consecutive or not, or if there is a pattern of non attendance, a Childsmile referral should be completed by admin and sent to the Childsmile generic e-mail inbox, cc to the clinician responsible.

A Childsmile OHSW will respond to any referral within approx 1 month by noting all contact made in R4 Patient Comms and HIC, OHSW will also record on EMIS. If no contact has been possible an email will be sent from the OHSW to the clinician (cc admin notifying them this has been done). This ensures that any concerns regarding the patient's treatment needs will be reported to the Children and Families Social Work duty team by the clinician if deemed necessary.

Any Child referred to PDS from Childsmile who is not brought to appointments should be referred back to Childsmile.

Secondary school children and young people up to age of 18

Where possible, all correspondence for secondary school aged children or young people should be directly with the young person i.e. letter addressed directly to young person, phoning or texting a personal mobile phone number, If no contact details are available for the young person directly, then use their parent/guardian's contact details.

If a young person is not brought/fails to attend for 1st exam appointment a member of the admin team will attempt to make contact by phone with the young person or parent/guardian. If no contact is made with this first call, a first CNB letter will be sent out. If no response to first CNB letter a second CNB letter will be sent 2 weeks later and the young person will be put on a 6 month recall.

On the day of the first missed appointment for treatment a member of the admin team will attempt to make contact with the young person or parent/guardian by phone. If no contact is made with this first call, a first CNB letter will be sent out 2 weeks later indicating that a referral will be made to the staff member responsible for secondary schools and all future appointments will be cancelled.

If a young person does not attend for 2 appointments, whether consecutive or not, or if there is a pattern of non attendance, a referral should be completed and sent to the staff member responsible for secondary schools (cc to the clinician responsible).

The staff member responsible for secondary schools will respond to any referral within approx 1 month by noting all contact made in R4 Patient Comms. If no contact has been possible an email will be sent to the clinician (cc to admin notifying them this has been done). This ensures that any concerns regarding the patient's treatment needs will be reported to the Children and Families Social Work duty team by the clinician if deemed necessary.

All children and young people aged 0-18 years

If the clinic is unable to make contact by phone, details will be entered on the CNB spreadsheet, which will be reviewed monthly by admin team to ensure all appropriate action has been taken regarding the child's attendance and that all documentary evidence is in the R4 notes, this will support and evidence all contact made by the PDS ensuring the child/young person does not fall through the safety net.

After 6 months and 12 months a letter will be sent inviting the young person or their parent/guardian to contact the clinic to make an appointment. If the young person or parent/guardian does not make contact, no further letter will be sent or contact made, though the child/young person will remain registered and able to access dental care until they are 18.

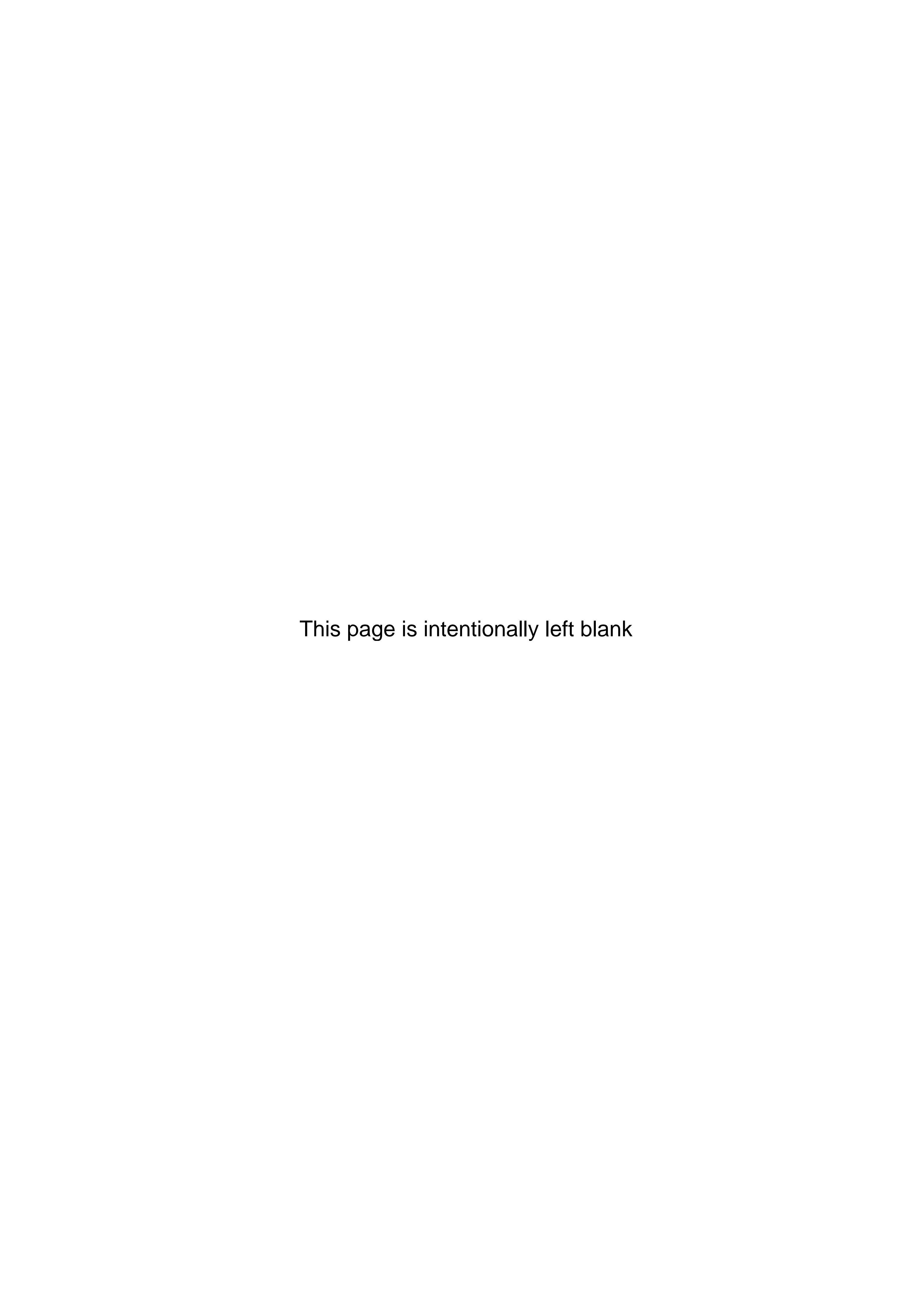
When the child/young person reaches the age of 18, a letter will be sent to them asking if they still wish to be registered with our service, and if so, to contact the dental clinic. If they do not contact us, they will be de-registered, and removed from the child not

brought spreadsheet.

Practitioner Services will inform the Public Dental Service (through the dentist's monthly schedule) if a child or young person becomes registered elsewhere, when picked up this must be noted on R4.

All dental team members must log every attempt to contact patients on R4 Comms - this supports chronologies outlining support given, should there be a need for a child/young person concern meeting.

If any child referred into the Public Dental service from a General Dental Practitioner does not attend their appointment they should be referred back to the referrer by a member of the admin team, any appeal on this action would be given consideration on a basis of individual need.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Scottish Borders Health & Social Care Integration Joint Board

Meeting Date: *2 March 2022*

Report By:	*Simon Burt, General Manager MH&LD*
Contact:	*Philip Grieve*
Telephone:	*01896 827152*
MILLAR HOUSE BUSINESS CASE	
Purpose of Report:	The purpose of the Business Case is to set out the rationale for evidenced benefits of and investment requirements / potential efficiencies relating to the proposed move of current core and cluster patients from accommodation in Galashiels to the bungalows at Millar House (Melrose) as part of the Mental Health Transformation programme. The risks of proceeding and of maintaining a status quo will be covered in this paper on Phase One. Aligned with Phase Two, the Business Case will describe the introduction of a Grade 5 supported accommodation facility as defined as “Intensive community rehabilitation providing earlier discharge from Grade 6 or alternative to admission. It is envisaged the staff team will consist of Health (inclusive of sessional medic), Social Care & Third Sector staff with 24 hour cover which will be based in Millar House.
Recommendations:	The Health & Social Care Integration Joint Board is asked to: • Agree this Business Case and the draft IJB Directions set out below: The IJB are being asked to Direct NHS Borders and Scottish Borders Council to Commission the Community Rehabilitation Service set out in the Millar House Business Case submitted on 2nd March 2022 (subject to Eildon HA Board approval to lease the Millar House site and accommodation to the commissioned service provider Carr Gom).
Personnel:	There will be a reduction in Health Board staffing due to the reduction in beds from 12 – 10. Partnership and staff have been communicated with. The relevant HR processes will be followed.
Carers:	This project will have a positive impact on carers as it will allow the repatriation of patients to the Borders and reduce the length of stay in hospital. An Equalities Impact Assessment has been completed.
Equalities:	An Equalities Impact Assessment has been completed.
Financial:	The new proposed model requires additional investment from both

Number	Risk	Level	Mitigation

	NHS Borders and SBC totalling circa £0.256m. However with the targeted efficiencies of circa £0.543m there is a potential net efficiency of circa £0.287m pa. Of the targeted efficiencies, we have a high level of confidence that 3 of the 4 efficiencies will be achieved with a 4th rated as likely (amber) in approximately 12 months' time (£0.195m). Additional savings may be forthcoming if: the bed base reduces in East Brig from 10 – 8 following review allowing for a further reduction in inpatient staffing; and the void costs can be absorbed within the rental income (circa £0.050m pa). There will be a small non-recurring upfront capital cost of circa £0.008m.
Legal:	Relevant legal contractual compliances will be adhered to
Risk Implications:	.
Direction required:	The IJB are being asked to Direct NHS Borders and Scottish Borders Council to Commission the Community Rehabilitation Service set out in the Millar House Business Case submitted on 2nd March 2022 (subject to Eildon HA Board and the Scottish Housing Regulatorapproval to lease the Millar House site and accommodation to the commissioned service provider Carr Gomm).

Risk 1	By remaining in Galashiels, we will have patients in accommodation that has been deemed not fit for purpose; increased likelihood of poor mental health outcomes for patients; potential for negative publicity; and will miss the opportunity to secure the improved accommodation when there are no available alternatives.	Possible Major High (12)	Currently no available alternatives
Risk 2	Clinical risk, seeking to house complex patients	Unlikely Moderate Medium (6)	Robust clinical and risk assessment processes commensurate to clinical picture e.g. for level 6 patients; ensure staff have up-to-date training to carry out assessments and regular reviews based on clinical guidance; building work thoroughly assessed and monitored to minimise physical risk factors
Risk 3	Community tolerance	Possible Major High (12)	Community engagement/allies/peer support/ lessons from Carr Gomm and Eildon elsewhere. Previous use was for social care housing
Risk 4	Eildon say no to the Business Case proposal	Unlikely Major Medium (8)	Currently no available alternatives
Risk 5	Reduction to access community services	Possible Minor Medium (6)	Build into recovery model
Risk 6	Contact with family and friends	Possible Minor Medium (6)	Preparation, information, practical support, and build into recovery model
Risk 7	Current position is a snap shot based on current provision however unable to forecast future demand	Possible Major High (12)	If proposal progresses and is established there will be close monitoring of activity. To mitigate void costs and ensure capacity we will retain access for general adult patients to use cluster accommodation which will also mitigate void costs Historical OOA ECR placements indicate 2 per year
Risk 8	Reduction in In-patient beds	Possible Major High	Reduction of Inpatient beds may have implications across wider in-patient footprint and a robust review of speciality and criteria should progress with governance and review

			of age range and where best patients should be cared for. DOCA indicates average of 9/12 of beds occupied.
Risk 9	Potential difficulties in recruitment to staff grade 5 accommodation	Possible major high	There may be a risk that we cannot recruit to posts within grade 5 accommodation and would need to consider alternative positions to support project

Millar House, Melrose

NHS Borders Community Rehabilitation Team (CRT)supported accommodation in core cluster – Phase One and
Introduce a Grade 5 supported accommodation as defined as "Intensive community rehabilitation providing earlier discharge from Grade 6 or alternative to admission" – Phase Two

Business Case

Version:	2.0
Date:	19th February 2022
Author:	Philip Grieve (Service Manager)
	Community Rehabilitation Team,
Owner:	Mental Health Transformational Programme

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Purpose

The purpose of the Business Case is to set out the rationale for evidenced benefits of and investment requirements / potential efficiencies relating to the proposed move of current core and cluster patients from accommodation in Galashiels to the bungalows at Millar House (Melrose) as part of the Mental Health Transformation programme. The risks of proceeding and of maintaining a status quo will be covered in this paper on Phase One.

Aligned with Phase Two, the Business Case will describe the introduction of a Grade 5 supported accommodation facility as defined as "Intensive community rehabilitation providing earlier discharge from Grade 6 or alternative to admission. It is envisaged the staff team will consist of Health (inclusive of sessional medic), Social Care & Third Sector staff with 24 hour cover which will be based in Millar House.

The Business Case has been through the relevant Health and Social Care Partnership Governance Groups for support and approval.

Rationale for Change

NHS Borders Mental Health Community Rehabilitation Team (CRT) currently has supported accommodation within Galashiels and properties predominately in and around Galashiels, based on a Core and Cluster model. CRT supports adults and older adults with severe and enduring mental illness, mainly schizophrenia and its associated care needs and risks.

The accommodation is supported by a commissioned service provided by Carr Gomm who provides 24 hour support to our service users.

A recent inspection by Scottish Borders Council of the Galashiels accommodation has determined that it is no longer fit for purpose. The service is required to source an alternative and in particular establish a Grade 5 supported accommodation facility that can provide Intensive community rehabilitation.

The over-arching aim is to provide high quality supported accommodation for patients with severe mental illness. Identifying suitable options for establishing a new model of service provision was informed by the following principles:

- Person-centred care;
- Recovery principles;
- High quality multi-disciplinary team care planning.

Additionally, having a suitable environment and being part of a community are essential components to developing the skills people need to live more independently.

Eildon Housing Association currently own Millar House. Millar House is a former sheltered housing development comprising a Grade C listed villa with four flatlets and shared communal facilities, and nine self-contained one-bedroom cottages. Although the development is of a high standard, the design and size of the development created both service delivery and financial challenges. Following completion of an options appraisal, Eildon's Board agreed in December 2019 to decommission the service and support tenants and staff to transfer to other care services managed by Eildon. The sheltered service ended in January 2022.Eildon would like to secure a long term joint working agreement with NHS Borders/Scottish Borders Council over a 10 year period, with the property being leased directly with the care provider, Carr Gomm.
Historical investment in Millar House (which is a listed Victorian house) requires that its future use remains as supported accommodation for vulnerable adults with social care support needs..

Strategic Drivers

This project delivers against the National Health and Social Care Outcomes as stated below. The quantitative outcomes listed in this section will be evaluated by seeking the feedback of those with lived experience in each of these areas before (as a baseline) and after implementation of the direction.

National Health and Wellbeing Outcomes
This project meets 8 of the 9 Health and Wellbeing Outcomes (Outcome 6 is not applicable to this project):

1. People are able to look after and improve their own health and wellbeing and live in good health for longer.
2. People, including those with disabilities or long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.
3. People who use health and social care services have positive experiences of those services, and have their dignity respected.
4. Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.
5. Health and social care services contribute to reducing health inequalities.
6. People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and well-being.
7. People who use health and social care services are safe from harm.

8. People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.
9. Resources are used effectively and efficiently in the provision of health and social care services.

Millar House Project Outcomes:

- Improve the quality to patient care and wellbeing
- Significantly improve the current living conditions for those within supported accommodation
- Further enhance re-ablement to a marginalised population of patients
- Reduce the length of stay and in turn reduce costs for patients placed out of area and allow timely repatriation
- Reduce the reliance on the inpatient care and treatment
- Reduce the costs to Health and Social Care budgets

Benefits

Summary of the benefits in delivering phase one; relocation from Galashiels and phase two the introduction of Grade 5 supported Accommodation at Millar House, Melrose:		
Safer	• Millar house is situated in a quieter and more pleasant location and supports implementation of the Wayfinder model (Grade 5 supports independent living - see appendix 10, page 21)	
Effective	• Currently the Galashiels accommodation is no longer fit for purpose (see SBAR in appendix 1, page 21)being of poor quality and not conducive to a homely or therapeutic setting. • The ability to respond to the outcomes from the Day of Care Audit which found that a number of individuals accommodated within the current in-patient model in Galashiels were in a less-than-appropriate care setting. • Similarly, there are currently individuals who currently cannot be cared for in the Scottish Borders due to a lack of appropriate provision and as a result are placed in expensive specialist hospital settings. • Evidenced benefits delivered elsewhere:Financial analysis of Tower Hamlets supported accommodation which has a similar model to our proposed model: • ▪ Improved outcomes for individuals ▪ Avoided costs and freed up hospital demand	

	▪ Lower comparative costs (refer to link in appendix 2, page 21 for full report)	
Efficient	Millar House and surrounding bungalows will home patients in Grade4 and 5 accommodations as part of the Mental Health Transformation programme. • Key benefits that are expected to be derived: More cost effective with better outcomes for individuals accommodated • Employment of a re-ablement approach • Greater ability for individuals to build resilience and independence • A reduction in the requirement for Inpatient ward beds • Phase 2will support an improved timeous return of out of area placements. *Reference Tower Hamlet – Financial analysis of Tower Hamlets supported accommodation which has a similar model to our proposed model.* • The potential ability to reduce the more expensive requirement to provide care and support to individuals in a Grade 7 setting (generally out of area specialist hospital placement) or Grade 6 setting (in-patient setting within the Scottish Borders e.g. East Brig).	
Equitable	• Consultation with those currently accessing support in Galashiels to seek their views on moving to alternative accommodation. This was achieved by commissioning Borders Independent Advocacy Service (BIAS) to assist in the completion of questionnaires.*(ref to questionnaire in appendix 3, page 21)* • The proposal is a service development that will increase both overall capacity and enable care to be provided across a range of individuals with wider mental health needs i.e. Millar House will accommodate more patients in area and with differing needs.	
Timely	• Millar House and its associated bungalow provision within its grounds fits the required Wayfinder level of support model and will be available within the necessary timeframe. • Increasing the footprint of the accommodation available within the Scottish Borders and the ability to offer shorter waiting times and timelier access to the service will ensure more appropriate and responsive care provision. • Future proofing (see appendix 8, page 21) and in particular, increasing community capacity in order to meet current and future levels of demand.	

Patient - centred	• A more suitable and therapeutic environment. • Supportive of a more recovery-focused approach, promoting re-ablement. Designated Occupational Therapist and Nursing care would be included in the staffing complement improving options for individualised care planning and key worker involvement. • Positive feedback from patients regarding the proposed move from the current model to Millar House*(refer to appendix 3, page 21)*	

Also refer to Health Inequalities Impact Assessment (HIIA) document in the appendix 11 (Page 21).

Risks

Tabled below:

Number	Risk	Level	Mitigation
Risk 1	By remaining in Galashiels, we will have patients in accommodation that has been deemed not fit for purpose; increased likelihood of poor mental health outcomes for patients; potential for negative publicity; and will miss the opportunity to secure the improved accommodation when there are no available alternatives.	Possible Major High (12)	Currently no available alternatives
Risk 2	Clinical risk, seeking to house complex patients	Unlikely Moderate Medium (6)	Robust clinical and risk assessment processes commensurate to clinical picture e.g. for level 6 patients; ensure staff have up-to-date training to carry out assessments and regular reviews based on clinical guidance; building work thoroughly assessed and monitored to minimise physical risk factors

Risk 3	Community tolerance	Possible Major High (12)	Community engagement/allies/peer support/ lessons from Carr Gomm and Eildon elsewhere. Previous use was for social care housing
Risk 4	Eildon say no to the Business Case proposal	Unlikely Major Medium (8)	Currently no available alternatives
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Risk 8	Reduction in In-patient beds	Possible Major High	Reduction of Inpatient beds may have implications across wider in-patient footprint and a robust review of speciality and criteria should progress with governance and review

			of age range and where best patients should be cared for. DOCA indicates average of 9/12 of beds occupied.
Risk 9	Potential difficulties in recruitment to staff grade 5 accommodation	Possible major high	There may be a risk that we cannot recruit to posts within grade 5 accommodation and would need to consider alternative positions to support project

Refer to NHS Borders Risk level Matrix in appendix 3, page 21for Levels.

NHS Borders Risk Levels (move to appendix)

Available Options

The existing supported accommodation service has been in place since 2014 and provides accommodation for up to 16 individuals who are supported by the mental health rehabilitation service. The accommodation is split between 5 'core' properties and 11 'cluster' properties all within the town of Galashiels. Care Provision is provided by Carr Gomm. There are however, a number of key issues with the current situation:

1. The 'core' accommodation in Galashiels; this accommodation has been poorly maintained by the current landlord and is sub optimal for individuals to live in

2. Some of the 'cluster' properties are also in a state of poor repair

3. It is proposed to extend the current contract with Carr Gomm for a further 3 years to support the move from the Galashiels accommodation to Millar House with the introduction of grade 5 supported accommodation.

4. An options appraisal for the transformation of mental health services delivered a preferred option of reducing in-patient Rehabilitation Unit beds whilst creating additional, more intensive supported accommodation elsewhere. This will require a change to the current supported accommodation service model which would see individuals with more complex needs cared for in a community setting rather than in a NHS hospital.

A **DOCA+**(day of care audit) exercise was carried out in October 2019 looking at patients in mental health service beds in Lindean, East Brig and Huntlyburn House. The purpose was to assess which patients at that date would be able to receive care in a non-hospital setting, and what services would be required to achieve this.

The findings suggested that five of the eleven patients in East Brig at the time the DOCA+ exercise took place were suitable for an alternative place of care(see below table).One such alternative place of care was to introduce grade 5 level supported accommodation which NHS Borders currently cannot provide. This proposed provision would allow flexibility within the whole system and allow some of the Out of Area placements to be repatriated back to the Borders as step down care.

Refer to appendix 5, page 21 for full report.

Tuesday 22nd October (Lindean, East Brig and Huntlyburn) Data				
Alternative Place of Care	**Lindean**	**East Brig**	**Huntlyburn**	**Grand Total**
A. Discharge home	1	1		2
B. Discharge home with social support (mental health social support)	1			1
C. Discharge home with adaptations/equipment		1		1
E. Discharge home with increased package of care with daily support from crisis or CRT	1	1	1	3
F. Discharge home with short-term enhanced - Other please specify..........			2	2
L. Discharge to Nursing Home		1	1	2
M. Discharge to Specialist Nursing Home – please specify type (dementia, neurological etc)	1		1	2
P. Requires Level 5 assisiterd lining accomodation		1		1
TOTAL	4	5	5	14

Bed occupancy data for East Brig has been gathered for the past 3 years and shows an average of 9 beds are occupied. This supports thenew model proposal and the introduction of grade 5 supported accommodation.
(refer to appendix 6, page 21 for data and step down flow chart)

Out of Area Placements
NHS Borders currently has 2 Out of Area Patients who form part of the cohort who potentially can be accommodated within the new proposal. The Community Rehab Team (CRT)is looking to repatriate both patients back to the Borders, one within the next 3 months to East Brig for initial assessment then step down to Grade 5 and one within the next 12 months.

Assumptions

- The new proposed model will reduce the length of stay of patients who are placed out of area with the ability to deliver potential efficiency savings – Refer to Tower Hamlets The financial case for integrated mental health services and supported housing pathwaysappendix2, page 21.
- One community placement to repatriate back to the Borders to grade 4 accommodation and support.

Options explored:

Options for Phase One		
Galashiels Accommodation (Galashiels) Status Quo	Millar House Bungalows(Melrose) Preferred Option	Botany Mill (Galashiels) Not suitable
• The building is no longer fit for purpose Both internal and external building defects have been identified.	• Proposed alternative (have been looking for a solution over the past 2 years)	▪ Early work took place in designing the property to house both core and cluster accommodation on the one site. This led to further thinking of expanding the project to include a number of hospital beds (east Brig ward) and social enterprise initiatives within the same site.
• This property has been poorly maintained by the current landlord and sub optimal for individuals to live in.	• Full NHS Borders approval and SBAR approval through OPG and Joint NHS/SBC committee. (see appendix 1, page 21)	

Proposed Option

The proposed option is to re-house the core patients within the 9 bungalows based at Millar House in Melrose.

Based on the site visit from the core group, feedback from a carer's representative and from service users via the questionnaires, it was determined that we had found a suitable site for relocation from the Galashiels accommodation. This will be considered as Phase 1.
(refer to patient questionnaires in appendix 3, page 21)

Phase 2 of the plan is to introduce Grade 5 supported accommodation as defined as

"Intensive community rehabilitation providing earlier discharge from Grade 6 or alternative to admission. Team consisting of Health (inclusive of sessional medic), Social Care & Third Sector staff 24 hour staffing." The plan would see the main house with the 4 flatlets enhanced to Grade 5 supported accommodation. This will reduce the bed compliment within East Brig at Galavale by 2 beds initially with a review in 1 years' time to potentially further reduce the bed compliment by a further 2. A workforce review has taken place and we will be reducing staffing resources to allow re-investment in staffing supporting the Grade 5 accommodation (following HR processes). This would include recruitment to a Band 6 registered nurse post and Band 6 Occupational Therapist post with on-going support from the Community Rehabilitation Team. A further workforce review will take place after the first year when we will be considering a further reduction in beds to 8.

A table top exercise took place with representation from CRT, nursing staff and Carr Gomm (care provider), at which they completed an extensive review of each patient currently in core and cluster plus Inpatient and Out of Area / community placements to determine the most appropriate level of support and suitable accommodation.

The following assumptions were made:

- Potential 8 patients identified to move into Millar House bungalows
- Potential 4 patients identified to move into Millar House – grade 5
- Potential 8/11 (cluster) patients to continue with visiting support total 75 hours per week (less than current model)
- 1 community and 1 out of area placements to bring back to the borders within the next 6 months (1 x bungalow grade 4 &1x grade 5) with 1 further out of area placement to return in approximately 12 months' time(to grade 5 accommodation following step down from East Brigs)
- 2 patients step down from East Brig to grade 4 & 5 accommodation

The below table details the current and proposed model:

Current Model				
Core	Cluster	East Brig Inpatient Ward		TOTAL
5 flats co-located at Galashiels (private landlord) Plus Carr Gomm (service provider) base/office	11 private flats (Various locations in Galashiels – private landlords)	12 beds Based in Galashiels – Tweed Road		28
Wayfinder model 4	Wayfinder model 3	Wayfinder model 6		
Proposed Model				

Core	Community Support	East Brig Inpatient Ward	Millar House – grade 5 accommodation	TOTAL
9 Individual Bungalows based at Millar House, Melrose ** Assumption 5 fromGalashiels plus 4 from private landlord/other*	8 private flats (Various locations in Galashiels and differing support hours)	10 beds	4 flatlets Level of support – x1 staff waking night Plus Carr Gommbase/office	31
Wayfinder model 4	Wayfinder model 3	Wayfinder model 6	Wayfinder model 5	

Assumptions:

- Introducing grade 5 supported accommodation.
- Implementation will be a stepped person-centre approach.
- With the introduction of Grade 5 supported accommodation. Additional level of care support will be required and include 10.5 hours of waking night.

When reviewing the current model, there is a requirement for more core supported accommodation to fulfil the unmet need. Refer to appendix 8, page 21.

Refer to Wayfinder Models in appendix 9 and 10, page 21.

Expenditure and Funding Requirement

In order to determine the overall affordability of the proposed model, detailed financial analysis has been undertaken of the 'before' and 'after' scenarios. This will ensure that not only is the potential to improve the daily living environment of individuals and capacity for them to be re-abled is evaluated, but the financial impact of the transformation can be also. A financial summary of the existing model of provision is detailed below:

Existing Provision		
Cost Base:		**£**
Expenditure		
	5 Core Grade 4 @ Douglas Bridge House Flatlets	247,378
	11 Cluster Grade 3 @ Various PSH	
	Carr Gomm Accomodation @ Douglas Bridge	
	Sleepover Cost	36,310
Total Expenditure		**283,688**

Funded by:		
	77% NHS Borders Baseline Funding	218,440
	23% SBC Baseline Funding	65,248
Total Funded by		**283,688**

The current model of provision provides accommodation and care to 16 individuals in Grade 3 and 4 accommodations, 5 within a flatlet facility in Galashiels and 11 in wider community based residential settings. The cost of this provision is £0.284m and is commissioned via a contract between Scottish Borders Council and Carr Gomm. This cost is funded 77% by NHS Borders (£0.218m) and 23% by Scottish Borders Council (£0.065m).

The proposed model of provision offers the opportunity for service development and the ability to accommodate not only more individuals within the model, but to introduce Grade 5 accommodation within the Scottish Borders for the first time.

In order to achieve this however, additional investment is required. The projected cost per annum of the new model is detailed below:

Proposed Provision		
Cost Base:		**£**
Direct Costs:		
	Lease of Millar House	86,400
	Tenancy Lease Agreement between Eildon and Clients	-
	9 Core Grade 4 @ Millar House	328,582
	8 Cluster / Community Visiting @ Various PSH	
	Additional Waking Night Grade 5	
	4 Grade 5 @ Millar House	
	Sleepover Cost	36,310
	Cluster Hours Additional Hours	82,830
	Cluster Visit Travel	15,000
	Void Tenancy Assumption 2/13	50,551
	Additional NHS Borders Staffing	97,296
Total Direct Costs		**696,969**
Direct Costs Funded:		
	77% NHS Borders Baseline Funding	415,725
	23% SBC Baseline Funding	124,178
	Housing Benefit / Tenancy Income to Eildon	86,400
	Factor Voids Cost into Rent of Tenants	50,551
	SLW Living Wage increase - assume SG will fund	20,115
Total Direct Costs Funded		**696,969**

As can be seen from the above, there is a significant additional investment required by the new model although offsetting this requirement is the potential for equally significant efficiency savings and in non-financial terms, improved outcomes for individuals.

The new model of care will now be able to accommodate 21 individuals across both Grade 3 and 4 accommodation, together with the introduction of Grade 5.

The new model of care is projected to cost £0.697m per annum. Maintaining the same cost-sharing arrangement between partners that currently exists will therefore require NHS Borders to increase its contribution to £0.416m (an increase of £0.197m) and an increased Scottish Borders Council contribution of £0.124m (an increase of £0.059m).

Targeted Efficiencies

Whilst delivery of the proposed new model requires additional recurring investment, as a direct consequence of its establishment, there are a significant number of potential efficiency opportunities that will directly offset this marginal cost. If delivered, these will enable not only the proposed model to be affordable overall, but additional cost savings to be made.

Potential Targeted Efficiencies			**Risk**
NHSB	ECR funded Out of Area Placement (1) (Ayre Clinic)	(195,000)	Green
NHSB	ECR funded Out of Area Placement (2) (Ayre Clinic)	(195,000)	Amber
NHSB	Enablement of Reduction in Beds Model at East Brig (2)	(105,033)	Green
SBC	Commissioned Specialist Nursing Home Placement	(47,948)	Green
Total Potential Targeted Efficiencies		**(542,981)**	

Following the additional investment requirements outlined above and the establishment of the new model of care provision, the ability to not only provide more care in more appropriate settings to more individuals but to enable the opportunity for delivery of targeted efficiency savings also, is created.

The potential for efficiency benefits exists across 3 main areas:

1. The repatriation of two individuals currently accommodated in Grade 7 specialist hospital accommodation
    - Currently there are two individuals accommodated within Ayre Clinic. Individual 1 would have a planned discharge to the Scottish Borders in March 2022, followed by a short-stay within East Brig hospital before transfer to Grade 5 accommodation within Millar House – Delivery Risk: Green
    - The situation with Individual 2 is more complex, but a planned discharge to the Scottish Borders before March 2023, followed by a short-stay within East Brig hospital before transfer to Grade 5 accommodation within Millar House – Delivery Risk: Amber

2. A reduction in the bed capacity within Grade 6 East Brig hospital in line with the DOCA+ findings

- Planned reduction from 12 in-patient beds to 10, enabling a smaller clinical staffing model to be implemented – Delivery Risk - Green

3. The ability to end a specialist nursing home social care contract for one individual
    - Individual accommodated within Whim Hall receiving specialist nursing care could be accommodated within Millar House as soon as facility becomes available – Delivery Risk: Green

It is projected that if delivered in full, in total there is the ability to reduce expenditure across each of the above 3 areas by £0.543m. When compared to the additional investment requirement of £0.256m, this opportunity is attractive enabling significant cost-avoidance, cashable saving or the ability to redirect resource in a targeted way elsewhere within care pathways.

Additional Contribution Required NHSB	**197,286**
Additional Contribution Required SBC	**58,929**
Additional Contribution Required Total	**256,215**

Potential Targeted Efficiencies NHSB	**(495,033)**
Potential Targeted Efficiencies SBC	**(47,948)**
Potential Targeted Efficiencies Total	**(542,981)**

In summary therefore, should each component element of the proposal be delivered in full, NHS Borders (across both delegated and non-delegated functions) could achieve a net efficiency benefit of £0.298m. Scottish Borders Council will require net additional investment to be made of £0.011m in order to increase the capacity of the care model and achieve the ability to accommodate individuals in Grade 5 accommodation settings.

Net Costs / (Benefit) NHSB	**(297,747)**
Net Costs SBC / (Benefit) SBC	**10,981**
Net Costs SBC / (Benefit) Total	**(286,766)**

Other Relevant Financial Factors

The NHS Borders Commissioning budget, from where the 2 individuals currently placed in specialist hospital settings are currently funded from, is not, unlike other Mental Health budgets, delegated to the Health and Social Care Partnership. Within this budget however, one individual is funded and therefore progression of the proposal would enable a direct cashable efficiency saving within the Commissioning budget. The placement of the other individual however is currently a cost pressure within the budget and whilst repatriation of this individual would result in direct cost avoidance, it is unlikely that budget could be retracted and the efficiency saving cashable.

There is also likely to be a small up-front capital investment requirement in order to equip the units with the required alarms network. This could take the form of capital grant to Eildon Housing, the landlord of the property and is estimated to cost £0.008m.

Projected Capital Requirement (Non-Recurring)	8,000

As the existing Carr Gomm contract has an historical funding split as detailed earlier in this paper, there is a pressing need for the Health and Social Care Partnership to agree a means and process for funding the health and social care aspects of service provision.

Executive Summary

The Business case has been compiled from the project steering group meetings.

Governance / Reporting:a monthly Highlight report is completed which feeds into the Mental Health Transformation Programme.

The Community Rehabilitation Team care for patients within the Scottish Borders who are described as having a severe and enduring mental health disorder, including psychosis, schizophrenia and Bipolar Disorder. The service commissions Carr Gomm a third sector care service to provide on-going support and care within supported accommodation situated within Galashiels. They also provide care support to those in their own tenancy predominantly within the Galashiels area and are described as a core and cluster model of support.

A recent review of the Galashielsaccommodationhas deemed the environment no longer fit for purpose and alternative accommodation is required to be sourced. Working closely with Eildon Housing and Carr Gomm, Millar House in Melrose was identified as an improved option and is which this business case is based upon. Indeed this is the only viable alternative accommodation option that has been identified.

The service has taken the opportunity to review the overall care provision and developed an improved model of care by introducing a grade 5 level of accommodation as part of the overall core and cluster model. This is closely based upon the Wayfinder rehabilitation model delivered in Edinburgh and the Tower Hamlet model both referenced within this business case. This improved model will provide us with a graded and integrated health and social care rehabilitation pathway. Grade 5 level accommodation supports individuals requiring enhanced support but do not require the level of support from an inpatient perspective. At present there is no alternative options other than to admit to our local inpatient facility or to expensive specialist out of area hospital beds.

Through modelling we have determined that we can progress to reduce the footfall of our in-patient bed compliment by 2 initially within the first year of the project and following review, it may be possible to further reduce this by another 2 beds in year 2 thus reducing the overall bed compliment from 12 beds to 8. This is in keeping with the national work conducted by Health Improvement Scotland – Reducing Reliance on Adult Mental Health Inpatient Care Pathfinder Programme, in which this project is involved.

On average we require to source 2 specialist out of area placements per year incurring significant cost to the health and social care partnership. With the introduction of the grade 5 accommodation we anticipate that we will be able to reduce the length of stay of these patients within these specialist areas, reducing overall cost. This is supported by the Tower Hamlet model (refer to link in appendix 2, page 21 “Avoided costs through avoided hospital stays”, “Avoided costs through reduced readmission rates” and “Cost efficiencies compared to NHS hospital wards”).

Finance

The current model of care requires increased investment of approximately £0.256m split between NHS Borders (77%) and SBC (23%).

However with the targeted efficiencies of circa £0.543m there is a potential net efficiency of circa £0.287m pa. Of the targeted efficiencies, we have a high level of confidence that 3 of the 4 efficiencies will be achieved with a 4th rated as likely (amber) in approximately 12 months’ time (£0.195m). Additional savings may be forthcoming if: the bed base reduces in East Brig from 10 – 8 following review allowing for a further reduction in inpatient staffing; and the void costs can be absorbed within the rental income (circa £0.050m pa).

There will be a small non-recurring upfront capital cost of circa £0.008m.

Summary

This business case therefore provides the Health and Social Care Partnership with the opportunity to deliver an enhanced model of integrated community rehabilitation for this client group at an overall reduced cost delivering the projects overall aims which are to:

- Improve the quality to patient care and wellbeing
- Significantly improve the current living conditions for those within supported accommodation
- Further enhance re-ablement to a marginalised population of patients
- Reduce the length of stay and in turn reduce costs for patients placed out of area and allow timely repatriation
- Reduce the reliance on the inpatient care and treatment
- Reduce the costs to Health and Social Care budgets.

Who has been involved / engaged in developing the project to date?
Suzy Asquith Community Rehab Team (CRT), *Team manager* Julie Waddell *Planning and commissioning SBC* Dr Joanna Bredski*Consultant Psychiatrist NHS* Amanda Miller *Eildon Manager* Karen Law *SBC contracts* RhonaMcGilp Carr GommManager (support provider in core and cluster) Philip Grieve *Service Manager Mental Health*

Bias – Advocacy service – supported patient with lived experience feedback (neutral) Carer representative Simon Burt *Joint Manager JLDS + General Manager Mental Health Services* Paul McMenamin*DD of Finance - Business Partner (IJB Services)* Gina Allen Project Manager Gillian Lewis *Carr GommOperations Manager* Lisa Clark *Clinical Nurse Manager* Gillian Myatt *Senior Charge Nurse* (East/West Brig) Local Communications Team John Yallop – SBC Finance Martyn Housecroft – SBC finance Amanda Miller – Eildon HA

Recommendations

- Approval to proceed to implement phase oneto move patients to Millar House Bungalows and phase two to Introduce Grade 5 supported accommodation at Millar House. (Please refer to proposed model on page 9)
- Support a phased person-centred implementation approach.

The Health and Social Care Parnership to agree a means and process for funding the health and social care aspects of service provision.

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Document version control

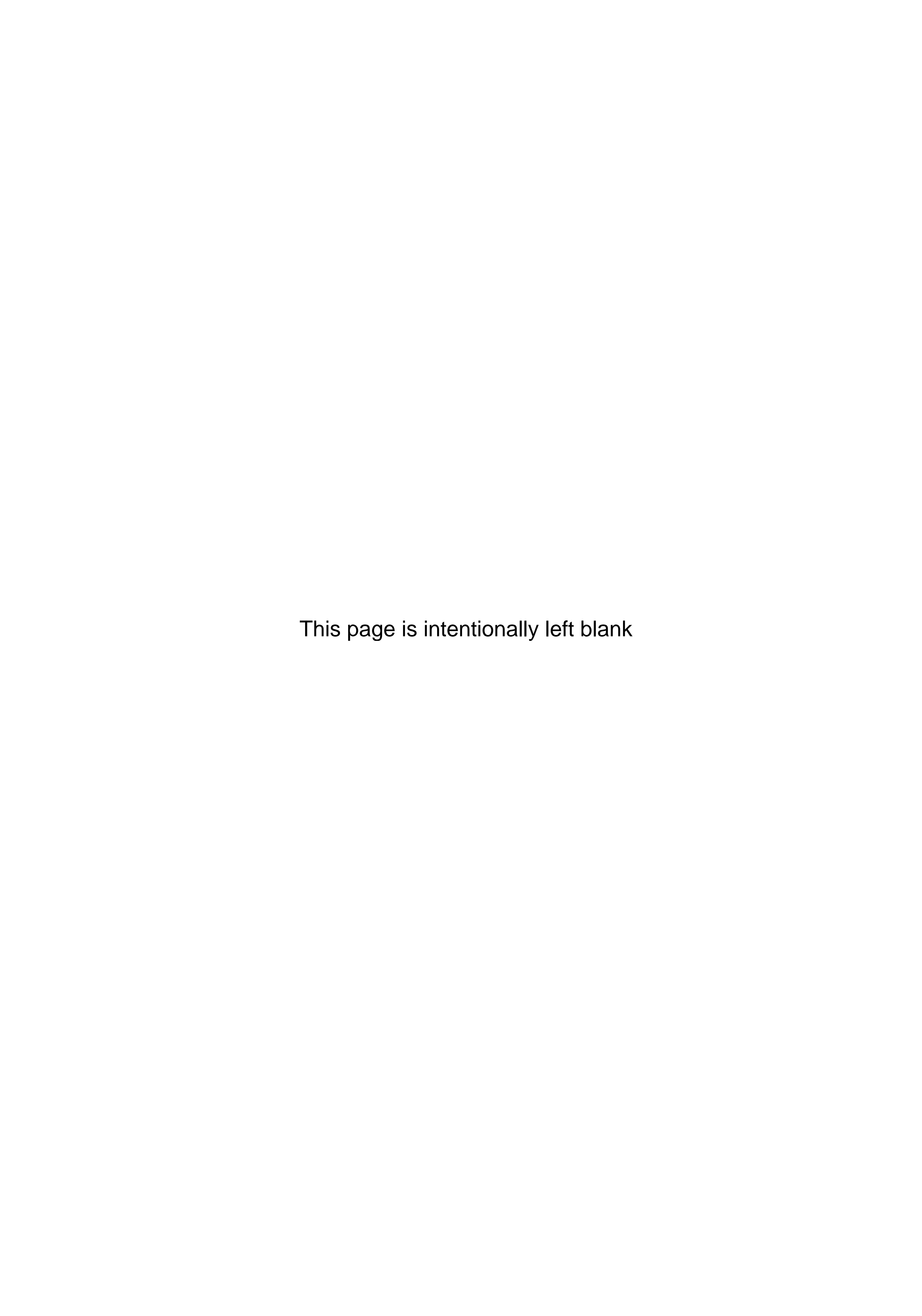
Version	Date	Summary of Changes	Name	Changes Marked
V1.1	September 2021	First Draft		
V1.2	November 2021	Comments from Julie Waddell		
V1.3	December 2021	Changes after steering group meeting		
V1.4	January 2022	Add financial section		
V1.5	January 2022	Steering group review		
V1.6	January 2022	Revise financial schedule – to include living wage uplift		
V1.7	February 2022	Additional comments		
V1.8	February 2022	Amend financial layout. Added capital in finance section		
V1.9	February	Add paragraph to		

	2022	Rationale for Change		
V2.0	February 2022	Amend Financial layout and investment allocation		
V3.0	February 2022	Proof reading		
V3.1	Feb 2022	Further amendment re future health and social care funding methodology		
V3.2	Feb 2022	Insert National H&SC outcomes		
V3.3	Feb 2022	Inserted updated financials agreed by NHS/SBC		

Appendices

1. Millar House SBAR	Millar House Melrose SBAR.docx
2. Tower Hamlet Full Report	https://www.housinglin.org.uk/_assets/Resources/Housing/OtherOrganisation/ReortedHousing.pdf
3. Patient Questionnaires	Questionnaires.pdf
4. Risk Matrix	Risk Level Matrix.docx
5. DOCA+ Results	2019_October MH Rehab Audit Summar
6. East Brig Bed Occupancy Data	2021-10-21 East Brig Occupancy.xlsx
7. Step down flow chart	Mental Health CRT Flow Chart.docx
8. Referral data from Carr Gomm	Referral Data Core & Cluster 2021.docx

9. Wayfinder PSP Model - Overview of Thresholds	Wayfinder thresholds.pdf
10. Overview of Wayfinder Graded Support Model and standardised assessments	Wayfinder Partnership Summary
11. Health Inequalities Impact Assessment (HIIA)	HIIA Millar House V2.docx
12. Cost and Funding schedule workings	Cost and Funding schedule workings v2
13. Out of Area Placement Data	MH Placement Activity (2014 onwarc



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DIRECTION FROM THE SCOTTISH BORDERS INTEGRATION JOINT BOARD
Direction issued under S26-28 of the Public Bodies (Joint Working) (Scotland) Act 2014

Reference number	SBIJB – 020322-3
Direction title	Commissioning the Millar House Integrated Community Rehabilitation Service
Direction to	NHS Borders and Scottish Borders Council
IJB Approval date	2 March 2022
Does this Direction supersede, revise or revoke a previous Direction?	No – new direction
Services/functions covered by this Direction	Mental Health Services (specifically the Mental Health Integrated Community Rehabilitation Service)
Full text of the Direction	NHS Borders and the Scottish Borders Council are requested to commission the Community Rehabilitation Service set out in the Millar House Business Case submitted on 2nd March 2022 (subject to Eildon Housing Association Board and the Scottish Housing Regulator's approval to lease the Millar House site and accommodation to the commissioned service provider Carr Gomm).
Timeframes	To start by: Provisional date 1 July 2022 To conclude by:
Links to relevant SBIJB report(s)	• Scottish Borders Integration Joint Board Integration Strategic Plan 2018-22 (3 Strategic Aims): https://www.scotborders.gov.uk/downloads/file/5131/integration_strategic_plan_2018-21 • Scottish Borders HSCP Mental Health Strategy 2015-20 (Vision and Objectives 3-5): http://www.nhsborders.scot.nhs.uk/media/521799/mentalhealthstrategy17.pdf
Budget / finances allocated to carry out the detail	Additional investment requirements (£256K Revenue + £8K Capital): • NHS Borders £197k • Scottish Borders Council £59k • NHS Borders Capital Grant £8k Funded by(£256K Revenue + £8K Capital): • NHS Borders Delegated Function (East Brig) £105k Saving • NHS Borders Non-Delegated Function £92k Saving • Scottish Borders Council Delegated Function £48k Saving • Scottish Borders Council Delegated Function £11k Other • NHS Borders Capital Programme 2022/23 £8k Other
Outcomes / Performance Measures	**The quantitative outcomes listed in this section will be evaluated by seeking the feedback of those with lived experience in each of these areas before (as a baseline) and after implementation of the direction.** **National Health and Wellbeing Outcomes** This project meets 8 of the 9 Health and Wellbeing Outcomes (Outcome 6 is not applicable to this project): 1. People are able to look after and improve their own health and wellbeing and live in good health for longer. 2. People, including those with disabilities or long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.

	3. People who use health and social care services have positive experiences of those services, and have their dignity respected. 4. Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services. 5. Health and social care services contribute to reducing health inequalities. 6. People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and well-being. 7. People who use health and social care services are safe from harm. 8. People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide. 9. Resources are used effectively and efficiently in the provision of health and social care services. **Millar House Project Outcomes:** • Improve the quality to patient care and wellbeing • Significantly improve the current living conditions for those within supported accommodation • Further enhance re-ablement to a marginalised population of patients • Reduce the length of stay and in turn reduce costs for patients placed out of area and allow timely repatriation • Reduce the reliance on the inpatient care and treatment • Reduce the costs to Health and Social Care budgets
Date Direction will be reviewed	January 2023 at the IJB Audit Committee. This will include a review of data provided by NHS Borders and the Scottish Borders Council on the impacts of this Direction against the: • National Health and Wellbeing Outcomes,and; • Millar House Project Outcomes

DIRECTIONS FROM THE SCOTTISH BORDERS INTEGRATION JOINT BOARD Directions issued under S26-28 of the Public Bodies (Joint Working) (Scotland) Act 2014	
Reference number	SBIJB-160222-1
Direction title	Development of a Scottish Borders HSCP Integrated Workforce Plan, including support of immediate workforce sustainability issues
Direction to	NHS Borders and the Scottish Borders Council
IJB Approval date	IN DRAFT AND NOT YET APPROVED: PENDING APPROVAL AT THE INTEGRATION JOINT BOARD ON 16 FEBRUARY 2022
Does this Direction supersede, revise or revoke a previous Direction?	No – new direction
Services/functions covered by this Direction	All delegated services, provided by NHS Borders, Scottish Borders Council and by partner providers
Full text of the Direction	To continue to progress the development of a Scottish Borders Health and Social Care Partnership Integrated Workforce Plan in line with the national timescales set out below, ensuring that the plan takes into account: • Scottish Government integrated workforce planning expectations • The immediate workforce sustainability issues faced by the HSCP, including existing workforce gaps and any service shortfalls, the increased risks of workforce, internal and partner supplier failure and future market for care (Strategic Risks: IJB003, IJB006 and IJB007), and how to promptly resolve these challenges locally • Future workforce needs, based on meeting need, including additional demand and any backlogs associated to Covid-19 • Plans for sustainable integrated workforce models across health and social care • Improved training, development, recruitment and retention across health and social care • Affordability in the context of the financial constraints across the IJB, NHS Borders and Scottish Borders Council As part of this process, it is expected that: • There will be full and appropriate consultation and engagement with all stakeholders, including (but not exclusively) appropriate staff, partnership; professional, independent sector, educational institutions (e.g. Borders College, NES, Universities), partner reference groups, the IJB Joint Staff Forum and the Strategic Planning Group • The HSCP Integrated Workforce Plan will be considered for final approval at the Integration Joint Board prior to submission to the Scottish Government Out of scope: The development of a plan for Unpaid Carers will be undertaken in the IJB's Carers Workstream, and as such should be considered as out of scope of the Integrated Workforce Plan.
Timeframes	To start by: With immediate effect To conclude: It is expected that the report will come to the Integration Joint Board for ratification by 15 June 2022 for submission to the Scottish Government following IJB ratification by the 31 July 2022 at the latest in line with current national timescales. Should the national timescales be adjusted then the IJB may consider a change to reporting timescales.
Links to relevant SBIJB report(s)	Items 6.3 Strategic Risk Register Update and 6.5 Integrated Workforce Plan: https://scottishborders.moderngov.co.uk/ieListDocuments.aspx?CId=218&MId=6088&Ver=4
Budget / finances allocated to carry out the detail	It is expected that the development costs of the Integrated Workforce Plan will be covered by the arrangements under the Scheme of Integration

Outcomes / Performance Measures	• Aligns to all National Health and Wellbeing Outcomes and Integration Planning Principles • Improved workforce retention rates • Reduced workforce vacancy rates • Reduced sickness absence rates • Improved staff governance, satisfaction and engagement • Increased levels of need met
Date Direction will be reviewed	At IJB Audit Committee on 12 September 2022

DIRECTIONS FROM THE SCOTTISH BORDERS INTEGRATION JOINT BOARD Directions issued under S26-28 of the Public Bodies (Joint Working) (Scotland) Act 2014	
Reference number	SBIJB-160222-2
Direction title	Local Authority and Health Board resource support for the development of the IJB's Strategic Commissioning Plan
Direction to	The Scottish Borders Council and NHS Borders
IJB Approval date	IN DRAFT AND NOT YET APPROVED: PENDING APPROVAL AT THE INTEGRATION JOINT BOARD ON 16 FEBRUARY 2022
Does this Direction supersede, revise or revoke a previous Direction?	No – new Direction
Services/functions covered by this Direction	All delegated services/ functions

Full text of the Direction	To provide planning, performance, communications and public engagement support for the development of the Strategic Commissioning Plan. This includes support for:
	• The design and production of a Strategic Joint Needs Assessment
	    ○ Population / Public Health Needs Assessment (NHS Borders)
	    ○ Performance and data support (NHS Borders and Scottish Borders Council)
	    ○ Communications support (NHS Borders and Scottish Borders Council)
	    ○ Full and appropriate consultation and engagement with stakeholders, staff and partners (NHS Borders and Scottish Borders Council)
	• The production of a Strategic Commissioning Plan based on the priorities identified by the Strategic Joint Needs Assessment
	    ○ Planning and Project Management support (NHS Borders and Scottish Borders Council)
	    ○ Liaison between finance teams, IJB Chief Finance Officer and IJB Chief Officer (NHS Borders and Scottish Borders Council)
	    ○ Full and appropriate consultation and engagement with stakeholders, staff and partners (NHS Borders and Scottish Borders Council)
	    ○ Communications support (NHS Borders and Scottish Borders Council)

Timeframes	To start by: March 2022 To conclude by: Expected to be a 12-18 month planning process (further detail will be confirmed following the February IJB Development session)
Links to relevant SBIJB report(s)	Item 5.5. https://scottishborders.moderngov.co.uk/ieListDocuments.aspx?CId=218&MId=6088&Ver=4
Budget / finances allocated to carry out the detail	The core budget for programme support is as per the scheme of integration. However as the plans are scoped, the IJB Chief Finance Officer, and IJB Chief Officer will work with the Chief Financial Officer/ Director of Finance and Planning Lead /Director of Planning of both organisations to ensure that this is appropriately reviewed and supported
Outcomes / Performance Measures	The development of the plan will be focused on the Integration Planning Principles and will also be financially sustainable: https://www.legislation.gov.uk/asp/2014/9/section/4/enacted.
Date Direction will be reviewed	Progress will be reviewed at the IJB Audit Committee in September 2022 and 3 monthly thereafter until completion of the programme

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DIRECTIONS FROM THE SCOTTISH BORDERS INTEGRATION JOINT BOARD Directions issued under S26-28 of the Public Bodies (Joint Working) (Scotland) Act 2014		
Reference number	SBIJB-160222-4	
Direction title	Development of Full Business Cases for Care Village in Tweedbank, and the scoping of Care Home Provision in Hawick to Outline Business Case.	
Direction to	The Scottish Borders Council	
IJB Approval date	IN DRAFT AND NOT YET APPROVED: PENDING APPROVAL AT THE INTEGRATION JOINT BOARD ON 16 FEBRUARY 2022	
Does this Direction supersede, revise or revoke a previous Direction?	No – new Direction	
Services/functions covered by this Direction	• Care Home services • Services and support for adults with Learning Disabilities	
Full text of the Direction	To scope the development of an Outline Business Care for Care Home service provision in Hawick, and progress the development of a Full Business Case for the Tweedbank Care Village. As part of this process, it is expected that: • There will be full and appropriate consultation and engagement with stakeholders • The model of services will be needs based It is recognised that the capital investment needed to deliver the Care developments is included in the Scottish Borders Council's Capital plan. It is expected that both of the Business Cases will be reviewed at the Integration Joint Board for consideration on the revenue spend prior to full sign off by the Scottish Borders Council.	
Timeframes	<u>Hawick Care Home Provision scoping for Outline Business Case</u> To start by: With immediate effect To conclude by: June 2022	<u>Tweedbank Care Village Full Business Case</u> To start by: With immediate effect To conclude by: December 2022
Links to relevant SBIJB report(s)	Item 6.6. https://scottishborders.moderngov.co.uk/ieListDocuments.aspx?CId=218&MId=6088&Ver=4	
Budget / finances allocated to carry out the detail	The budget for programme support is as per the scheme of integration. It is expected that the revenue model will be within the existing revenue budget for existing care settings for both developments, unless expressly agreed with the IJB at a later date.	
Outcomes / Performance Measures	• NHWB2: People, including those with disabilities or long-term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community • NHWB3: People who use health and social care services have positive experiences of those services, and have their dignity respected • NHWB4: Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services • NHWB7: People who use health and social care services are safe from harm • NHWB9: Resources are used effectively and efficiently in the provision of health and social care services	
Date Direction will be reviewed	At IJB Audit Committee's first meeting after June 2022 for the Hawick development and December 2023 for the Tweedbank development	

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DIRECTIONS FROM THE SCOTTISH BORDERS INTEGRATION JOINT BOARD Directions issued under S26-28 of the Public Bodies (Joint Working) (Scotland) Act 2014	
Reference number	SBIJB-160222-5
Direction title	Health Board development of the Oral Health Plan
Direction to	NHS Borders
IJB Approval date	IN DRAFT AND NOT YET APPROVED: PENDING APPROVAL AT THE INTEGRATION JOINT BOARD ON 16 FEBRUARY 2022
Does this Direction supersede, revise or revoke a previous Direction?	No – new Direction
Services/functions covered by this Direction	• General Dental Services • Public Dental Services, including Oral Health Improvement Hospital Dental Services are out with the scope of the Integration Joint Board, but it is requested to NHS Borders that these are included within the Oral Health Plan to ensure that there is a comprehensive approach to planning across the Oral Health pathway

Full text of the Direction	To provide planning and performance, communications and public engagement support for the development of the Oral Health Plan, which will be based upon the 2020 Oral Health Needs Assessment. This includes support for:
	• The production of an Oral Health Plan based on the priorities identified by the Oral Health Needs Assessment
	  ○ Planning and Project Management support (NHS Borders)
	  ○ Re-establishment of the Dental Services and Oral Health Strategy Group
	  ○ Consultation and engagement with stakeholders, staff and partners on the draft plan (NHS Borders)
	  ○ Communications support (NHS Borders)
	
	It is expected that the plan will be referred to in the broader revised IJB Strategic Commissioning Plan once complete.

Timeframes	To start by: March 2022 To conclude by: October 2022
Links to relevant SBIJB report(s)	TBC – as IJB papers for 16 February 2022 have not yet been published online
Budget / finances allocated to carry out the detail	The core budget for programme support is as per the scheme of integration
Outcomes / Performance Measures	The development of the plan will be focused on - the Integration Planning Principles: https://www.legislation.gov.uk/asp/2014/9/section/4/enacted. - the National Public Health Priorities - the National Oral Health Improvement Plan The plan will also be financially sustainable, within the resources available
Date Direction will be reviewed	Progress will be reviewed at the IJB Audit Committee in June 2022, September 2022 and December 2022.

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MONTHLY REVENUE MANAGEMENT REPORT

Summary	2021/22	At end of Month:	December

	Base Budget £'000	Actual to Date £'000	Revised Budget £'000	Projected Outturn £'000	Outturn Variance £'000
Joint Learning Disability Service	19,595	16,753	22,735	22,529	206
Joint Mental Health Service	19,211	16,208	22,068	22,514	(446)
Older People Service	9,880	2,356	11,599	11,599	0
SB Cares	16,924	13,780	15,332	15,332	0
Targeted Savings	(4,740)	0	(4,740)	(290)	(4,450)
Physical Disability Service	2,734	2,085	2,561	2,558	3
Prescribing	23,132	17,497	23,132	23,401	(269)
Generic Services	67,468	62,910	93,403	92,246	1,157
Large Hospital Functions Set-Aside	24,211	21,768	27,301	29,025	(1,724)
Total	178,415	153,357	213,391	218,914	(5,523)

Scottish Borders Health and Social Care PARTNERSHIP

MONTHLY REVENUE MANAGEMENT REPORT

Delegated Budget Social Care Functions **2021/22** **At end of Month:** **December**

	Base Budget £'000	Actual to Date £'000	Revised Budget £'000	Projected Outturn £'000	Outturn Variance £'000
Joint Learning Disability Service	16,122	13,455	19,140	18,949	191
Joint Mental Health Service	2,196	1,564	2,024	2,174	(150)
Older People Service	9,880	2,356	11,599	11,599	0
SB Cares	16,924	13,780	15,332	15,332	0
Physical Disability Service	2,734	2,085	2,561	2,558	3
Generic Services	6,339	3,176	7,980	8,026	(46)
Total	54,195	36,416	58,636	58,638	(2)

Summary Financial Commentary

Learning Disability: £64k saving resulting from 1 client moving from 24 hour permanent care into community based care setting. £16k saving from day centre transport costs. £14k saving from continued non-recruitment to vacancies. £60k increased client income resulting from client financial (re)assessments. £26k reductions to community based care packages. Budget now includes confirmed funding to provide for Social Care pay uplift.

Mental Health: Pressures relating to individual client care packages across the service relating to both new and existing clients. Revised budget also reflects confirmed funding to provide for Social Care pay uplift.

Older People: Budget includes funding to provide for £1.454m Homecare winter planning and £0.417m Social Care pay uplift.

SB Cares: Savings in Disability Services relating to continued reduction in service provision due to Covid-19 (£135k). Lower than anticipated staffing costs in Care Homes and Home Care services due to continued high level of vacancies and also savings in associated clothing / uniform costs (£90k). Community Equipment Store forecasting a balanced position, however increasing demands on service may cause financial pressure. This is being closely monitored, including Covid related pressures. Total service savings (£225k) allocated against current undelivered savings. In addition, pressures around interim care, current funded from within the service has allowed confirmed in-year Scottish Government funding to be allocated against remaining undelivered savings - Reablement of Homecare and Enterprise Mobility.

PWPD: Budget now includes funding to provide for Social Care pay uplift.

Generic: £89k higher than anticipated costs relating to Locality based care packages, off-set by a net saving of £43k in locality based staffing teams. Also proposed earmarked balance of £423k in relation to delays in progressing Carers Act expenditure in 2021-22.

MONTHLY REVENUE MANAGEMENT REPORT

Delegated Budget Healthcare Functions **2021/22** **At end of Month:** **December**

	Base Budget £'000	Actual to Date £'000	Revised Budget £'000	Projected Outturn £'000	Outturn Variance £'000
Joint Learning Disability Service	3,473	3,298	3,595	3,580	15
Joint Mental Health Service	16,616	14,062	19,414	19,710	(296)
Joint Alcohol and Drugs Service	399	582	630	630	0
Prescribing	23,132	17,497	23,132	23,401	(269)
Targeted savings	(4,740)	0	(4,740)	(290)	(4,450)
Allocated Non Recurring Savings Projects	0	0	0	0	0
Allocated Brokerage	0	0	0	0	0
Generic Services					
Independent Contractors	30,069	25,209	33,071	33,071	0
Community Hospitals	5,770	4,349	5,910	5,810	100
Allied Health Professionals	6,531	5,276	7,540	7,330	210
District Nursing	3,701	2,980	4,221	3,821	400
Generic Other	15,058	21,920	34,681	34,188	493
Total	100,009	95,173	127,454	131,251	(3,797)

Summary Financial Commentary

Mental Health: Medical staffing budgets are £591k overspent. The medical establishment is not staffed to capacity and ongoing recruitment gaps are backfilled by agency locums at increased hourly rates, generating this overspend. This forecast pressure is partially offset by vacancies across the Older Adult Service, Psychology, Administration and Adult Mental Health Services.

Prescribing: A small forecast adverse pressure in Primary Care Prescribing is also projected (£269k) due to an increased number of items and forms issued over the last quarter and particularly in advance of the festive period. There has also been an increase in the average unit cost per item dispensed. At the end of M09, the pressure is £70k and close monitoring will continue over the remainder of the year, with expectation that costs will continue to increase, although this may not be the case as further information is made available in relation to recent months.

Targeted Efficiency Savings: Planned savings within NHS Borders (£4.450m) that are forecast not to be delivered due to CV-19. Scottish Borders Council savings offset by virement from non-delegated functions.

Generic Services: is also forecasting an underspend position across Community Hospitals (£100k), AHP services (£210k) and District Nursing (£400k) due to ongoing vacancies, together with a general saving due to reduced service activity during the first half of the financial year as a result of the ongoing impact of Covid-19. Additional funding from Scottish Government is also a factor within District Nursing, with some slippage in its expenditure forecast. This is partially offset by an adverse pressure in Home First due to slippage in the review of the service against the planned reduction to its funding envelope of £300k. There is also a significant underspend within Dental Services (480k) and there continues to be a number of vacancies within dental which are linked to a reduction/step down of services as well as a continuation of vacancies. The remainder of Generic Other is largely attributable to underspends in Public Dental Services, Sexual Health, Out of Hours and Health Promotion arising as a result of activity and staffing reductions, offset by pressures caused by fixed term recruitment in general staffing to support the management of remobilised services (net £313k).

MONTHLY REVENUE MANAGEMENT REPORT

Large Hospital Functions Set-Aside	2021/22	At end of Month:	December

	Base Budget £'000	Actual to Date £'000	Revised Budget £'000	Projected Outturn £'000	Outturn Variance £'000	Summary Financial Commentary
Accident & Emergency	2,762	3,216	3,698	4,288	(590)	A&E: Accident and Emergency continues to experience cost pressure as a result of additional nursing as a result of increased activity / triage and also in response to the Covid-19 pandemic. Some of this is expected to be funded directly from Scottish Government Covid-19 allocations but elements relate to permanent redesign which will require additional funding to be made available in future financial years.
Medicine & Long-Term Conditions	16,187	13,995	18,056	18,660	(604)	General Medicine: Within Medicine and Long-Term conditions, the adverse position is entirely attributable to increased drugs spend.
Medicine of the Elderly	6,352	4,557	6,593	6,077	516	Medicine for the Elderly: An ongoing reduction in activity as a result of the deployment of staff to support Covid-19 mobilisation is the main driver of the favourable forecast position in DME.
Targeted Savings	(1,090)	0	(1,046)	0	(1,046)	Targeted Efficiency Savings: In terms of efficiency savings, this is the set-aside share of recurring acute savings related to NHS Borders overall allocated targets this year - Total £3.2m.
Allocated Non Recurring Savings Projects	0	0	0	0	0	
Allocated Brokerage	0	0	0	0	0	
Total	24,211	21,768	27,301	29,025	(1,724)	

Scottish Borders Health & Social Care
Integration Joint Board

Meeting Date: 2 March 2022

Report By	David Robertson, Chief Finance Officer SBC & Andrew Bone, Chief Financial Officer, NHS Borders
Contact	David Robertson, Chief Finance Officer SBC & Andrew Bone, Chief Financial Officer, NHS Borders
Telephone:	01835 825012 / 01896 825555

MONITORING AND FORECAST OF THE HEALTH AND SOCIAL CARE PARTNERSHIP BUDGET 2021/22 AT 31 DECEMBER 2021

Purpose of Report:	The purpose of this report is to update the IJB on the forecast year end position of the Health and Social Care Partnership (H&SCP) for 2020/21 based on available information to the 31 December 2021.
Recommendations:	The Health & Social Care Integration Joint Board is asked to: a) **Note** the combined forecast adverse variance of (£5.523m) for the Partnership for the year to 31 March 2022 based on available information and arrangements in place to partially mitigate this position; b) **Note** that whilst the forecast position includes direct costs relating to mobilising and remobilising in respect of Covid-19, it also assumes that all such costs will again be funded by the Scottish Government in 2021/22; c) **Note** that the position includes additional funding vired to the Health and Social Care Partnership during the first half of the financial year by Scottish Borders Council to meet reported pressures across social care functions from managed forecast efficiency savings within other non-delegated local authority services and funding brought forward in respect of Covid-19 expenditure; **d)** **Note** that any residual expenditure in excess of the delegated budgets at the end of 2021/22 will require to be funded by additional contributions from the partners in line with the approved Scheme of Integration. **e)**
Personnel:	There are no resourcing implications beyond the financial resources identified within the report. Any significant resource impact beyond those identified in the report that may arise during 2021/22 will be reported to the Integration Joint Board.

Carers:	N/A
Equalities:	There are no equalities impacts arising from the report.
Financial:	There are no resourcing implications beyond the financial resources identified within the report. The report draws on information provided in finance reports presented to NHS Borders Board and Scottish Borders Council Executive Committee. Both partner organisations' Finance functions have contributed to its development and will work closely with IJB officers in delivering its outcomes.
Legal:	Monitoring against the partnership's Financial Plan supports the delivery of the Strategic Plan and is in compliance with the Public Bodies (Joint Working) (Scotland) Act 2014 and any consequential Regulations, Orders, Directions and Guidance.
Risk Implications:	Risks are reviewed in line with agreed risk management strategy. The key risks outlined in the report form part of the draft financial risk register for the partnership.

Background

2.1 The report relates to the Month 09 forecast position on both the budget supporting all functions delegated to the partnership (the "delegated budget") and the budget relating to large-hospital functions retained and set aside for the population of the Scottish Borders (the "set-aside budget").

2.2 The forecast position is based on the available information presented to Scottish Borders Council Executive Committee and the Board of NHS Borders. It highlights the key areas of financial pressure at 31 December 2021. A further report will be brought to the IJB during the remainder of the financial year. When this happens, further analysis and refinement as a result of the impact of the Covid-19 pandemic on activity levels, mobilisation costs, remobilisation plans and associated costs, lost income and unachievable savings will take place and a further indicative outturn position ascertained and reported.

Overview of Monitoring and Forecast Position at 31 December 2021

3.1 The paper sets out the consolidated financial performance for the period to end of December 2021 (month 9). This position includes a forecast of the year end outturn which due to uncertainty of a range of factors including activity levels, staffing challenges and the wider impact of Covid-19 on services both delegated and set-aside, IJB remains subject to a number of risks and uncertainties which are likely to result in ongoing revision as greater clarity and assurance emerges.

3.2 At the end of month 9, functions delegated to the partnership are forecasting an adverse projected pressure of £3.799m and the large hospital budget retained and set-aside is forecasting a similarly adverse pressure of £1.724m. Within delegated functions, following the delegation of additional budget to social care functions by

Scottish Borders Council, a small forecast overspend position (£0.002m) and therefore the majority of the adverse pressure (£3.797m) therefore sits entirely across healthcare functions, mainly attributable to the forecast non-delivery of financial efficiency savings partially offset by savings on core operational budgets.

Efficiency Savings

3.3 Forecasts include the estimated impact of non-delivery of savings plans. This position remains under review and will be updated following the conclusion of the Scottish Government / NHS quarterly review process and the ongoing review and challenge of assumptions across Scottish Borders Council's Fit for 2024 and NHS Borders' Financial Turnaround Programmes.

	Targeted Savings per Financial Plan £m	Projected Savings to be Delivered £m	Shortfall £m
Healthcare Functions	(4.740)	(0.290)	(4.450)
Social Care Functions	(3.356)	(2.576)	(0.780)
Set-Aside Functions	(1.090)	0	(1.090)
	(9.186)	(2.866)	(6.320)

3.4 In order to partially offset the above, a contribution will be made from the IJB reserve brought forward at the start of the financial year. Within the overall reserves position, £1.103m has been earmarked specifically to support slippage in the delivery of the partnership's financial efficiency plan in 2021/22 with the remaining forecast balance requiring additional contributions to be made by respective partners in line with the Scheme of Integration, from other forecast operational savings across non-delegated services.

Year End Forecast

Healthcare functions

3.5 The Delegated Healthcare and Set-Aside forecasts at month 9 are based on detailed review currently being undertaken through the Q3 review process. As such, members should recognise that the forecast is presented as an indication of current expenditure trend and is unlikely to be a full representation of the likely outturn position. Additional costs relating to Covid-19 are included, with the expectation and corresponding assumption that these will be funded by the Scottish Government. Presently, NHS Borders' is presenting forecast savings undelivered in full, until funding allocations to meet this adverse impact are received from the Scottish Government. Beyond the additional costs of Covid-19, including the non-delivery of planned savings on which the overall affordability of the partnership's Financial Plan is predicated, operational functions are still reporting a reduction in a number of areas of core activity over 3rd quarter of the financial year that, excluding the additional costs of Covid-19 and undelivered savings, results in a favourable position at the end of month 9.

3.6 At the end of December, delegated healthcare functions are reporting a favourable net variance on core operational budgets of £0.653m. This is primarily attributable to ongoing delay / challenges in recruitment to vacant posts during the financial year due to the ongoing impact of Covid-19, slippage in the planned useage of recent additional funding allocations (district nursing, health visiting, etc) and a continued reduction in core activity in areas such as Dental Services. The position includes other net reductions in spend across Primary and Community Services and Mental Health / Learning Disability services offset by a pressure within the Mental Health medical budget of £0.591m as a result of the use of agency / locums due to ongoing vacant consultant posts. The forecast also includes an adverse pressure of £0.300m relating to the Home First service. This service is currently under review and to mitigate the pressure in the interim until the review is completed, a further £0.300m has also been earmarked within the IJB reserves brought forward on a non-recurring basis this financial year.

Social Care functions

3.7 At 31 December, Scottish Borders actual spend to date on social care functions, as stated in Appendix 1, is £36.416m which represents 67%% of the current budget. This is slightly less than the position expected ¾ of the way through the financial year and is again attributable to a number of factors specific to 2021/22. These relate to the upfront transfer of social care funding and health board resource transfer from NHS Borders during the first quarter for the whole of the financial year to enable local authority cash-flow, additional Scottish Government Covid-19 funding for social care sustainability and the offset of 2020/21 funding allocations brought forward into 2021/22.

3.8 The Scottish Borders Council forecast at month 9 is based on detailed monthly monitoring during the first 9 months of the financial year. It is noted that in order to deliver a breakeven position, social care functions assume all Covid-19 costs included within the Local Mobilisation Plan, including undelivered efficiency savings, will be funded by the Scottish Government in full.

Large Hospital functions retained and set-aside

3.9 Accident and Emergency continues to experience significant cost pressure as a result of additional nursing as a result of increased activity / triage and also in response to the Covid-19 pandemic. Within Medicine and Long-Term conditions, the adverse position is entirely attributable to increased drugs spend. To date, little progress has been made planning or delivering the set-aside share of recurring acute savings target as a result of reduced capacity due to Covid-19, which has continued into 2022 as a result of the increasing Omnicron variant and required clinical prioritisation. These pressures are marginally offset by a reduced activity in Department of Medicine for the Elderly leading to a forecast underspend in this service area.

General

3.10 Additional costs of Covid-19 to date, together with the opportunity cost of lost income and non-delivery of financial plan savings, continues to outweigh any financial benefit and reduced cost within core operational services attributable to a reduction in activity during the first 9 months of 2021/22. This position may be mitigated considerably as a clearer picture of likely funding allocations from the Scottish Government emerges. A commitment however has been received from the Scottish Government that it will underwrite non-delivery of savings reported by

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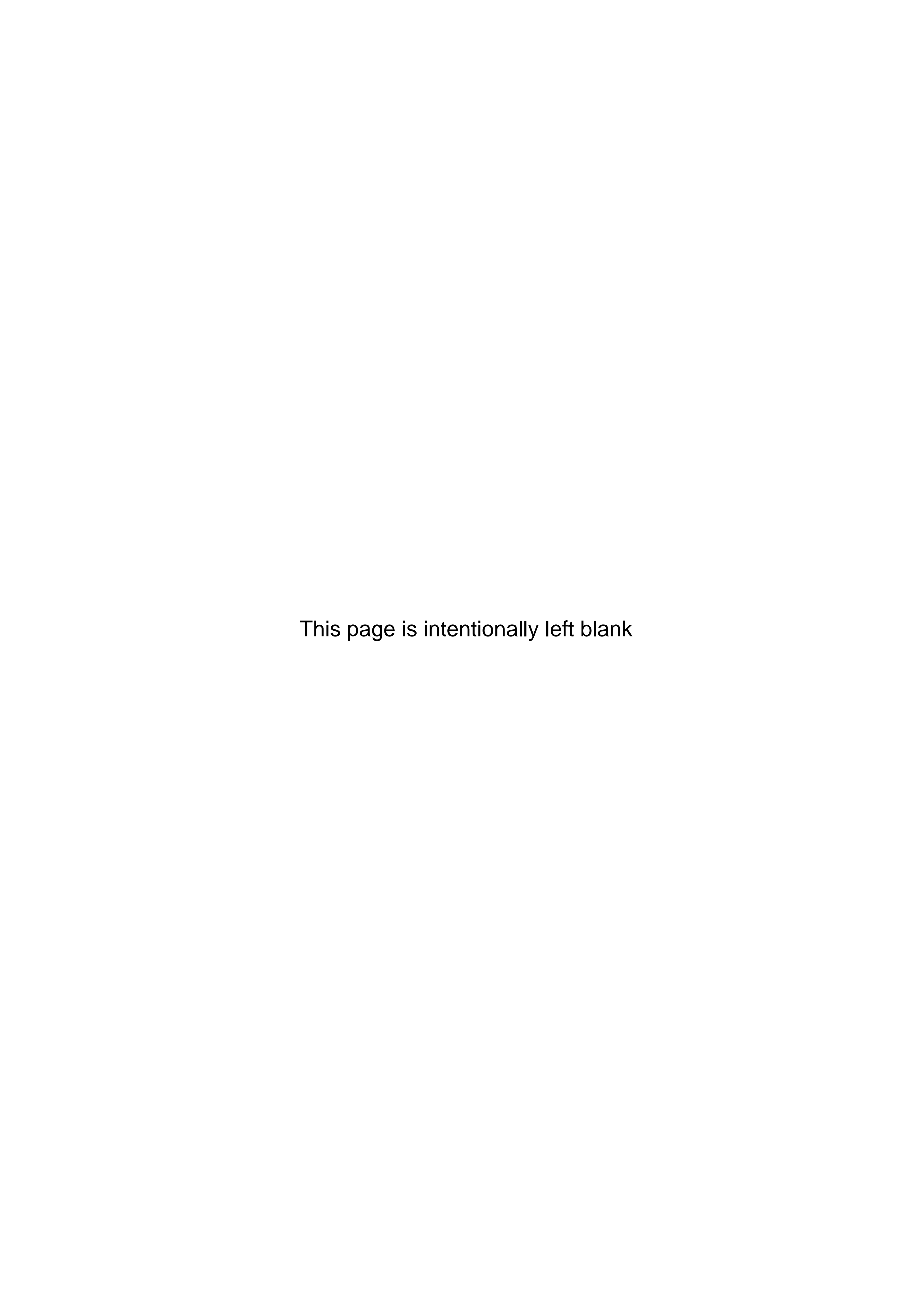
partnerships within their Covid-19 local mobilisation plans, subject to further review of any available flexibility within IJB reserve positions brought forward into 2021/22 to support this non-delivery also.

3.10 A further reports will be brought to the Integration Joint Board as greater clarity develops. To enable this, work will be continue to be undertaken across a number of key areas in order to refine the forecast impact on the IJB in 2021/22 including:

- Ongoing analysis and reporting of the Health and Social Care Partnership's (and wider NHS Borders' and Scottish Borders Council's) local mobilisation plan financial models;
- Further review, challenge and remodelling of planned efficiency savings programmes as increased capacity is rebuilt;
- Ongoing engagement with other partnerships, health boards, local authorities and, in particular, the Scottish Government over likely funding scenarios;
- Review of all costs, expenditure profiles, future commitments and refinement of assumptions for projected expenditure to the end of the year.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Agenda Item 6b
Appendix-2022-5

Scottish Borders Health & Social Care
Integration Joint Board

Scottish Borders
Health and Social Care
PARTNERSHIP

Meeting Date: 2 March 2022

Report By:	Chris Myers, Chief Officer
Contact:	Hayley Jacks
Telephone:	Via Microsoft Teams
UPDATE ON IMPACT OF INTEGRATION JOINT BOARD REQUIREMENTS AS CATEGORY 1 RESPONDERS UNDER THE CIVIL CONTINGENCIES ACT 2004	
Purpose of Report:	To provide the Health & Social Care Integration Joint Board with further information on the application of the amendment to the Civil Contingencies Act 2004 to include Integration Joint Boards as Category 1.
Recommendations:	The Health & Social Care Integration Joint Board is asked to: a) **Consider and note** the assessment of the obligations, and assessed requirements for the Integration Joint Board outlined within this update paper in relation to the amendment to The Civil Contingencies Act 2004 (Amendment of List of Responders) (Scotland) Order 2004 b) **Request** that the IJB Audit Committee to build in the review of ongoing arrangements in relation to the Civil Contingencies Act (Amendment of List of Responders) (Scotland) Order 2004 into their audit cycle to ensure that these obligations are met
Personnel:	It is expected that this change will provide further support to staff, by clarifying expectations, and communications that should improve a category 1 response.
Carers:	As above
Equalities:	Equality and diversity implications will be considered in response.
Financial:	The Scottish Government has indicated that this should be a consolidation of the relationship with partners increasing resilience and without additional resource. The IJB does not employ officers to support this area of work specifically and indeed the Health and Social Care Partnership has no specific officers. On the basis it is not expected that there will be additional costs associated to these changes for the Integration Joint Board, and should there be any financial requirement, this would be minimal.
Legal:	It is expected that the arrangements outlined in this paper will ensure compliance against the Civil Contingencies Act 2004

Risk Implications:	It is requested that the IJB Audit Committee be asked to monitor the ongoing risks in compliance.
Direction required:	No Direction required

AMENDMENT TO CIVIL CONTINGENCIES ACT 2004 TO INCLUDE INTEGRATION JOINT BOARDS AS CATEGORY 1 RESPONDERS: FEBRUARY 2022 UPDATE PAPER

Scottish Borders Health and Social Care Integration Joint Board

SITUATION

In September 2020, Jeane Freeman, former Cabinet Secretary for Health and Sport, wrote a letter to the chair of the Scottish Resilience Partnership to give notification of an amendment that the Scottish Government intended to make to the Civil Contingencies Act 2004 (hereinafter referred to as the Act) to add Integration Joint Boards as Category 1 responders in Scotland. A further letter was sent by Jeane Freeman to NHS and Local Authority Chief Executives, and IJB Chief Officers in January 2021, outlining the next steps in the inclusion of IJB's as Category 1 responders under the Act.

Following consultation, the amendment was considered in the Scottish Parliament in January 2021. Scottish Ministers concluded that there was no reason not to legislate for IJB inclusion within the Civil Contingencies Act 2004 to ensure formal coordinated and appropriate arrangements are in place. The amendment to the Act came into effect in the Spring of 2021.

The Scottish Borders Integration Joint Board noted the letter from the former Cabinet Secretary for Health and Sport in its February 2021 meeting, and that as a public body responsible for strategic commissioning rather than operational delivery, which, the Integration Joint Board was required to that the application of this was limited to the fact that services that are commissioned may be impacted upon in the event of an emergency event requiring a category one response.

In the context of the recent Omicron variant wave of Covid-19, the Integration Joint Board Chief Officer, Chair and Vice Chair of the Integration Joint Board have considered these arrangements further to ensure that the Integration Joint Board is fulfilling its duties under the Act. This report summarises their findings and is intended to provide assurance to the Integration Joint Board that these duties are being fulfilled.

BACKGROUND

Integration Joint Boards, Health Boards and Local Authorities now share a joint responsibility and accountability for drawing up suitable plans which take account of functions managed by each individual body. Therefore, the Integration Joint Board Chief Officers and their teams are now expected to work alongside Health Board and Local Authority colleagues when carrying out the duties relevant to the Civil Contingencies Act 2004.

The excerpt from the Scottish Government website, highlighting the rationale for extending Category 1 Responder status to IJB's and specifically the role of the Chief Officer, can be found at https://www.gov.scot/publications/consultation-amend-civil-contingencies-act-2004-include-integration-joint-boards-government-response/

Where there is a risk of an emergency which will impact functions delegated to the Integration Joint Board, there will be formal coordinated and appropriate arrangements in place for emergency planning; information sharing and cooperation with other responders; and joined up information sharing and advice for the public.

The aim of the amendment is to consolidate the partnership relationship, ensuring an effective and efficient and timely response for services delegated to Integration Joint Boards.

ASSESSMENT

The Civil Contingencies Act (2004) puts into place the obligations listed below for Category 1 Responders. The assessment of the Chief Officer, Chair and Vice Chair of the obligations of the Scottish Borders Health and Social Care Integration Joint Board in respect of implementing its duties under the Act are outlined below:

Obligation	Assessed requirement for the Scottish Borders Integration Joint Board	Current status
1. Assess the risk of emergencies occurring and use this to inform contingency planning.	The Integration Joint Board is required to work closely with partners in NHS Borders, the Scottish Borders Council and Lothian and Borders Local Resilience Partnership partners. The Integration Joint Board is required to assess the risk of emergencies occurring that could impact on strategic commissioning functions of the IJB in delivering its overall strategic objectives.	This is in place, through the Chief Officer and Chair of the Integration Joint Board.
2. Put in place emergency plans.	The role of the Integration Joint Board is to be assured that emergency and business continuity plans have been put into place by NHS Borders and the Scottish Borders Council, and to provide strategic support to these delivery partners in the event of an emergency response.	Emergency and business continuity plans are in place in both organisations. In addition, the business continuity plans of operational partners are reviewed by the Health and Social Care Partnership teams in NHS Borders and Scottish Borders Council.

3. Put in place business continuity management arrangements.	The development of Critical Functions framework supports compliance with the Civil Contingencies Act (2004). In addition, Integration Joint Board members may be asked to support the Chief Officer, along with operational partners in NHS Borders and Scottish Borders Council by temporarily reducing the strategic requirements / building in tolerance to planning processes or Directions issued by the Integration Joint Board in the event of an emergency situation where business continuity arrangements are put into place.	A Health and Social Care Critical Functions framework has been developed which has been developed in partnership with NHS Borders and the Scottish Borders Council. This has now been adopted by the Health and Social Care operational teams. The Critical Functions framework is a risk-based approach, with the following three operational objectives: 1. Protect individuals and areas at highest risk; 2. Prioritise measures to reduce risks and harm to individuals / hospital demand where possible; and, 3. Proactively manage risk
4. Put in place arrangements to make information available to the public about civil protection matters and maintain arrangements to warn, inform and advise the public in the event of an emergency.	This will be undertaken in partnership with NHS Borders and the Scottish Borders Council.	In early January, a joint press release went out of behalf of NHS Borders, the Scottish Borders Council and the Integration Joint Board to the public during the Omicron Covid-19 wave. We have also communicated with our service users in writing to outline the impacts of the pandemic on service users and increased risks.
5. Share information with other local responders to enhance co-ordination.	The Integration Joint Board has a duty to cooperate with other local responders, including through the Local Resilience Partnership, NHS Borders Gold Command, and the Scottish Borders Council Recovery Group.	The Integration Joint Board Chief Officer liaises with the Scottish Borders Council, NHS Borders, the Lothian and Borders Local Resilience Partnership and Community Planning Partnership.
6. Co-operate with other local responders to enhance co-ordination and efficiency.	As above.	As above.

RECOMMENDATIONS

The Scottish Borders Health and Social Care Integration Joint Board are asked to:

a) Consider and note the assessment of the obligations, and assessed requirements for the Integration Joint Board outlined within this update paper in relation to the amendment to The Civil Contingencies Act 2004 (Amendment of List of Responders) (Scotland) Order 2004
b) Request that the IJB Audit Committee to build in the review of ongoing arrangements in relation to the Civil Contingencies Act (Amendment of List of Responders) (Scotland) Order 2004 into their audit cycle to ensure that these obligations are met

SCOTTISH BORDERS COUNCIL'S

CHIEF SOCIAL WORK OFFICER ANNUAL REPORT

2020 /2021

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INTRODUCTION

I have pleasure in presenting the Scottish Borders Chief Social Work Officers Annual report for 2020/21. This report is an opportunity to reflect on the past year, highlight the progress made against service priorities, to celebrate what has gone well, and to acknowledge the significant impact of the pandemic on supported people, their families, staff, volunteers and communities.

It has been a significantly challenging year for everyone in society, with those who were already disadvantaged being disproportionately impacted by the COVID-19 pandemic.

The Pandemic has caused significant pressure on the Local Authority, colleagues in NHS, third sector and other partners which has led to a seismic shift in the way we support our communities. With the rapid transition to the use of technology to manage the delivery of services and to reduce risk, agencies have adapted well to the challenge, whilst maintaining physical support to those requiring it. We recognise that significant challenges remain and we continue to work together to mitigate the impact on the people of Scottish Borders.

Please note that the format of this report has been amended for the second year in a row by Scottish Government, in order to enable Chief Social Work Officers to present reports for local governance structures, whilst having due regard to current pressures being experienced across the sector as a result of COVID-19.

I would like to take this opportunity to acknowledge the exceptional work and dedication of all Social Work and Social Care staff across Scottish Borders for their tireless work over the past year. This has been “a year like no other” and without fail, staff and carers have gone above and beyond what was expected of them to deliver critical services to the people of Scottish Borders.

I am incredibly proud of the efforts of all staff and hope that my words will in some way convey my gratitude to all those who have continued to deliver essential services throughout the pandemic.

GOVERNANCE AND ACCOUNTABILITY

Local authorities are required, under Section 3 (1) of the Social Work (Scotland) Act 1968 as amended, to appoint a Chief Social Work Officer (CSWO). The role of CSWO in Scottish Borders is fulfilled by the Chief Social Work & Public Protection Officer.

The role of the CSWO is to ensure professional oversight of social work practice and service delivery; this includes professional governance, leadership and accountability for the delivery of social work and social care services, whether provided by the local authority or commissioned through the third or independent sector.

Scottish Borders Social Work services have clear governance arrangements in place. The CSWO is a member of the Council's Corporate Management Team and as such has direct access to Elected Members, the Chief Executive and senior managers of other Council services. The governance of Social Work Services is undertaken through two separate but interconnected structures. Children and Families Social Work, Justice and Public Protection services are directly managed through internal Council structures and all other delegated services are managed through the Integration Joint Board (IJB). These arrangements are embedded and provide assurance that the social work function is being undertaken to the highest possible standards. The CSWO is a non-voting member of the IJB and offers professional advice and guidance to the IJB on matters relating to Social Work service delivery. The CSWO is also a member of IJB Leadership Team and other senior leadership forums between NHS Borders and Scottish Borders Council, further strengthening the integration of services.

In all Social Work services there are a range of multi-agency operational and strategic groups that add significant value to the work of Social Work. There continues to be a strong emphasis on partnership working in these forums and, given the co-terminus nature of the Local Authority with the local NHS Board, this continues to be a crucial element of our ongoing improvement.

The CSWO has continued to monitor, review and advise the Council on Social Work matters, whilst providing leadership for all staff in Social Work and Social Care in providing high quality and safe services for the Borders. The CSWO assures the quality of social workers and of social work practice by ensuring that we have robust auditing processes, quality and performance indicators and quality assurance/improvement measures in place.

The CSWO has responsibilities in respect of statutory decision making, specifically the public protection arrangements. The CSWO also has oversight of practice standards relating to services delivered by registered social workers. This also includes statutory decision making in relation to public protection and/or the restriction of individual liberty and requires consideration of individual

circumstances with regard to rights, risks, needs and capacity. These considerations are often complex in nature and need to take into account a range of issues, including the risks to the wider community. The statutory decision making includes the placement of children in secure accommodation, transfers of children and young people in cases of urgent necessity who are subject to Compulsory Supervision Orders, adoption, fostering, community payback orders, statutory interventions linked to the Mental Health Officer role, adults with incapacity measures, and the protection of children and adults at risk.

THE IMPACT OF COVID-19

I feel it is important and appropriate at this point to highlight the impact that COVID-19 has had on Social Work in order to contextualise the remainder of the report and to highlight the excellent work undertaken by frontline staff and managers.

As COVID-19 started to impact on how and where we worked, the accepted boundaries between work and home life dissolved as workers suddenly "did life together", videoconferencing into each other's homes. It should also be noted that our first priority was and is to safeguard staff, ensuring their immediate health and safety, providing remote and flexible work options, and focusing on providing safe work environments. Without these, the ability for the services to respond to the changing needs of people in our communities would be impossible.

In some instances workers started to conduct from home what is normally community-based work, attempting, and sometimes struggling, to maintain fragile relationships as well as addressing increased concerns about the safety, health, and wellbeing of people who access services.

At the beginning of the pandemic, and on an on-going basis, caseloads were reviewed and prioritised to ensure a consistent approach to supporting and protecting those most in need, maintaining face to face contact where required, intervening as early as possible to prevent an escalation in need and risk.

All actions and decisions made in relation to service delivery have been based on the principles of the Scottish Government "Framework for Decision Making", namely:

- Safe: We will ensure that transmission of the virus remains suppressed and that our NHS and care services are not overwhelmed.
- Lawful: We will respect the rule of law which will include ensuring that any restrictions are justified, necessary and proportionate.
- Evidence-based: We will use the best available evidence and analysis.
- Fair & Ethical: We will uphold the principles of human dignity, autonomy, respect and equality.
- Clear: We will provide clarity to the public to enable compliance, engagement and accountability.
- Realistic: We will consider the viability and effectiveness of options.
- Collective: We will work with our partners and stakeholders.

Engagement with staff has ensured an awareness of how the pandemic has impacted on them and to ensure the right level of support was provided. From those discussions it was clear that some staff were working longer hours and finding it difficult to separate office from home when working from home.

It was recognised that additional staff support was needed, which included additional reflective space and time for staff to slow down for short periods, creating opportunities for connection with colleagues across teams and service areas and to share and learn together.

Over a four month period in Autumn 2020, the Professional Development Team provided a range of 'Supportive Practices' sessions to create a new route for reflection, support and connection.

From early 2021, additional team and individual support was made available, by way of mentoring and coaching sessions. This was in addition to the extensive range of Council and National wellbeing, resilience and self-care material being made available to all social work staff.

It became clear in spring 2020 that in order to keep providing learning and development opportunities to staff, training courses and workshops would need to be moved online. A large number of courses across all sectors had to be postponed due to the coronavirus outbreak and those that were rescheduled were all delivered virtually via MS Teams, such as Permanence training or the Solihull Approach.

Priority was given to maintaining Student and Newly Qualified Social Work (NQSW) group sessions, and group sessions started to be conducted virtually in partnership with neighbouring Councils from September 2020 onwards.

Within Justice social work, the limited availability of national training resulted in delayed delivery of essential training to new staff and the professional development of others, and had a significant impact on the ability to deliver service. Three Social Workers recruited during the reporting period were unable to timeously complete the Level of Service Case Management Inventory (LSCMI) and other training including Stable and Acute, SARA and Caledonian, resulting in an inability to undertake risk assessments informing Court Reports. This resulted in additional pressure being placed on existing staff, who carry more complex caseloads. Despite increased delivery of training, there continued to be a presenting challenge as Community Justice Scotland training and development colleague's attempted to address the backlog in unmet training need across all Local Authorities.

The increased use of digital technology permitted maintained contact with each other, with people who access services, and with other professionals. It has offered a degree of flexibility and accessibility that we need to utilise going forward.

Within Children & Families Social Work (C&FSW), the utilisation of digital technology has had its challenges which included meetings being disrupted where one or more of the participants encountered poor connectivity and limitations to remotely support parents and children/young through discussion of difficult issues. The time taken to undertake a meeting was considerably longer using virtual means than "in person", however this was in some way off-set by reduced travelling time for both staff and families.

Where it was assessed that face-to-face contact was required, meetings took considerably longer, due to the need for adequate planning associated with COVID-19, such as ensuring appropriate PPE; all child protection visits remained as face-to-face throughout the time period.

Within Wheatlands residential care home, restrictions were placed on family and friends visiting children and young people as a result of public health guidance and, again, technology assisted communication was implemented.

As a result of the curtailment of court proceedings, there have been significant delays in formal decision-making in respect of children requiring alternative permanent care. This has also impacted on the ability to progress court applications for Guardianship.

Within the Family Placement Team, as a result of public health and Care Inspectorate guidance, the Short Breaks Service (respite for children and young people with complex needs) was postponed; additionally, whilst the assessment of prospective foster carers continued throughout the pandemic, the restrictions on face-to-face contact and home visits resulted in considerably longer assessment timescales.

There are a number of children and young people in care placements outwith Scottish Borders, who would in normal circumstances be visited by their social worker more frequently than was possible or safe during lockdown, however alternative means of communication was utilised.

As a result of moving to virtual Children's Hearings, the number of Hearings which took place was reduced which resulted in a backlog of meetings, and this is something that services continue to work hard on with colleagues in the Scottish Children's Reporter Administration.

Within Justice social work, a prioritised case management system was implemented to ensure those assessed as presenting as a high risk to themselves and/or others or who were vulnerable due to other factors continued to be managed and supported throughout the pandemic on a face to face basis; for other service users telephone contact was maintained.

The volume of new court-generated work was significantly reduced as a result of the temporary closure of local courts, with only essential business being conducted from Edinburgh, and, as such, the above delivery model worked well in practice.

During the initial and subsequent lockdown period, a percentage of justice social work staff, were redeployed to assist with the undertaking of shielding calls. Staff were later relocated to community resilience hubs and local health centres to assist with the support of ongoing communication and ensuring support services were in place for vulnerable members of the community. Unpaid work service staff assisted with the delivery of food parcels, medication and other essential goods to those identified as requiring support through the Shielding calls, Resilience Hubs and Out of Hours social work service.

Management of individuals subject to Multi Agency Public Protection Arrangements (MAPPA), was maintained, with panel meetings moving onto a digital platform and Risk Management Case Conferences being undertaken via telephone conferencing. This arrangement maintained the oversight of Risk Management and provided support and reassurance to staff from across agencies, ensuring plans were robust and deliverable despite the challenges of working within COVID-19 restrictions.

Risk Management Plans continued to be adhered to, ensuring priority contact for those assessed as High and Very High risk, and there was a focus on responding to the challenges of prison liberation for those requiring to travel home on release across Local Authorities in differing restriction tiers.

Adult Social Work services adjusted immediately to cope with the sudden and whole system impact from COVID-19. With immediacy the Adult Social Work teams restructured to work and lead the integrated response at a community level. Through the formation of locality hubs our social care and social work responses were triaged through Community Assistance Hubs to allow for community responses for lower levels of need.

The Social Work teams operated over a 7 day week to provide social work and social care and also to support the distribution of PPE across care homes, care providers and unpaid carers. Our teams formed cohorts of staff at a local level and staff worked virtually and from the local offices in line with government guidance.

Our Occupational Therapists and Social Workers used technology as well as following PPE guidance throughout the period. The resilience of the social work teams was strong with teams focused on the challenges of the pandemic as well as supporting their existing clients in very different ways. To maintain wellbeing each team formed different forums in which to virtually meet up and check-in with each other about their work and to maintain relationships.

The Local area coordination service provided face to face contact where required; access to community resources was restricted due to the wider impact of COVID-19 on universal and voluntary sector services.

Within Adult Social Work and Social Care crisis command and incident management protocols were implemented to ensure a coordinated approach took place across the delivery landscape of all health & social care settings. NHS Borders, Public Health, Scottish Borders Council, Emergency planning team and other partners such as Care Inspectorate were included as necessary.

Throughout the year our statutory duties in regards to assessment and specifically in relation to hospital discharge have remained in place. During the period we implemented a Trusted Assessment Scheme within NHS Borders. The Trusted Assessment Scheme was not required as an emergency measure but is now in place and is being further developed. Trusted assessors are where Allied Health Professionals & Nurses can look to provide an initial assessment or 'social prescription' which has the oversight and signoff by a qualified Social Work professional. In essence, this is to speed the process of assessment for those who use our services.

Over the period additional resources were placed into the Community Care Review Team. This team undertakes community reviews across Care Homes, Home Care and Unpaid carers. Whilst the additional pressure of undertaking unscheduled reviews within care homes added a pressure due to the timescale of completion, the service has undertaken the significant majority of reviews whilst also supporting NHS & Public Health monitoring of care homes.

Adult Learning Disability services have managed to deliver all statutory functions, although like all other areas of provision, pressure within the social work team is high. The ability to undertake timely reviews and proactive transition planning has been impacted as a consequence of Covid-19.

The closure of Day Services for adults with learning disabilities due to the impact of Covid-19 has placed increased pressure on family carers and supported living tenancies adding to the risk of placement breakdown. To mitigate the impact, priority was given to those in greatest need to identify what urgent replacement support was required, and outreach support was provided by day service staff or commissioned through external agencies.

ACHIEVEMENT HIGHLIGHTS DURING 2020/21

CHILDREN AND FAMILY SOCIAL WORK COMMISSIONED SERVICES PARTNERSHIP WORKING

The Aberlour Sustain "Edge of Care" project continued to operate throughout the pandemic, and families continued to engage positively, taking advantage of various means of support including virtual support over MS Teams, text, and telephone. As restrictions permitted, support was also offered during home visits and family contact in person and families engaged with 'garden visits' and 'socially distanced walks', observing social distancing and with the use of PPE.

Although Sustain is a service supporting families where children are assessed as being on the 'edge of care', support is offered as early as possible, and involves collaborative working with social work staff.

The Children 1st Abuse and Trauma Recovery Service, jointly commissioned by Children and Families Social Work and the Children and Young People Leadership Group, also continued to deliver services.

The service is available for children and young people aged 3-18 who have experienced sexual, physical and/or emotional abuse and where there is an impact of parental behaviour, providing Tier 2 and 3 support for young people who are not eligible for CAMHS specialist support, but are considered too complex for more universal support such as schools based emotional health and wellbeing service.

Children 1st prioritise referrals based on a number of factors such as severity of trauma symptoms, age, and trauma history, with children and young people who have experienced sexual abuse being given primary priority.

Engagement with Children 1st identified that the number of referrals increased over the period of the COVID-19 pandemic, at the time of writing a further financial commitment to the service has been agreed to ensure additional capacity is available to meet need.

STRATEGIC CARE HOME OVERSIGHT GROUP

This multi-agency group was established in response to the pandemic and its impact on social care provision, and has proved to be invaluable for partners to respond to specific issues in Care Home and care at home provision across the authority area. There have been significant challenges in the management of COVID-19 outbreaks, hospital discharge, staff needing to self-isolate and being able to recruit to vacancies. All of these factors placed significant additional pressure on service providers across the Social Work and Social Care landscape and the group provided a platform to support co-ordinated decision-making and approaches to service delivery.

PUBLIC PROTECTION

The Scottish Borders multi-agency Public Protection Committee (PPC) was established in January 2020 to provide leadership and oversight of the governance arrangements for Public Protection across the Scottish Borders on behalf of Scottish Borders Critical Services Oversight Group (CSOG). The PPC holds responsibility for adult support and protection and child protection and functions as the local 'Adult Support and Protection Committee' and 'Child Protection Committee' in line with Scottish legislation and Government guidance. The PPC also has oversight of Domestic Abuse services and MAPPA activity locally.

Throughout the pandemic the PPC has continued to meet remotely to ensure that local public protection services continue to operate effectively. Throughout the reporting period, the COVID-19 pandemic and restrictions on face to face contacts put in place to control the spread of the virus has had a significant influence on the work of the Public Protection Committee and partner services. Across services, managers and front line staff rose to the challenge of adapting practice to the new environment and increased adversity and risk for those vulnerable in our communities. Despite restrictions, where risk was present, staff have continued to carry out visits to provide appropriate assurance that mitigations are reducing risk.

Throughout the pandemic, the Critical Services Oversight Group maintained an overview of public protection services, ensuring that a clear focus was maintained on Child Protection, Adult Support & Protection and Domestic Abuse.

From the onset of the pandemic all Local Authorities have produced a weekly reports to Scottish Government on key delivery areas of:

- Child Protection activity
- Adult Support & Protection activity
- Homelessness numbers
- Children subject to multi-agency plans
- Children subject to through care and aftercare provision

Whilst this has been of particular benefit in ensuring consistent and regular reporting and monitoring at a local and national level, it is acknowledged that it has also been a significant undertaking for the performance team and operational services, and the efforts of those involved are greatly appreciated.

SAFE AND TOGETHER

We continue to develop the use of the Safe and Together approach to working with families where Domestic Abuse is a significant concern. We have embarked on multi-agency training to ensure that all partners are aligned to the benefits of this approach and crucially are able to begin using the same language in the understanding of Domestic Abuse. The approach aims to improve the support given to women and children by keeping children with the survivor parent, focusing on the strengths of the survivor parent, and intervening with the abuse perpetrator to reduce risk of harm. This has significant benefits in assessment and planning, including better assessment of coercive control, less victim blaming and better assessment and documentation of the impact of perpetrator's behaviour on children.
The PPC is committed to embedding the Safe and Together agenda across services and agencies, and a dedicated short life Oversight Group leads on this development work.

WELLBEING SUPPORT

The wider impact of the pandemic has seen many children experience disruption in relationships with people who are important to them including their parents, brothers and sisters, other family members, friends, professionals, social and school supports. Many families have experienced challenges due to increased unemployment and furlough schemes, and increased anxiety for children and young people.

As part of the response to COVID-19, some additional short-term funding was provided by Scottish Government to enable additional support. We have worked collaboratively with partners to make best use of this funding to ensure discretionary financial support is available to families in need, ensuring they can access food, goods and additional service provision from third sector partners.

EMPLOYMENT, TRAINING AND LEARNING

The Justice Service commissioned employment and training support and entered into a partnership with Works+, a local 3rd sector provider. Through delivery of employability support, Works+ supports people aged 18+ to overcome barriers leading to employment and/or training.

Further commissioning work saw a partnership arrangement put in place with The Community Learning and Development Service (CLDS), with CLDS delivering support to learners through a combination of virtual, postal and face to face platforms. This service is for people aged 18 +, to access sustained engagement in learning, achieve self-identified goals through an Individual Learning Plan, gain SQA accreditation and progress to other learning opportunities (CLD service, Borders College, Open University etc.)

Both commissioned services aim support desistance from further offending, and as a result build safer communities across the Scottish Borders.

CONNECTING SCOTLAND

Social Work services supported the roll-out of the Connecting Scotland project, which targeted provision of digital devices and connectivity. 160 devices were provided to a range of services within Children and Families Social Work and Justice Social Work, and support was also provided by social work staff who volunteered to act as Digital Champions, delivering support remotely, and engaging with new learners who lacked digital skills and confidence, and supporting children, young people and families to use the internet confidently and safely.

TRANSITIONS PRINCIPLES INTO PRACTICE

The Learning disability services along with partners in education, children and families' teams and adult social work have been accepted on the Principles into Practice Transitions trial along with a number of other local authorities in Scotland, supported by The Association for Real Change (ARC) Scotland. During this 2 year programme we will carry out a self-assessment of existing practices and identify priority actions to improve and deliver within the principles framework, building upon the work developed by the Learning Disability Service.

SERVICE QUALITY AND PERFORMANCE

During the period, the complaints process continued and the following table denotes the number of complaints made. The difference in the open and closed columns is due to some complaints not being resolved within the reporting period of this report.

Total Complaints	Opened	Closed
Children and Families Social Work	35	28
Health Social Care	4	3
Adult Social Work	71	54
Total Complaints Social Work Services	**110**	**85**

Total Complaints	Opened	Closed	Closed
Children and Families Social Work	6	22	**28**
Health Social Care	0	3	**3**
Social Work	19	35	**54**
Total Closed by Outcome for Social Work Services	**25**	**60**	**85**

DUTY OF CANDOUR

The organisational Duty of Candour provision of the Health (Tobacco, Nicotine etc. and Care) (Scotland) Act 2016, and The Duty of Candour Procedure (Scotland) Regulations 2018, set out the procedure that organisations providing health and care services and social work services in Scotland are required by law to follow when there has been an unintended or unexpected incident that results in death or harm.

If we believe an event may trigger Duty of Candour we must seek the views of a Registered Health Professional (RHP) to confirm that one of these "harms" has occurred as a result of the unexpected or unintended incident, rather than as a result of the individual's illness or underlying condition.

Scottish Borders Council Services have identified a number of routes for incidents which may trigger the duty of candour, including accidents reported by staff providing services, review of significant occurrences, incidents reported through Adult or Child Protection processes, complaints, or claims received by the Council.

Between 1 April 2020 and 31 March 2021, there were zero incidents where the duty of candour applied.

EXTERNAL SCRUTINY

There are a number of services subject to registration with the Care Inspectorate and subject to inspection.

CHILDREN'S SERVICE INSPECTIONS

There were no external children's services inspections during the period 1 April 2020 to 31 March 2021, however a Care Inspectorate report relating to an unannounced inspection at Wheatlands children's residential home on 5 March 2020 was published.

Wheatlands is registered as a care home for children and young people and can care for a maximum of seven young people between the ages of 12 and 22 years including two over 16 years in a nearby satellite flat, and provides residential care for young people who are assessed as requiring medium to long-term care. It is the Council's only residential service for children and young people within Scottish Borders.

In evaluating quality, the Care Inspectorate use a six point scale where 1 is unsatisfactory and 6 is excellent. During the inspection 2 areas were subject to scrutiny:

1. How well do we support children and young people's wellbeing? 6 - Excellent

The report noted consistent evidence of warm nurturing relationships, and that all young people reported feeling safe.

2. How well is our care and support planned? 5 - Very Good

The report noted that all young people had plans which appropriately assessed and met their needs.

Suggestions for improvement included a more up to date computer system and greater use of technology to permit staff more direct contact with young people.

SIGNIFICANT CASE REVIEWS AND SERIOUS CASE REVIEWS

There has been one Initial Case Review (ICR) under Adult Support & Protection and one under Child Protection in the period. Neither of these cases required to escalate to a Significant Case Review (SCR).

Additionally, there were no Justice service Serious / Significant Case Reviews undertaken during the reporting period. There were two social work-led cases which were subject to initial notifications to the Care Inspectorate and Multi Agency Public Protection Arrangements (MAPPA) Strategic Overview Group. No further action was required for either of these cases.

The learning from reviews undertaken within other local authority areas are considered within the structure of Public Protection.

SCOTTISH BORDERS COUNCIL INTERNAL AUDIT

During 2020-21 a Scottish Borders Council Internal Audit was undertaken in respect of Kinship and Foster Care payments, internal controls assurance work.

The report noted a number examples of good practice, including improvements in the electronic recording system, regular budget and service meeting, robust record keeping for all payments, regular reporting to the Scottish Government and that a formal plan was in place to ensure policies are reviewed, updated and published in a timely manner.

The report concluded that internal audit were able to provide comprehensive assurance that sound risk, control, and governance systems are in place, that these should be effective in mitigating risks to the achievement of objectives, and made no recommendations.

As well as the audit of Foster and Kinship Carer Payments, internal audit also carried out an audit of the Physical Disabilities Services (Adults & Children) and attended meetings of the Social Work Performance Board and Social Work Review Delivery Group to aid with an independent review of these meetings.

Internal Audit also carried out an audit of the Community Equipment Service; reviewing the governance of the service, statutory obligations to meet needs of customers, service delivery and value for money. An audit of Social Work Locality Offices' Payments regarding financial support to Corporate Appointees, Social Work Section Payments during the pandemic and the use of 'allpay' cards to meet customers' needs was conducted.

PERFORMANCE SUMMARY
CHILDREN & FAMILIES SOCIAL WORK DUTY TEAM

During the period 1 April 2020 to 31 March 2021, the number of referrals made was 2490, a slight increase on the 2326 referrals in 2019/20.

Robust arrangements are in place to screen and prioritise referral information quickly. Whilst social work is not an emergency service, swift responses to referrals are considered good practice.

LOOKED AFTER CHILDREN

In 2020-21 there was a monthly average of 182 Looked After Children (LAC) in Scottish Borders, a decrease from the monthly average of 197 in 2019/20.

As of 31 March 2021 there were 172 LAC; of these 35 were at home, 52 were in kinship care, 55 in internal foster care, 2 in external foster care, 1 in secure care, 25 in residential care and 2 in "other."
The most marked change in relation to LAC is the rise in the number of kinship care placements, increasing from 25 children in 2011 to 52 children in 2021. For the first time, the number of children in kinship care is greater than foster care.

Kinship care is a formal care status and regulated under the Children and Young People Act (Scotland) 2014. Kinship carers are paid an allowance for the children they care for which equates to the allowance paid to foster carers (foster carers also receive a fee in addition to the allowance and therefore costs are greater).

The benefits of providing alternative care for children within their own family and community are clear in terms of positive identity, relationships and sense of community, and is also the most cost effective form of alternative care for children and young people.

The number of children looked after at home has reduced over time, with the number of children in foster care and residential care remaining relatively stable.

The % of population aged 0-17 who are LAC in Scottish Borders in 2020 was 0.9%, lower than the national average of 1.4%.

Further details in respect of fostering, permanence and adoption are contained with the Scottish Borders fostering Panel Annual Report 2020 and the Scottish Borders Adoption and Permanence Panel Annual Report 2020; both reports are based on the calendar rather than financial year period.

Fostering Panel Annual Report 2020

Permanence Panel Annual Report 2020

CONTINUING CARE

Under the provisions of the Children and Young People (Scotland) Act 2014, local authorities in Scotland are required to provide care leavers with the opportunity to continue with the accommodation and assistance they were provided with immediately before they ceased to be looked after.

The Continuing Care Service, registered since November 2018, enables continuity in care placements for young people aged 16-21 who are no longer 'looked after' but have a legal status of 'continuing care'.

Continuing Care is an opportunity to plan in a gradual way increasing independence at a rate and stage that suits the evolving capacity of the young person. The aim of the provision is to ensure that all eligible looked after young people are encouraged, enabled and empowered to stay in an existing care placement until they are able to transition to interdependent living.

With regard to service delivery, this effectively means that young people are in care placements longer than they would historically have been. Young people who enter Continuing Care are able to remain in their placement until their 21st birthday. The financial impact is compounded when young people are in external care placements.

As of 31 March 2021, there were 31 young people within continuing care placements. The majority of young people were within internal foster care, however there were young people in kinship care, external foster care, internal residential care and external residential care.

ALBERT PLACE SUPPORTED ACCOMMODATION

Commencing in 2010, Albert Place is a joint Scottish Borders Council and Scottish Borders Housing Association (SBHA) initiative which provides semi-supported accommodation for care experienced young people.

The project consists of 4 self-contained semi-furnished transitional flats, 1 Training Flat and a Concierge Office. SBC Concierge staff provide tenants with on-site security & support from 6pm to 6am, 365 days a year.

SBHA Transitions staff provide emotional & practical hands on support with a variety of day to day issues, as well as information, advice & guidance on all aspects of housing options, tenancy management, independent living skills, safe door control & neighbourly respect.

Albert Place has had significant success in providing support and accommodation for care experienced young people and enabled many of them to sustain permanent tenancies of their own following the period of transitional support.

The 10 Year Anniversary report, published in September 2020, highlighted that, having had the opportunity to take their first steps towards independent living within Albert Place, 33 young care leavers out of 36 had been successful in maintaining a tenancy for 12 months or more. This equates to a success rate of 91.66%.

In addition, 35 young people had used the training flat which is designed to support young people develop independent living skills (524 overnight stays).

The vast majority of young care leavers engage with the care and support they receive and this has a direct and positive effect on their ability to manage their own tenancies in the wider community and ultimately their long term outcomes.

CHILD PROTECTION

reporting period 01 April - 31 March	2012 -13	2013 -14	2014 -15	2015 -16	2016 -17	2017 -18	2018 -19	2019 -20	2020 -21
Children on the Child Protection Register (at 31 March)	25	28	32	30	47	42	46	30	**53**
Children re-registered within 2 yers (at 31 March)	4%	0%	0%	14%	13%	7%	2%	7%	**4%**
Children on register aged 4 or under (at 31 March)	64%	58%	48%	61%	50%	45%	35%	63%	**60%**
Total Children registered during the year	49	45	52	46	89	55	69	50	**64**
Total Children de-registered during the year	58	42	48	49	72	59	65	66	**41**
Average number of weeks registered (of those on the CPR at 11 March)	28	28	24	24	31	41	35	37	**51**

Report:
Child Protection:
Time on Register

As can be seen there was an increase in the number of children registered over the whole year, however there have been a number of large sibling groups where all children have been registered, and the increase is also likely to be impacted by the effects of Covid-19 on some families (through increased emotional and financial stress; financial stress; increase in substance use; increase in domestic abuse rates).

The Child Protection Reviewing Officers who independently chair Child Protection Case Conferences have commented that Covid-19 has also impacted on decision-making in this forum, with a degree of uncertainty as to what extent "universal" services were functioning and professionals viewing continued registration as ensuring support was provided. This is something which was raised with managers and continues to form the basis of multi-agency discussions to ensure that children are only registered when appropriate to do so.

The information in the table above in relation to the number of children de-registered, which has decreased, and average number of weeks on the register, which has increased, confirms the experience of the Reviewing Officers.

The number of children re-registered within 2 years continues to show a downward trend since 2015/16, albeit higher this year than 2018/19.

CHILD PROTECTION ORDERS

01 Apr - 31 Mar	2015 -16	2016 -17	2017 -18	2018 -19	2019 -20	2020 -21
Child Protection Orders granted	**11**	**12**	**5**	**8**	**9**	**18**

The number of Child Protection Orders granted by the court has risen from 9 in 2019/20 to 18 in 2020/21.

By way of assurance, all applications are scrutinised by managers within the service before submission to court and the court provides a significant level of rigour to such applications.

Managers identified that some applications involved sibling groups and there were no identifiable concerns that early intervention had not been enacted to support families.

JUSTICE SOCIAL WORK

Justice social work continued to deliver services throughout the period of restrictions as a result of Covid-19. This was and continues to be a challenging time for staff and service users alike.

Directed by Scottish Government and Local Authority guidance, the service quickly established a delivery model based around a reduced office-based team that maintained essential service delivery, primarily focused on the management of risk, with other staff redeployed and engaged directly with the Covid-19 support programme from home and other community locations.

The service maintained links with Scottish Prison Service utilising digital platforms and safe visiting measures implemented to conduct Court Report interviews and attend prison-based case management meetings. While the service was impacted by a small number of staff who required to self-isolate, it was not affected by staff illness. PPE was readily available and presented no issues.

during reporting period 01 April - 31 March

during the reporting year 01 April - 31 March	2017 -18	2018 -19	2019 -20	2020 -21
CJSWR Completed	363	345	247	143
CPO - Supervision Only	52	39	43	33
CPO - UPW only	117	108	110	63
CPO - UPW plus Supervision	55	59	40	13
Total CPO issued	223	206	207	110
No. of Diversion from Prosecution Referrals			22	43
No. of Diversion from Prosecution Assessment			22	27
Number of open DTTO's			8	3
% of successfully completed DTTOs			44%	60%
DTTOs Imposed			4	0
No. of new Voluntary Throughcare Cases Offered			30	10
No. of new Voluntary Throughcare Cases Accepted			10	4
Open Statutory Throughcare Cases			61	57
In Custody			40	42
In Community			21	15

As can be seen from the data, the number of Criminal Justice Social Work Reports (CJSWR) considerably reduced, this was a result of the reduction in court business.

The reduction in court business also resulted in lower numbers of Community Payback Orders being imposed.

During 2020/21 81% of Community Payback Orders (CPO) were completed successfully.

The Criminal Justice Social Work Service continued to work in partnership with other professionals to assess and manage the risk posed by people who present a risk of significant harm to others. This includes working within Multi-agency Public Protection Arrangements (MAPPA). The operation of MAPPA is subject to a separate annual report by the Independent chair of the MAPPA Strategic Oversight Group for Edinburgh, Lothians and Scottish Borders.

Unpaid work (UPW) undertaken by supported people as a requirement of a Court Order is a significant part of the Justice Service remit. Due to COVID-19 restrictions, UPW ceased in March 2020. As guidance and restrictions eased, unpaid work staff were redeployed across council services to assist with COVID-19 support. Staff primarily engaged in emergency delivery of food and medical supplies, linking into Community Resilience Hubs and EDT. The services Justice Officer worked with both Scottish Borders Council and a local GP service undertaking shielding support calls. Staff gradually returned to their substantive posts as restrictions eased in the Autumn 2020, when they facilitated the co-ordination and delivery of IT devices across the Borders, to those who experienced digital poverty or who did not have access to IT equipment or WIFI availability, to enable communication and maintain links with key services as part of the Connect Scotland phase 2 roll out.

Powers implemented through the Coronavirus (Scotland) Act 2020 and the Coronavirus (Scotland) (No.2) Act 2020 legislated for the extension of pre-existing orders, facilitating additional time for order completion. In addition, in 15 March 2021, The Community Orders (Scotland) Regulations 2021, legislated for a 35% reduction to original CPO's with UPW or Other Activity, excluding those imposed for domestic abuse, sexual offences or stalking. This has reduced the number of unmet hours in the borders by 5,110.75 to 10,996 as at 31st March 2021.

The service has sought to identify additional opportunities for those subject to UPW to complete their hours through other activity, including the commissioning of The Wise Group CPO Connect pilot in February 2021. Delivery of the digital suite of programmes, originally scheduled to end May 2021 will continue through to July and possibly beyond.

Scottish Government carried out the early release of prisoners who met a certain criteria within the prison establishment, however, there were no early prison releases in Scottish Borders There was no significant increase in relation to longer custodial sentences or people on remand noted during the reporting period, however we are currently seeing an increase in remand numbers and rise in the number of individuals sentenced to between 6 months – less than 2 years. Given the broad Scottish Prison Service reporting criteria for this measure, it is not known how many, if any, of these convictions fall below the 12 month Presumption Against Short Term Sentences.

Further information regarding Justice social work will be available within the Community Payback Order (CPO) Annual Report, however the 2020/21 CPO annual report template has only just been issued and is due for submission to Community Justice Scotland by 31st October.

ADULT SERVICES

The following information highlights some key information over the year:

409 social work cases allocated per month. (12 month average to Feb 2021)	**1,280** patients have gone through Home First (Year to Nov 2020)	On average **15,128** hours of Homecare delivered per month, for **716** people	Clients recieved, on average, **21 hours** of care per month.	**1,800** active Community Alarms in individual's homes in the Scottish Borders

The response to Covid-19 has shaped service delivery. From March 2020 onwards Community Assistance Hubs were utilised to triage and direct social work and social care.

Adult Social Work teams coordinated third sector and formal care support according to demand and risk, and provided a care management approach to allow identification and prioritising of resources through a time of high unpredictability.

Adult Social Work played a key role in supporting the distribution of PPE and providing information, guidance and virtual and face to face support to people including unpaid carers in a long-term state of emergency response.

Throughout the period social work teams have undertaken full assessments including from within hospital settings.

Within hospitals and locality teams daily and intra-week multi-disciplinary meetings were held virtually with attendance of third and independent sector providers alongside health and social work. These discussions took place to ensure appropriate prioritisation of community and hospital demands.

In times during lockdown it was essential to reduce non-critical support to individuals in order to prioritise critical care support. In these instances care was re-instated as a priority or reviewed in conjunction with the person/ family as many families had moved-in together or were able to provide unpaid support as a result of not-working or working from home.

The Borders has made progress towards our aim of providing more care in the community and enabling older people to live independently at home:

- 94.3 % of our over 75 population lives at home - either with no requirement for any care at all or supported through social care to remain at home
- 5.7% of our over 75 population are cared for in a care home, hospice or a hospital setting.

Referrals Received	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	20/21 TOTAL
Central	77	113	137	121	122	157	134	130	113	133	119	145	1501
Duns	37	50	52	62	76	64	49	48	35	49	48	58	628
Hawick	78	82	88	115	99	115	84	95	99	123	96	126	1200
Kelso	72	74	91	93	87	84	76	85	85	73	85	105	1010
Peebles	43	59	87	78	68	63	76	69	83	69	64	71	830
START	43	45	49	59	54	32	45	32	40	22	33	35	489
Total	350	423	504	528	506	515	464	459	455	469	445	540	5658

Clients on Waiting List	at 31.03.2020	at 31.03.2021
Central	98	136
Duns	39	31
Hawick	80	47
Kelso	90	51
Peebles	70	22
All Areas	**377**	**287**

As can be seen in the above tables, the level of referrals received seen significant increase. This was despite the lower volumes of people who were engaging with GP practices, hospitals or the support they would ordinarily have been linked into prior to lockdown.

A significant proportion of people awaiting a social work response (current 50% - 60%) was in relation to Occupational Therapy assessment. As people were less active and more prone to the adverse effects of social isolation it is anticipated there will be a prolonged period of increase in demand for Occupational therapy input.

Significantly, a number of home adaptations have not been able to be progressed due to Covid-19 restrictions and the impact on planning, accessing materials and works being undertaken.

LEARNING DISABILITY & MENTAL HEALTH:

Learning Disability Social Work continues to manage their waiting lists through a monthly prioritisation meeting. As a service they continue to develop appropriate accommodation and support arrangements in line with needs of service user groups. They are progressing plans to develop local complex care accommodation to enable a reduction in the likelihood of accessing placements out with the Borders. To achieve this, a project delivery group is in place and it is planned that the service will be up and running within 2024/25

The recent commission of a new Shared Lives scheme (March 2020) has delivered 6 new placements to date and further placements are planned for this year, including respite care and day care support.

Mental Health Social Work based within Integrated Mental Health Services are developing a Mental Health Transformation programme. This includes all service areas with priority areas initially being identified in Community Mental Health Teams, Crisis services and Liaison Services. Several projects are also underway to review the Mental Health Day Service and the provision of Mental Health supported living services.

During COVID the focus of the Mental Health teams was supporting service users and responding to the need for ensuring food parcels and financial issues were addressed for those using services across the whole of Scottish Borders.

Like other Social Work services, managing with reduced staff numbers due to recruitment issues made the delivery of services challenging. It is acknowledged within Mental Health services that demand for services for complex needs, which is led by social work is increasing, often for young adults with neuro developmental conditions which are increasing in prevalence. This work involves multi-disciplinary assessments and seeking suitable resources which are often bespoke to the individual's needs. Mental Health services have also had a high demand for Council Officer work in relation to Adult Support & Protection, throughout the Pandemic.

MENTAL HEALTH OFFICER (MHO)

Statutory social work services provided under the Mental Health (Care & Treatment) (Scotland) Act 2003 and Adults with Incapacity (Scotland) Act 2000 are delivered by AHSCP.

The following table highlights that there has been a marked increase in Emergency detentions and Short term detentions over the reporting period.

during reporting period 01 April - 31 Mar	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21
Emergency Detention	21	18	27	17	28	30	25	34	49
Short Term Detention	74	62	77	61	71	71	82	87	101
Compulsory Treatment	37	43	41	28	29	26	33	26	27

The likelihood of a link to increased stress and isolation as a result of the pandemic and subsequent restrictions is highly probable. This is an issue which will be explored in more detail in the future.

The following table denotes the number of private welfare guardianships and the number of Chief Social Work Officer welfare guardianships that have taken place in the reporting period.

As at 31 March	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21
Private Welfare Guardianship	41	64	71	97	115	137	164	182	193
Chief SW Officer Welfare Guardianship	20	22	18	29	38	35	46	56	70

Notably there is a continuing increase in private welfare guardianship applications in line with previous years but also a significant increase in Chief Social Work Officer applications for this reporting year. Some of this increase in the latter applications will be in response to ensuring that appropriate legal frameworks are in place for individuals where there are no power of attorney or welfare guardianship arrangements in place. Having appropriate legal frameworks in place is critical to ensure that individuals' rights are protected and promoted.

RESOURCES & FINANCIAL PRESSURE

CHILDREN AND FAMILIES SOCIAL WORK

The overall revised budget for C&FSW has remained relatively static despite additional expectations from National legislative, policy and guidance changes and increased costs. The largest spend within C&FSW budget is in relation to "External Placements" which includes Day Care - Complex Needs; Day Care - Social, Emotional & Behavioural Needs; Residential Care - Social, Emotional & Behavioural Needs; Residential Care - Complex Needs; and Foster Care - External Provision.

There have been a number of changes and trends over the last 5 years in children's social care needs. These have included a rise in the number of children either requiring accommodation or being on the edge of accommodation due to significant and complex physical and mental health issues.

This has been compounded by limited local specialist resources; it is estimated that around 65% of external placements require specialist provision due to their additional or complex needs, or behavioural needs.

Most external providers have 'in-house' health and psychological services and offer a range of therapeutic services not available within local resources. Placements are based on needs assessment and providers on the Scotland Excel Frameworks are preferred to others, and there are a set of schedules including terms and conditions and specification that all providers have signed up to. For those not on the framework we have a standard set of terms and conditions and use the same specification as the framework.

Prices are generally non-negotiable although the council's Procurement Team have worked hard to limit uplifts and placement costs through challenging proposed increases from providers who are not part of the Scotland Excel Framework.

As a small local authority with relatively few external placements we spot-purchase which leaves no option of block negotiation.

There are no year-to-year increases in C&FSW budget allocation to reflect increases to external placement costs which places strain on the budget.

Aberlour Child Care Trust, in partnership with Scottish Borders Housing Association (SBHA) and SBC are planning to build a residential provision for children with complex needs in the Scottish Borders. Scottish Borders Council staff are part of the management group which is progressing this development. The anticipated cost of care is projected at £125,000 per annum, considerably lower than external residential care costs. Crucially, this provision will allow children and young people who require this type of provision, to remain within the Scottish Borders rather than being placed out with.

The costs associated with kinship care continue to rise as the number of carers increases; the costs associated with payments have risen from £585,238 in 2017/18 to £813,760 in 2020/21. Additionally, as the number of kinship carers has grown, so too has the level and volume of support provided.

Likewise, continuing care is placing additional pressure on the service budget and there will be an on-going financial impact unless additional action is taken, and investment made, to reduce the number of children in care.

In 2019, as a result of a number of local authorities citing Continuing Care as a key driver of budget pressure, COSLA surveyed all local authorities in order to determine the extent of the degrees of financial pressures accommodating young people potentially up to the eve of their 26th birthday would bring. At that time, based on the detailed care records of eligible young people, Scottish Borders Council estimated that Continuing Care could cost SBC an additional £4,000,000 - £5,000,000 per annum by 2024.

Continuing Care will require additional financial commitments which are likely to continue to rise unless additional action is taken, and investment made, to reduce the number of children in care and external care provision.

A further pressure relates to discretionary payments for accommodation for previously looked after children within further or higher education. Whilst there is no consistent approach across Scotland, Scottish Borders are one of only a few local authorities where a deduction is made to account for a young person contributing the "local rent" average which is deducted from the bursary payment.

During 2020/21, 47 young people from Scottish Borders were provided with payment, should there be a requirement to pay the bursary in full the financial impact would have been in excess of £130,000.

Increasing the use of Self Directed Support in C&FSW and the development of local, community based packages of care for children with complex needs and disabilities is creating some financial pressure on budget.

There are a growing number of young people with complex behavioural and emotional needs, and at present there are a number of young people aged 14+ with complex needs, including Autistic Spectrum Disorder.

There has been a consistent and sustained growth for supervised parental contact (directed by Children's Hearings and the court) and this has eroded the early intervention support role of the Social Work Assistant, with the majority of staff time now directed towards safely facilitating, hearing or court mandated contact between parents and children.

A snapshot of volume demand in October 2020 indicated 61 weekly contacts, with 87.5 hours staff time involved in contact and 90 hours additional travel, with a total distance of 2523 miles travelled.

In addition there is 0.5FTE staff member dedicated to planning contacts, travel involved prior to the contact e.g. to collect car seats and travel to carers, and all staff are required to update case records and assessments following contact.

Recruitment and retention of social workers has been an issue within C&FSW for a number of years which has resulted in posts remaining vacant or being filled by temporary agency staff at a significantly increased cost.

More recently, there are fewer agency staff available to undertake short term roles; it is likely this is due to a shortage of social workers nationally resulting in a high level of demand for agency workers as a result of COVID-19.

Agency staff costs in 2019/20 was £420,799.45, falling to £315,380.93 in 2020/21

ADULT SOCIAL WORK AND SOCIAL CARE

Adult Social Work and Social Care extended the existing contracts with third and independent sector organisations. During 2020 we set out a plan to undertake a large scale commissioning and engagement programme which would see the re-commissioning of home care services and our community response services.

This dialogue was paused in terms of progressing with a participation plan for the recommissioning but the conversation on our commissioning approach as being Community Led and aiming to achieve partnerships of organisations focused on outcomes for individuals was ongoing.

This approach and greater involvement in commissioning by a range of service users, service user organisations and our third sector interface organisations is reaching a point of realisation. This has included a consultation through our Older Peoples Planning Group to gather views on their experience of Scottish Borders response during lockdown. Also, it was essential we reviewed our charging policy for non-residential care as we had two extra care housing developments reaching completion in 2021. We also wanted to introduce financial assessment to instances where we had previously had flat rate charges that were not financially assessed.

In reviewing our charges we took a light touch in line with COSLA guidance and in light of the global pandemic impact. We had an online consultation on our charging policy review as well as engagement with third sector organisations and service user forums.

Learning Disabilities services identified that financial pressures have occurred, the number of children transitioning to adult services with and the replacement care costs for those unable to access Day Services due to the impact of COVID-19.

Work is underway to increase local resources to reduce the number of people being placed out of Scottish Borders and we continue to work with NHS Lothian in the development of NHS inpatient facilities for Adults with a Learning Disability to reduce the number of expensive private hospital placements.

The Shared Lives service provides more cost efficient care and support than previously available models of support.

Mental Health Services continue to experience financial pressures. The service is focussing on maximising its re-ablement services such is the Local Area Coordination service as well as reviewing its day service model of support.

ADULT SOCIAL WORK AND SOCIAL CARE

The Justice Social Work service has a dedicated ring-fenced budget from Scottish Government to deliver the statutory Justice services locally.

WORKFORCE PLANNING

Across Scotland, Social Work and Social Care are experiencing real challenges with regard to the recruitment and retention of staff. This is particularly challenging in more rural areas and has led to significant challenges in being able to effectively deliver services in Scottish Borders.

Locally, Children and Families Social Work in particular have had significant challenges in recruiting qualified social workers, which is a risk in relation to delivering essential services and on the well-being of staff who are working above their contracted hours to ensure children are safe. As an organisation, we are mindful of the potential for 'hidden harm' in relation to the impact on staff from this level of ongoing pressure, the importance of ensuring that staff are appropriately supported through support and supervision by line managers is critical in mitigating this.

WORKFORCE DEVELOPMENT

A key response to the challenges of having a sufficient number of qualified social workers is our Trainee Scheme to 'grow our own' qualified Social Workers.

Scottish Borders' partnership with the Open University offers existing permanent staff the opportunity to have a pathway to social work qualification. It provides the opportunity to develop and retain current staff as well as attract new talent.

As mentioned earlier, workforce development is a key aspect for the recruitment and retention of staff in Scottish Borders. Each and every Social Work service has had difficulty in attracting staff to vacant posts. To support the recruitment process, staff in conjunction with Human Resources colleagues have worked hard to make Scottish Borders a good place to live and work. We have embarked upon extending where we advertise as well as using what we have learned from COVID-19 and the more agile way of working via the use of technology to attract the right people for the right roles.

It should be noted that there is a national issue in relation to the recruitment and retention of staff in Social Work and Social Care. By looking at how we create career pathways for those we employ, as well as offering attractive learning and development opportunities, we hope to be able to successfully fill permanent posts which are vacant.

That being said, there is a real need for a review of what role Social Workers undertake, aligned to the capacity we have given the challenges of recruitment and look openly at how we can deliver services differently in the future. This is a piece of work which we will be undertaking in the near future and will likely require significant changes.

THE YEAR AHEAD 2021/22

Social Work managers recognise that Recovery may create anxiety amongst staff and people who access social work services, and understanding these fears is critical to restoring confidence and charting our Recovery pathway.

Covid-19 has been the catalyst to fundamental changes e.g. the "virtualisation" of work. The necessity of operating differently has given us the opportunity to understand what we can do, and what we may want to continue doing; it may also result in altering our strategy and planning.

We need to be in a position to shape our Recovery so that we can emerge stronger, and be in a position to reinvent, identifying new opportunities and becoming the drivers of our "new normal".

We need to consider changes to demand, explore opportunities for collaboration and conduct scenario planning based on needs.

Questions to consider include:

- Determining which functions, work, and roles need to return to the workplace to be effective, and which can continue to work remotely (blended approach to service delivery).
- Modelling scenarios that evaluate potential workforce and workplace options.
- Adjusting the workplace as needed to ensure staff well-being, health, and safety.
- Establishing feedback channels to understand workforce concerns and conditions.
- Assessing what supplemental support, technology and tools are needed.

We also need to ensure the role of Social Work and the purpose of our services remains clear and we fully comply with the Scottish Social Services Council Codes of Practice for Workers and Employers.

What I can say with some confidence is that the full extent and impact of Covid-19 is not yet known, and it is likely that it will be years before we are able to fully understand the changed demands on services.

The Independent Review of Adult Social Care was published on 3 February 2021 and, whilst the original scope of the consultation focussed on Adult Social Care services, the Scottish Government have expanded this to consider the scope, remit, inclusivity and delivery mechanisms of the National Care Service in its widest sense and a consultation has commenced which also seeks views on the children and young people, criminal justice, community justice, alcohol and drug services, and social work.

The findings of the Independent Care Review culminated in the publication of seven reports in February 2020, including 'The Promise'. This has since been followed up with the publication of the Plan 21-24 and most recently The Change Programme One.

Whilst the overall service delivery landscape may be impacted by the implementation of the Independent Review of Adult Social Care, the activity required to deliver on The Promise will remain relevant and of critical importance across all organisations. We will continue to support the delivery of that vision, building on the good practice that already exists across services for children and young people.

Within the public protection landscape, 2021 will see the publication of new Child Protection Guidance. Whilst the exact detail has yet to be seen (publication is due in September 2021), there are a number of thematic changes of which I am aware, including an increased emphasis on prevention and early help in order to keep children safe without drawing families unnecessarily into child protection procedures, new guidance on information sharing, increased focus on engagement and collaboration with families, and ensuring a learning culture in workforce supervision, training and development.

Within Children and Family Social Work, investment will be made in developing engagement with children and young people, and commissioning a Family Group Decision Making service as part of a "test of change" to support early intervention with families to support the need to reduce the number of children entering non-familial care.

It also worth noting that The Scottish Parliament passed the Redress for Survivors (Historical Child Abuse in Care) (Scotland) Bill in March 2021. Redress Scotland, a new non departmental public body, will assess applications from survivors, make decisions and review appeals for the financial redress award(s) for the next 5 years. The scheme will provide financial and non-financial redress for survivors.

Within Justice Social Work, the planned service expansion which was put on hold in 2020/21 due to the impact of COVID-19 and will be taken forward in the coming year. The service will progress with recruiting a Wellbeing Officer post in the coming year, this 2 year post being jointly funded by Community Justice and the NHS Joint Health Improvement Team.

Two Group Work Co-ordinators will also be recruited in 2021 to deliver the Caledonian Men's Programme, following work undertaken to disaggregate the previous delivery partnership. The new arrangement ended a long-standing partnership with Edinburgh and the Lothian's and is aimed at increasing the number of men from the Scottish Borders referred into and who complete the Court mandated domestic abuse programme.

ADULT SOCIAL WORK

Over the next 2-3 years the demands on adult social work and social care are going to increase from three main issues: Firstly, there will be the natural demand that was predictable; secondly, there is the pent up demand as a result of lockdown, people not able to engage with services or the wider world supports and thirdly, there are the people who were living well pre-Covid and but who have been significantly impacted by what the pandemic has inflicted on their lives. Due to COVID-19, the impact of lockdown and a Health system which has predicted 3 years of high pressure on primary and secondary care resources will naturally mean that community social work and strengthening the alliance across third sector, independent sector, public sector and communities must be a focus in terms of service. However, in providing that service and meeting the additional demands it will take organisational change, a reshaping of resources and a vision for social work based on a world which is moving faster. Therefore, over the next year, maintaining a sense of urgency – 'COVID-19 is not over' – is critical. Our organisational cultures have changed over the last year, however, the comfort of the past is often more attractive than fast, frequent change; we must be careful to ensure a sense of urgency, immediacy in both Practice and Change.

Strengthening community social work is essential as it embraces statutory duties, is flexible and adaptive. These attributes will better allow Social Work and Social Care to both prevent crisis and respond to crisis situations; whether this is within a family, community or in response to a national or global pandemic. Given the challenges that COVID-19 has presented, it is anticipated that there will be an ongoing period of additional demand as the full scale of the impact of the pandemic becomes clearer. As mentioned earlier, the need to review the way in which we operate will be fundamental to address these challenges.

CONCLUSION

In conclusion to this year's annual report, as the Chief Social Work Officer, I am privileged to have the opportunity to highlight the effort that has been made to support our communities and would like to thank each and every member of staff from Social Work and Social Care for their hard work and dedication in providing critical services in exceptionally challenging circumstances. Their commitment to keeping people who use our services at the centre of everything that they have done is commendable.

It is also important to note that the pandemic itself is not over and the longer term impact is not yet known. It is crucial that we continue to support our staff groups to continue to collaborate with partners, communities and individuals to support those most in need.

The coming years will be challenging for a number of reasons, however, by supporting our staff and continuing to innovate the way in which we operate, I am confident that Scottish Borders Social Work services will continue to rise to the challenge.

Stuart C. Easingwood
Director of Social Work & Practice (CSWO)

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Minutes of a meeting of the **Scottish Borders Health & Social Care Strategic Planning Group** held on **Wednesday 3 November 2021** at **10am** via Microsoft Teams

Present: Lucy O'Leary, Non-Executive NHS Borders (Chair)
Chris Myers, Chief Officer
Gerry Begg, Housing Strategy Manager
Lynn Gallacher, Borders Carers Centre
Caroline Green, Public Member
Wendy Henderson, Independent Sector Lead
Colin McGrath, Community Councillor
Graeme McMurdo, Programme Manager
Clare Oliver, Communications Manager
Brian Paris, Deputy Chief Social Work Officer
Jenny Smith, Borders Care Voice

In Attendance: Laura Prebble, Minute Taker
Matthew Hilferty, Development Officer for Health & Social Care Alliance Scotland

1. APOLOGIES AND ANNOUNCEMENTS

Apologies received from Keith Allan, Stuart Easingwood, Diana Findlay, Susan Holmes, Jill Stacey.

The Chair confirmed the meeting was quorate.

Introductions were made for the new Chief Officer. Agenda change noted.

2. MINUTES OF THE PREVIOUS MEETING

The minutes of the previous meeting held on 4 August 2021 were approved with the following amendment:
- Jenny Miller to be amended to Jenny Smith.

3. MATTERS ARISING

Action Tracker: All items complete. Graeme McMurdo shared the link to the approved performance report in the Teams chat.

The **STRATEGIC PLANNING GROUP** noted the Action Tracker as complete.

4. ALLIANCE REPORT – Matthew Hilferty

Matthew was welcomed to the meeting to present the new ALLIANCE report summing up the learning from their work with Borders Care Voice and the TSI this year. The report '20 Years into the Future' was shared on screen. Matthew thanked Borders Care Voice and TSI for organising forums to gather information in July. ALLIANCE is a national 3rd sector intermediary with 3 core aims; putting people at the centre, supporting transformation of change and championing and supporting the 3rd sector. Their aim is to capture the voices of the 3rd sector to influence decision making. There are 7 key themes; community support, family support, carer support, person centred approach, financial concerns, promotion of Scottish Borders and engagement with Health & Social Care services.

Summary: People want to remain in their own homes. They want adequate home care and child care to be in place to ensure parents and grandparents are able to work, volunteer and support the community. For there to be support for carers to ensure they are able to carry out their role. For the voice of the lived experience to be heard and incorporated into the strategic planning. For services to be person centred. Greater financial resources to be allocated to the third sector and health and social care services. For the Scottish Borders to be promoted as a place to live and work. To have fully integrated health and social care services which offer a choice of face to face, online and telephone support.

Lynn Gallacher noted that the report was really interesting. Lynn added that there is a critical need for respite in the Borders at present. She added that this report echoes the findings of Borders Carers. Only 2% of attendees at the forum event agreed that respite is working with 67% wanting building centred day care. Matthew Hilferty added that respite was not good pre pandemic but is felt to be worse now. Lynn added that voices are not being heard and actions are not being taken.

Clare Oliver commented that the report added nothing new and that the information was already known. It is now about acting on the information. There is a commitment to listen but views are not being heard. To pick up on this.

Caroline Green commented that the majority of people would prefer to have end of life care at home. She asked is Marie Curie had been included in the report and Matthew Hilfery noted that they were not. The statutory SBC and NHS and the 2 forums in April and July were used to gather data. Caroline Green added that Marie Curie and the Red Cross can help with equipment to help people stay at home saving the necessity of having an NHS bed. She wanted to raise the issue that Marie Curie do a lot in integrated support.

Wendy Henderson added that the report reflects the views of the providers of adult social care. This may be an opportunity to tie work in. Wendy noted that 75% of care homes are in the independent sector. To look at how to join up and support each other as we go into the commissioning strategy.

Chris Myers noted that it was helpful that all the pieces of work are saying the same thing. The SPG advises the IJB on the direction of travel. This is a timely piece of work as we need to listen to and understand the needs of the public, staff and partners to be able to make a new plan to act on them. Chris added that there is a national review of palliative care due for refresh

this year and the new national strategy will be on the SPG radar which will include Marie Curie. The new strategy will come to the SPG when the national framework is published.

Graeme McMurdo commented on the promotion of the Scottish Borders. Now people are able to work from home the Borders can now attract more people in. There is a need now to invest in connectivity rather than the road and rail network. The pandemic has brought this benefit to the Borders. He added that grandparents are often a free child care option which is the reason they are used. He added that a single point of contact is also a single point of failure.

Colin McGrath noted the same theme, putting people at the centre. Being person led is part of the Community Empowerment Act. All members of the community, including patients, have an empowered voice. Colin added that they need to be informed about this legislation which empowers their voice.

Clare Oliver noted that there is are joint strategies for recruitment in the future.

The Chair concluded that that is an excellent demonstration of multiple ways of coming to the same conclusion. Whole system working approach is needed. There is a 3rd forum planned and Jenny Smith noted that there this may now be in the new year. Jenny will link with Wendy Henderson to take on board the need to involve national organisations such as Marie Curie.

Action: Matthew Hilferty to send the link to the full report to Lucy/Chris to circulate to members. The report can be shared beyond this group.

The Chair asked where the report will go to now and Matthew noted that it was up to this group where the report goes. It can go to the IJB or any other forums. It will be fed into the Older Persons Pathway. **Action**: Chair to take the report to the IJB as a progress report

The **STRATEGIC PLANNING GROUP** noted the report and thanked Matthew Hilferty for his presentation.

5. STRATEGIC PLANNING APPROACH – Chris Myers

Chris Myers circulated the paper for discussion.

There will be major strategic developments in the next 12 months feeding into the developing Strategic Commissioning Plan. A joint needs assessment is needed to decide what is to be commissioned. To have a Future Strategy Group which reports into the SPG. The 10 workstreams remain but to agree which committee they report into, maybe the Audit Committee. To renew the Terms of Reference (ToR) so as to be able to do what is needed. The Chair agreed clarity of the committee's ToR makes sense.

Caroline Green and Colin McGrath both noted that it is unknown what services are integrated following the 2014 Act. It is unknown which members of staff are integrated and who they are employed by. The Chief Officer and the Chief Financial Officer are named in the Act. Colin asked what services are transferring and what services have been integrated. Colin asked that the legislation is considered.

Wendy Henderson noted that anything that allows and speeds up decision making is welcomed. The Act has not provided a unified approach as different approaches have been taken across Scotland. It will be good to be thinking of the National Care Service (NCS) in the new year.

Jenny Smith noted that more clarity is needed on the governance structure. To look at the overall resources of the partnership and to capture the work being done. The NCS is trying to remedy the inconsistencies.

Lynn Gallacher also supported the report adding that it is important to have the right people around the table. Lynn added that there need to be more evidence that the SPG influences the decisions of the IJB. Lynn suggested the SPG should meet more frequently to keep up with the current fast pace of change.

Clare Oliver supported the report. From an engagement and involvement perspective it is important to have a really good representative of members. To ensure how information is fed through committees. Clare also flagged the issue of inadequate resource.

Graeme McMurdo supported the report and asked what the strategies going forward. The legislation is fine but ineffective.

Brian Paris supported the report and noted that integration needs to be clearer. There is a need to be able to respond at pace. To put a structure in place to be able to plan but it needs to be flexible to meet the pace of change in the world. To be able to use resources to deliver statutory duties and what we want to achieve in the Borders. Resourcing social care is a significant issue. The workforce is now a world market. To take action now for what workforce we need in the future. Technology will be key. Brian agreed a review of the structure is essential. To look at how adaptive governance is.

Wendy Henderson noted the huge opportunities. There is a need to be flexible. To look at how we continue to deliver care in a time of crisis. There are no new staff coming in for anyone to employ.

Lynn Gallacher asked that the pre-pandemic strategic decisions do not get in the way of post pandemic strategic decisions. Decisions should meet the current needs going forward.

The Chair concluded that a solid sustainable strategy for a fast changing world is needed.

Chris Myers thanked everyone for their comments on getting the right governance and securities in place. Chris noted the fact that a number of services are on the edge. Chris asked for members to read the paper fully and make any further comment or suggestions to him. The report will be taken to the next IJB in December.

The **STRATEGIC PLANNING GROUP** noted the report.

Action: Chris Myers to give feedback from IJB at the next meeting.

6. TIMESCALE/APPROACH FOR THE SOCIAL CARE PLAN – Graeme McMurdo/Chris Myers

Graeme gave a presentation on screen.
The Social Care Plan was due for renewal in April 2021 and a 12 month extension due to Covid was approved. The plan can be for 3, 5 or 10 years which would pick up everything and is now due in April 2022. Since then the Feeley Report has been published. Sustainability is an issue – increased demand and less resource. To be able to measure progress. Various committees will need to sign off the plan. Graeme noted that it may not be a good plan if it needs to be ready by April 2022 and is raising the concern here. For there to be enough time to write a comprehensive plan a further extension is needed. Approval is requested of the SPG to ask the Scottish Government for a further extension. If not there is a risk the plan will not be we want for the next 3, 5 or 10 years. Chris Myers added that last year the IJB were allowed an extended their planning period to review their plan and the feedback from the Scottish Government was that there needs to be support to seek an extension and to seek a steer from them, if appropriate.

Wendy Henderson supported the request and added that an integrated assessment was required to demonstrate compliance. Wendy asked if any other authorities were in the same position and Graeme noted that Glasgow have also requested an extension until April 2023. The NCS is raising questions. There is a plan in place but a year extension is needed to do it properly.

Jenny Smith noted that the data required is not possible to gather in the current time frame. Jenny asked how the Scottish Government will respond to a developmental approach. Chris Myers agreed an integrated impact assessment is needed to develop a commissioning approach that aligns with other processes. For SBC and NHS and IJB to all have a plan that are in alignment. Consultations to be aligned. Strategic corporate planning needs to dovetail better. To do one needs assessment rather than three. Wendy Henderson supported this alignment to reduce the number of events and allow for connections.

The Chair also supported the approach outlined in the slides. More clarity is needed on what is being suggested. Lucy suggested that Graeme and Chris make a plan to align the social care plan so as to be ready for the NCS.

Graeme noted that at a strategic level the 3 objectives in the plan were unlikely to change but the workstreams underneath may change.

The **STRATEGIC PLANNING GROUP** agreed that an extension can be sought from the Scottish Government.

7. ANY OTHER BUSINES

- Lynn Gallacher noted that the mental health and wellbeing of unpaid carers is in crisis leading to hospital admissions. They are asking for more respite as well as building based respite for middle and high level need and dementia. Locally, there is no support for this group. Action needs to happen now. Lynn acknowledged that it is difficult to recruit staff and suggested that existing staff could be used differently. Lynn asked to

raise this to the IJB for them to look at commissioning to meet this need. Lynn added that there has been an event ‘Change is a good as a rest’. **Action**: Lynn to present this to the group at the next meeting. The Chair to have a discussion with Chris Myers as to any possible short term solutions.

- Wendy Henderson noted that in other areas they have been unable to continue existing care packages and have asked carers to help out in other ways. This has enabled the sustained delivery by care at home staff to deliver care and reduce hospital admissions. Chris Myers agreed that sustainability is an issue. The demand for care has increased without there being an increase in the workforce. Chris noted that increased funding will not help as there is a shortage of available staff. To work to build sustainability and capacity. Chris added that the public should be made aware of the situation and that some communication should go out to advise them of the current pressures.

- The Chair noted that the NCS response from the IJB has been submitted. **Action**: Chair to share this with the group.

8. DATE AND TIME OF NEXT MEETING

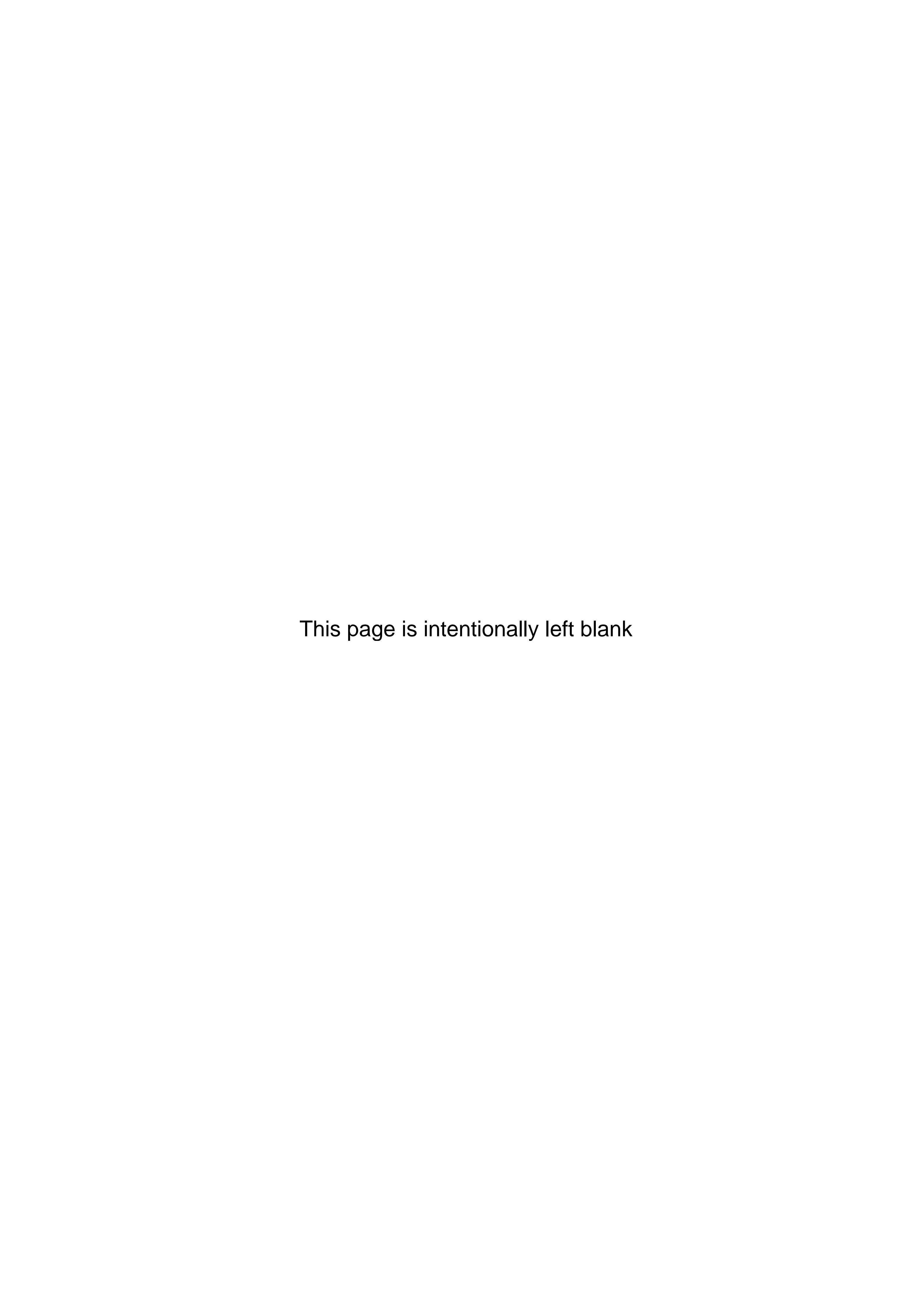
The Chair confirmed the next meeting of the Strategic Planning Group would be held on Wednesday 2 February 2022 at 10am to 12pm via Microsoft Teams.

Meeting Dates 2022:
2 February 2022
4 May 2022
3 August 2022
2 November 2022

Scottish Borders Health & Social Care
Integration Joint Board

Meeting Date: 2 March 2022

Report by:	Iris Bishop, Board Secretary
Contact:	Iris Bishop, Board Secretary
Telephone:	01896 825525
STRATEGIC PLANNING GROUP MINUTES	
Purpose of Report:	To provide the Integration Joint Board with the minutes of the recent Strategic Planning Group meeting, as an update on key actions and issues arising from the meeting held on 3 November 2021.
Recommendations:	The Health & Social Care Integration Joint Board is asked to: a) **Note** the minutes.
Personnel:	As detailed within the minutes.
Carers:	As detailed within the minutes.
Equalities:	As detailed within the minutes.
Financial:	As detailed within the minutes.
Legal:	As detailed within the minutes.
Risk Implications:	As detailed within the minutes.



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