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Scottish Borders
Health and Social Care
PARTNERSHIP

A meeting of the **Scottish Borders Health & Social Care Integration Joint Board** will be held on **Wednesday 15 June 2022** at 10am via Microsoft Teams

AGENDA

Time	No		Lead	Paper
10.00	**1**	**ANNOUNCEMENTS & APOLOGIES**	**Chair**	Verbal
10.02	**2**	**DECLARATIONS OF INTEREST** *Members should declare any financial and non financial interests they have in the items of business for consideration, identifying the relevant agenda item and the nature of their interest.*	**Chair**	Verbal
10.05	**3**	**MINUTES OF PREVIOUS MEETING** 02.03.22	**Chair**	Attached
10.10	**4**	**MATTERS ARISING** Action Tracker	**Chair**	Attached
10.15	**5**	**FOR DECISION**		
10.15	5.1	Membership	**Board Secretary**	Appendix-2022-8
10.20	5.2	Code of Conduct	**Board Secretary**	Appendix-2022-9
10.25	5.3	Direction - Commissioning of Day Services for Adults with Learning Disabilities	**General Manager MH&LD**	Appendix-2022-10
10.35	5.4	Direction - Health Board development of the Oral Health Plan	**Locum Consultant in Dental Public Health**	Appendix-2022-11

10.45	5.5	Direction - Pharmacy Support to Social Care service users	**Chief Officer**	Appendix-2022-12
10.55	5.6	2021-22 Annual Performance Report & 2022-23 Commissioning Plan	**Chief Officer**	Appendix-2022-13
11.05	5.7	Direction - 2022-23 Financial Plan	**Chief Financial Officer**	Appendix-2022-14
11.20	**6**	**FOR NOTING**		
11.20	6.1	Monitoring of the Health & Social Care Partnership Budget	**Chief Financial Officer**	Appendix-2022-15
11.25	6.2	Strategic Risk Register Update	**Chief Officer**	Appendix-2022-16
11.35	6.3	Primary Care Improvement Plan Update	**General Manager P&CS**	Appendix-2022-17
11.45	6.4	Mental Health and Wellbeing in Primary Care Services	**General Manager MH&LD**	Appendix-2022-18
11.55	6.5	Strategic Planning Group Minutes: 02.02.22	**Board Secretary**	Appendix-2022-19
11.58	**7**	**ANY OTHER BUSINESS**	**Chair**	
12.00	**8**	**DATE AND TIME OF NEXT MEETING** Wednesday 21 September 2022 10am to 12pm Microsoft Teams	**Chair**	Verbal

Minutes of a meeting of the **Scottish Borders Health & Social Care Integration Joint Board held** on **Wednesday 2 March 2022** at **9am** via Microsoft Teams

Present:
(v) Cllr D Parker (Chair)
(v) Cllr S Haslam
(v) Cllr T Weatherston
(v) Cllr E Thornton-Nicol
(v) Mrs L O'Leary, Non Executive
(v) Mrs H Campbell, Non Executive
(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 V MacPherson, Partnership Representative NHS
Mr D Bell, Staff Side SBC
Mr N Istephan, Chief Executive Eildon Housing
Mr S Easingwood, Chief Social Work and Public Protection Officer
Ms L Jackson, LGBTQ+
Dr L McCallum, Medical Director

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 D Robertson, Chief Financial Officer SBC
Mr A Bone, Director of Finance, NHS Borders
Dr T Patterson, Director of Public Health
Mr S Burt, General Manager MH&LD
Mrs C Oliver, Head of Communications & Engagement NHS
Mr P McMenamin, Deputy Director of Finance NHS
Mr G Samson, Audit Scotland
Ms S Flower, Chief Nurse Health & Social Care Partnership
Ms N Austin-Hunt, Chief Executive Third Sector Dumfries & Galloway

1. APOLOGIES AND ANNOUNCEMENTS

1.1 Apologies had been received from Cllr Jenny Linehan, Mrs Sarah Horan, Director of Nursing, Midwifery & AHPs, NHS, Dr Kevin Buchan GP, Ms Juliana Amaral, BAVs, Mrs Jen Holland, Director of Strategic Commissioning and Partnerships SBC, Mrs Lynn Gallacher, Borders Carers Centre.

1.2 The Chair welcomed a range of attendees including, Norma Austin Hart, Chief Executive, Third Sector Dumfries & Galloway, Simon Burt, General Manager, Mental Health & Learning Disabilities service and Paul McMenamin, Deputy Director of Finance, NHS

1.3 The Chair confirmed the meeting was quorate.

2. DECLARATIONS OF INTEREST

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

2.2 Mr Nile Istephan declared that Eildon Housing had a financial interest in item 5.3 on the agenda.

2.3 Cllr Elaine Thornton-Nicol declared that she was a potential party to the lease of the property at item 5.3 on the agenda.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the verbal declarations made.

3. MINUTES OF THE PREVIOUS MEETING

3.1 The minutes of the previous meeting of the Health & Social Care Integration Joint Board held on 15 December 2021 were approved.

4. MATTERS ARISING

4.1 **Action 2020-3:** Mr Chris Myers advised the review of the Scheme of Integration had been taken forward by Scottish Borders Council and NHS Borders and consulted on with the general public through Citizen Space. The consultation had concluded on 28 February 2022 and the results were being reviewed.

4.2 **Action 2021-5:** Mr Chris Myers advised that the Joint Needs Assessment would enable meaningful engagement with unpaid carers across the Borders and their influence of the IJB Strategic Commissioning Plan and directions.

4.3 **Action 2021-7:** The monitoring of the direction would take place through the IJB Audit Committee. The action would be marked as complete if the direction was agreed by the IJB.

4.4 **Action 2021-8:** The monitoring of the direction would take place through the IJB Audit Committee. The action would be marked as complete if the direction was agreed by the IJB.

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

5. HEALTH, SOCIAL CARE AND ADULT SOCIAL WORK PRESSURES AND LEVELS OF RISK

5.1 Mrs Suzie Flower provided an overview of the pressures within health, social care and the care home setting over her previous 18 months. She highlighted several challenges including: recruitment; short and long term sickness; transfers of patients to

residential care beds; increasing pressures on community hospitals and in the acute setting; and more deconditioned patients at admission. In terms of progress there was closer working between health and social care through the provision of mutual aid in social care and increasing capacity in the Home First service. The wellbeing of staff was paramount given the challenges in recruitment and a whole social care and health approach to staff wellbeing was being taken to ensure patients received the right level of care.

5.2 Mr Stuart Easingwood spoke of the mitigations and collaborative work being taken forward to address the various pressures across the provision of health and social care services which had enabled innovations and flexibility to be taken across the whole system. He further highlighted caseload allocations and the percentage of work that had increased with particular pressures with adult social work. The Scottish Government had recognised the increase in workload and need for further resource which they had supplied and work was underway to use that additional resource to bolster the workforce and maximise the benefits across the whole system to improve outcomes for people.

5.3 Mr Easingwood reassured the Board that it was a national situation and work was progressing to mitigate risks and promote innovation in challenging circumstances.

5.4 Mrs Karen Hamilton enquired if there were examples of good practice that could be transferred to Borders. Mr Easingwood commented that good practice was already being seen in terms of keeping people in their communities and patients at the centre of their care. Innovation, best practice and how to do things differently was being sought out in various networks both regionally and nationally.

5.5 Mr Tris Taylor enquired about the context of the update to the Board, any consequential risks to the Board and a quantification of the scale of the challenge. Mr Easingwood commented that the update had been provided to the Board to keep it abreast of what was happening on the front line for health and social care services. If required he would be happy to return to the Board with a metrics to provide assurance on the mitigations of risk, quantification of work and performance.

5.6 Mr Chris Myers commented that he was keen that the Board as commissioners of services were sighted on the pressures and challenges faced across the whole system, in the context of the outcomes being sought by the Integration Joint Board.

5.7 Mr Ralph Roberts commented that the outcomes and delivery of services sat with the parties to the Integration Joint Board and it was helpful to share those in the joint space. In terms of assurance he commented that the Board should be assured in terms of partnership working. In relation to health outcomes it was important that the Board understood the delivery of unscheduled care, elective care and planned care was not as it should be, often due to flow through the whole system and in effect that lead to harm for people and collectively none of the whole system organisations were comfortable with that position.

5.8 Cllr Tom Weatherston commented that the past 18 months had been a huge challenge for the provision of care in the community and he congratulated staff for being agile and continuing to deliver services during that time.

5.9 Ms Linda Jackson commented that she accepted the unprecedented pressures on staff across the whole system and highlighted that parent carers and dementia carers were exhausted due to a lack of capacity, availability of staff, some requiring building based services and others seeing their packages of care being reduced. She suggested it was helpful to be engaged with to understand the issues and what could be done to help carers and reduce unnecessary hospital admissions.

5.10 Mr Easingwood commented that opportunities were being explored to meet the needs of the whole health and social care system through working with communities and carers and those with lived experience to enhance working together to identify the best options available. He was committed to finding opportunities to meet unmet need and reduce the current pressures on families.

5.11 Mr Taylor suggested it was vital that unmet need was quantified as it would be a key element of the metrics moving forward.

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

6. COMMUNITIES MENTAL HEALTH AND WELLBEING FUND UPDATE

6.1 Ms Norma Austin Hart, provided a presentation and update on the community mental health and wellbeing fund and highlighted: the fund was administered for Dumfries and Galloway and the Scottish Borders; the process followed and the results of the first round for Scottish Borders: the lessons learned and a heads up on key decisions; the role of the Steering Group and governance processes; application form and scoring criteria; and the next round of bids would commence in April for 2022/23.

6.2 Mr John McLaren sought clarification that the 10 projects in the lowest group did not receive funding. Ms Austin Hart commented that of the 22 projects received there were 10 projects that did not exceed the quality threshold and in order to preserve the integrity of the process any projects below the quality threshold did not receive funding.

6.3 Mrs Lucy O'Leary enquired if there were lessons learned on how to encourage and stimulate smaller organisations to apply or for organisations to apply for smaller amounts. Ms Austin Hart commented that the main barrier for organisations had been the short timescale for applications and the lack of time to prepare the application, develop the idea and concept. She suggested it would be addressed in the next round of bids where the plan was to take several months to work through the third sector interface with local communities and resilience groups to develop their capacity and capability.

6.4 Mr Chris Myers commented that it was a clear demonstration of the power of the third sector and the impact of the fund across local communities would support the

partnership to deliver against the outcomes outlined in the strategic commissioning plan.

6.5 Dr Lynn McCallum welcomed the opportunities that were included in the fund and highlighted that the one thing the pandemic had highlighted had been the inequalities within the south of Scotland region and she enquired if deprivation had been taken into account when assessing applications. Ms Austin Hart commented that it had been considered for any groups at risk, for those living in poverty and for any project that addressed mental health inequality.

6.6 Cllr Elaine Thornton-Nicol enquired if there was a risk of repeating work that was already being undertaken. Ms Austin Hart commented that the steering group had asked the scoring panel to produce a portfolio of projects that would strike a balance in terms of geographic spread, diversity of applicants and benefits.

6.7 Ms Austin Hart commented that in summary the key decisions were taken by the steering group, a process was agreed for allocating underspends and considerations were given to maximum amounts of grants to be applied. The timescale for the next round of applications would commence in April through to July. The fund would be opened in August and the results of the applications would be known in November with funds being committed the following March.

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

7. 2022/23 JOINT FINANCIAL PLAN

7.1 Mr Andrew Bone provided a presentation on the draft financial plan and highlighted the work being taken forward to clarify detail and the content of the allocation letter.

7.2 Cllr Shona Haslam commented that it would be helpful to be able to set the budget before the commencement of the financial year. Mr Bone commented that both he and Mr David Robertson were disappointed that they had been unable to present a budget to the Board for sign off ahead of the next financial year due to the amount of uncertainty in terms of level of detail and funding allocations to be provided to local authorities and health boards. He advised that the recruitment process for a Chief Financial Officer for the Integration Joint Board was underway and part of their remit would be to develop a timetable and approach to financial planning in order to settle the budget before the next financial year and then amend it moving forward in light of late allocations.

7.3 Cllr Haslam noted that the additional money this year meant the IJB could offset the savings target for this year. In terms of the COVID funding for one year, she enquired if it would lead to increased pressures for a further year. Mr Bone commented that in relation to COVID expenditure a level of resource had been confirmed to be sufficient to offset COVID expenditure to be incurred in the coming year.

7.4 Mr David Robertson commented that the savings that Scottish Borders Council had brought forward were in the region of £1.3m and in setting the budget, the IJB had

clarity on what they were looking at in terms of individual savings packages. He suggested the level of savings required would be set out in the final budget paper for the IJB to approve and the areas to be targeted for those savings would be clarified along with any residual gap that might exist.

7.5 Cllr Haslam reminded the Board that a period of purdah for councillors would be entered into in mid March and enquired when the budget paper would be brought to the IJB to ensure the meeting would be quorate. Mr Robertson confirmed that routine business, such as agreeing the budget, could continue during the period of purdah.

7.6 Cllr David Parker noted that the next meeting of the IJB was scheduled for 20 April however he was concerned that it might not be quorate.

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

8. NEEDS ASSESSMENT: ORAL HEALTH AND DENTAL SERVICES

8.1 The item was deferred to the next meeting.

9. MILLAR HOUSE

Mr Nile Istephan had declared an interest in the item.

Cllr Elaine Thornton-Nicol had declared an interest in the item.

9.1 Mr Simon Burt provided an overview of the content of the report and highlighted: the core services provided by the rehab service; the provision of inpatient beds both within NHS Borders and external providers; unsuitability of the current provision of accommodation for long term clients; efficiency savings; working through a business case; and repatriation of clients currently outwith Borders in line with national guidance.

9.2 Mrs Netta Meadows enquired if the risk sharing of failing would be equally split across the partnership. Mr Burt commented that 4 efficiency savings had been identified which were RAG rated. Mr Burt advised that the financial model had been discussed and the largest risk was in terms of efficiencies. It was a 77%/23% balance in funding and was mirrored in the new model.

9.3 Mr Ralph Roberts commented that he thought it was the right thing to do and noted that there was a risk issue in not being able to guarantee there were not other clients coming forward who would need external provision. The reality was that one of those clients was funded outwith the budget and that was a cost pressure on the service. The intention was that the nature of the service would give flexibility to minimise the risk. The other issue was the split of risk and it was set out as it was currently split and a piece of work needed to be taken forward jointly on joint funding also on getting better at managing risk shares and working through that without any prejudged assumptions on what the impact would be for each partner.

9.4 Mrs Jenny Smith welcomed the efficient use of the estate that had become available. She noted that Carr Gom were positive about the process and she welcomed the reference to working with lived experience and carers. She enquired if the reference in the direction to quantitative should have been qualitative. Mr Myers confirmed that it should have been qualitative feedback and not quantitative.

9.5 Cllr Haslam enquired what consultation had taken place with the families involved and how they would be supported through the transition. Mr Burt advised that discussions and questionnaires had been completed with all the tenants to be impacted by the change. It was a coproduced project and would continue to be coproduced as it moved to the implementation stage. The transition plan would be progressed with those with lived experience. Carr Gom would continue to be the provider for a period of time as the transition took place. The community rehab team would work closely with the client group and provide some enhanced health support to the new accommodation. Mr Burt assured the Board that there had been consultation and each transfer would be individually designed to meet the needs of each individual.

9.6 Cllr Haslam enquired about the level of consultation. Mr Burt confirmed that consultation had taken place before the project had reached the current point. Mrs Smith commented that consultation had taken place through the provision of questionnaires, involvement of carers representatives and the involvement of those with lived experience through BIAS. It had taken into account where possible the challenges with the unknowns in terms of raising the expectations of a vulnerable client group. She was content with the consultation process undertaken. Cllr Haslam commented that following Mrs Smith's clarification she was also content with the process undertaken.

9.7 Mr Tris Taylor enquired about the verification of the opinion of service users and carers and sought to understand in what way the proposal had changed due to the involvement of those with lived experience and carers. He further enquired if the proposal was a major service change. Mr Burt advised that it was not a major service change as it was a reprovision of a service with an enhancement.

9.8 Mr Taylor enquired about the governance route for the proposal. Mr Burt advised that it had been presented to the Health & Social Care Senior Leadership Team, the NHS Operational Planning Group, the NHS Board Executive Team and the IJB Strategic Planning Group. Both informal and formal discussions with the Finance teams in both partner organisations had taken place and the final body to present to would be the Housing provider at their meeting in April. He assured the Board that both the Chief Executives of NHS Borders and Scottish Borders Council and their senior teams were in support of the proposal.

9.9 Mr Taylor suggested it was important to understand the appropriate location for the scrutiny of services and changes to those services that affected the population and the discharge of the duties of the deliverers.

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** agreed the 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)."

10. DIRECTIONS

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** approved the directions as set out below:-

10.1 Direction: HSCP Integrated Workforce Plan

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.

10.2 Direction: Strategic Commissioning Plan

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)

10.3 **Direction: Care Village Provision**

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.

10.4 **Direction: Oral Health Plan. The direction was deferred.**

10.5 **Direction: Millar House**

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).

10.6 **Direction: 2022/23 Budget. The direction was deferred.**

11. MONITORING AND FORECAST OF THE HEALTH AND SOCIAL CARE PARTNERSHIP BUDGET 2021/22 AT 31 DECEMBER 2021

11.1 Mr Paul McMenamin provided an overview of the content of the report.

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

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.

12. UPDATE ON IMPACT OF INTEGRATION JOINT BOARD REQUIREMENTS AS CATEGORY 1 RESPONDERS UNDER THE CIVIL CONTINGENCIES ACT 2004

12.1 Mr Chris Myers provided an overview of the content of the report.

12.2 Mrs Karen Hamilton assured the Board as the Chair of the IJB Audit Committee that it would welcome the opportunity to take on the review of the on-going arrangements in relation to the Civil Contingencies Act.

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** considered and noted 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

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** requested that the IJB Audit Committee to build in the review of on-going 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

13. CHIEF SOCIAL WORK OFFICE ANNUAL REPORT

13.1 Mr Stuart Easingwood provided an overview of the report which pertained to 2020/21 but had been delayed in being presented to the IJB due to demands on the IJB agenda. Mr Easingwood highlighted several elements from within the report including: references throughout the report to the COVID-19 pandemic and how services were delivered; the significant impact of the pandemic on carers, households and communities across the Scottish Borders; the strength and resilience of local communities; the workforce which was a massive asset in the delivery of services to all during the pandemic; recruitment and retaining professionally qualified social work staff; and creating career pathways for existing staff to do professional training.

13.2 Mr Easingwood further commented that currently there were 5 staff who would graduate this summer to allow them to be matched into existing vacancies across the social work and social care landscape.

13.3 Cllr Elaine Thornton-Nicol offered congratulations to the people within the services covered by the report and also thanked Mr Easingwood for his work throughout the pandemic period.

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

14. STRATEGIC PLANNING GROUP MINUTES: 03.11.21

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

15. ANY OTHER BUSINESS

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

16. DATE AND TIME OF NEXT MEETING

16.1 The Chair confirmed that the next meeting of the Scottish Borders Health & Social Care Integration Joint Board would be held on Wednesday 20 April 2022, from 10am to 12noon, via Microsoft Teams.

The meeting concluded at 11.20am.

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~~ September 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. **Update 15.06.22:** Will be reviewed at IJB Audit Committee on 12.09.22 (as full agenda for Audit Committee on 20.06.22)	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 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	G

					(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. **Update 31.03.22: Completed:** The SoI was reviewed and agreed by SBC and NHS Borders, submitted to Scottish Ministers for formal approval by 31.03.22.	

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
2021 - 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 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.)*	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. **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	G

					Commissioning Plan to be developed over 2022-23 **Completed.** **Update 15.06.22:** Home First will be reviewed at the IJB Audit Committee on 20.06.22	

Meeting held 15 December 2021

Agenda Item: IJB Strategic Commissioning Approach

Action Number	Reference in Minutes	Action	Action by:	Timescale	Progress	RAG Status
2021 - 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 completed. **Completed: 02.03.22.**	G

Agenda Item: Day Services Petition and Future Provision

Action Number	Reference in Minutes	Action	Action by:	Timescale	Progress	RAG Status
2021 - 6	10	The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** sought a timeline for the work to be	Stuart Easingwood	April 2022	**In Progress:** Work to define the Carers Needs Assessment has commenced with the IJB Carers Workstream. The needs	G

		taken forward.			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. **Update 15.06.22:** Needs assessment questionnaire went out to unpaid carers on 06.06.22	

Agenda Item: Integrated Workforce Plan

Action Number	Reference in Minutes	Action	Action by:	Timescale	Progress	RAG Status
2021 - 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 **Completed: 02.03.22.**	G

Agenda Item: Tweedbank Care Village

Action Number	Reference in Minutes	Action	Action by:	Timescale	Progress	RAG Status
2021 - 8	16	The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted that it would issue a direction	Chris Myers	April 2022	**In Progress:** A Direction to the Scottish Borders Council is included in the agenda	G

		to commission the provision of care within the care village which would clarify the role and requirements of the IJB from a governance perspective			**Completed: 02.03.22.**	

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

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Scottish Borders Health & Social Care Integration Joint Board

Scottish Borders Health and Social Care PARTNERSHIP

Meeting Date: 15 June 2022

Report By:	Iris Bishop, Board Secretary
Contact:	Iris Bishop, Board Secretary
Telephone:	01896 825525
MEMBERSHIP	
Purpose of Report:	To appraise the IJB of the changes in the voting membership of the IJB following the local authority elections held in May.
Recommendations:	The Health & Social Care Integration Joint Board is asked to: a) **note** the current membership of the IJB; b) **confirm** the Chair and Vice Chair of the IJB; c) **confirm** the membership of the IJB Audit Committee.
Personnel:	Not Applicable
Carers:	Not Applicable
Equalities:	Not Applicable
Financial:	Not Applicable
Legal:	As required by the Joint Working Public Bodies (Scotland) Act 2014.
Risk Implications:	Not Applicable
Direction required:	No Direction required

1. Current Membership

1.1 Following the Local Authority Elections held in May 2022 there has been a change in the local authority voting membership of the IJB, with 2 new members having been appointed who are Cllr Jane Cox and Cllr Robin Tatler.

1.2 The voting and non-voting membership of the IJB is attached at **Annex A.**

2. Chair and Vice Chair roles

2.1 In line with the Standing Orders of the IJB the roles of Chair and Vice Chair are filled by a Local Authority voting member and an NHS Non Executive voting member and rotate every 3 years. As of April 2022, Mrs Lucy O'Leary, Non Executive voting member has rotated into the role of Chair of the IJB for the next 3 years.

2.2 A nomination from the Local Authority voting members of the IJB is required to fulfil the Vice Chair position.

2.3 The Vice Chair of the IJB also becomes the Chair of the Strategic Planning Group that reports to the IJB.

2.4 The standing orders of the IJB are attached at **Annex B.**

3. Audit Committee Membership

3.1 The Audit Committee membership consists of 2 local authority voting members of the IJB and 2 NHS voting members of the IJB. The membership currently consists of:

- Mrs Lucy O'Leary
- Mrs Karen Hamilton
- Cllr Tom Weatherston
- Vacant

3.2 A nomination from the Local Authority voting members of the IJB is required to fulfil the vacant position on the IJB Audit Committee.

3.3 The role of Chair of the IJB Audit Committee also rotates for the same length of time and at the same time as the IJB Chair rotation.

3.4 The Terms of Reference of the IJB Audit Committee are attached at **Annex C.**

Membership of the Integration Joint Board 15 June 2022

Name	Designation	Membership status
Ms. Lucy O'Leary	Non-Executive Director, NHS Borders	Voting member
Mrs. Harriet Campbell	Non-Executive Director, NHS Borders	Voting member
Ms. Karen Hamilton	Non-Executive Director, NHS Borders	Voting member
Mr. John McLaren	Non-Executive Director, NHS Borders	Voting member
Mr. Tris Taylor	Non-Executive Director, NHS Borders	Voting member
Cllr. David Parker	Elected Member, Scottish Borders Council	Voting member
Cllr. Jane Cox	Elected Member, Scottish Borders Council	Voting member
Cllr. Robin Tatler	Elected Member, Scottish Borders Council	Voting member
Cllr. Elaine Thornton-Nicol	Elected Member, Scottish Borders Council	Voting member
Cllr. Tom Weatherston	Elected Member, Scottish Borders Council	Voting member
Mr. Stuart Easingwood	Director of Social Work and Practice	Chief Social Work Officer
Dr. Kevin Buchan	Chair of GP Subcommittee	General Practitioner
Dr. Lynn McCallum	Executive Medical Director	Secondary Care Medical Practitioner
Ms. Sarah Horan	Director of Nursing and Midwifery and Allied Health Professionals	Nursing representative
Mr. David Bell	Unite	Staff-side
Ms. Vikki MacPherson /Ms. Gail Russell	Partnership NHS	Staff-side
Ms. Jenny Smith	Borders Care Voice	Third Sector representative
Ms. Juliana Amaral	Berwickshire Association of Voluntary Services and Borders Third Sector Interface	Third Sector representative
Ms. Lynn Gallacher	Borders Carers Centre	Carer representative
Ms. Linda Jackson	LGBTQ+ representative	Service User representative
Mr. Nile Istephan	Chief Executive, Eildon Housing Association	Housing representative
Mr. Chris Myers	Chief Officer and Joint Director of Health and Social Care	Integration Joint Board Chief Officer representative
Mrs. Hazel Robertson From 01.08.22	Chief Financial Officer	Section 95 Officer of the Integration Joint Board

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Scottish Borders
Health and Social Care
PARTNERSHIP

Scottish Borders Health & Social Care Integration Joint Board

STANDING ORDERS

Version	**9**
Date	**19.12.19**
Author	**Iris Bishop, Board Secretary**

1. General

1.1 The Standing Orders of the Scottish Borders Health & Social Care Integration Joint Board are set up in accordance with the Public Bodies (Joint Working) (Scotland) Act 2014.

1.2 Any statutory provision, regulation or direction issued by the Scottish Ministers shall have precedence if they are in conflict with the Standing Orders.

2. Membership

2.1 The Integrated Joint Board shall comprise five NHS Non-Executive Directors appointed by Borders Health Board, and five Elected Councillors appointed by Scottish Borders Council. In addition, there will be non-voting representatives drawn from health and social care professionals, staff, the third sector, users, the public and carers as identified by the Integration Joint Board. The Chief Officer of the Integration Joint Board, Chief Financial Officer and the Chief Executives of NHS Borders and Scottish Borders Council, and any other senior officers as appropriate, will be invited to attend the Integration Joint Board as non-voting members.

2.2 The term of office of voting Members of the Integration Joint Board shall last as follows:

(a) for Local Government Councillors, three years, thereafter Scottish Borders Council will identify its replacement Councillor(s) on the Integration Joint Board,

(b) for Borders Health Board nominees, three years, thereafter Borders Health Board will identify its replacement Non Executive(s) on the Integration Joint Board.

2.3 Where a Voting Member resigns or otherwise ceases to hold office, the person appointed in his/her place shall be appointed for the unexpired term of the Voting Member they replace.

2.4 On expiry of a Voting Member's term of appointment the Voting Member shall be eligible for re-appointment provided that he/she remains eligible and is not otherwise disqualified from appointment.

2.5 Any Voting Member appointed to the Integration Joint Board who ceases to fulfil the requirements for membership detailed in the Scheme of Integration approved by the Scottish Ministers shall be removed from membership on the serving by the Board Secretary of notice to that effect.

2.6 A Voting Member of the Integration Board may resign his/her membership in writing at any time during their term of office by giving notice to the Board Secretary or the Clerk to the Council. The resignation shall take effect from the date notified in the notice or on the date of receipt if no date is notified.

2.7 If a Voting Member has not attended three consecutive Ordinary Meetings of the, Integration Joint Board, the Board Secretary shall, by giving notice in writing to that Voting Member, remove that person from office unless the Integration Joint Board are satisfied that :-

(a) The absence was due to illness or other reasonable cause; and

(b) The Voting Member will be able to attend future Meetings within such period as the Integration Joint Board consider reasonable.

2.8 The acts, meetings or proceedings of the Integration Joint Board shall not be invalidated by any defect in the appointment of any Member.

3. Chair

3.1 The first Chair of the Integration Joint Board shall be from the body not employing the Integration Joint Board's Chief Officer, with the Vice-Chair from the body employing the Chief Officer. The Chair and Vice Chair posts shall rotate on a three year basis between the NHS Board and the Council, with the Chair being from one body and the Vice-Chair from the other.

3.2 The Vice-Chair may act in all respects as the Chair of the Integration Joint Board if the Chair is absent or otherwise unable to perform his/her duties.

3.3 At every Meeting of the Integration Joint Board the Chair, if present, shall preside. If the Chair is absent from any Meeting the Vice-Chair, if present, shall preside. If both the Chair and the Vice-Chair are absent, a chair shall be appointed from within the voting members present for that meeting.

3.4 Powers, authority and duties of Chair and Vice-Chair.

The Chair shall specifically:-

(a) Preserve order and ensure that every Member has a fair Hearing;

(b) Decide on matters of relevancy, competency and order, and whether to have a recess during the Meeting, having taken into account any advice offered by the Chief Officer or other relevant officer in attendance at the Meeting;

(c) Determine the order in which speakers can be heard;

(d) Ensure that due and sufficient opportunity is given to Members who wish to speak to express their views on any subject under discussion;

(e) If requested by any Member ask the mover of a motion, or an amendment, to state its terms;

(f) Maintain order and at his/her discretion, order the exclusion of any Member of the public who is deemed to have caused disorder or misbehaved;

(g) The decision of the Chair on all matters within his/her jurisdiction shall be final;

(h) Deference shall at all times be paid to the authority of the Chair. When he/she rises to speak, the Chair shall be heard without interruption and

(i) Members shall address the Chair while speaking.

4. Meetings

4.1 The Integration Joint Board shall meet at such place and such frequency as may be agreed by the Integration Joint Board and no less than four times per year.

4.2 The Chair may convene Extra Ordinary Meetings if it appears to him/her that there are items of urgent business to be considered. Such Meetings will be held at a time, date and venue as determined by the Chair. If the Office of Chair is vacant, or if the Chair is unable to act for any reason the Vice-Chair may at any time call such a Meeting.

4.3 If the Chair refuses to call a Meeting of the Integration Joint Board after a requisition for that purpose specifying the business proposed to be transacted, signed by at least one third of the whole number of voting Members, has been presented to the Chair or if, without so refusing, the Chair does not call a Meeting within seven days after such requisition has been presented, those Members who presented the requisition may forthwith call a Meeting provided no business shall be transacted at the Meeting other than specified in the requisition.

5. Notice of Meeting

5.1 Before every Meeting of the Integration Joint Board a Notice of the Meeting, specifying the time, place and business to be transacted at it shall be delivered to every Member or sent by post to the usual place of residence of such Members or delivered by electronic means so as to be available to them at least seven clear days before the Meeting. Members may opt in writing addressed to the Chief Officer to have Notice of Meetings delivered to an alternative address. Such Notice will remain valid until rescinded in writing. Lack of service of the Notice on any Member shall not affect the validity of a Meeting.

5.2 In the case of a Meeting of the Integration Joint Board called by Members in default of the Chair, the Notice shall be signed by those Members who requisitioned the Meeting. The meeting will consider the business specified in the notice. Such meeting shall be held within fourteen days of receipt of the notice by the Chief Officer.

5.3 At all Ordinary or Special Meetings of the Integration Joint Board, no business other than that on the Agenda shall be discussed or adopted except where by reason of special circumstances, which shall be specified in the Minutes, the Chair is of the opinion that the item should be considered at the Meeting as a matter of urgency.

5.4 The Board Secretary shall be responsible for giving public notice of the time and place of each Meeting of the Integration Joint Board by posting within the main offices of the Integration Joint Board not less than three clear days before the date of each Meeting.

6. Quorum

6.1 No business shall be transacted at a Meeting of the Integration Joint Board unless there are present, and entitled to vote both Council and NHS Board members. Three

Elected Members from Scottish Borders Council and three Non Executive members from NHS Borders shall constitute a Quorum.

7. Codes of Conduct and Conflicts of Interest

7.1 Members of the Integration Joint Board shall subscribe to and comply with both the Standards in Public Life - Code of Conduct for Members of Devolved Public Bodies and Councillors Code of Conduct and Guidance made in respect thereto which are incorporated into the Standing Orders. All members who are not already bound by the terms of either Code shall be obliged before taking up membership, to agree in writing to be bound by the terms of the Code of Conduct for Members of Devolved Public Bodies.

7.2 If any Member has a financial or non-financial interest as defined in the Councillors' Code of Conduct or the Code of Conduct of Members of Devolved Public Bodies and is present at any Meeting at which the matter is to be considered, he/she must as soon as practical, after the Meeting starts, disclose that he/she has an interest and the nature of that interest and if he/she is precluded from taking part in consideration of that matter.

7.3 If a Member or any business associate, relative or friend of theirs has any pecuniary or any other interest direct or indirect, in any Contract or proposed Contract or other matter and that Member is present at a Meeting of the Integration Joint Board, that Member shall disclose the fact and the nature of the relevant interest and shall not be entitled to vote on any question with respect to it. A Member shall not be treated as having any interest in any Contract or matter if it cannot reasonably be regarded as likely to significantly affect or influence the voting by that Member on any question with respect to that Contract or matter.

7.4 A Member who has an interest in service delivery may participate in the business of the Integration Joint Board, except where they have a direct and significant interest in a matter, unless the Integration Joint Board formally decides and records in the Minutes of the Meeting that the public interest is best served by the Member remaining in the Meeting and contributing to the discussion. During the taking of a decision by the Integration Joint Board on such matter, the Member concerned shall absent him/herself from the Meeting.

8. Adjournment of Meetings

8.1 A Meeting of the Integration Joint Board may be adjourned by a motion, which shall be moved and seconded and put to the Meeting without discussion. If such a motion is carried by a simple majority of those present and entitled to vote, the Meeting shall be adjourned to another day, time and place specified in the motion.

9. Disclosure of Information

9.1 No Member or Officer shall disclose to any person any information which falls into the following categories:-

- Confidential information within the meaning of Section 50(a)(2) of the Local Government (Scotland) Act 1973.

- The full or any part of any document marked not for publication by virtue of the appropriate paragraph of Part 1 of Schedule 7A of the Local Government (Scotland) Act 1973.

- Any information regarding proceedings of the Integration Joint Board from which the Public have been excluded unless or until disclosure has been authorised by the Council or the NHS Board or the information has been made available to the Press or to the Public under the terms of the relevant legislation.

9.2 Without prejudice to the foregoing no Member shall use or disclose to any person any confidential and/or exempt information coming to his/her knowledge by virtue of his/her office as a Member where such disclosure would be to the advantage of the Member or of anyone known to him/her or which would be to the disadvantage of the Integration Joint Board, the Council or the NHS Board.

10. Recording of Proceedings

10.1 No sound, film, video tape, digital or photographic recording of the proceedings of any Meeting shall be made without the prior approval of the Integration Joint Board.

11. Admission of Press and Public

11.1 Members of the public and representatives of the Press will be admitted to every formal meeting of the Board but will not be permitted to take part in discussion (Public Bodies (Admission to Meetings) Act 1960; Local Government (Scotland) Act 1973)

11.2 The Board may exclude the public and press while considering any matter that is confidential. (Local Government (Scotland) Act 1973, Schedule 7; Freedom of Information (Scotland) Act 2002 (the Act) and Environmental Information (Scotland) Regulations 2004 (the Regulations)

11.3 The terms of any resolution specifying the part of the proceedings to which it relates and the categories of exempt information involved shall be specified in the minutes.

11.4 Members of the public and representatives of the press admitted to meetings shall not be permitted to make use of photographic or recording apparatus of any kind unless agreed by the Board. (Local Government (Scotland) Act 1973; Public Bodies (Admission to Meetings) Act 1960)

11.5 Members of the public and press should leave when the meeting moves into reserved business. It is at the discretion of the Chair of that meeting if officers can remain.

11.6 Subject to the extent of the accommodation available and subject to the terms of Sections 50A and 50E of the Local Government (Scotland) Act 1973, and Public Bodies (Admission to Meetings) Act 1960 meetings of the Integration Joint Board shall be open to the public.

11.7 Every Meeting of the Integration Joint Board shall be open to the public but these provisions shall be without prejudice to the Integration Joint Board's powers of exclusion in order to suppress or prevent disorderly conduct or other misbehaviour at a Meeting. The Integration Joint Board may exclude or eject from a Meeting a

member or members of the Press and Public whose presence or conduct is impeding the work or proceedings of the Integration Joint Board.

12. Reception of deputations

12.1 Every application for the receiving of a deputation must be in writing, duly signed and delivered or e-mailed to the Board Secretary at least seven clear working days prior to the date of the meeting at which the deputation wish to be received. The application must state the subject and the action which it proposes the Integration Joint Board should take.

12.2 The deputation shall consist of not more than ten people.

12.3 No more than two members of any deputation shall be permitted to address the meeting, and they may speak in total for no more than ten minutes.

12.4 Any member of the Integration Joint Board may put any relevant question to the deputation, but shall not express any opinion on the subject matter until all questions have been asked. If the subject matter relates to an item of business on the agenda, no debate or discussion shall take place until the relevant minute or other item is considered in the order of business.

12.5 The Integration Joint Board may make the following decisions regarding any deputation:

(i) refer the petition to another organisation or Officer of another organisation, with or without a recommendation or comment. That Organisation or Officer shall then make the final decision which could include taking no further action;

(ii) that the issue(s) raised do not merit or do not require further action.

13. Receipt of petitions

13.1 Every petition shall be delivered to the Board Secretary at least seven clear working days before the meeting at which the subject matter may be considered. The Chair will be advised and will decide whether the contents of the petition should be discussed at the meeting or not.

13.2 The Board may make the following decisions regarding any petition:

(i) refer the petition to another organisation or Officer of another organisation, with or without a recommendation or comment. That Organisation or Officer shall then make the final decision which could include taking no further action;

(ii) that the issue(s) raised do not merit or do not require further action.

14. Alteration, Deletion and Rescission of Decisions of the Integration Joint Board

14.1 Except insofar as required by reason of illegality, no motion to alter, delete or rescind a decision of the Integration Joint Board will be competent within six months from the decision, unless a decision is made prior to consideration of the matter to suspend this Standing Order.

15. Suspension, Deletion or Amendment of Standing Orders

15.1 Any one or more of the Standing Orders in the case of emergency as determined by the Chair upon motion may be suspended, amended or deleted at any Meeting so far as regards any business at such Meeting provided that two thirds of the voting Members of the Integration Joint Board present and voting shall so decide. Any motion to suspend Standing Orders shall state the number or terms of the Standing Order(s) to be suspended.

16. Order of business

16.1 For ordinary meetings of the Board or its Committees, the business shown on the agenda shall normally proceed in the following order:

- Business determined by the Chair to be a matter of urgency by reason of special circumstances
- Reception of deputations, followed by consideration of any items of business on which the deputations have been heard
- Petitions
- Minutes of the previous meeting for approval
- Minutes of Sub-Committees
- General Business
- Questions and motions of which due notice has been given

16.2 No item of business shall be transacted at a meeting, unless either:

- It has been included on the agenda for the meeting; or
- It has been determined by the Chair to be a matter of urgency by reason of special circumstances

17. Motions, Amendment and Debate

17.1 It will be competent for any voting Member of the Integration Joint Board at a Meeting of the Integration Joint Board to move a motion directly arising out of the business before the Meeting.

17.2 No Member, with the exception of the mover of the motion or amendment, will speak supporting the motion or amendment until the same will have been seconded.

17.3 Subject to the right of the mover of a motion, and the mover of an amendment, to reply, no Member will speak more than once on the same question at any Meeting of the Integration Joint Board except:-

- On a question of Order
- With the permission of the Chair
- In explanation or to clear up a misunderstanding in some material part of his/her speech.

In all of the above cases no new matter will be introduced.

17.4 The mover of an amendment and thereafter the mover of the original motion will have

the right of reply for a period of not more than 5 minutes. He/she will introduce no new matter and once a reply is commenced, no other Member will speak on the subject of debate. Once these movers have replied, the discussion will be held closed and the Chair will call for the vote to be taken.

17.5 Amendments must be relevant to the motions to which they relate and no Member will be at liberty to move or second more than one amendment to any motion, unless the mover of an amendment has failed to have it seconded. The mover and seconder of the motion will not move an amendment or second an amendment, unless the mover of the motion has failed to have it seconded.

17.6 It will be competent for any Member who has not already spoken in a debate to move the closure of such debate. On such motion being seconded, the vote will be taken, and if a majority of the Members present vote for the motion, the debate will be closed. However, closure is subject to the right of the mover of the motion and of the amendment(s) to reply. Thereafter, a vote will be taken immediately on the subject of the debate.

17.7 Any Member may indicate his/her desire to ask a question or offer information immediately after a speech by another Member and it will be the option of the Member to whom the question would be directed or information offered to decline or accept the question or offer of information.

17.8 When a motion is under debate, no other motion or amendment will be moved except in the following circumstances:

- to adjourn the debate; or
- to close the debate.

17.9 A motion or amendment once moved and seconded cannot be altered or withdrawn unless with the consent of the majority of those present.

18. Voting

18.1 Every effort shall be made by Members to ensure that as many decisions as possible are made by consensus.

18.2 Only the five Members nominated by the NHS Board, and the five Members appointed by the Council shall be entitled to vote. Those Members drawn from health and social care professionals, staff, the third sector, users, the public and carers shall not be entitled to vote.

18.3 Every question at a Meeting shall be determined by a majority of votes of the Members present and who are entitled to vote on the question. In the case of an equality of votes the Chair shall not have a second or casting vote. In the event of an equality of votes, the matter shall be referred to the NHS Borders Board and to Scottish Borders Council for final decision.

19. Minutes, agendas and papers

19.1 The Board Secretary is responsible for ensuring that Minutes of the proceedings of a meeting of the Integration Joint Board or its Committees, including any decision or

resolution made at that meeting, shall be drawn up. The minutes shall be submitted to the next meeting of the Integration Joint Board, or relevant Committee, for approval by members as a record of the meeting subject to any amendments proposed by members and shall be signed by the person presiding at that meeting. A Minute purporting to be so signed shall be received in evidence without further proof.

19.2 The names of members present at a meeting of the Integration Joint Board or of a Sub-Committee of the Board shall be recorded in the Minute, together with the apologies for absence from any member.

19.3 Minutes of Meetings shall be submitted by the Chief Officer or an officer so designated by him/her to the Council and the NHS Board for noting.

19.4 The Freedom of Information (Scotland) Act 2002 gives the public a general right of access to all recorded information held. Therefore, when minutes of meetings are created, it should be assumed that what is recorded will be made available to the public. This does not apply to Minutes of a private section of any meeting.

19.5 The Minute of a meeting being held where authority or approval is being given by the Integration Joint Board and the Minutes are intended to act as a record of the business of the meeting, then the Minute should contain:

- A summary of the Integration Joint Board's discussions
- A clear and unambiguous statement of all decisions taken
- If no decision is taken, a clear and unambiguous statement of where the matter is being referred or why the decision has been deferred
- Where options are presented, a summary of why options were either accepted or rejected
- Reference to any supporting documents relied upon
- Any other relevant points which influenced the decision or recommendation
- Any recommendations which require approval by a higher authority

19.6 The contents of a Minute will depend upon the purpose of the meeting. If the meeting agrees actions they will be recorded in an Action Tracker:

- A description of the task, including any phases and reporting requirements
- The person accepting responsibility to undertake the task
- The time limits associated with the task, its phases and agreed reporting

19.7 The agendas and papers for all Integration Joint Board, Committee and Sub-Committee meetings shall be circulated to members by post or electronic means at least seven days before any given meeting.

19.8 The draft minutes and action trackers from all Integration Joint Board, Committee and Sub-Committee meetings shall be issued as soon as possible following a meeting, ideally within five working days.

20. Freedom of Information (Scotland) Act 2002

20.1 The Freedom of Information (Scotland) Act 2002 (FOI(S)A) was introduced by the Scottish Parliament to ensure that people have the right to access information held

by Scottish public authorities. The Act states that any person can receive information that they request from a public authority, subject to certain exemptions such as protection of personal data and commercial interests, or national security. It came into force on 1 January 2005 and is retrospective.

Under FOI(S)A NHS Borders and Scottish Borders Council are required to:

- Provide applicants with help and assistance in finding the information they require within a given timescale
- Maintain a publication scheme of information to be routinely published
- Put in processes for responding to enquiries and undertaking appeals against decisions to withhold information

20.2 Information as defined under FOI(S)A includes copies or extracts, including drafts, of any documents such as:

- reports and planning documents
- committee minutes and notes
- correspondence including e-mails
- statistical information

20.3 The FOI(S)A provides a range of exemptions which may be applied allowing the public authority to withhold information. Exemptions must be considered on a case by case basis and may be applied to all or only part of the information requested.

- All documents will be scrutinised for information which may be withheld under an exemption to the Act prior to release.
- Full details of the FOI(S)A exemptions and how to apply them can be found in the Freedom of Information (Scotland) Act 2002.
- Briefings on how to apply exemptions can be found on the Scottish
- Information Commissioners website http://www.itspublicknowledge.info/ScottishPublicAuthorities/ScottishPublicAuthorities.asp.

21. Records management

21.1 Under the Freedom of Information (Scotland) Act 2002, NHS Borders and Scottish Borders Council must have comprehensive records management systems and process in place which must give clear guidance on time limits for the retention of records and documents.

22. Reserved Business

22.1 A Private meeting of the Integration Joint Board may be called at any time by the Chair, or one third of the Members. Generally a minimum notice period of three days should be observed. However, in exceptional circumstances and provided the majority of Integration Joint Board members are present and given the opportunity to attend, appropriate matters pertaining to a Private session may be conducted at the conclusion of an Integration Joint Board meeting. To allow for appropriate notice periods to be observed the wording “At the conclusion of the Board meeting, the board will reconvene for any matters of reserved business.” should be clearly stated at the bottom of each Integration Joint Board meeting agenda.

23. Suspension and Disqualification

23.1 Any Member of the Integration Joint Board may on reasonable cause shown be suspended from the Integration Joint Board or disqualified from taking part in any business of the Integration Joint Board in circumstances specified for NHS Board appointed nominees by the NHS Board, and for Council appointed nominees by the Council.

24. Working Groups

24.1 The Integration Joint Board may establish any Sub-Committee or Working Group as may be required from time to time but each Working Group shall have a limited time span as may be determined by the Integration Joint Board.

24.2 The Membership, Chair and quorum of any Sub-Committee or Working Groups will be determined by the Integration Joint Board.

24.3 The Terms of Reference of the Sub-Committee or Working Group will be determined by the Integration Joint Board.

24.4 A Sub-Committee or Working Group does not have any delegated powers to implement its findings and will prepare a Report for consideration by the Integration Joint Board.

24.5 Agendas for consideration at a Sub-Committee or Working Group will be issued by electronic means to all Members no later than seven working days prior to the start of the Meeting.

25. Urgent Decisions

25.1 If a decision which would normally be made by the Integration Joint Board or its Committee, requires to be made urgently between meetings of the Integration Joint Board or Committee, the Chief Officer, in consultation with the Chair and Vice Chair, may take action, subject to the matter being reported to the next meeting of the integration Joint Board or Committee. In the absence of the Chair, Vice Chair or Chief Officer the Chief Executives of NHS Borders and Scottish Borders Council will be the named substitutes.

Scottish Borders
Health and Social Care
PARTNERSHIP

Scottish Borders Health & Social Care Integration Joint Board AUDIT COMMITTEE

TERMS OF REFERENCE

SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD
AUDIT COMMITTEE
TERMS OF REFERENCE

Constitution

The IJB shall appoint the Committee. The Committee will consist of at least four voting members of the IJB, excluding professional advisors, and one additional member from an external source. The Committee should agree the professional advisors it requires on a regular and ad hoc basis. The Committee is required to review its terms of reference on an annual basis.

The Committee will meet at least twice per annum. The Committee will be supported and serviced by the IJB's Chief Officer, Chief Financial Officer, Chief Internal Auditor and Board Secretary. The Audit Committee will report to the IJB.

Chair

The Chair of the Committee will be a voting member nominated by the IJB, noting that the Chair of the IJB cannot also chair the Audit Committee. The Chair of the Committee will rotate at the same time as the rotation of the Chair of the IJB and will be a voting member from the other partner to that of the Chair of the IJB.

Quorum

Three members of the Committee will constitute a quorum.

Functions Referred

The following functions of the IJB shall stand referred to the Audit Committee:

1. Assess the adequacy and effectiveness of the IJB's internal controls and corporate governance arrangements against the good governance framework and consider the annual governance reports and assurances to ensure that the highest standards of probity and public accountability are demonstrated;
2. Assess the adequacy and effectiveness of the IJB's risk management arrangements and consider the assurances on compliance with an appropriate risk management strategy within annual governance reports;
3. Review and approve the Internal Audit Annual Plan on behalf of the IJB, receive reports and oversee and review progress on actions taken on audit recommendations and report to the IJB on those as appropriate;
4. Review the Records Management Plan on behalf of the IJB, receive reports and oversee and review progress on actions and recommendations and report to the IJB on those as appropriate;
5. Consider the External Audit Annual Plan on behalf of the IJB, receive reports and consider matters arising from these and management actions identified in response before submission to the IJB;
6. Review annual financial accounts and related matters before submission to and approval by the IJB;

7. Promote the highest standards of conduct and professional behaviour by IJB members in line with The Ethical Standards and Public Life etc (Scotland) Act 2000;
8. Assess the adequacy and effectiveness of the IJB's corporate governance arrangements that underpin the delivery of best value services and consider the assurances on value for money service delivery for those delegated functions within annual governance reports; and
9. Investigate any activity within its terms of reference, and in doing so, seek any information it requires.

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Scottish Borders Health & Social Care Integration Joint Board

Scottish Borders Health and Social Care PARTNERSHIP

Meeting Date: 15 June 2022

Report By:	Iris Bishop, Board Secretary
Contact:	Iris Bishop, Board Secretary
Telephone:	01896 825525
CODE OF CONDUCT	
Purpose of Report:	To appraise the IJB of the new model code of conduct for members of devolved public bodies and the clarification of paragraph 4.20.
Recommendations:	The Health & Social Care Integration Joint Board is asked to: a) **adopt** the new model code of conduct.
Personnel:	Not Applicable
Carers:	Not Applicable
Equalities:	Not Applicable
Financial:	Not Applicable
Legal:	Legal requirement.
Risk Implications:	Not Applicable
Direction required:	No Direction required

1.1 The Code of Conduct has been issued by the Scottish Ministers, with the approval of the Scottish Parliament, as required by the Ethical Standards in Public Life etc. (Scotland) Act 2000 (the "Act"). The Code is attached at Annex 1.

1.2 The purpose of the Code is to set out the conduct expected of those who serve on the boards of public bodies in Scotland.

1.3 The Code has been developed in line with the nine key principles of public life in Scotland.

1.4 Clarification has been provided in regard to paragraph 4.20 of the Code and is attached at Annex 2.

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Scottish Borders
Health and Social Care
PARTNERSHIP

Code of Conduct for Members of the Scottish Borders Health & Social Care Integration Joint Board

CONTENTS

SECTION 1: INTRODUCTION TO THE CODE OF CONDUCT

1.1 This Code has been issued by the Scottish Ministers, with the approval of the Scottish Parliament, as required by the Ethical Standards in Public Life etc. (Scotland) Act 2000 (the "Act").

1.2 The purpose of the Code is to set out the conduct expected of those who serve on the boards of public bodies in Scotland.

1.3 The Code has been developed in line with the nine key principles of public life in Scotland. The principles are listed in Section 2 and set out how the provisions of the Code should be interpreted and applied in practice.

My Responsibilities

1.4 I understand that the public has a high expectation of those who serve on the boards of public bodies and the way in which they should conduct themselves in undertaking their duties. I will always seek to meet those expectations by ensuring that I conduct myself in accordance with the Code.

1.5 I will comply with the substantive provisions of this Code, being sections 3 to 6 inclusive, in all situations and at all times where I am acting as a board member of my public body, have referred to myself as a board member or could objectively be considered to be acting as a board member.

1.6 I will comply with the substantive provisions of this Code, being sections 3 to 6 inclusive, in all my dealings with the public, employees and fellow board members, whether formal or informal.

1.7 I understand that it is my personal responsibility to be familiar with the provisions of this Code and that I must also comply with the law and my public body's rules, standing orders and regulations. I will also ensure that I am familiar with any guidance or advice notes issued by the Standards Commission for Scotland ("Standards Commission") and my public body, and endeavour to take part in any training offered on the Code.

1.8 I will not, at any time, advocate or encourage any action contrary to this Code.

1.9 I understand that no written information, whether in the Code itself or the associated Guidance or Advice Notes issued by the Standards Commission, can provide for all circumstances. If I am uncertain about how the Code applies, I will seek advice from the Standards Officer of my public body, failing whom the Chair or Chief Executive of my public body. I note that I may also choose to seek external legal advice on how to interpret the provisions of the Code.

Enforcement

1.10 Part 2 of the Act sets out the provisions for dealing with alleged breaches of the Code, including the sanctions that can be applied if the Standards Commission finds that there has been a breach of the Code. More information on how complaints are dealt with and the sanctions available can be found at **Annex A**.

SECTION 2: KEY PRINCIPLES OF THE MODEL CODE OF CONDUCT

2.1 The Code has been based on the following key principles of public life. I will behave in accordance with these principles and understand that they should be used for guidance and interpreting the provisions in the Code.

2.2 I note that a breach of one or more of the key principles does not in itself amount to a breach of the Code. I note that, for a breach of the Code to be found, there must also be a contravention of one or more of the provisions in sections 3 to 6 inclusive of the Code.

The key principles are:

Duty
I have a duty to uphold the law and act in accordance with the law and the public trust placed in me. I have a duty to act in the interests of the public body of which I am a member and in accordance with the core functions and duties of that body.

Selflessness
I have a duty to take decisions solely in terms of public interest. I must not act in order to gain financial or other material benefit for myself, family or friends.

Integrity
I must not place myself under any financial, or other, obligation to any individual or organisation that might reasonably be thought to influence me in the performance of my duties.

Objectivity
I must make decisions solely on merit and in a way that is consistent with the functions of my public body when carrying out public business including making appointments, awarding contracts or recommending individuals for rewards and benefits.

Accountability and Stewardship
I am accountable to the public for my decisions and actions. I have a duty to consider issues on their merits, taking account of the views of others and I must ensure that my public body uses its resources prudently and in accordance with the law.

Openness
I have a duty to be as open as possible about my decisions and actions, giving reasons for my decisions and restricting information only when the wider public interest clearly demands.

Honesty
I have a duty to act honestly. I must declare any private interests relating to my public duties and take steps to resolve any conflicts arising in a way that protects the public interest.

Leadership
I have a duty to promote and support these principles by leadership and example, and to maintain and strengthen the public's trust and confidence in the integrity of my public body and its members in conducting public business.

Respect
I must respect all other board members and all employees of my public body and the role they play, treating them with courtesy at all times. Similarly, I must respect members of the public when performing my duties as a board member.

SECTION 3: GENERAL CONDUCT

Respect and Courtesy

3.1 I will treat everyone with courtesy and respect. This includes in person, in writing, at meetings, when I am online and when I am using social media.

3.2 I will not discriminate unlawfully on the basis of race, age, sex, sexual orientation, gender reassignment, disability, religion or belief, marital status or pregnancy/maternity; I will advance equality of opportunity and seek to foster good relations between different people.

3.3 I will not engage in any conduct that could amount to bullying or harassment (which includes sexual harassment). I accept that such conduct is completely unacceptable and will be considered to be a breach of this Code.

3.4 I accept that disrespect, bullying and harassment can be:

a) a one-off incident,
b) part of a cumulative course of conduct; or
c) a pattern of behaviour.

3.5 I understand that how, and in what context, I exhibit certain behaviours can be as important as what I communicate, given that disrespect, bullying and harassment can be physical, verbal and non-verbal conduct.

3.6 I accept that it is my responsibility to understand what constitutes bullying and harassment and I will utilise resources, including the Standards Commission's guidance and advice notes, my public body's policies and training material (where appropriate) to ensure that my knowledge and understanding is up to date.

3.7 Except where it is written into my role as Board member, and / or at the invitation of the Chief Executive, I will not become involved in operational management of my public body. I acknowledge and understand that operational management is the responsibility of the Chief Executive and Executive Team.

3.8 I will not undermine any individual employee or group of employees, or raise concerns about their performance, conduct or capability in public. I will raise any concerns I have on such matters in private with senior management as appropriate.

3.9 I will not take, or seek to take, unfair advantage of my position in my dealings with employees of my public body or bring any undue influence to bear on employees to take a certain action. I will not ask or direct employees to do something which I know, or should reasonably know, could compromise them or prevent them from undertaking their duties properly and appropriately.

3.10 I will respect and comply with rulings from the Chair during meetings of:

a) my public body, its committees; and
b) any outside organisations that I have been appointed or nominated to by my public body or on which I represent my public body.

3.11 I will respect the principle of collective decision-making and corporate

responsibility. This means that once the Board has made a decision, I will support that decision, even if I did not agree with it or vote for it.

Remuneration, Allowances and Expenses

3.12 I will comply with the rules, and the policies of my public body, on the payment of remuneration, allowances and expenses.

Gifts and Hospitality

3.13 I understand that I may be offered gifts (including money raised via crowdfunding or sponsorship), hospitality, material benefits or services ("gift or hospitality") that may be reasonably regarded by a member of the public with knowledge of the relevant facts as placing me under an improper obligation or being capable of influencing my judgement.

3.14 I will never **ask for** or **seek** any gift or hospitality.

3.15 I will refuse any gift or hospitality, unless it is:

a) a minor item or token of modest intrinsic value offered on an infrequent basis;
b) a gift being offered to my public body;
c) hospitality which would reasonably be associated with my duties as a board member; or
d) hospitality which has been approved in advance by my public body.

3.16 I will consider whether there could be a reasonable perception that any gift or hospitality received by a person or body connected to me could or would influence my judgement.

3.17 I will not allow the promise of money or other financial advantage to induce me to act improperly in my role as a board member. I accept that the money or advantage (including any gift or hospitality) does not have to be given to me directly. The offer of monies or advantages to others, including community groups, may amount to bribery, if the intention is to induce me to improperly perform a function.

3.18 I will never accept any gift or hospitality from any individual or applicant who is awaiting a decision from, or seeking to do business with, my public body.

3.19 If I consider that declining an offer of a gift would cause offence, I will accept it and hand it over to my public body at the earliest possible opportunity and ask for it to be registered.

3.20 I will promptly advise my public body's Standards Officer if I am offered (but refuse) any gift or hospitality of any significant value and / or if I am offered any gift or hospitality from the same source on a repeated basis, so that my public body can monitor this.

3.21 I will familiarise myself with the terms of the Bribery Act 2010, which provides

for offences of bribing another person and offences relating to being bribed.

Confidentiality

3.22 I will not disclose confidential information or information which should reasonably be regarded as being of a confidential or private nature, without the express consent of a person or body authorised to give such consent, or unless required to do so by law. I note that if I cannot obtain such express consent, I should assume it is not given.

3.23 I accept that confidential information can include discussions, documents, and information which is not yet public or never intended to be public, and information deemed confidential by statute.

3.24 I will only use confidential information to undertake my duties as a board member. I will not use it in any way for personal advantage or to discredit my public body (even if my personal view is that the information should be publicly available).

3.25 I note that these confidentiality requirements do not apply to protected whistleblowing disclosures made to the prescribed persons and bodies as identified in statute.

Use of Public Body Resources

3.26 I will only use my public body's resources, including employee assistance, facilities, stationery and IT equipment, for carrying out duties on behalf of the public body, in accordance with its relevant policies.

3.27 I will not use, or in any way enable others to use, my public body's resources:

a) imprudently (without thinking about the implications or consequences);
b) unlawfully;
c) for any political activities or matters relating to these; or
d) improperly.

Dealing with my Public Body and Preferential Treatment

3.28 I will not use, or attempt to use, my position or influence as a board member to:

a) improperly confer on or secure for myself, or others, an advantage;
b) avoid a disadvantage for myself, or create a disadvantage for others or
c) improperly seek preferential treatment or access for myself or others.

3.29 I will avoid any action which could lead members of the public to believe that preferential treatment or access is being sought.

3.30 I will advise employees of any connection, as defined at Section 5, I may have to a matter, when seeking information or advice or responding to a request for information or advice from them.

Appointments to Outside Organisations

3.31 If I am appointed, or nominated by my public body, as a member of another body or organisation, I will abide by the rules of conduct and will act in the best interests of that body or organisation while acting as a member of it. I will also continue to observe the rules of this Code when carrying out the duties of that body or organisation.

3.32 I accept that if I am a director or trustee (or equivalent) of a company or a charity, I will be responsible for identifying, and taking advice on, any conflicts of interest that may arise between the company or charity and my public body.

SECTION 4: REGISTRATION OF INTERESTS

4.1 The following paragraphs set out what I have to register when I am appointed and whenever my circumstances change. The register covers my current term of appointment.

4.2 I understand that regulations made by the Scottish Ministers describe the detail and timescale for registering interests; including a requirement that a board member must register their registrable interests within one month of becoming a board member, and register any changes to those interests within one month of those changes having occurred.

4.3 The interests which I am required to register are those set out in the following paragraphs. Other than as required by paragraph 4.23, I understand it is not necessary to register the interests of my spouse or cohabitee.

Category One: Remuneration

4.4 I will register any work for which I receive, or expect to receive, payment. I have a registrable interest where I receive remuneration by virtue of being:

a) employed;
b) self-employed;
c) the holder of an office;
d) a director of an undertaking;
e) a partner in a firm;
f) appointed or nominated by my public body to another body; or
g) engaged in a trade, profession or vocation or any other work.

4.5 I understand that in relation to 4.4 above, the amount of remuneration does not require to be registered. I understand that any remuneration received as a board member of this specific public body does not have to be registered.

4.6 I understand that if a position is not remunerated it does not need to be registered under this category. However, unremunerated directorships may need to be registered under Category Two, “Other Roles”.

4.7 I must register any allowances I receive in relation to membership of any organisation under Category One.

4.8 When registering employment as an employee, I must give the full name of the employer, the nature of its business, and the nature of the post I hold in the organisation.

4.9 When registering remuneration from the categories listed in paragraph 4.4 (b) to (g) above, I must provide the full name and give details of the nature of the business, organisation, undertaking, partnership or other body, as appropriate. I recognise that some other employments may be incompatible with my role as board member of my public body in terms of paragraph 6.7 of this Code.

4.10 Where I otherwise undertake a trade, profession or vocation, or any other work, the detail to be given is the nature of the work and how often it is undertaken.

4.11 When registering a directorship, it is necessary to provide the registered name and registered number of the undertaking in which the directorship is held and provide information about the nature of its business.

4.12 I understand that registration of a pension is not required as this falls outside the scope of the category.

Category Two: Other Roles

4.13 I will register any unremunerated directorships where the body in question is a subsidiary or parent company of an undertaking in which I hold a remunerated directorship.

4.14 I will register the registered name and registered number of the subsidiary or parent company or other undertaking and the nature of its business, and its relationship to the company or other undertaking in which I am a director and from which I receive remuneration.

Category Three: Contracts

4.15 I have a registerable interest where I (or a firm in which I am a partner, or an undertaking in which I am a director or in which I have shares of a value as described in paragraph 4.19 below) have made a contract with my public body:

a) under which goods or services are to be provided, or works are to be executed; and
b) which has not been fully discharged.

4.16 I will register a description of the contract, including its duration, but excluding the value.

Category Four: Election Expenses

4.17 If I have been elected to my public body, then I will register a description of, and statement of, any assistance towards election expenses relating to election to my public body.

Category Five: Houses, Land and Buildings

4.18 I have a registrable interest where I own or have any other right or interest in houses, land and buildings, which may be significant to, of relevance to, or bear upon, the work and operation of my public body.

4.19 I accept that, when deciding whether or not I need to register any interest I have in houses, land or buildings, the test to be applied is whether a member of the public, with knowledge of the relevant facts, would reasonably regard the interest as being so significant that it could potentially affect my responsibilities to my public body and to the public, or could influence my actions, speeches or decision-making.

Category Six: Interest in Shares and Securities

4.20 I have a registerable interest where:

a) I own or have an interest in more than 1% of the issued share capital of the company or other body; or
b) Where, at the relevant date, the market value of any shares and securities (in any one specific company or body) that I own or have an interest in is greater than £25,000.

Category Seven: Gifts and Hospitality

4.21 I understand the requirements of paragraphs 3.13 to 3.21 regarding gifts and hospitality. As I will not accept any gifts or hospitality, other than under the limited circumstances allowed, I understand there is no longer the need to register any.

Category Eight: Non–Financial Interests

4.22 I may also have other interests and I understand it is equally important that relevant interests such as membership or holding office in other public bodies, companies, clubs, societies and organisations such as trades unions and voluntary organisations, are registered and described. In this context, I understand non-financial interests are those which members of the public with knowledge of the relevant facts might reasonably think could influence my actions, speeches, votes or decision-making in my public body (this includes its Committees and memberships of other organisations to which I have been appointed or nominated by my public body).

Category Nine: Close Family Members

4.23 I will register the interests of any close family member who has transactions with my public body or is likely to have transactions or do business with it.

SECTION 5: DECLARATION OF INTERESTS

Stage 1: Connection

5.1 For each particular matter I am involved in as a board member, I will first consider whether I have a connection to that matter.

5.2 I understand that a connection is any link between the matter being considered and me, or a person or body I am associated with. This could be a family relationship or a social or professional contact.

5.3 A connection includes anything that I have registered as an interest.

5.4 A connection does not include being a member of a body to which I have been appointed or nominated by my public body as a representative of my public body, unless:

a) The matter being considered by my public body is quasi-judicial or regulatory; or
b) I have a personal conflict by reason of my actions, my connections or my legal obligations.

Stage 2: Interest

5.5 I understand my connection is an interest that requires to be declared where the objective test is met – that is where a member of the public with knowledge of the relevant facts would reasonably regard my connection to a particular matter as being so significant that it would be considered as being likely to influence the discussion or decision-making.

Stage 3: Participation

5.6 I will declare my interest as early as possible in meetings. I will not remain in the meeting nor participate in any way in those parts of meetings where I have declared an interest.

5.7 I will consider whether it is appropriate for transparency reasons to state publicly where I have a connection, which I do not consider amounts to an interest.

5.8 I note that I can apply to the Standards Commission and ask it to grant a dispensation to allow me to take part in the discussion and decision-making on a matter where I would otherwise have to declare an interest and withdraw (as a result of having a connection to the matter that would fall within the objective test). I note that such an application must be made in advance of any meetings where the dispensation is sought and that I cannot take part in any discussion or decision-making on the matter in question unless, and until, the application is granted.

5.9 I note that public confidence in a public body is damaged by the perception that decisions taken by that body are substantially influenced by factors other than the public interest. I will not accept a role or appointment if doing so means I will have to declare interests frequently at meetings in respect of my role as a board member. Similarly, if any appointment or nomination to another body would give rise to objective concern because of my existing personal involvement or affiliations, I will not accept the appointment or nomination.

SECTION 6: LOBBYING AND ACCESS

6.1 I understand that a wide range of people will seek access to me as a board member and will try to lobby me, including individuals, organisations and companies. I must distinguish between:

a) any role I have in dealing with enquiries from the public;
b) any community engagement where I am working with individuals and organisations to encourage their participation and involvement, and;
c) lobbying, which is where I am approached by any individual or organisation who is seeking to influence me for financial gain or advantage, particularly those who are seeking to do business with my public body (for example contracts/procurement).

6.2 In deciding whether, and if so how, to respond to such lobbying, I will always have regard to the objective test, which is whether a member of the public, with knowledge of the relevant facts, would reasonably regard my conduct as being likely to influence my, or my public body's, decision-making role.

6.3 I will not, in relation to contact with any person or organisation that lobbies, do anything which contravenes this Code or any other relevant rule of my public body or any statutory provision.

6.4 I will not, in relation to contact with any person or organisation that lobbies, act in any way which could bring discredit upon my public body.

6.5 If I have concerns about the approach or methods used by any person or organisation in their contacts with me, I will seek the guidance of the Chair, Chief Executive or Standards Officer of my public body.

6.6 The public must be assured that no person or organisation will gain better access to, or treatment by, me as a result of employing a company or individual to lobby on a fee basis on their behalf. I will not, therefore, offer or accord any preferential access or treatment to those lobbying on a fee basis on behalf of clients compared with that which I accord any other person or organisation who lobbies or approaches me. I will ensure that those lobbying on a fee basis on behalf of clients are not given to understand that preferential access or treatment, compared to that accorded to any other person or organisation, might be forthcoming.

6.7 Before taking any action as a result of being lobbied, I will seek to satisfy myself about the identity of the person or organisation that is lobbying and the motive for lobbying. I understand I may choose to act in response to a person or organisation lobbying on a fee basis on behalf of clients but it is important that I understand the basis on which I am being lobbied in order to ensure that any action taken in connection with the lobbyist complies with the standards set out in this Code and the Lobbying (Scotland) Act 2016.

6.8 I will not accept any paid work:

a) which would involve me lobbying on behalf of any person or organisation or any clients of a person or organisation.

b) to provide services as a strategist, adviser or consultant, for example, advising on how to influence my public body and its members. This does not prohibit me from being remunerated for activity which may arise because of, or relate to, membership of my public body, such as journalism or broadcasting, or involvement in representative or presentational work, such as participation in delegations, conferences or other events.

ANNEX A: BREACHES OF THE CODE

Introduction

1. The Ethical Standards in Public Life etc. (Scotland) Act 2000 ("the Act") provided for a framework to encourage and, where necessary, enforce high ethical standards in public life.

2. The Act provided for the introduction of new codes of conduct for local authority councillors and members of relevant public bodies, imposing on councils and relevant public bodies a duty to help their members comply with the relevant code.

3. The Act and the subsequent Scottish Parliamentary Commissions and Commissioners etc. Act 2010 established the Standards Commission for Scotland ("Standards Commission") and the post of Commissioner for Ethical Standards in Public Life in Scotland ("ESC").

4. The Standards Commission and ESC are separate and independent, each with distinct functions. Complaints of breaches of a public body's Code of Conduct are investigated by the ESC and adjudicated upon by the Standards Commission.

5. The first Model Code of Conduct came into force in 2002. The Code has since been reviewed and re-issued in 2014. The 2021 Code has been issued by the Scottish Ministers following consultation, and with the approval of the Scottish Parliament, as required by the Act.

Investigation of Complaints

6. The ESC is responsible for investigating complaints about members of devolved public bodies. It is not, however, mandatory to report a complaint about a potential breach of the Code to the ESC. It may be more appropriate in some circumstances for attempts to be made to resolve the matter informally at a local level.

7. On conclusion of the investigation, the ESC will send a report to the Standards Commission.

Hearings

8. On receipt of a report from the ESC, the Standards Commission can choose to:

    - Do nothing;
    - Direct the ESC to carry out further investigations; or
    - Hold a Hearing.

9. Hearings are held (usually in public) to determine whether the member concerned has breached their public body's Code of Conduct. The Hearing Panel comprises of three members of the Standards Commission. The ESC will present evidence and/or make submissions at the Hearing about the investigation and any conclusions as to whether the member has contravened the Code. The member is entitled to attend or be represented at the Hearing and can also present evidence and make submissions. Both parties can call witnesses. Once it has heard all the evidence and submissions, the Hearing Panel will make a determination about whether or not it is satisfied, on the balance of probabilities, that there has been a contravention of

the Code by the member. If the Hearing Panel decides that a member has breached their public body's Code, it is obliged to impose a sanction.

Sanctions

10. The sanctions that can be imposed following a finding of a breach of the Code are as follows:

- **Censure**: A censure is a formal record of the Standards Commission's severe and public disapproval of the member concerned.
- **Suspension**: This can be a full or partial suspension (for up to one year). A full suspension means that the member is suspended from attending all meetings of the public body. Partial suspension means that the member is suspended from attending some of the meetings of the public body. The Commission can direct that any remuneration or allowance the member receives as a result of their membership of the public body be reduced or not paid during a period of suspension.
- **Disqualification**: Disqualification means that the member is removed from membership of the body and disqualified (for a period not exceeding five years), from membership of the body. Where a member is also a member of another devolved public body (as defined in the Act), the Commission may also remove or disqualify that person in respect of that membership. Full details of the sanctions are set out in section 19 of the Act.

Interim Suspensions

11. Section 21 of the Act provides the Standards Commission with the power to impose an interim suspension on a member on receipt of an interim report from the ESC about an ongoing investigation. In making a decision about whether or not to impose an interim suspension, a Panel comprising of three Members of the Standards Commission will review the interim report and any representations received from the member and will consider whether it is satisfied:

- That the further conduct of the ESC's investigation is likely to be prejudiced if such an action is not taken (for example if there are concerns that the member may try to interfere with evidence or witnesses); or
- That it is otherwise in the public interest to take such a measure. A policy outlining how the Standards Commission makes any decision under Section 21 and the procedures it will follow in doing so, should any such a report be received from the ESC can be found here.

12. The decision to impose an interim suspension is not, and should not be seen as, a finding on the merits of any complaint or the validity of any allegations against a member of a devolved public body, nor should it be viewed as a disciplinary measure.

ANNEX B: DEFINITIONS

“Bullying” is inappropriate and unwelcome behaviour which is offensive and intimidating, and which makes an individual or group feel undermined, humiliated or insulted.

"Chair" includes Board Convener or any other individual discharging a similar function to that of a Chair or Convener under alternative decision-making structures.

“Code” is the code of conduct for members of your devolved public body, which is based on the Model Code of Conduct for members of devolved public bodies in Scotland.

"Cohabitee" includes any person who is living with you in a relationship similar to that of a partner, civil partner, or spouse.

“Confidential Information” includes:

- any information passed on to the public body by a Government department (even if it is not clearly marked as confidential) which does not allow the disclosure of that information to the public;
- information of which the law prohibits disclosure (under statute or by the order of a Court);
- any legal advice provided to the public body; or
- any other information which would reasonably be considered a breach of confidence should it be made public.

"Election expenses" means expenses incurred, whether before, during or after the election, on account of, or in respect of, the conduct or management of the election.

“Employee” includes individuals employed:

- directly by the public body;
- as contractors by the public body, or
- by a contractor to work on the public body’s premises.

“Gifts” a gift can include any item or service received free of charge, or which may be offered or promised at a discounted rate or on terms not available to the general public. Gifts include benefits such as relief from indebtedness, loan concessions, or provision of property, services or facilities at a cost below that generally charged to members of the public. It can also include gifts received directly or gifts received by any company in which the recipient holds a controlling interest in, or by a partnership of which the recipient is a partner.

“Harassment” is any unwelcome behaviour or conduct which makes someone feel offended, humiliated, intimidated, frightened and / or uncomfortable. Harassment can be experienced directly or indirectly and can occur as an isolated incident or as a course of persistent behaviour.

“Hospitality” includes the offer or promise of food, drink, accommodation, entertainment or the opportunity to attend any cultural or sporting event on terms not available to the general public.

“Relevant Date” Where a board member had an interest in shares at the date on which the member was appointed as a member, the relevant date is – (a) that date; and (b) the 5th April immediately following that date and in each succeeding year, where the interest is retained on that 5th April.

“Public body” means a devolved public body listed in Schedule 3 of the Ethical Standards in Public Life etc. (Scotland) Act 2000, as amended.

“Remuneration" includes any salary, wage, share of profits, fee, other monetary benefit or benefit in kind.

“Securities” a security is a certificate or other financial instrument that has monetary value and can be traded. Securities includes equity and debt securities, such as stocks bonds and debentures.

“Undertaking” means:
a) a body corporate or partnership; or
b) an unincorporated association carrying on a trade or business, with or without a view to a profit.

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Covid Recovery and Public Service Reform Directorate
Mary McAllan, Director

E: Mary.McAllan@gov.scot

The Scottish Government
Riaghaltas na h-Alba

20 May 2022

Dear Chair,

MODEL CODE OF CONDUCT FOR MEMBERS OF DEVOLVED PUBLIC BODIES – CLARIFICATION – INTEREST IN SHARES AND SECURITIES.

The purpose of this letter is to issue a point of clarification relating to Section 4, Registration of Interests, Category Six: Interest in Shares and Securities of the 2021 Model Code of Conduct for Members of Devolved Public Bodies.

Paragraph 4.19 in the 2014 version of the Model Code included the qualification that an interest in shares and securities should only be registered if it could be "*significant to, of relevance to, or bear upon, the work and operation of the public body*". However, the corresponding paragraph 4.20 of the 2021 revised Model Code does not contain this provision.

The Standards Commission for Scotland and the Ethical Standards Commissioner agree that the omission of this qualification in the 2021 version of the Model Code was an oversight. Paragraph 4.20 of the Code should therefore be applied in line with the 2014 provision. As such, the Standards Commission for Scotland will provide clarification of the requirements to register interests in shares and securities in their Guidance.

I'd like to apologise for the confusion around this requirement.

I'd also like to take the opportunity to address any concerns around the registration of pensions. An interest under shares and securities will include investments made under self-invested pension plans only if, at the relevant date, they are either more than 1% of the issued share capital of a specific company or body or are greater than £25,000. This is provided the shares and securities in question are significant to, relevant to, or bear upon the work or operation of the public body of which you are a member.

Victoria Quay, Edinburgh EH6 6QQ
www.scotland.gov.uk

Please note that the objective test still applies in relation to these matters. Should at any point your shares or interests be regarded as bearing influence on subjects raised in any future Board meetings or the operations of your organisation this will be required to be declared as per Section 5 of the Model Code.

Please accept this letter as assurance that the Model Code can be adopted by your organisation without amendment to paragraph 4.20.

Yours sincerely,

Mary McAllan
Director for Covid Recovery and Public Service Reform

Victoria Quay, Edinburgh EH6 6QQ
www.scotland.gov.uk

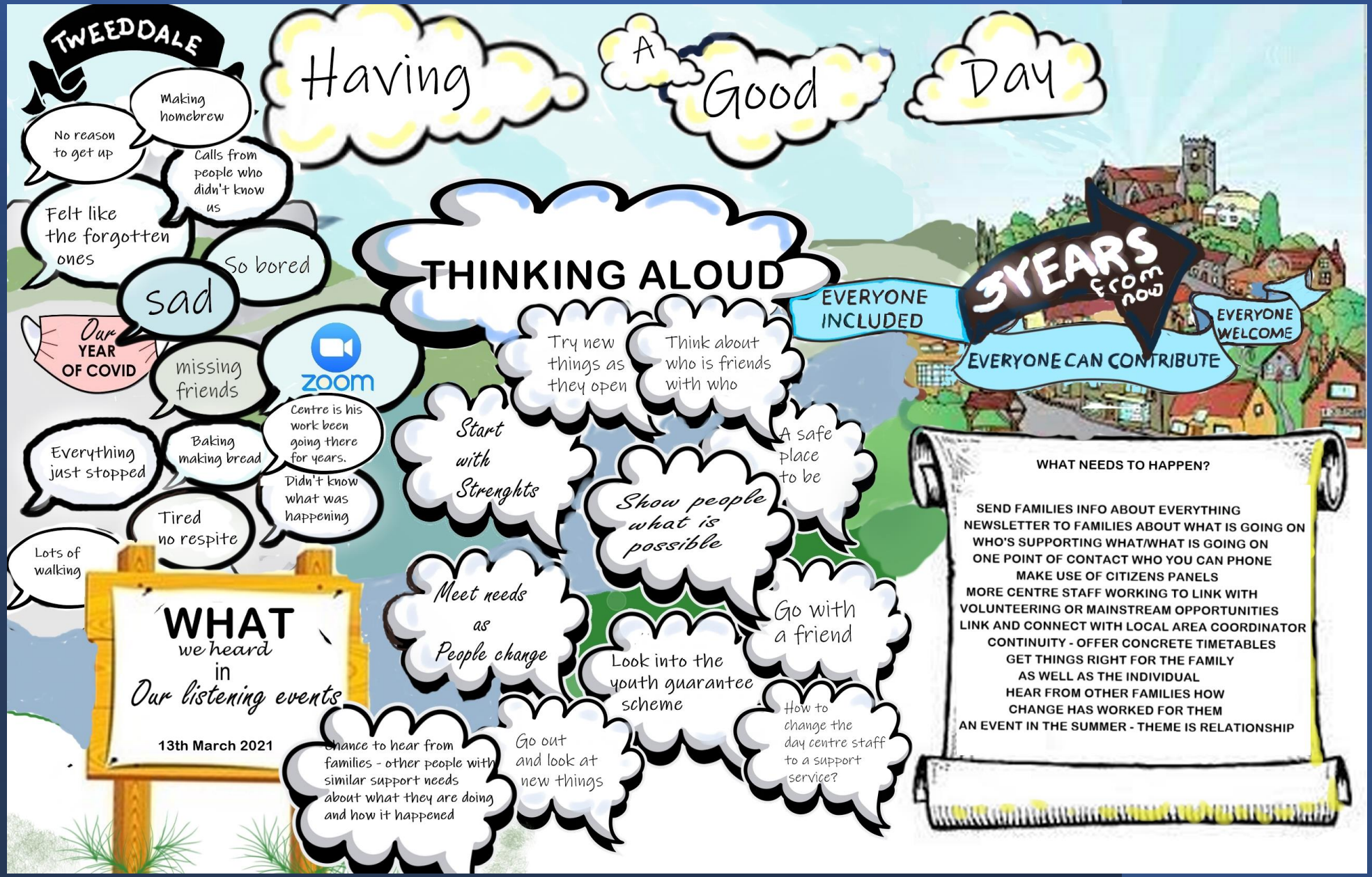
Learning Disability Day Services Review

Output from

NDTi Consultation

events

Spring 2021


TWEEDDALE
Having A Good Day
Making homebrew
No reason to get up
Calls from people who didn't know us
Felt like the forgotten ones
So bored
sad
Our YEAR OF COVID
missing friends
zoom
Centre is his work been going there for years.
Didn't know what was happening
Everything just stopped
Baking making bread
Tired no respite
Lots of walking
THINKING ALOUD
Try new things as they open
Think about who is friends with who
Start with Strenghts
A safe place to be
Show people what is possible
Meet needs as People change
Go with a friend
Look into the youth guarantee scheme
How to change the day centre staff to a support service?
Go out and look at new things
Chance to hear from families - other people with similar support needs about what they are doing and how it happened
WHAT we heard in Our listening events
13th March 2021
EVERYONE INCLUDED
3YEARS from now
EVERYONE WELCOME
EVERYONE CAN CONTRIBUTE
WHAT NEEDS TO HAPPEN?
SEND FAMILIES INFO ABOUT EVERYTHING
NEWSLETTER TO FAMILIES ABOUT WHAT IS GOING ON
WHO'S SUPPORTING WHAT/WHAT IS GOING ON
ONE POINT OF CONTACT WHO YOU CAN PHONE
MAKE USE OF CITIZENS PANELS
MORE CENTRE STAFF WORKING TO LINK WITH VOLUNTEERING OR MAINSTREAM OPPORTUNITIES
LINK AND CONNECT WITH LOCAL AREA COORDINATOR
CONTINUITY - OFFER CONCRETE TIMETABLES
GET THINGS RIGHT FOR THE FAMILY
AS WELL AS THE INDIVIDUAL
HEAR FROM OTHER FAMILIES HOW CHANGE HAS WORKED FOR THEM
AN EVENT IN THE SUMMER - THEME IS RELATIONSHIP

Having A Good Day

THINKING ALOUD

Haven't seen anyone

Numbers have halved
People are more able to be themselves

Sitting in his room

Walking the dogs

OUR YEAR OF COVID

Donkey sanctuary

Missing having our own lives apart from each other

Carers come but just sit inside together

Dreaming of a good nights sleep

Missing friends

Rent out the building for revenue.

A wee hub to go to would be good

Could the space be used for a changing space?

What about people getting to retirement.

Invite others in. Make a community facility.

Could Lanark Lodge open at weekends?

What about a drop in cafe? We have a lot to offer that others would love to use.

Could Lanark Lodge go to bubbles?

Red tape around who ...n come into the ...gets in the way

A community space

3YEARS from now

Safe

Freedom to choose

A place that welcomes people of all ages

BERWICKSHIRE

WHAT WE HEARD
in
Our listening events
23rd March 2021

WHAT NEEDS TO HAPPEN?

Create a space where people can socialise safely
Be more visible in the community
Chance to see what is possible - see what others have done
Open Lanark Lodge up, invite the community in
Reeducate the community - get involved in local meetings
Support people who use the service to be represented in community groups
Explore being a facility like a cafe
Explore what everyone -staff and people needing support bring to the services - their gifts and abilities
Recognise people's anxieties about coming back
Make sure family get a proper break too

Having a good day

Putting on shows and music
BORDERS got TALENT

Dream holiday
Seeing the rugby

BEACH
Go back to PORTUGAL

Ready to have own life
Out of the farm

DREAMING ABOUT THE FUTURE

Moving house

To be happy and fulfilled

Movies, theatre, live shows
WWW WRESTLING
Dwayne the rock

Freedom and balance

The beach
Horseriding
Have my happy boy back

Music and swimming and dancing

Teviot & Cheviot
WHAT WE HEARD
in
OUR LISTENING EVENTS
18th March 2021

Shielding for over a year
Car count how many times I left the house
Services just stopped
No support during first lockdown
Big effect on mental wellbeing

HEARING ABOUT the NIGHTMARE

Life threatening illness didn't stop
Everything has been taken away
Left with fear of going out

All she wants is to be somewhere
Just wants to be with familar people
Can't do the things she used to
Capabilities are deteriorating

THINKING ALOUD

Family could support with some stuff eg swimming

Mix of social, learning skills and learning independence

Support people in groups around interests eg library and computers

Having routine and clear plan for the week.

Having a building helps us support people in groups

Support around doing community things for part of the day

Longer support time

Some people go from home themselves. Support to get to and from places

Being useful having sense of purpose

In the area there's not much going on.

Match support workers better. People do get on with supporters. Allow for more consistent support.

Not so many clubs for people to join. Don't want people sat in cafe's all day with supporters on their mobiles

Staff who want to do the job and love it. It's not just about qualifications and experience

Skills development supported to happen organically

Have people involved in recruiting and choosing their own staff

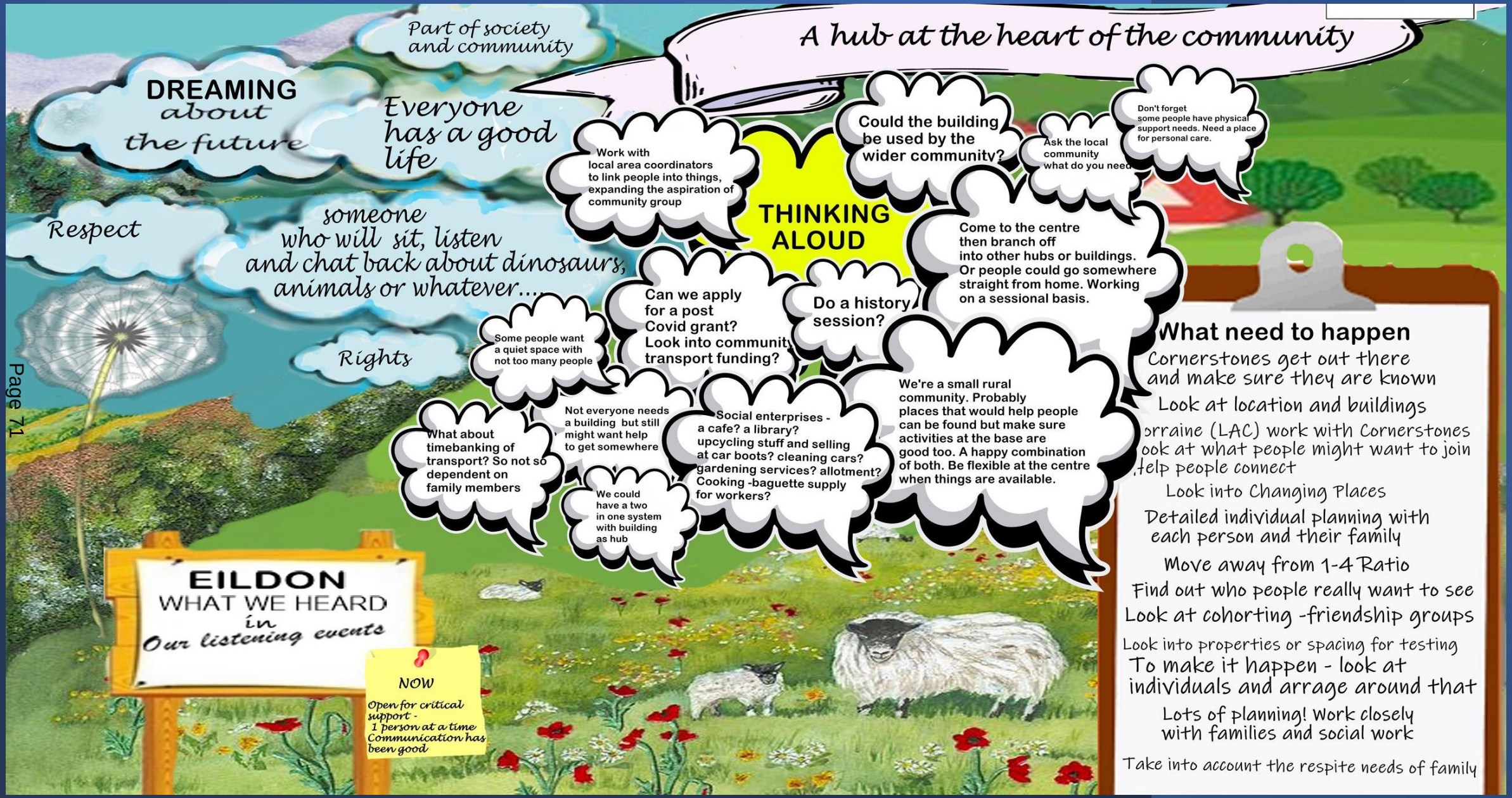
Being able to contribute to others

3 years from now

who really want to do the job
Flexible services
No more block purchasing
Space for us all to learn and grow

What needs to happen now

We need to get back out there again
We need the services to reopen
We need you to understand carers coming to the house is not the same
People to start joining in things with friends when allowed to be in groups again
Individualised planning for return
A phased return with smaller groups
Clear communication to families
Get staff returning, available as soon as possible
Take small steps with people
Recruit more people
Form small bubbles with friends
Open very small services -even partially
Some people have found and preferred other things
Need to understand the needs and wishes of young people coming through - need to hear from families


A hub at the heart of the community
DREAMING about the future
Part of society and community
Everyone has a good life
Respect
someone who will sit, listen and chat back about dinosaurs, animals or whatever....
Rights
THINKING ALOUD
Work with local area coordinators to link people into things, expanding the aspiration of community group
Could the building be used by the wider community?
Ask the local community what do you need
Don't forget some people have physical support needs. Need a place for personal care.
Come to the centre then branch off into other hubs or buildings. Or people could go somewhere straight from home. Working on a sessional basis.
Can we apply for a post Covid grant? Look into community transport funding?
Do a history session?
Some people want a quiet space with not too many people
Not everyone needs a building but still might want help to get somewhere
What about timebanking of transport? So not so dependent on family members
We could have a two in one system with building as hub
Social enterprises - a cafe? a library? upcycling stuff and selling at car boots? cleaning cars? gardening services? allotment? Cooking -baguette supply for workers?
We're a small rural community. Probably places that would help people can be found but make sure activities at the base are good too. A happy combination of both. Be flexible at the centre when things are available.
What need to happen
Cornerstones get out there and make sure they are known
Look at location and buildings
orraine (LAC) work with Cornerstones
ook at what people might want to join
,elp people connect
Look into Changing Places
Detailed individual planning with each person and their family
Move away from 1-4 Ratio
Find out who people really want to see
Look at cohorting -friendship groups
Look into properties or spacing for testing
To make it happen - look at individuals and arrage around that
Lots of planning! Work closely with families and social work
Take into account the respite needs of family
EILDON
WHAT WE HEARD
in
Our listening events
NOW
Open for critical support - 1 person at a time Communication has been good

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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-150622-2 LD Day services
Direction title	Commissioning of Day Services for adults with Learning Disabilities
Direction to	Scottish Borders Council
IJB Approval date	TBC – Direction to be considered by Integration Joint Board on 15 June 2022
Does this Direction supersede, revise or revoke a previous Direction?	No
Services/functions covered by this Direction	The current 5 building based day services provided by SB Cares and the service commissioned from the Third sector provider, Cornerstone.
Full text of the Direction	To recommission a new model of Learning Disability Day Services by going to the open market in line with the relevant papers agreed at the Integration Joint Board on 15 June 2022.
Timeframes	The service should transition from the existing service providers to the new providers from November 2022.
Links to relevant SBIJB report(s)	The Health & Social Care Integration Joint Board Strategic Plan 2018 – 2023 indicated that we redesign day services with a focus on early intervention and prevention. In addition, a key element of the Scottish Borders Learning Disability Strategic Commissioning Plan 2016-19 was to review the impacts of the previous review of Day Services. This was paused during COVID-19.
Budget / finances allocated to carry out the detail	Budget allocation for Learning Disability Day services: £1,993,097 Revised budget allocation 2022-23: £1,643,000 Savings target: £350,000
Outcomes / Performance Measures	It is expected that detailed information will be collected by Scottish Borders Council to evidence improvements in the following areas: **National Health and Wellbeing Outcomes** 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. **<u>Project outcomes:</u>** From independent consultation in 2021, the following outcomes were identified by supported people and their carers: • People develop a sense of purpose through what they love doing and how they contribute to others in their local community. • People develop and maintain friendships • Outdoor and local opportunities for people to be part of • Opportunities for fitness and wellbeing • Opportunities around enjoying and contributing to others through food- cooking, baking sharing and growing • Opportunities to take part in the arts, music, local history and leisure in a way that connects people with like-minded people • Opportunities to try new things, explore existing and new hobbies, and see what is going on • Families want personalised support • Families and people with learning disabilities need a break from one another • Personalised finance options to increase flexibility of support • A place to be and meet others- which is accessible and can be a place from which to branch out • An improved place for people come together, and meet is open to others in the local community, rather than a segregated closed space.
Date Direction will be reviewed	May 2023 Integration Joint Board Audit Committee

Scottish Borders Health & Social Care Integration Joint Board

Meeting Date: 15 July 2022

Report By:	Simon Burt / Chris Myers
Contact:	Susan Henderson
Telephone:	07772912373 / 01896 840299
LEARNING DISABILITY DAY SERVICES REVIEW	
Purpose of Report:	To seek approval to recommission the Learning Disability Day support services currently provided by SB Cares and Cornerstone (existing providers) from 'The Market'.
Recommendations:	The Health & Social Care Integration Joint Board is asked to: **Agree** to issue Direction to Scottish Borders Council to recommission the Learning Disability Day support services from the market.
Personnel:	Existing staff will be eligible to TUPE across to new Providers.
Carers:	This project will have a positive impact on carers as the day support services provides a dual purpose in that it also provides respite for carers and family members. Engagement with Carers took place through 2020-2022 and this has informed the model to be commissioned. A small number of families are actively working with us in establishing the evaluation criteria for Tender submission and will participate in formal interviews at evaluation and selection stage.
Equalities:	Inequalities integrated Impact assessment has been carried out (attached for information Appendix 1)
Financial:	A savings target of £350k is attached to this project and is reported through the Council's Fit for 2024 programme board.
Legal:	Relevant legal contractual compliances will be adhered to.
Risk Implications:	1. The commissioning process may not attract suitable applicants to deliver any or all of the contract. In this scenario SB Cares and the current independent sector provider will need to continue to reshape while the Learning Disability Service re-visit and consider reshaping the model further. 2. A lack of suitable applicants will place the financial savings target at significant risk. Currently £200k has been saved recurrently. However this reduction, in the event of there being no suitable applicants for contracts, is unlikely to be sustainable as services remobilise from the COVID-19 pandemic restrictions. 3. Out-sourcing the 5 existing day services run by SB Cares may attract adverse public, Trade Unions and impacted

	staff commentary.
Direction required:	The IJB are asked to issue Direction to Scottish Borders Council to Commission the Learning Disability Day support services from The Market.

Situation

1. The last significant review of learning disability day services was in 2011 with a shift to more localised support, disinvestment in some buildings based support, and re-investment in Local Area Coordination support.

2. We now need to continue on the journey of modernisation of locally based services by commissioning a refreshed model of support that maximises the independence of individuals, ensuring there are some buildings based services for those with the most complex needs and providing services closer to home.

3. Our focus needs to continue to shift towards meeting people's outcomes in a variety of settings within a model of support that can respond flexibly.

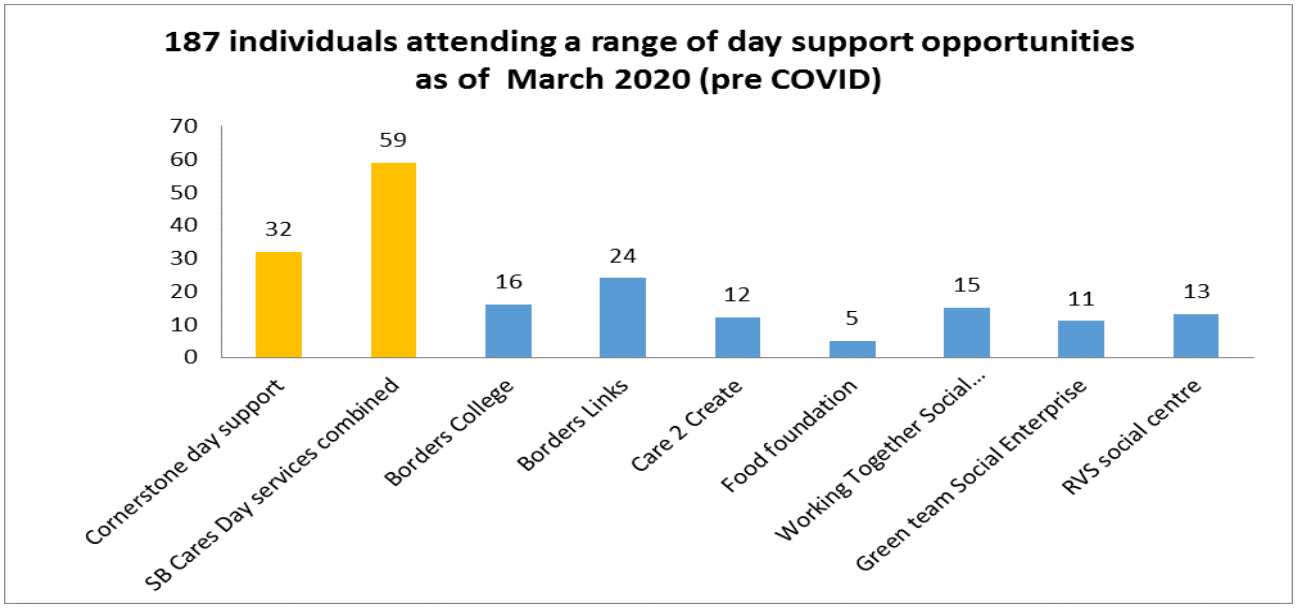
4. The service requires to deliver more financially efficient services to manage within allocated budgets and cope with increasing demand, primarily driven by increasing complexity of support needs rather than numbers of service users.

Background

2.1 Learning Disability day support has been a journey for over 10 years with the last significant review taking place in 2011 resulting in:

- a shift to more localised support
- disinvestment in some buildings based support
- re-investment in Local Area Coordination support.

2.2 Pre COVID-19 Learning Disability Services attendance



2.3 In scope for the review:

Services provided by Scottish Borders Council:
- Green Gardens – Peebles (Tweeddale)
- Katherine Elliot Centre – Hawick (Teviot)
- Rutherford Square – Kelso (Cheviot)
- Lanark Lodge – Duns (Berwickshire)
- Jedburgh Day Service (Cheviot)

Provided by 3rd sector
- Cornerstone – Galashiels (Eildon)

2.4 We now need to:
- continue on the journey of modernisation of locally based services
- maximise independence of individuals
- make sure there are some buildings based services available for those with the most complex of needs

2.5 Our focus needs to continue to shift towards meeting people's outcomes in a variety of settings and within a model that can respond flexibly, across 7 days where demand is identified.

2.6 The COVID-19 Pandemic has changed life for everybody over the past year and perhaps for the years to come. We will not return to exactly how things were before. Our refreshed service model has been designed upon the principles established through a series of stakeholder consultation events facilitated by an external consultancy, NDTI (Appendix 2) and based on flexible service delivery established during the pandemic.

Assessment

Key Principles:

3.0 Our new model of support needs to adhere to the following key principles:

3.1 People with learning disabilities want to:
- develop a sense of purpose through what they love doing and how they contribute to others in their local community.
- develop and maintain friendships

3.2 We need to:
- strengthen resilience and create efficiency through collaboration and innovation
- maximise the use of resources that are both commissioned and community led
- have services tailored to individuals and their communities that are outcomes focussed
- involve people, community groups, the third sector interfaces, organisations and service teams in the commissioning processes
- embrace and use technology by using technology as a partner
- work closely with the Local Area Coordination team to strengthen community connectedness.

3.3 Accommodation

The new model will continue to require use of a building in each locality. Scottish Borders Council (SBC) have agreed to make a building available in the Teviot, Cheviot, Tweeddale and Berwickshire localities for new providers to use as there is currently no suitable alternative building space available. This will ensure that people have access to the appropriate environment with required space and equipment and no lengthy delay in service provision.

The Provider in the Eildon Locality is expected to source a suitable building space. This is currently being taken forward by the existing commissioned service provider as their existing building will no longer be available from the end of 2022.

3.4 Efficiencies
The new model needs to deliver the allocated efficiencies target of £350k.

3.5 Stakeholder outcomes
Following an independent consultation with supported people, family Carers and a range of other stakeholders, by the National Development Team for Inclusion in spring 2021, the following were identified:

3.6 What people said they want to do

People want to have:

- access to outdoor and local opportunities to participate in
- opportunities for fitness and wellbeing
- opportunities around enjoying and contributing to others through food - cooking, baking, sharing and growing
- opportunities to take part in the arts, music, local history and leisure in a way that connects people with like-minded people
- opportunities to try new things, explore existing and new hobbies, and find out what is going on in their local areas.

3.7 Enablers and Support to achieve these outcomes:

- People have a way of getting around (transport linked to the service and links to community transport where possible)
- Families want personalised support
- Families and people with learning disabilities get a break from one another
- Personalised finance options to increase flexibility of support
- A place to be and meet others - which is accessible and can be a place from which to branch out.
- The place we come together, and meet is open to others in the local community, rather than a segregated closed space.

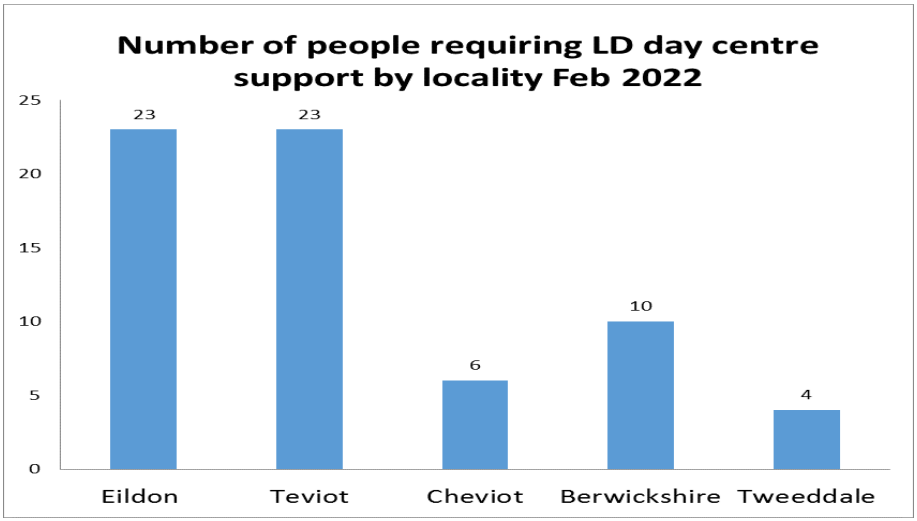
3.8 New service specification will embrace the key principles established from the consultation events, use the learning through the COVID-19 pandemic and outline expectations of the services to include service provision being:

- more flexible and delivered, potentially across 7 days of support where required and feasible to do so
- not always buildings based

- more community facing with opportunities identified for integrated activities and greater collaboration with local community groups
- more closely linked with the Local Area Co-ordination service
- able to deliver flexible transport options
- focused on outcomes and not outputs alone.

3.9 Demand

The information in the graph below identifies the number people requiring a day support service in localities by end of 2022. This includes a small number of young people leaving school this year.



Future demand is predicted through the Learning Disability Transitions tracker meeting bi-annually.
Currently this is predicted as follows although may change following more detailed individual assessments.

Locality	Predicted demand for day support - number of young people 2023-2024	Predicted demand for day support - number of young people 2024-2025
Eildon	1	5
Cheviot	1	1
Teviot	4	3
Tweeddale	2	2
Berwickshire	3	1

3.10 Contract duration
In order to allow providers to establish and develop locality based services, they will need the time and security of contract to do so. Moving forward we recommend that contracts be a minimum of 5 years with the option of extending by another 2 years. All contracts will have the option for either the provider or Commissioner to give notice if the contract cannot or is not being delivered satisfactorily.

Recommendations

1. The Learning Disability Service goes to the Market to commission learning disability service based upon the revised service model highlighted within this report.

2. The length of contract should be for a standard 5 years with the option of extending for an additional 2 years.

Appendix 1
Integrated impact assessment

Appendix 2
Report out from NDTi

Integrated Impact Assessment (IIA)

Part 1 Scoping

1 Details of the Proposal

Title of Proposal:	Review of Learning Disability Day service provision (SB cares and Cornerstone) across Scottish Borders
What is it?	A revised Policy/Strategy/Practice

Description of the proposal:
(Set out a clear understanding of the purpose of the proposal being developed or reviewed (what are the aims, objectives and intended outcomes, including the context within which it will operate)

Aim - Review and re-provide day support for some adults with learning disabilities. The review will engage stakeholders and benchmark service provision with other local authorities in Scotland and propose alternative service provision. This will include the new digital strategy to support providing services in different ways to reduce isolation and increase social interaction. This is likely to be a change from purely building to community /building based hybrid model of support.

Our ways of working

- A blend of building bases and community/outreach model of support in each of the 5 localities

Outcomes

We start with people's strengths-.

- People develop **a sense of purpose** through what they love doing and how they contribute to others in their local community.
- People develop and maintain **friendships**

The kinds of things people want to do:

- **Outdoor and local opportunities** for people to be part of
- Opportunities **for fitness and wellbeing**
- Opportunities around enjoying and **contributing to others through food**- cooking, baking sharing and growing.
- Opportunities to take part in the **arts, music, local history** and leisure in a way that connects people with like-minded people.
- Opportunities to **try new things, explore** existing and new hobbies, and see what is going on

Enablers and Support to achieve these outcomes:

- People have a **way of getting around**
- Families want **personalised support**
- **Families and people with learning disabilities get a break from one another**
- **Personalised finance options** to increase flexibility of support
- **A place to be** and meet others- which is accessible and can be a place from which to branch out.
- The place we come together, and meet is **open to others in the local community**, rather than a segregated closed space.

Stakeholders included in building the model are -
People who currently use SB Cares and Cornerstone Day support services and their families; SB cares, Cornerstone (existing commissioned provider); 2 open events held Dec 21 and April 22 for any Provider to work with the core team sharing information; Learning Disability Service; senior leadership teams in SBC and Health and Social Care Partnership. Full group identified in Communication strategy.

Service Area: **Department:**	Scottish Borders Learning Disability Service
Lead Officer: **(**Name and job title)	Simon Burt General manager Learning Disabilities and Mental health
Other Officers/Partners involved: (List names, job titles and organisations)	Jen Holland – **Director of Strategic Commissioning and Partnerships**; Lisa Sansom – Service Manager SB Cares; Julie Glen – Operations Director SB Cares; Elaine Firth – Service Manager, SB Cares; Andrew McInnes- Area manager – Cornerstone; Susan Henderson – Planning and Development Officer, Learning Disability Service; Douglas Ireland – Acting Group Manager Learning Disability Service; Iain Davidson, – Employee Relations Manager; Mark Williamson – HR Business Partner; various family members; Social workers from Learning Disability Service; Sue Bell – SBC Communications team; John Yallop Senior Finance Officer, SBC finance team; Vivienne Kennedy Senior Contracts officer, SBC; Claire Veitch Local Area Coordinator Manager, SBC
Date(s) IIA completed:	Feb 2021; Feb 2022, April 2022

2 Will there be any cumulative impacts as a result of the relationship between this proposal and other policies?

No
If yes, - please state here:

3 Legislative Requirements

3.1 Relevance to the Equality Duty:
Do you believe your proposal has any relevance under the Equality Act 2010? YES *(If you believe that your proposal may have some relevance – however small please indicate yes. If there is no effect, please enter "No" and go to Section 3.2.)*

Equality Duty	**Reasoning:**
Elimination of discrimination (both direct & indirect), victimisation and harassment. *(Will the proposal discriminate? Or help eliminate discrimination?)*	Increasing social interaction and reducing social isolation will assist in eliminating discrimination.
Promotion of equality of opportunity? *(Will your proposal help or hinder the Council with this)*	Enabling service users to maximise their opportunity and independence will help with equality of opportunity.
Foster good relations? *(Will your proposal help or hinder the council s relationships with those who have equality characteristics?)*	A focus on gaining independence and increasing social interaction will help in fostering good relationships. Although there may be opposition by families, with the potential for this to be perceived as a Council cost savings exercise

3.2 Which groups of people do you think will be or potentially could be, impacted by the implementation of this proposal? (You should consider employees, clients, customers / service users, and any other relevant groups)

Please tick below as appropriate, outlining any potential impacts on the undernoted equality groups this proposal may have and how you know this.

	Impact			Please explain the potential impacts and how you know this
	No Impact	**Positive Impact**	**Negative Impact**	
Age Older or younger people or a specific age grouping		**X**		Enabling service users to maximise their opportunity and independence will aid groups of all ages. Planning ahead as part of transition process will improve opportunities or support better design of support. Potential negative impact is staff change – continuity of care and support affected may impact on supported people. Risk of shift in quality of support at Transition of service provision.

Disability e.g. Effects on people with mental, physical, sensory impairment, learning disability, visible/invisible, progressive or recurring		X	X	Enabling service users to maximise their opportunity and independence will aid groups of all ages. Planning ahead as part of transition process will improve opportunities or support better design of support. Potential negative impact is staff change – continuity of care and support affected may impact on supported people. Risk of shift in quality of support at Transition of service provision.
Gender Reassignment Trans/Transgender Identity anybody whose gender identity or gender expression is different to the sex assigned to them at birth	X			
Marriage or Civil Partnership people who are married or in a civil partnership	X			
Pregnancy and Maternity (refers to the period after the birth, and is linked to **maternity** leave in the employment context. In the non-work context, **protection** against **maternity** discrimination is for 26 weeks after giving birth),	X			
Race Groups: including colour, nationality, ethnic origins, including minorities (e.g. gypsy travellers, refugees, migrants and asylum seekers)	X			
Religion or Belief: different beliefs, customs (including atheists and those with no aligned belief)	X			
Sex women and men (girls and boys)	X			
Sexual Orientation, e.g. Lesbian, Gay, Bisexual, Heterosexual	X			

3.3 Fairer Scotland Duty

This duty places a legal responsibility on Scottish Borders Council (SBC) to actively consider (give due regard) to how we can reduce inequalities of outcome caused by socioeconomic disadvantage when making strategic decisions.

The duty is set at a strategic level - these are the key, high level decisions that SBC will take. This would normally include strategy documents, decisions about setting priorities, allocating resources and commissioning services.

Is the proposal strategic? YES

Yes ***(please delete as applicable)***

If No go to Section 4

If yes, please indicate any potential impact on the undernoted groups this proposal may have and how you know this:

	Impact			State here how you know this
	No Impact	**Positive Impact**	**Negative Impact**	
Low and/or No Wealth – enough money to meet basic living costs and pay bills but have no savings to deal with any unexpected spends and no provision for the future.	**X**			
Material Deprivation – being unable to access basic goods and services i.e. financial products like life insurance, repair/replace broken electrical goods, warm home, leisure and hobbies	**X**			
Area Deprivation – where you live (e.g. rural areas), where you work (e.g. accessibility of transport)		**X**		Retaining day support service in each of the 5 localities supports those living in rural areas having to travel less distance
Socio-economic Background – social class i.e.	**X**			

parents' education, employment and income				
Looked after and accommodated children and young people	X			
Carers paid and unpaid including family members		X		Increasing options for service users will provide greater respite opportunities for carers.
Homelessness	X			
Addictions and substance use	X			
Those involved within the criminal justice system	X			

4 Full Integrated Impact Assessment Required

Select No if you have answered "No" to all of Sections 3.1 – 3.3.

Yes

If a full impact assessment is not required briefly explain why there are no effects and provide justification for the decision.

Signed by Lead Officer:	**Simon Burt**
Designation:	**General Manager Mental Health and Learning Disabilities**
Date:	
Counter Signature Director	**Chris Myers**
Date:	**IJB Chief Officer / Director of Health and Social Care, Scottish Borders Health and Social Care Partnership**

Part 2 Full Integrated Impact Assessment

5 Data and Information

What evidence has been used to inform this proposal?
(Information can include, for example, surveys, databases, focus groups, in-depth interviews, pilot projects, reviews of complaints made, user feedback, academic publications and consultants' reports).

Commissioning LD day support has been a journey for over 10 years and support arrangements have undergone several re-configurations to ensure that they are fit for purpose. The last significant review was in 2011 with a shift to more localised support, disinvestment in some buildings based support, and re-investment in Local Area Coordination support. We need to continue on the journey of modernisation of locally based services that maximise independence of individuals, ensuring there are some buildings based services for those with the most complex needs. Our focus needs to continue to shift towards meeting people's outcomes in a variety of settings and models that can respond flexibly.

National context

The Public Bodies (Joint Working) (Scotland) Act: This Act changed how services were commissioned across health & social care in recent years. Setting the framework for the integration of Health & Social Care, this Act required integration partners to prepare a strategic plan for their area, setting out arrangements for the delivery of integration functions and how the national health and wellbeing outcomes will be met. Commissioning of social care services is now the responsibility of integration authorities via health and social care partnerships.

Scottish Government review of social care: The COVID-19 pandemic reset and refocused the agenda on social care. The Review engaged with people and organisations including those who have lived experience of using social care services and supports, carers and families. This resulted in options and recommendations that cut across: funding, delivery, governance and regulation, and how continuous improvement can be assured in social care services.

Self Directed Support (SDS): SDS Provides four options for people, providing different degrees to which they are directly involved in organising their care. The aim of SDS is to help people live better lives by making sure that people get the kind of support they want - support that is personalised.

Background evidence:

https://ihub.scot/media/8322/new-models-for-day-support-collaborative-evidence-summary-v10.pdf

Local context

The Health & Social Care Partnership Strategic Plan: This Strategic plan 2018-2021 had three aims. That Learning Disability Day Services provide meaningful activity for assessed support needs towards meeting supported people's outcomes and maintaining the health and well being of their carers. In turn this supports the wider aims of the local strategic plan.

Fit for 2024: This programme aims to prepare for and meet the predicted demands for services; the challenges of meeting the needs of our growing older population, the need to grow the economic performance of the area; the far-reaching reforms in Health and Social Care; new requirements in Education; rapid digital transformation as a continuous and permanent feature of our environment; new duties under tackling Poverty and Inequality and budgetary, legislative and regulatory impacts as a re-driving improvement through collaboration.

Scottish Borders Council Local Plan – key areas: Clean, green future – locally based services ;Fulfilling our potential – outcomes focused individual planning and occupation; Empowered, vibrant communities – being part of and shaping local communities Good health and wellbeing – meeting physical and mental health needs; Working together, improving lives – of both families and carers.

Outcomes focused Commissioning: Traditional commissioning of services is the process by which councils would decide how to spend their money to get the best possible services. Our future commissioning will aim to achieve the best possible outcomes for individuals and communities by understanding and accessing collective resources. We must also achieve best value, national quality standards, Equality, keeping people safe and involving them in why, how and what we commission.

Place making: This approach is in line with the Cosla Place Principle for "A more joined-up, collaborative and participative approach to services, land and buildings, across all sectors within a place, enables better outcomes for everyone and increased opportunities for people and communities to shape their own lives".

Learning Disability Specific - National

The Keys to Life (2013) and implementation plan: The **keys to life strategy** recognises that people who have a learning disability have the same aspirations and expectations as everyone else and is guided by a vision shaped by the Scottish Government's ambition for all citizens. The 2019-2021 implementation framework focuses on 4 key areas: Healthy life; choice and control; independence; active citizenship.

Principles of Good Transitions 3: The Principles of Good Transitions 3 provides a framework to inform, structure and encourage the continual improvement of support for young people with additional needs between the ages of 14 and 25 who are making the transition to young adult

life. It is divided into 8 parts with seven key principles of good transitions. Scottish Borders Learning Disability Services have led improvements in this area locally.

The Charter for Involvement: The **Charter for Involvement** is written by the National **Involvement** Network. It sets out in their own words how supported people want to be **involved** in the support that they get in the organisations that provide their services.

Learning Disability specific – local

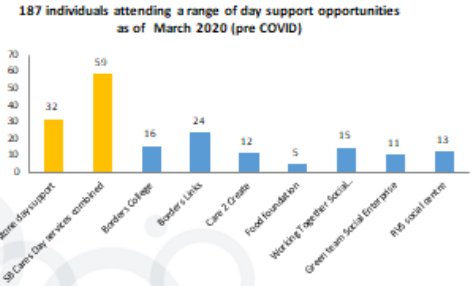
Scottish Borders Learning Disability Strategic Commissioning Plan 2016-19: This strategy set out the commissioning priorities for the Learning Disability Service or the period from 2016 – 19. A key element of this strategy was to review the impacts of the previous review of Day Services. The new strategic commissioning plan was paused during COVID-19 and consultation will be restarted.

Other information Post pandemic: The COVID-19 Pandemic has changed life for everybody over the past two years and perhaps for the years to come. We will not return to exactly how things were before.

We need to: strengthen resilience and create efficiency through collaboration and innovation: maximise the use of resources that are both commissioned and community led; have services tailored to individuals and their communities that are outcomes focussed; involve people, community groups, the third sector interfaces, organisations and service teams in the commissioning processes; embrace and use technology by using technology as a partner. Prior to the COVID-19 pandemic there were 187 people with learning disability attending some form of day time opportunity.

Information gathered from LD social workers what matters assessments; engagement work through National Development team for Inclusion in spring 2021. Various families meetings, staff engagement sessions, Borders carer centre engagement; meeting with senior leadership staff; local elected members.

Recap: the case for change
Learning disability service day support data



Prior to COVID-19 there were 187 adults with learning disabilities attending some form of day time opportunity.

The scope of this review is to modernise the traditional day services within SB Cares and Cornerstone – a total of 6 day centres with 91 attendees.

Recap: the case for change
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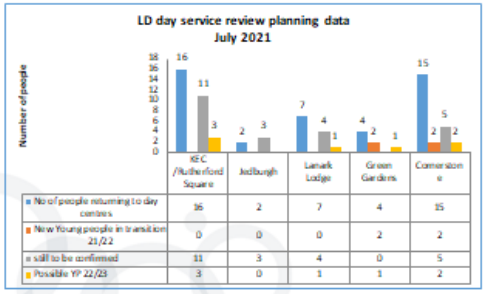
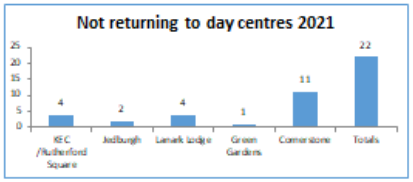
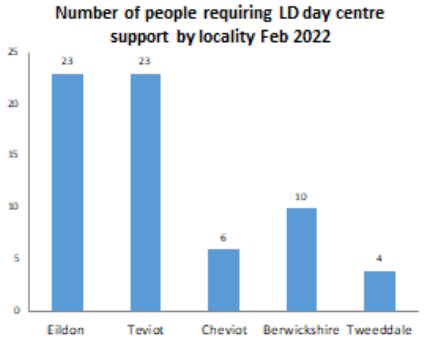




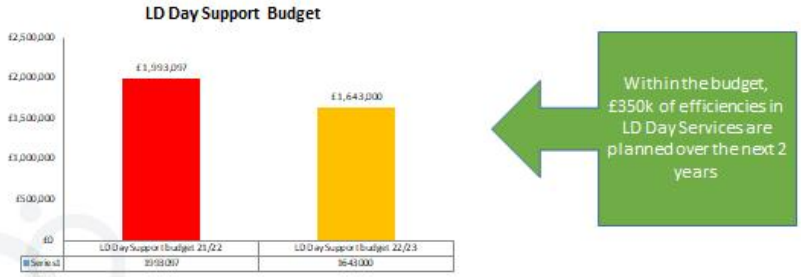
The case for change:
Learning disability service day support current data



- Mixed model approach: some buildings based; community outreach; home and alternatives e.g. Direct Payments, increased Provider support
- Currently still operating COVID safe 1m distancing

8

Recap: The case for change
Current & Future levels of council resources



- Continue to develop daytime support in line with earlier reviews
- Services need to be locality based in line with national and local strategic direction.
- Services need to support individuals to achieve their outcomes and promote independence and individuality as highlighted through consultation.
- Services need to be provided from within the available budget.
- Build the specification and quality questions – looking for families who might want to take part in this.
- The new service specification will be written and presented to the IJB for directions June 2022.
- A formal commissioning process will begin in the summer with new services from November 2022 onwards.

Describe any gaps in the available evidence, then record this within the improvement plan together with all of the actions you are taking in relation to this (e.g. new research, further analysis, and when this is planned)

Please state your answer here

Data for young people coming through Transition in 2023-24 – plan to gather this in May 2022

6 Consultation and Involvement

Which groups are involved in this process and describe their involvement

Supported people and families: NDTi independent engagement sessions in 2021 and graphic outputs fed into review; offer to participate in MS teams meetings; offer to be involved in building specification and setting quality questions for tendering services to the market; presentations shared. Day support staff: MS teams meetings; meetings with managers and HR; Trade Unions involved throughout and presentations 2021, 2022 Briefings to elected members throughout at key decision points LD service – emails – some direct involvement from key participants LD providers: PIN notice sent out and 2 market engagement sessions Dec 21, April 22 SBC and IJB – briefing papers and discussions on MS teams and presentations Borders carer centre – MS teams meetings and presentation Feb 22 Set up email box for specific questions from SB cares staff; FAQ developed 2022

Describe any planned involvement saying when this will take place and who is responsible for managing the process

Continued offer to families to engage. 2 furthers sessions planned for May 22 Families invited to be part of evaluation and specification setting and take part in interview process. Anticipate that a few families will want to take part from engagement to date.

Describe the results of any involvement and how you have taken this into account.

Feedback from all engagement sessions, emails, conversations and participation in online meetings collated. These will inform the service specifications and help to direct the quality question setting for the tender process.

What have you learned from the evidence you have and the involvement undertaken? Does the initial assessment remain valid? What new (if any) impacts have become evident?
(Describe the conclusion(s) you have reached from the evidence, and state where the information can be found.)

Importance of getting it right for supported people and family carers need for respite; mixed model of support essential; Continuity of care and support essential for this group of people

7 Mitigating Actions and Recommendations

Consider whether:

Could you modify the proposal to eliminate discrimination or reduce any identified negative impacts?
(If necessary, consider other ways in which you could meet the aims and objectives of the proposal.)

Could you modify the proposal to increase equality and, if relevant, reduce poverty and socioeconomic disadvantage?

Describe any modifications which you can make without further delay (e.g. easy, few resource implications)

Mitigation

Please summarise all mitigations for approval by the decision makers who will approve your proposal

Equality Characteristic/Socio economic factor	Mitigation	Resource Implications (financial, people, health, property etc.)	Approved Yes/No
Age, Disability	All families invited to be involved in specification setting. Small number of families involved in writing service specification and evaluation questions. 2 workshops with providers pre –tender to lay out expectation and discuss opportunities		

	Continuity of care – clear transition plans and sharing of support plan information across organisations		
	Accessible buildings available as the base for services		

8 Recommendation and Reasoning *(select which applies)*

- Implement proposal with no amendments
- Implement proposal taking account of mitigating actions (as outlined above)
- Reject proposal due to disproportionate impact on equality, poverty, health and Socio -economic disadvantage

Reason for recommendation:

Signed by Lead Officer:	**Simon Burt**
Designation:	**General manager Mental Health and Learning Disability Services**
Date:	
Counter Signature Director	**Chris Myers**
Date:	**IJB Chief Officer / Director of Health and Social Care, Scottish Borders Health and Social Care Partnership**

Office Use Only (not for publication)

This assessment should be presented to those making a decision about the progression of your proposal.

If it is agreed that your proposal will progress, you must send an electronic copy to corporate communications to publish on the webpage within 3 weeks of the decision.

Complete the below two sections. For your records, please keep a copy of this Integrated Impact Assessment form.

Action Plan (complete if required)

Actioner Name:	**Action Date:**
What is the issue?	
What action will be taken?	
Progress against the action:	
Action completed:	**Date completed:**

Monitoring and Review

State how the implementation and impact of the proposal will be monitored, including implementation of any amendments? For example what type of monitoring will there be? How frequent?

Please state your answer here

What are the practical arrangements for monitoring? For example who will put this in place? When will it start?

Please state your answer here

When is the proposal due for review?

Please state your answer here

Who is responsible for ensuring that this happens?

Please state your answer here

Learning Disability Day Services Review Update to families March 2022

Recap: Why review?

This presentation aims to help service providers, stakeholders and community groups understand the future environment for their work and make plans for the future.

It sets out our priorities for Learning Disability (LD) day services, opportunities for providers and how we will work with the market.

It will also be informative for providers already delivering services in Scottish Borders; businesses and community groups looking to develop new activities; organisations which do not currently work in Scottish Borders who wish to do so; people (and carers) who purchase services from their own resources or with a personal budget/Direct Payment.

Commissioning LD day support has been a journey for over 10 years and support arrangements have undergone several re-configurations to ensure that they are fit for purpose.

The last significant review was in 2011 with a shift to more localised support, disinvestment in some buildings based support, and re-investment in Local Area Coordination support.

We need to continue on the journey of modernisation of locally based services, that maximise independence of individuals, ensuring there are some buildings based services for those with the most complex needs.

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Scottish Borders Council Local Plan – key areas

Clean, green future – locally based services
Fulfilling our potential – outcomes focused individual planning and occupation
Empowered, vibrant communities – being part of and shaping local communities
Good health and wellbeing – meeting physical and mental health needs
Working together, improving lives – of both families and carers

Learning disability specific context

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Recap: the case for change
Living in post COVID-19 communities

The COVID-19 Pandemic has changed life for everybody over the past year and perhaps for the years to come. We will not return to exactly how things were before.

We need to:

- strengthen resilience and create efficiency through collaboration and innovation
- maximise the use of resources that are both commissioned and community led
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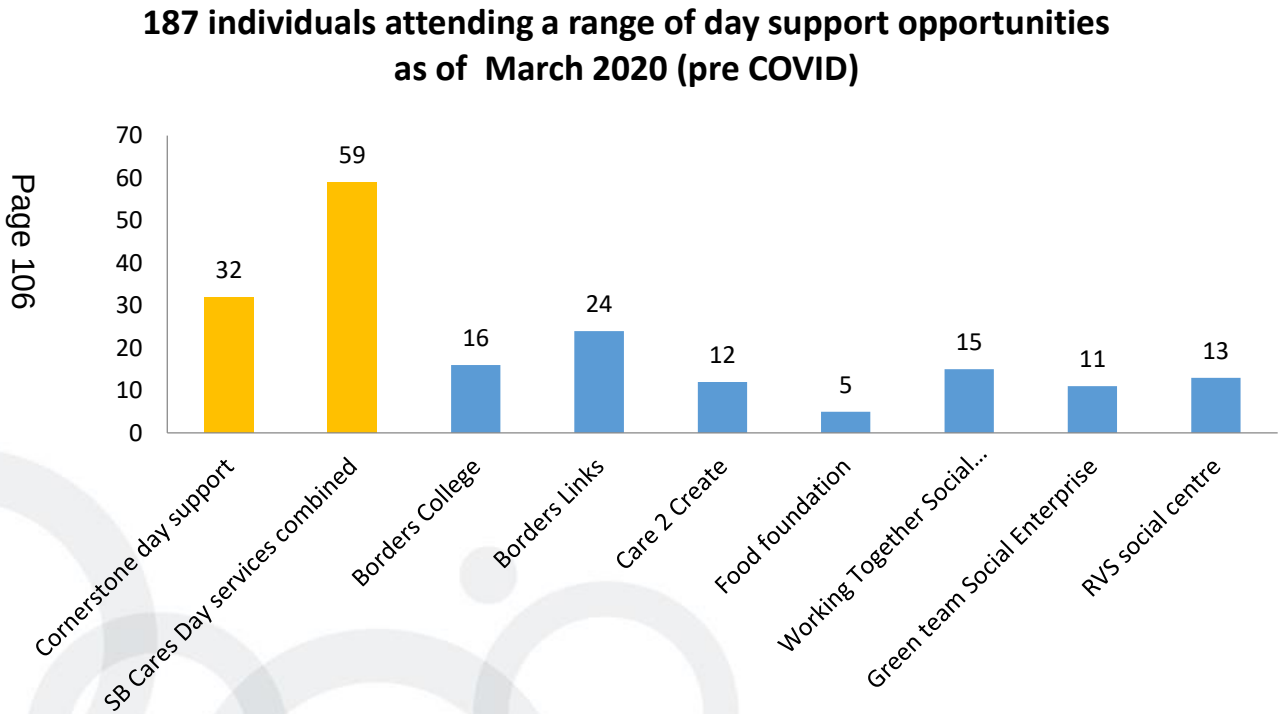

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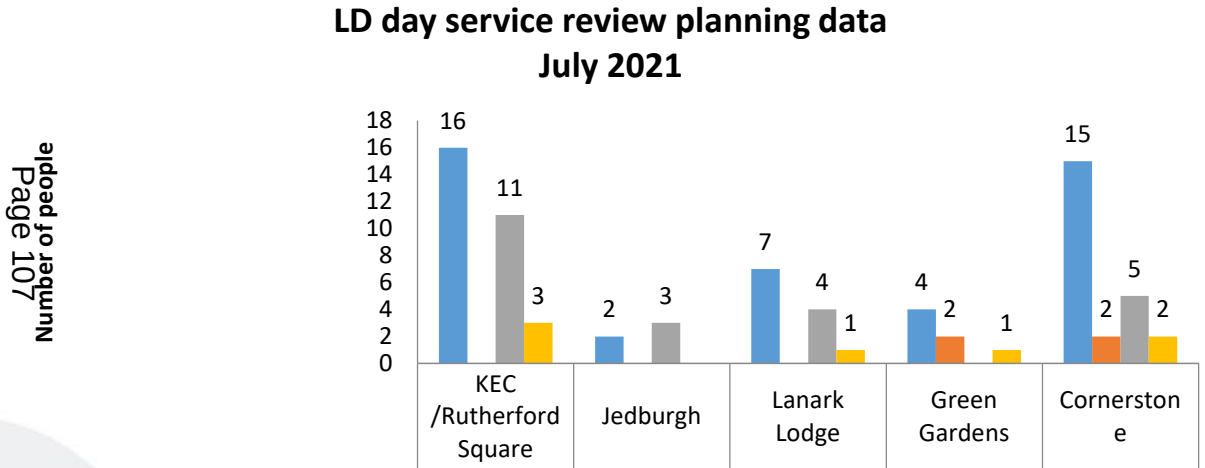

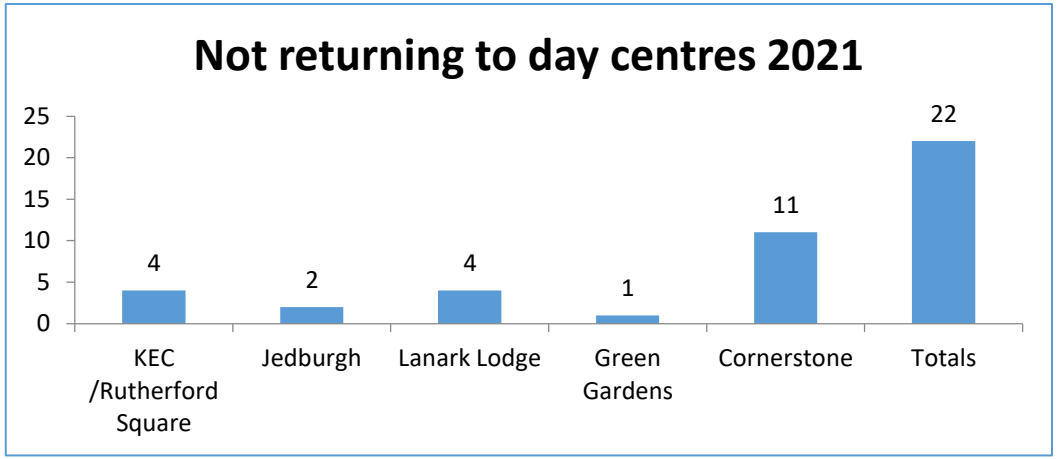

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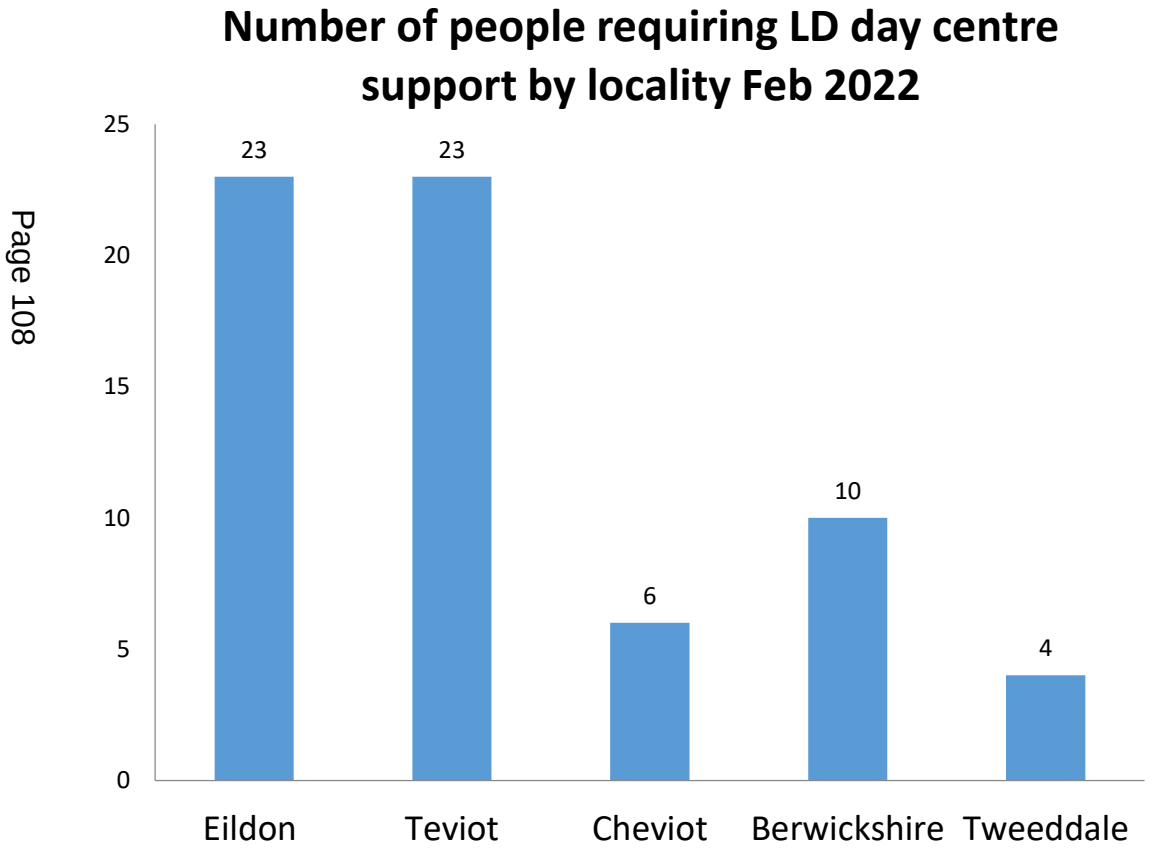

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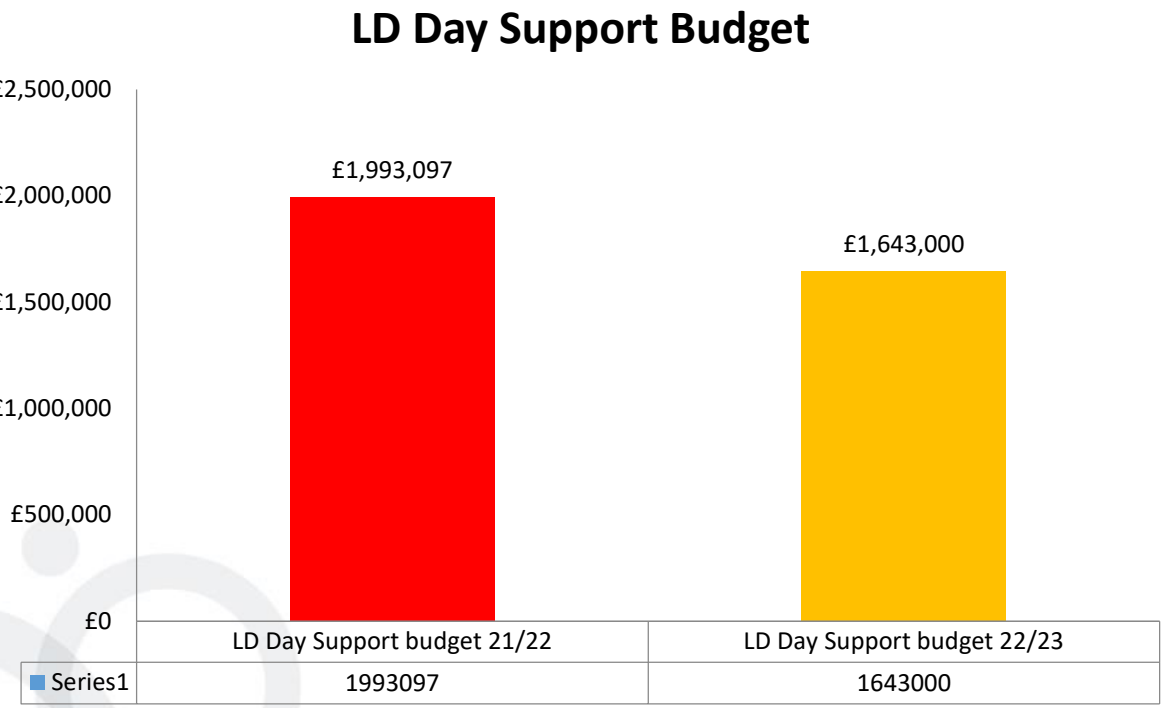
Recap: The case for change
Current & Future levels of council resources



Within the budget, £350k of efficiencies in LD Day Services are planned over the next 2 years

Recap: Key learning messages from the Independent Review of Adult Social Care (2021)

"Service design and delivery can only improve if people with lived experience are involved in the process. It is impossible to address inequality if the people who experience it are not in the room"

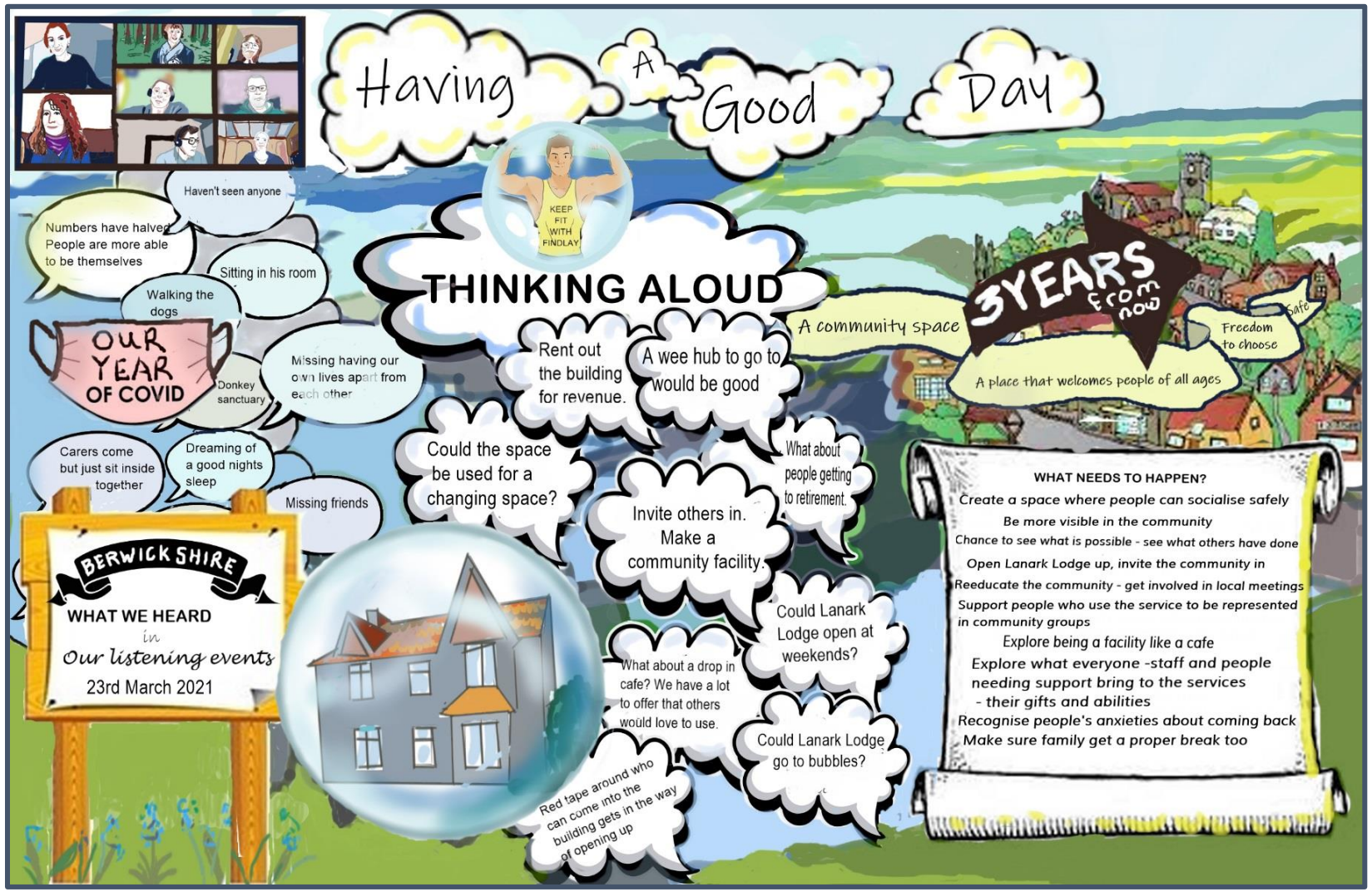
"We heard that our current system too often does not feel like a system at all: it feels like a guddle, and that causes people worry and anxiety"

"People also told us that the threshold for accessing support is too high, and too often meaningful support is only available when people are acutely unwell or in crisis"

"People spoke to us about 'short-termism' resulting in providers spending significant time and resources applying and reapplying for contracts"

"We heard that the market approach to commissioning and procurement produces 'competition, not collaboration', which, in turn, leads to too much focus on costs rather than high quality, person-centred care and support"

Recap: local consultation events - spring 2021



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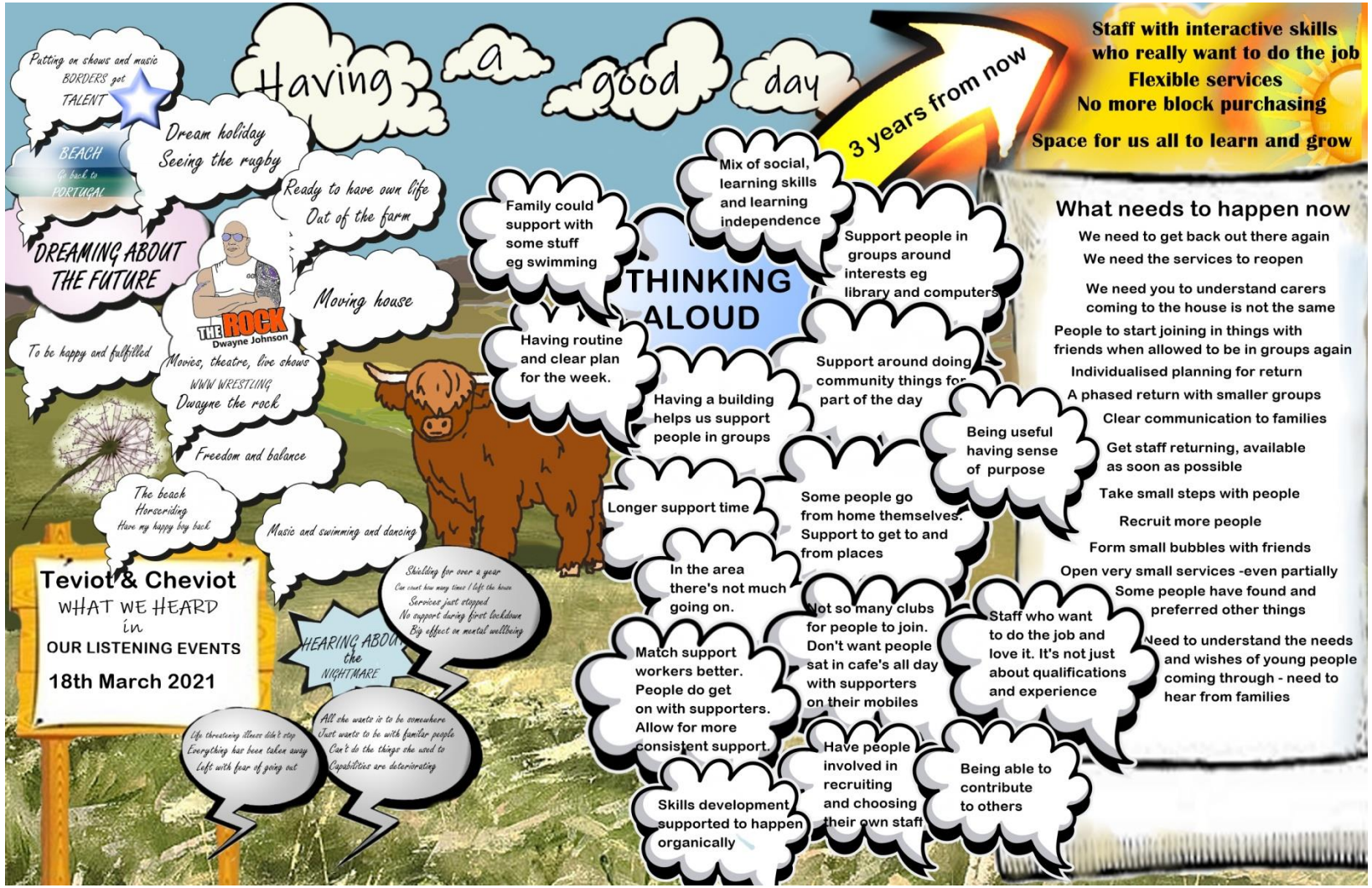

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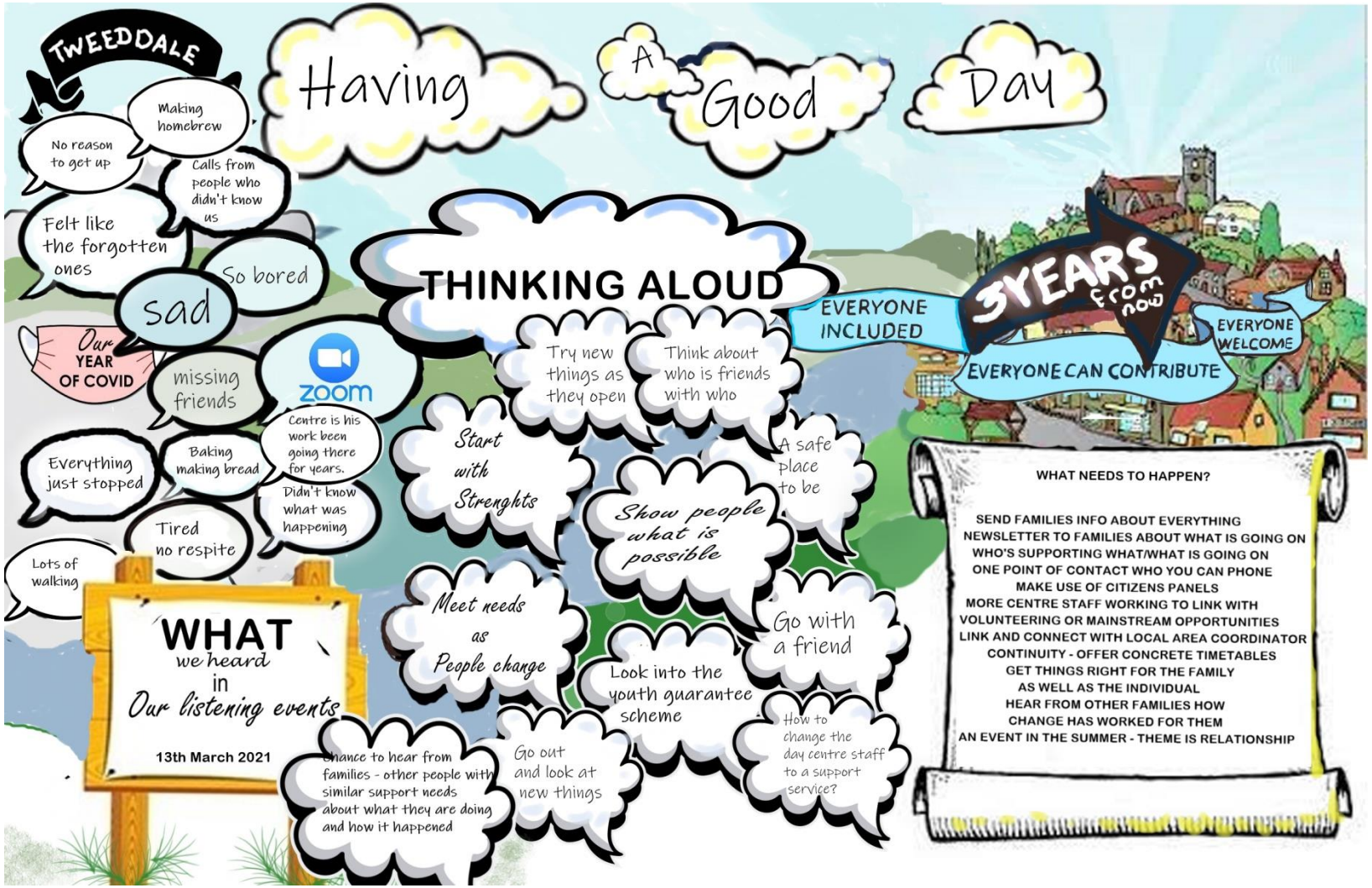

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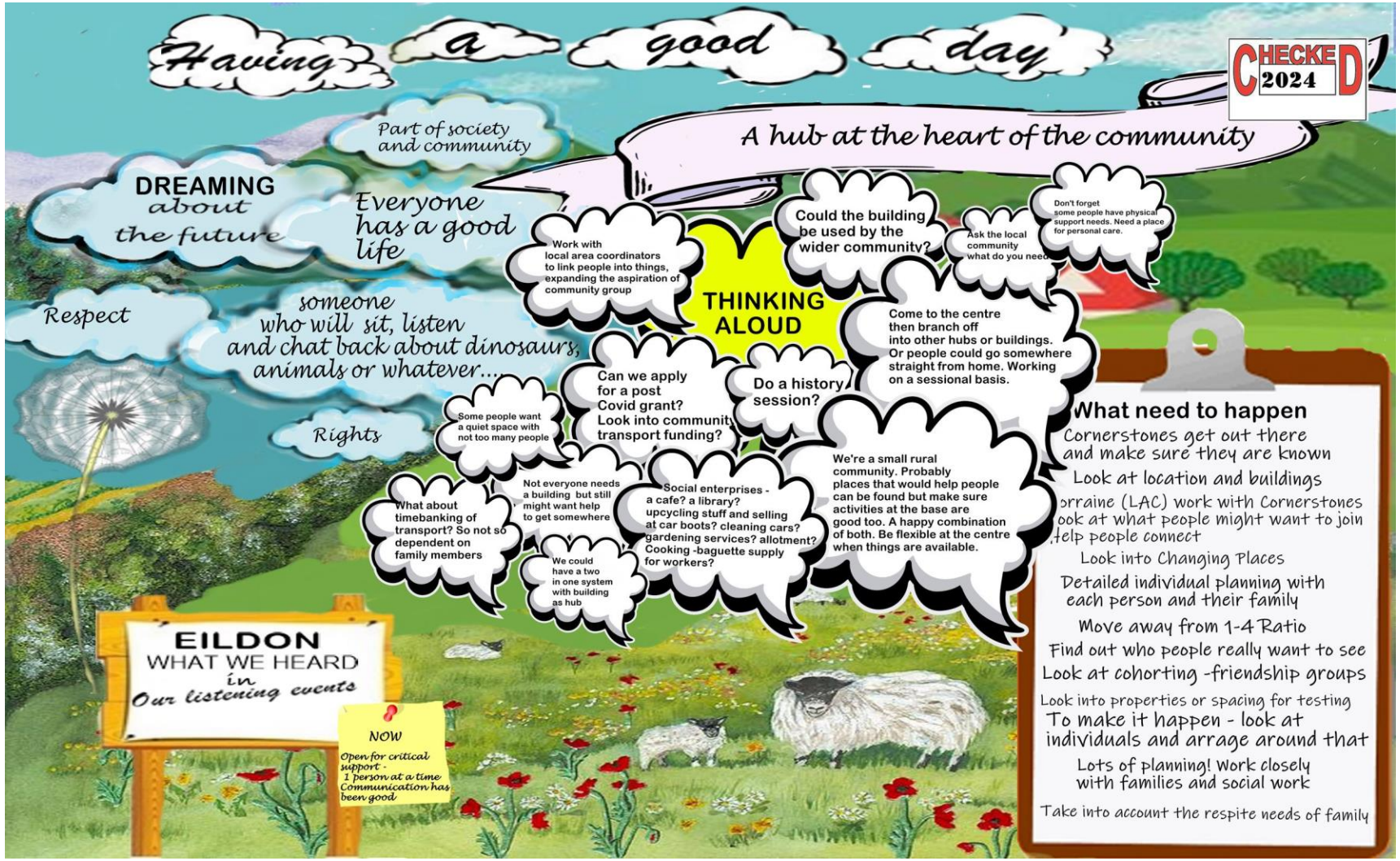


Recap: 2021 consultation events themes:

We start with people's strengths-.

- People develop **a sense of purpose** through what they love doing and how they contribute to others in their local community.
- People develop and maintain **friendships**

The kinds of things people want to do:

- **Outdoor and local opportunities** for people to be part of
- Opportunities **for fitness and wellbeing**
- Opportunities around enjoying and **contributing to others through food**- cooking, baking sharing and growing.
- Opportunities to take part in the **arts, music, local history** and leisure in a way that connects people with like-minded people.
- Opportunities to **try new things, explore** existing and new hobbies, and see what is going on

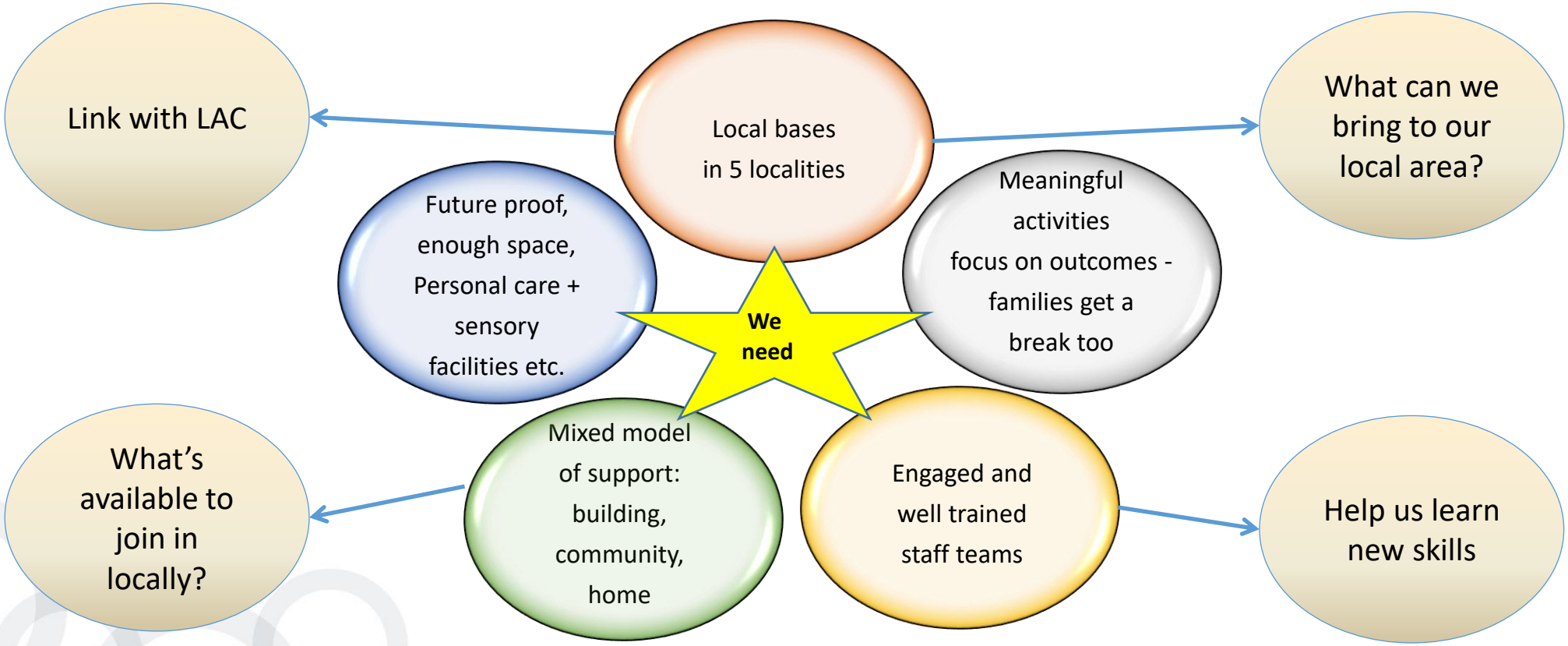
Enablers and Support to achieve these outcomes:

- People have a **way of getting around**
- Families want **personalised support**
- **Families and people with learning disabilities get a break from one another**
- **Personalised finance options** to increase flexibility of support
- **A place to be** and meet others- which is accessible and can be a place from which to branch out.
- The place we come together, and meet is **open to others in the local community**, rather than a segregated closed space.

Families and Borders Carers Centre

- Met with small group of family carers of young people with learning disabilities Feb 2022
- Parents looking for opportunities for their young people to:
    - learn / grow new life skills
    - meet /make friends
    - be part of their local communities
    - have stimulating and safe environments with access to personal care facilities and support
    - flexible support arrangements

Day support needs to include:



Updated project timeline

High level plan

Action	Jun-20	Jul-20	Aug-20	Sep20 Mar 21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr 22	May 22	Jun Aug 22	Sept Oct 22	Nov 22
Paper to CMT																					
Engage external consultant support																					
gather ideas of what the future could look like																					
Consult on findings; stat to plan model																					
Carry out options appraisal																					
Carry out EQIA on potential new model																					
Review findings																					
Carry out assessments - agree size of day support needed																					
Soft market testing																					
Governance; SLT, IJB																					
Commissioning process for new model(s)																					
Service spec and quality questions																					
Preparation for procurement																					
Procurement processes																					
Evaluation																					
Award new contract(s)																					
Implement new model of day support																					

Summary

- Continue to develop daytime support in line with earlier reviews
- Services need to be locality based in line with national and local strategic direction.
- Services need to support individuals to achieve their outcomes and promote independence and individuality as highlighted through consultation.
- Services need to be provided from within the available budget.
- Build the specification and quality questions – looking for families who might want to take part in this.
- The new service specification will be written and presented to the IJB for directions June 2022.
- A formal commissioning process will begin in the summer with new services from November 2022 onwards.

Questions?

Project Sponsor

Simon Burt

General Manger Learning Disabilities and Mental Health

Project Manager

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Scottish Borders Health & Social Care Integrated Joint Board

Meeting Date: 15 June 2022

Report By:	Morag Muir, Locum Consultant in Dental Public Health
Contact:	Morag Muir, Locum Consultant in Dental Public Health
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

Contents

List of Tables and Figures

Tables

Figures

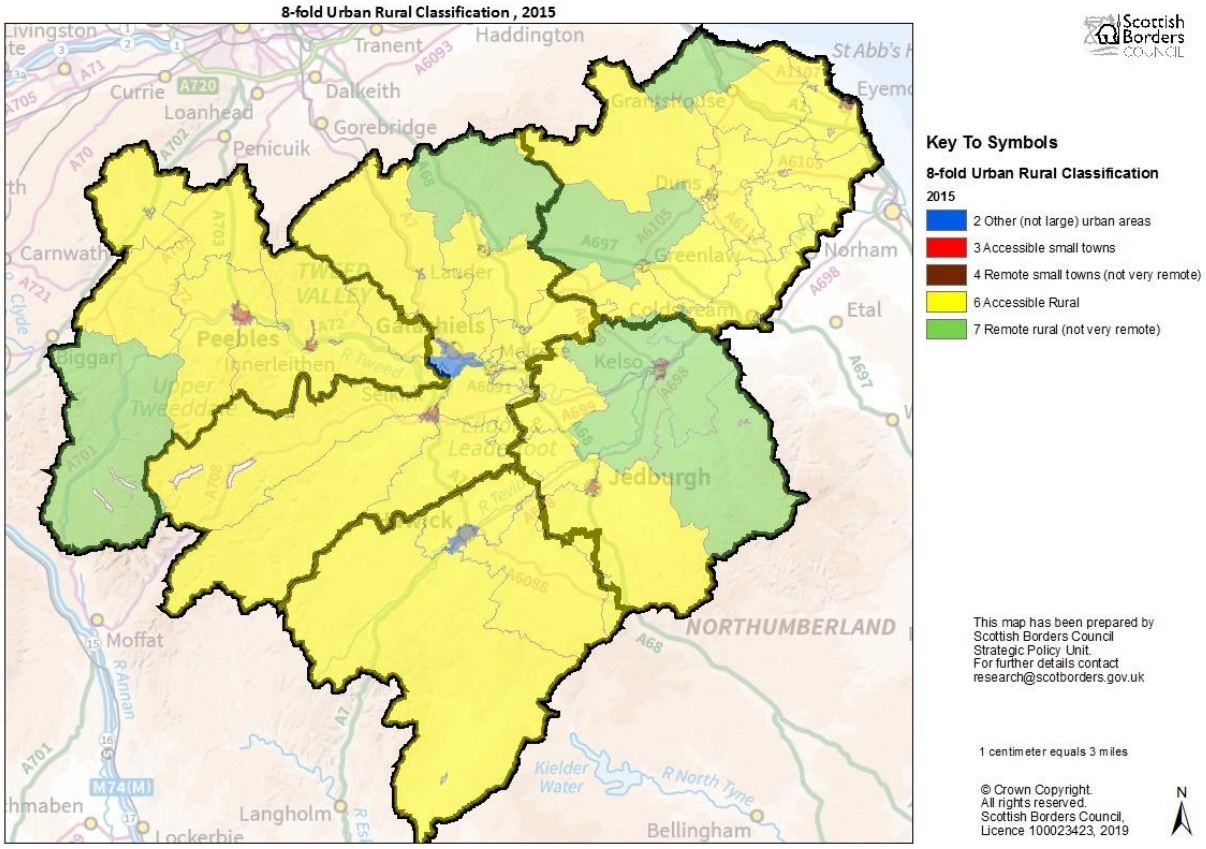
1. Background

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

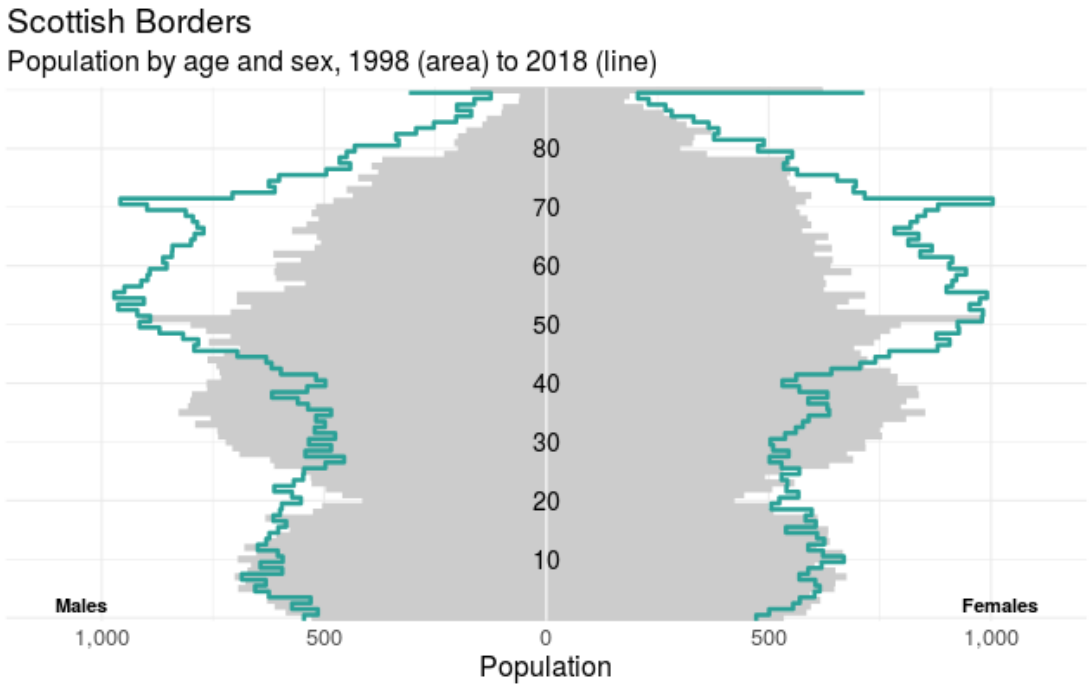
Profile

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.

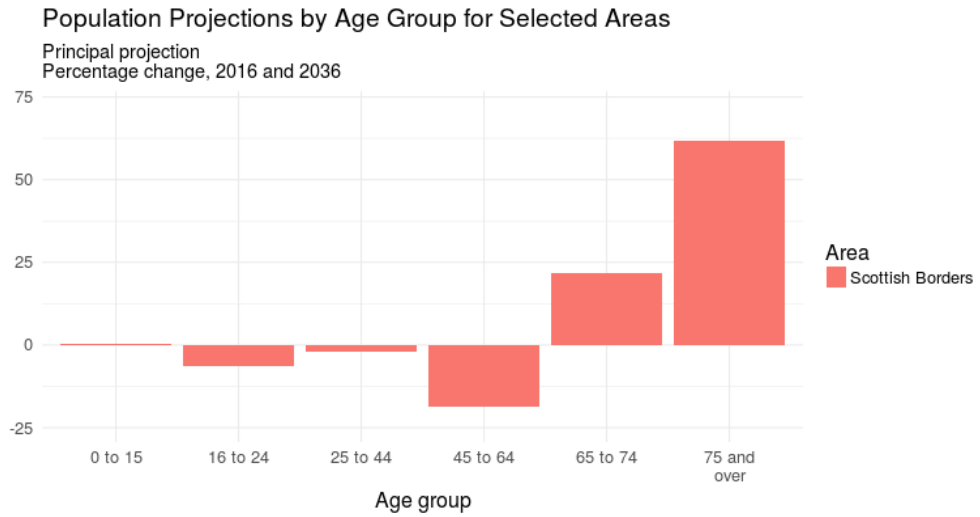
Figure 2 - Change in Age Structure of Population in the Borders 1998 (shaded) and 2018 (line)



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.

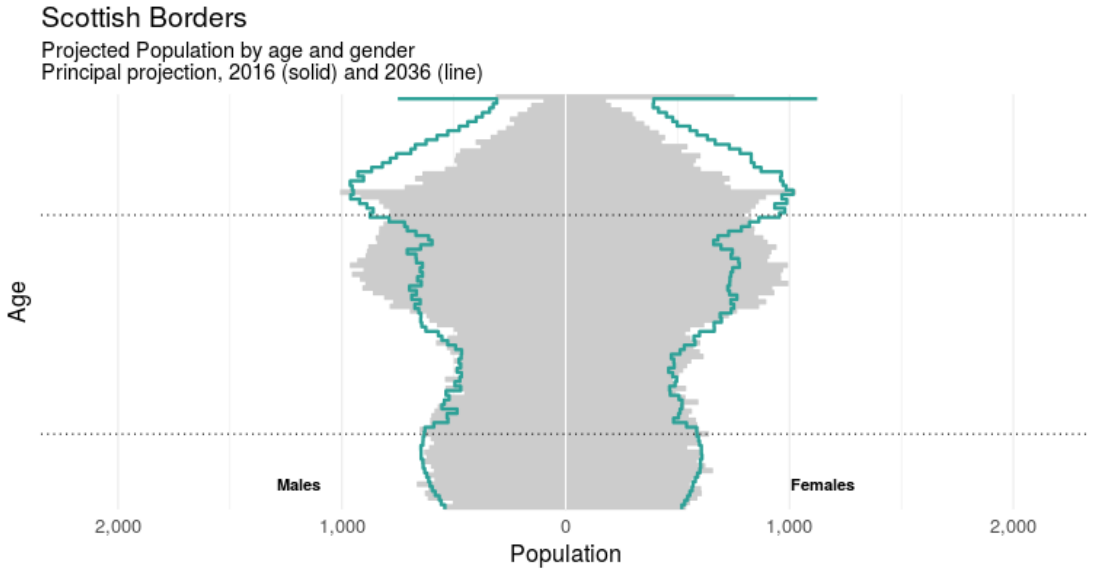
Figure 3 - Projected population change (%) by age group 2016-36 in the Borders



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)

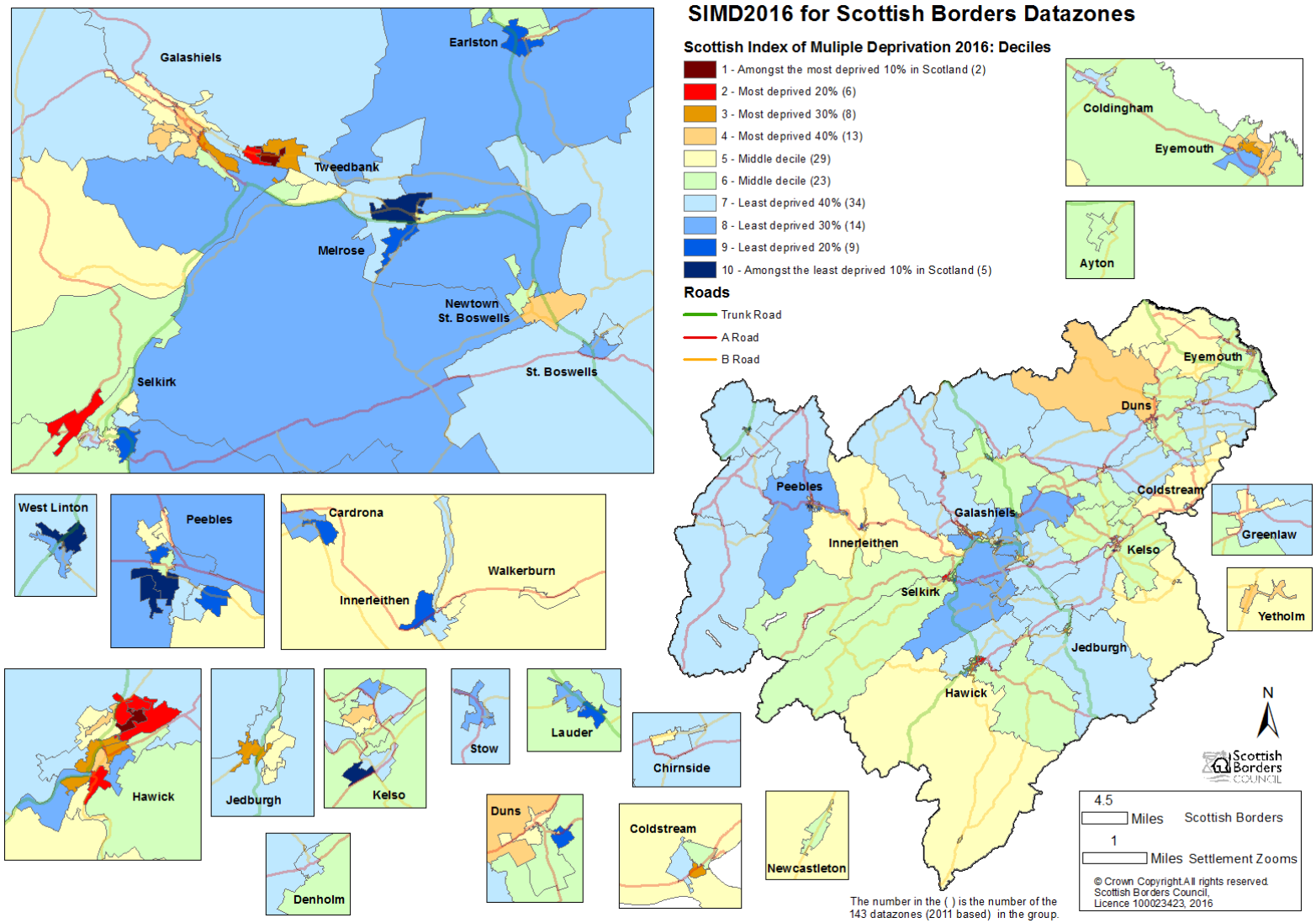


https://scotland.shinyapps.io/nrs-population-projection-variants-scotland-uk/

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≥25) is slightly higher than the national average at 66% (compared to 65%), though the proportion who are obese (BMI≥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

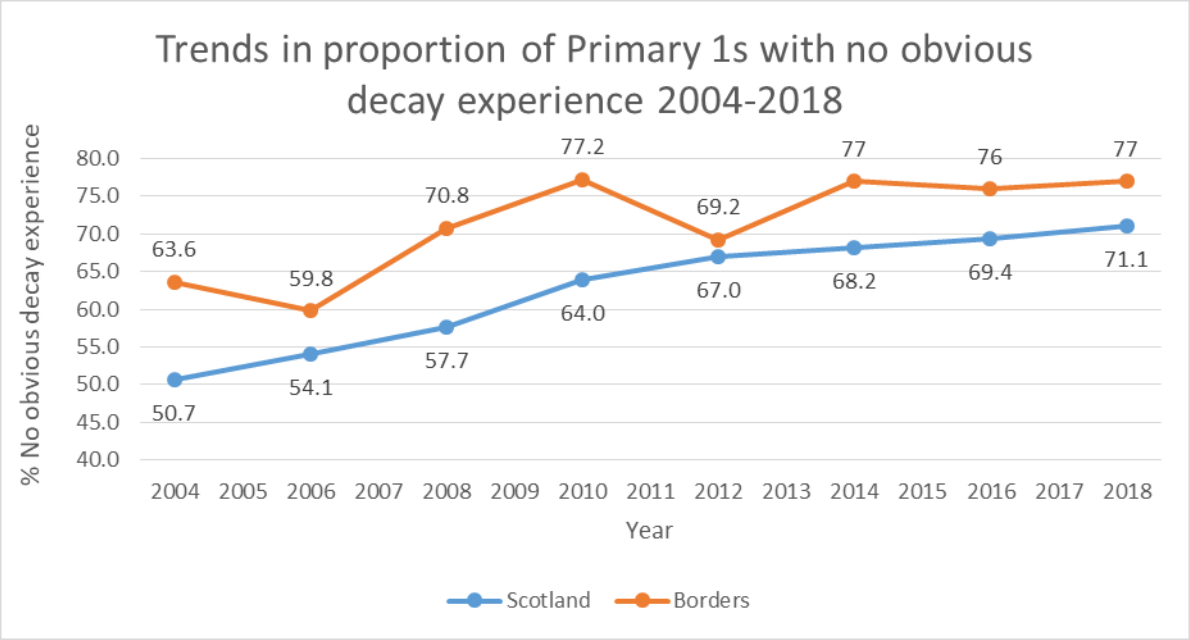
Robust data on children's oral health is gathered through the National Dental Inspection Programme (NDIP). On an annual basis, all children in Primary 1 and Primary 7 attending Local Authority schools are offered a Basic Inspection to provide monitoring data and inform parents/carers of their child's 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.

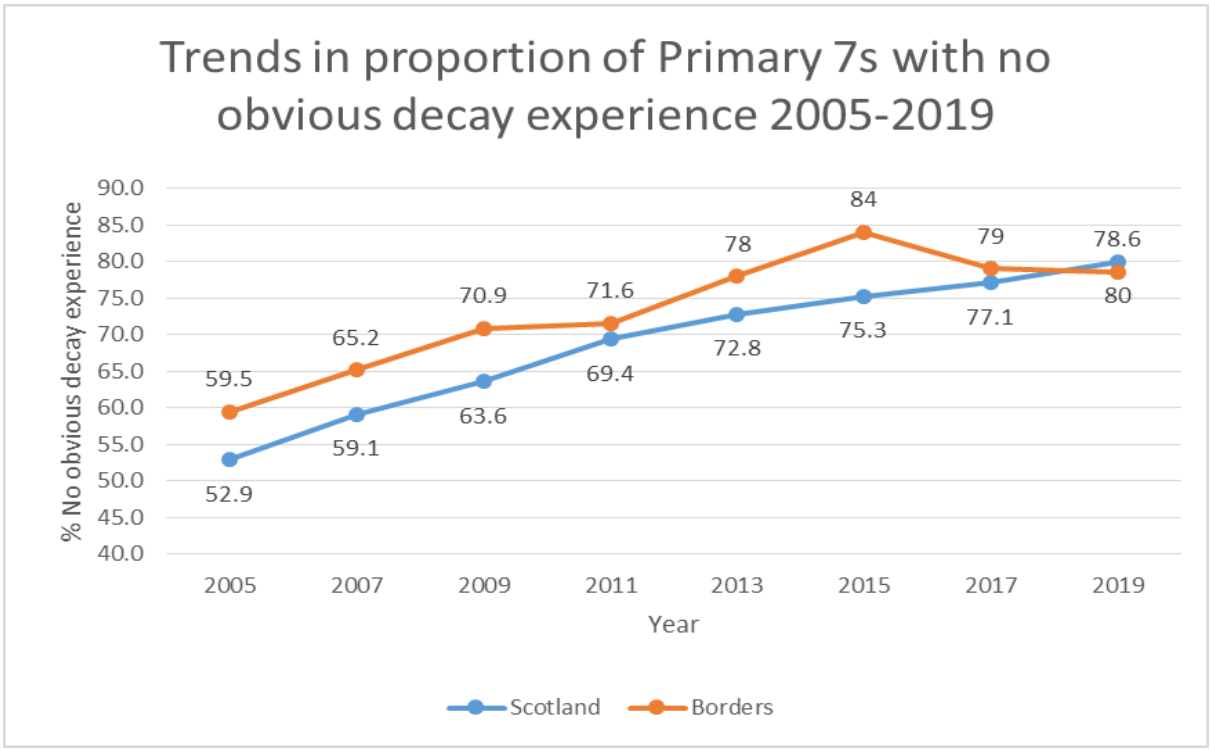
Caution is required in interpreting trends in obvious caries experience over time within the Borders due to the relatively small sample size. Sampling for the Detailed NDIP inspection is at class level, aiming to include a minimum of 250 children or 8% of the population of the year group (P1 or P7 depending 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

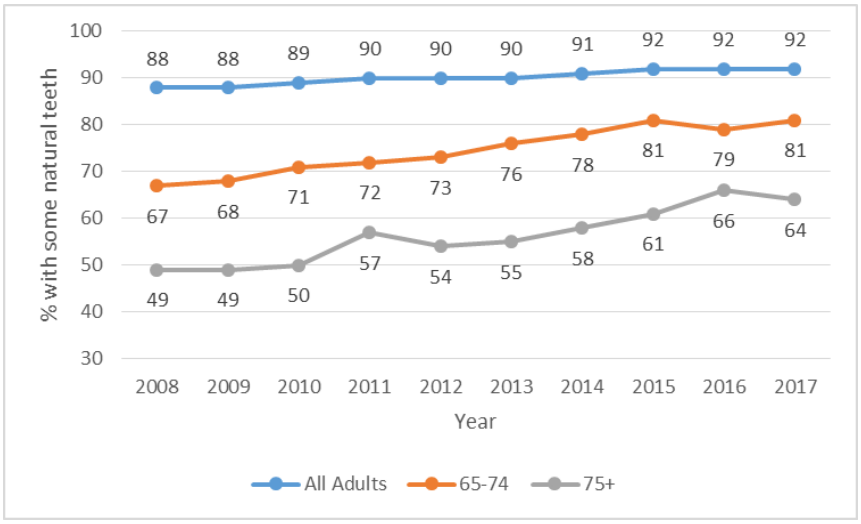
Less data are available to describe the oral health of adults, with most only reported at national level. As childhood oral health is known to predict future oral health it would be hoped that the good oral health observed in children in the Borders would also translate to older age groups.

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.

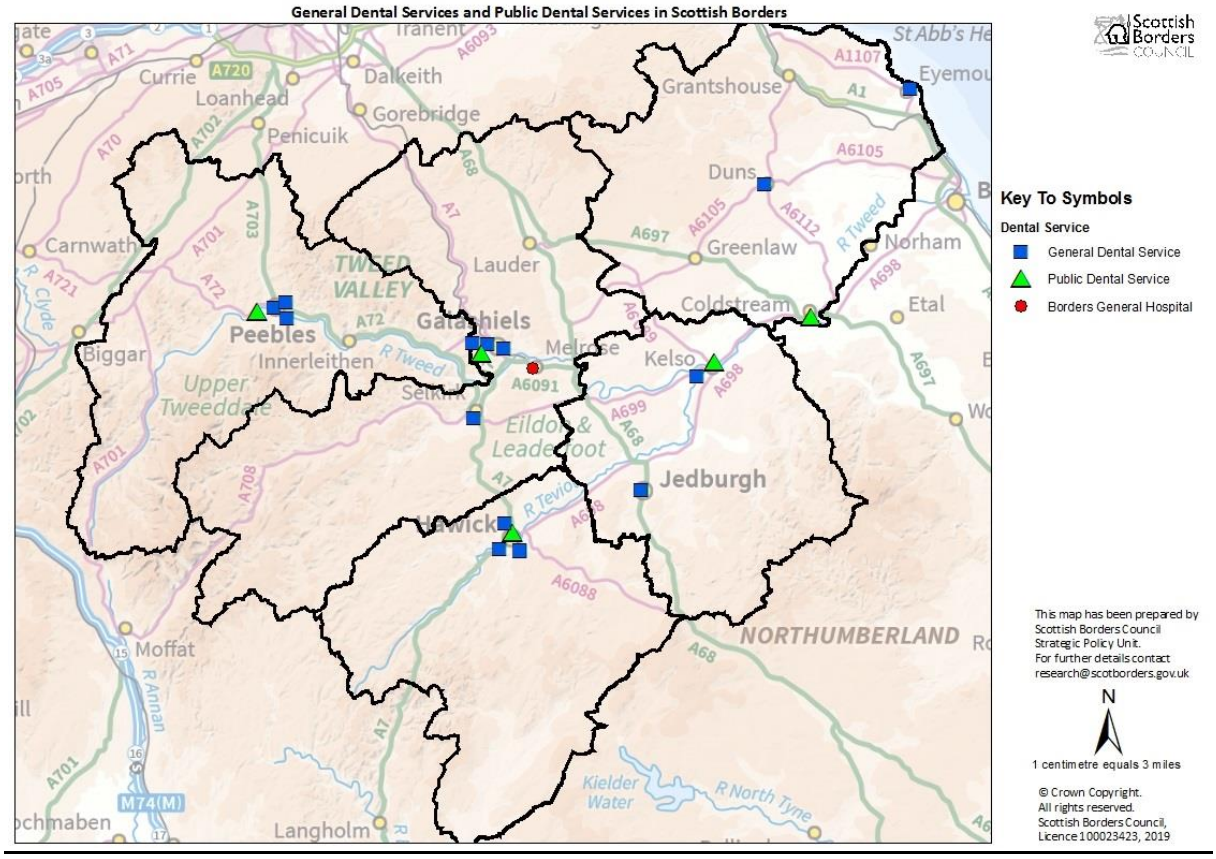
SECTION 2:
DENTAL SERVICES IN THE BORDERS

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.

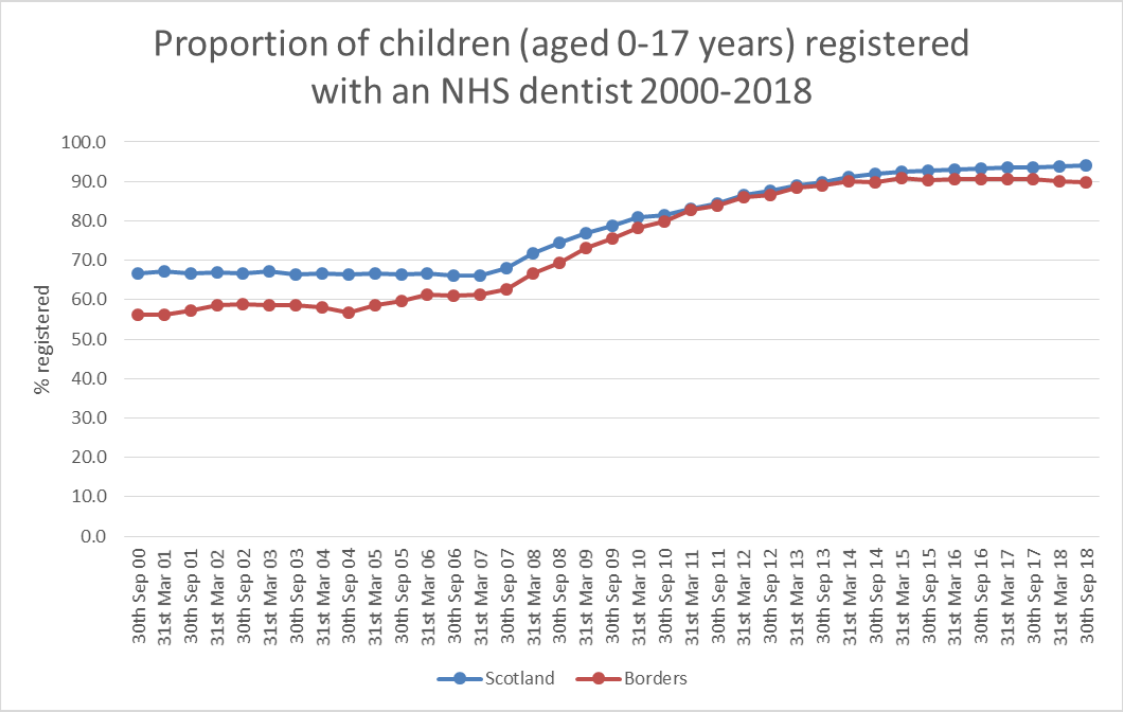
Dental Registration

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

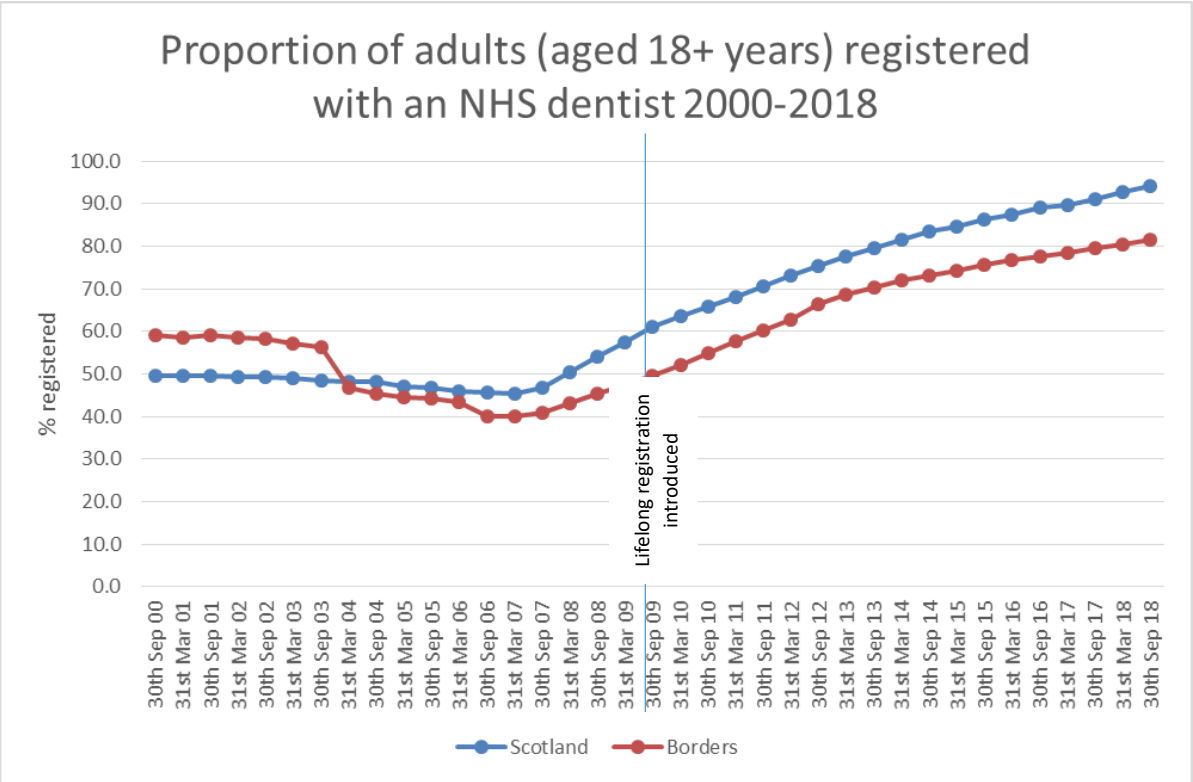


https://www.isdscotland.org/Health-Topics/Dental-Care/Publications/2019-01-22/2019-01-22-Dental-Report.pdf

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

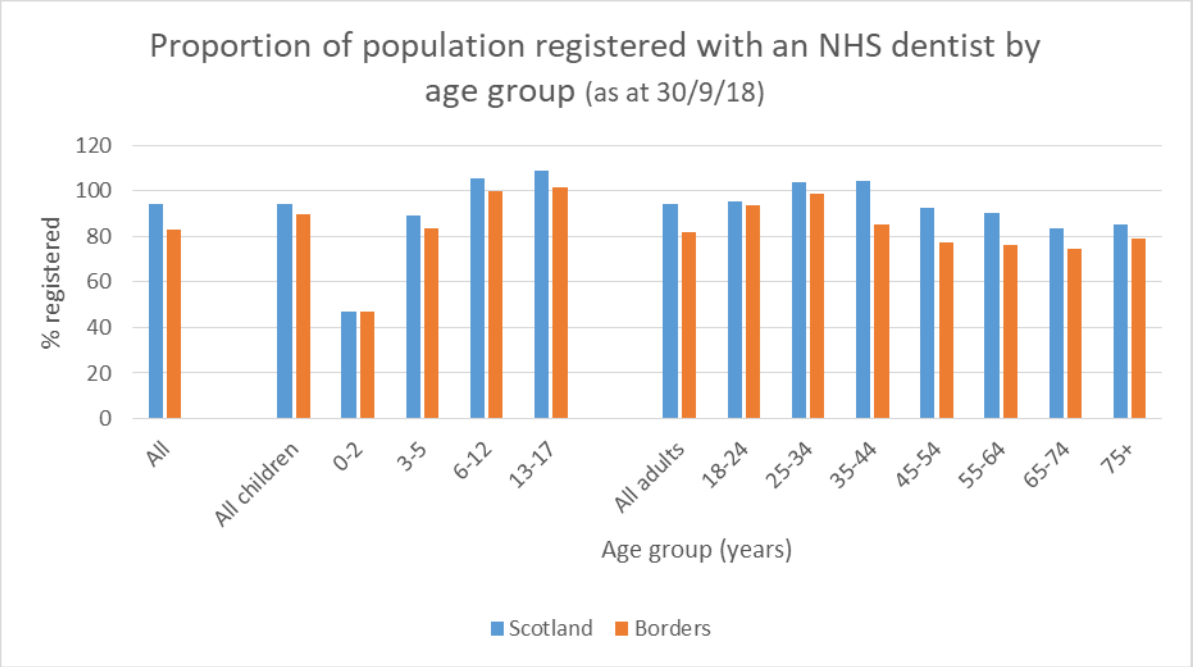


https://www.isdscotland.org/Health-Topics/Dental-Care/Publications/2019-01-22/2019-01-22-Dental-Report.pdf

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



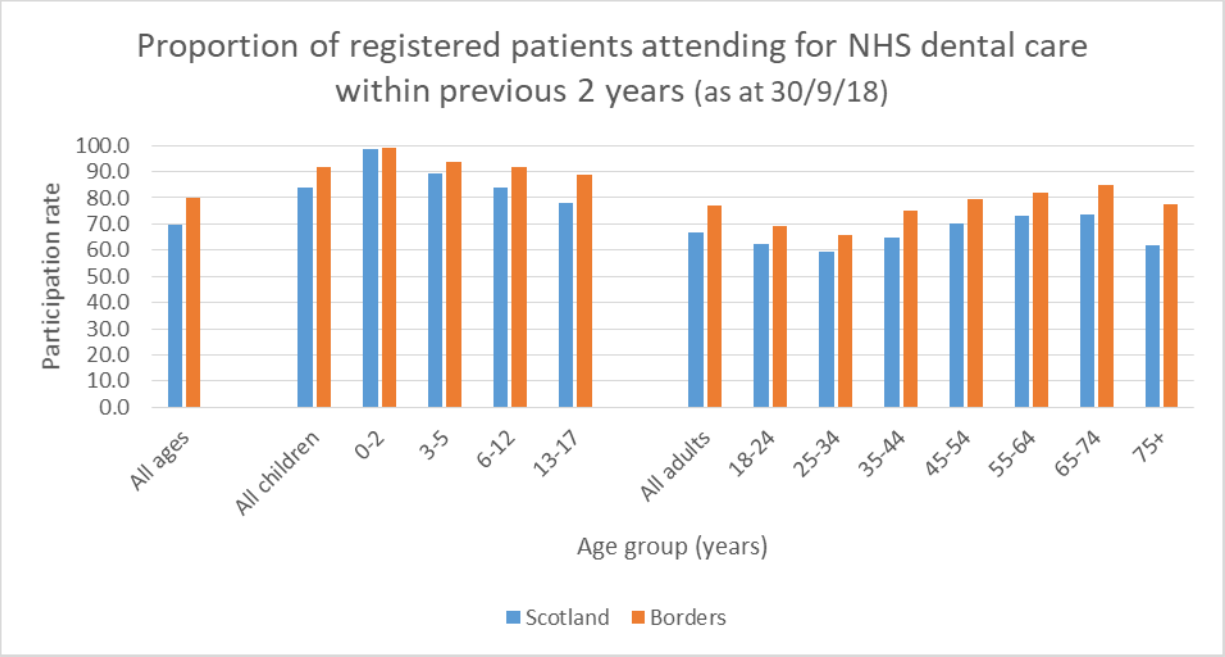
https://www.isdscotland.org/Health-Topics/Dental-Care/Publications/2019-01-22/2019-01-22-Dental-Report.pdf

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



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.

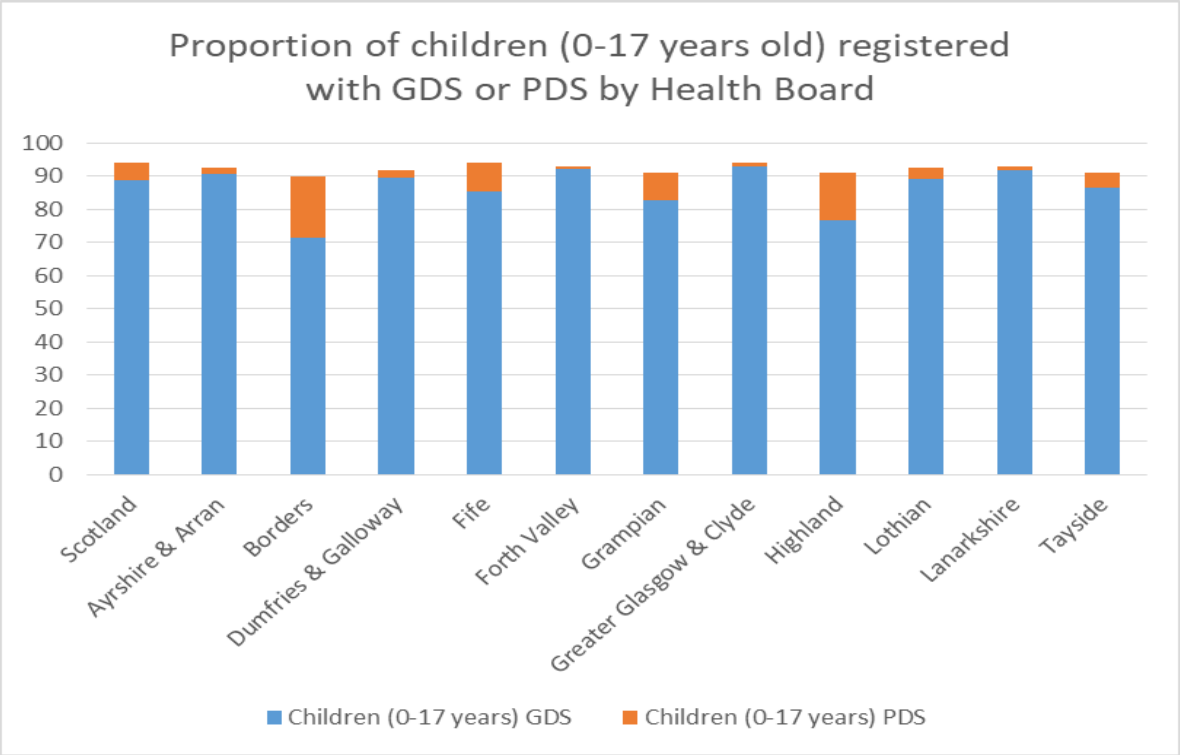
Public Dental Service

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.

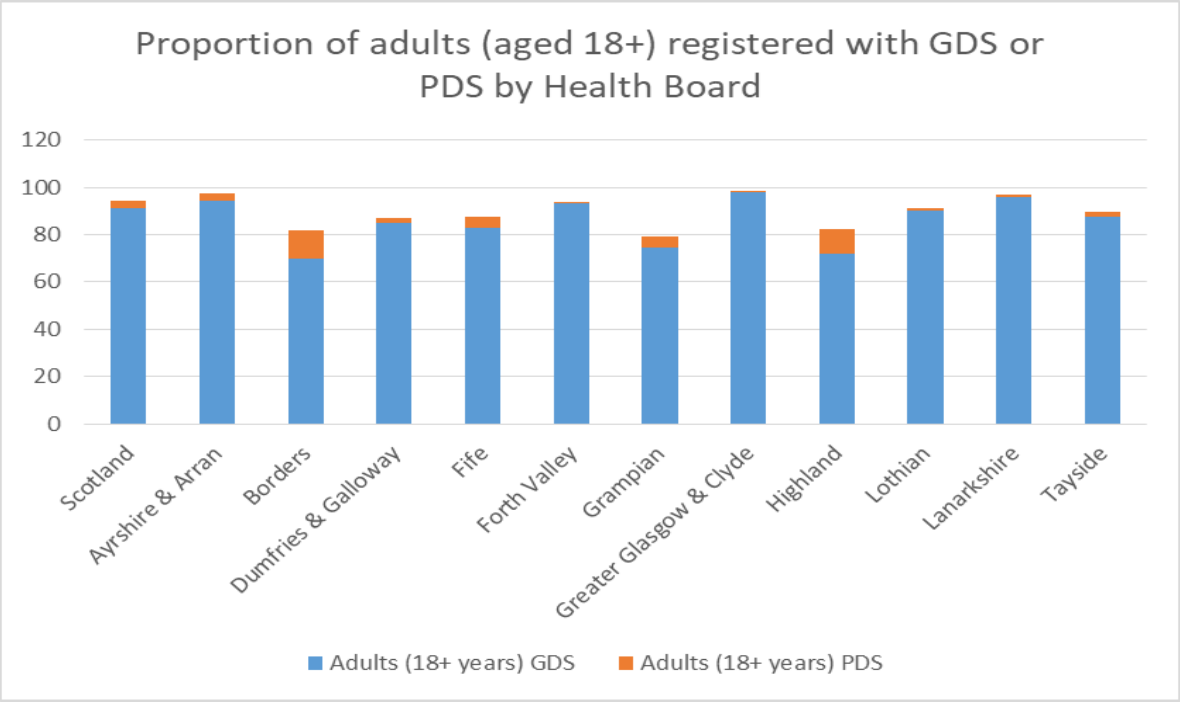
Nationally access is no longer considered to be a political priority and there is increasing emphasis on encouraging patients to attend a GDP where possible. PDS main focus will then be on the care of more complex patients for whom treatment in a GDS setting would not be possible. In the Borders the 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



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.

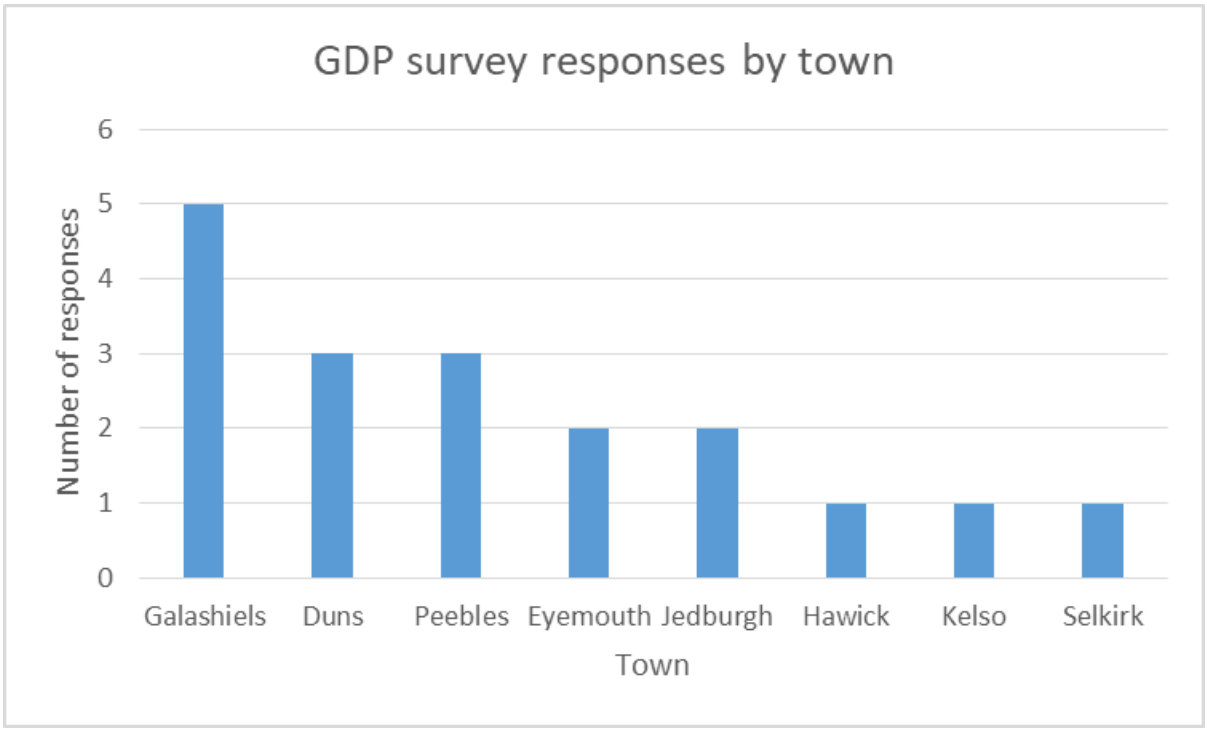
7. Reported Current Primary Care Dental Provision and Future Possibilities

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



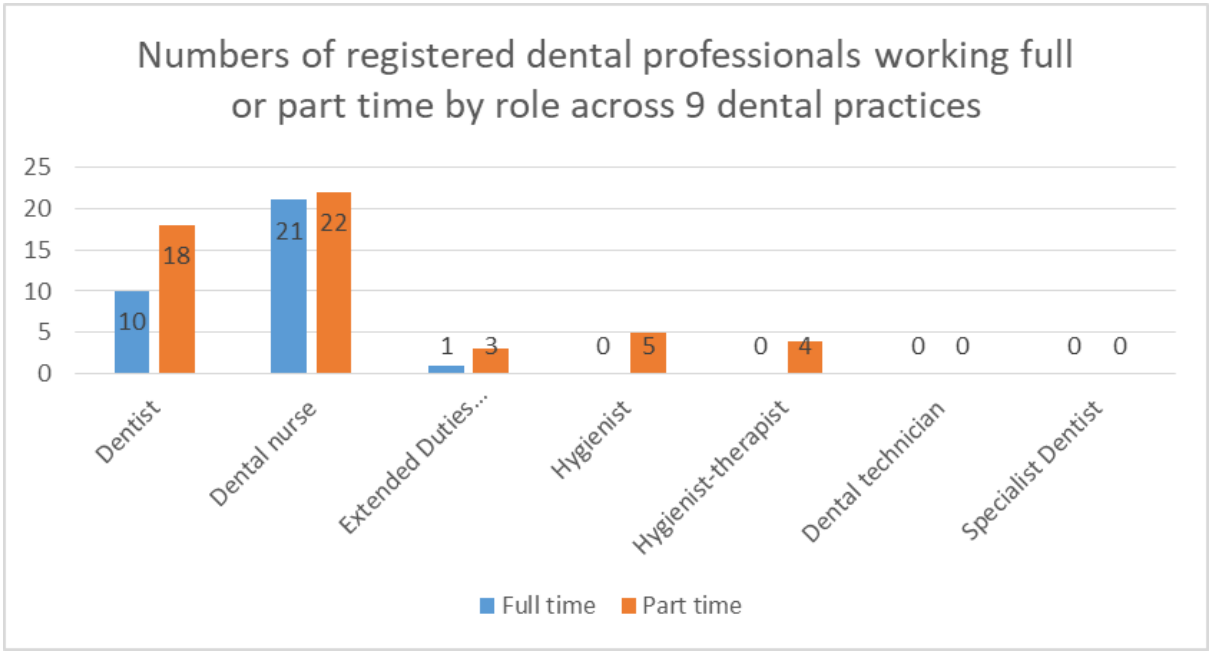
Survey Respondents

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

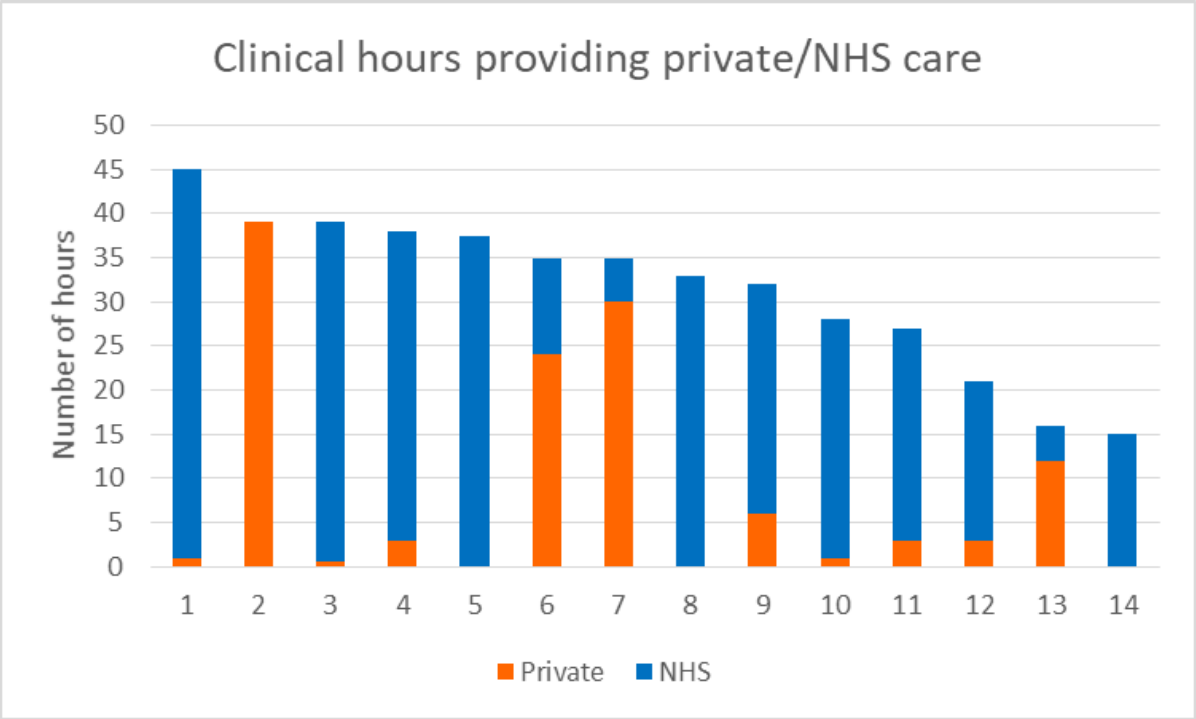


Two practices (22%) reported that they currently had at least one vacant post within their practice. Both of the vacancies were for associate dentists. One practice had no current vacancies but reported that they had advertised for an associate dentist the previous year and were unable to fill the post. 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

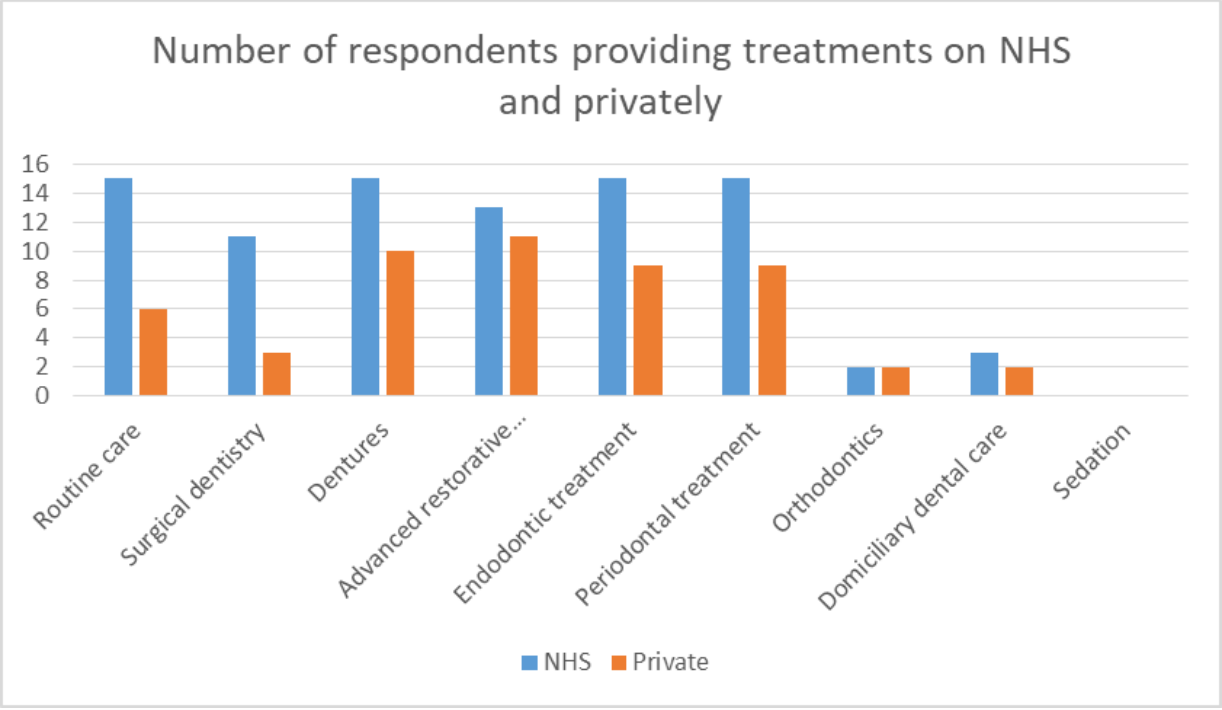
likely to wait longer for an appointment, with only one respondent able to offer an appointment within a month, and the majority (44%) reporting that a new patient would be seen within 6 months to a year.

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:

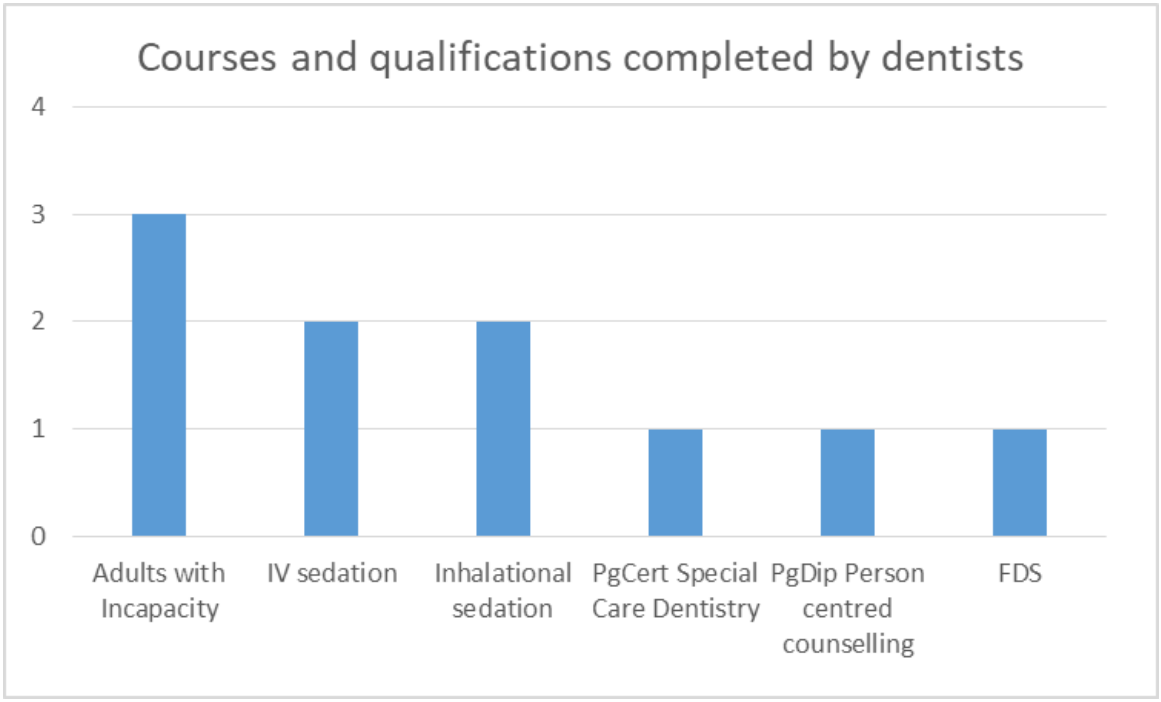
I am happy and get satisfaction	I don't mind	I have little or no experience but willing to learn	I would prefer not to do this

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".

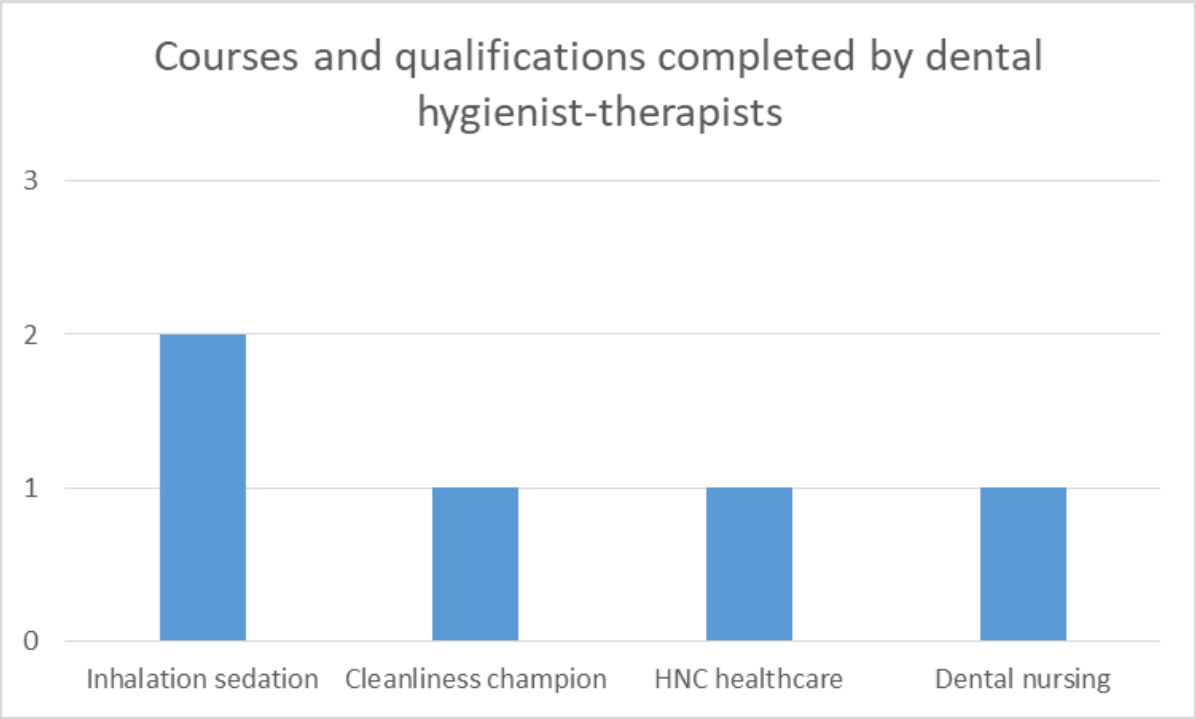
Dentists were either happy or didn't mind providing most types of treatment. The only procedure which the majority would prefer not to do was minor oral surgery. Dentists were either happy to provide treatment under general anaesthetic or sedation or not. No one "didn't mind", they were either happy, 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.

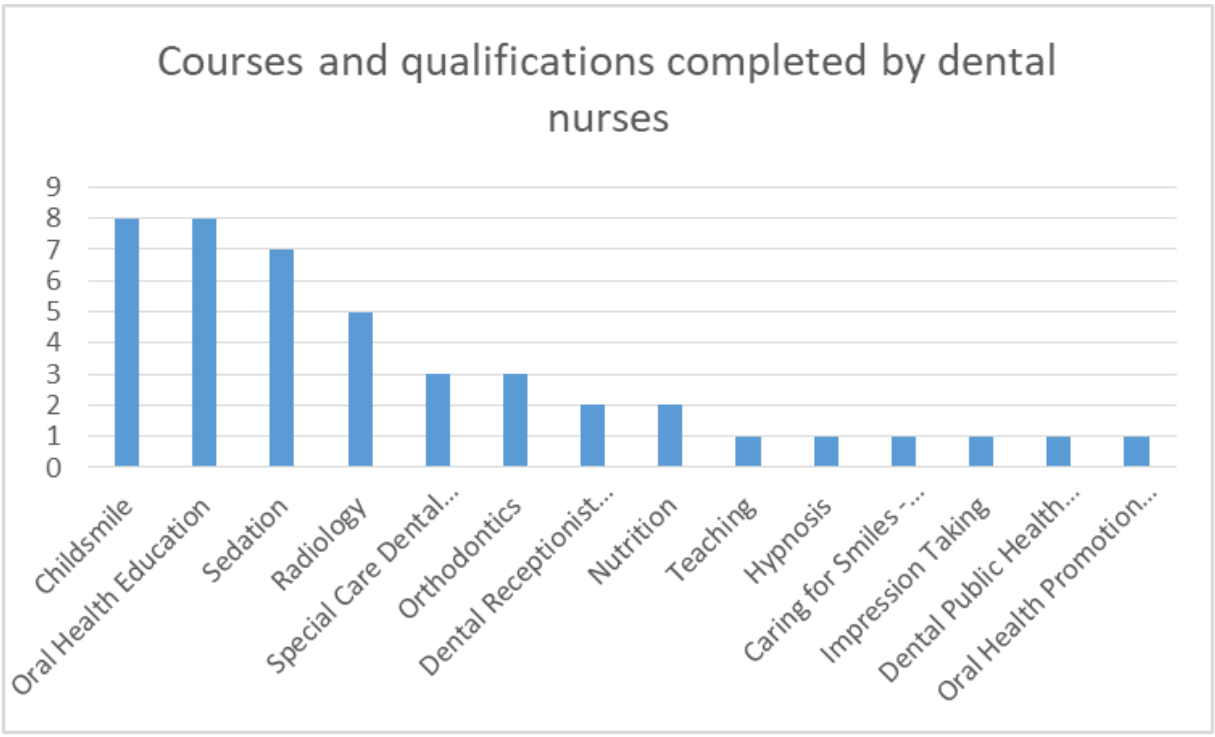
One of the hygienist-therapists indicated through additional comments a preference for treating anxious children and enjoyment of undertaking acclimatisation with adults with learning disabilities. Another felt that they would enjoy working in the hospital environment with complex adults and children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

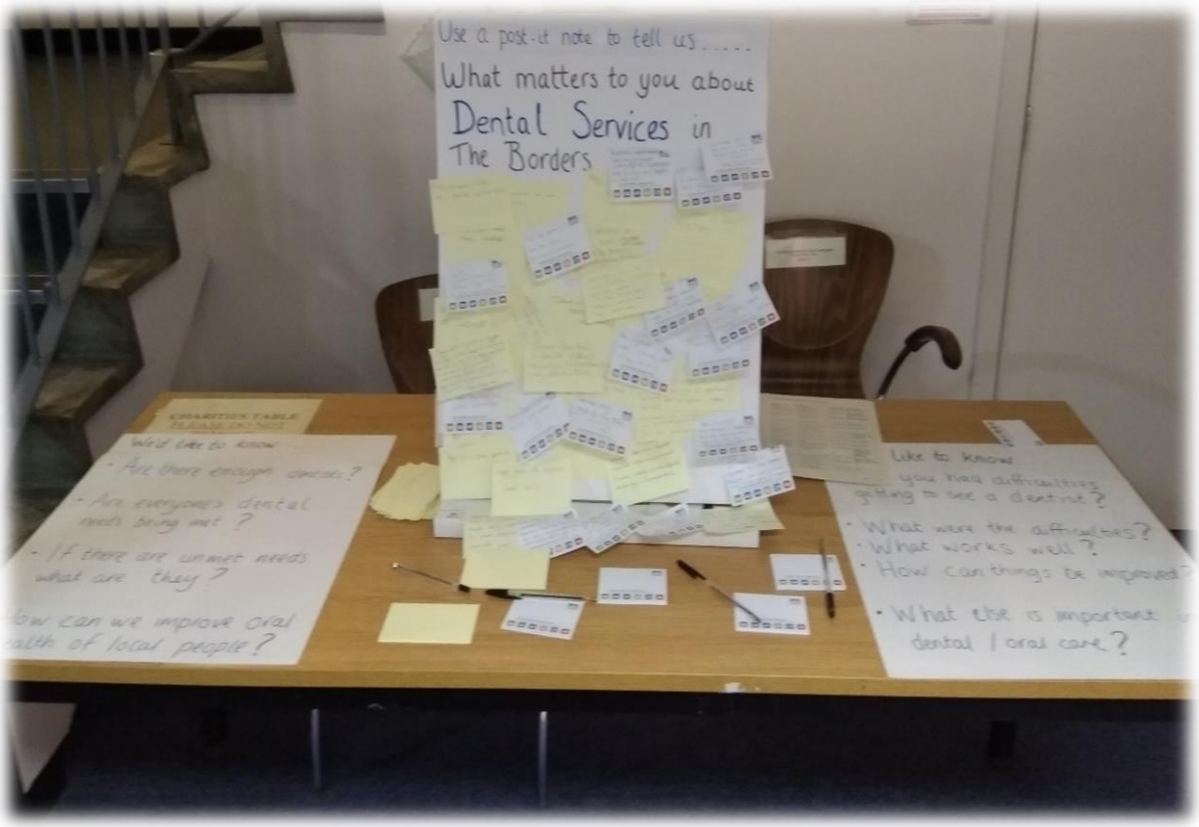
Referrals into the PDS and dental specialties based in BGH are received through SCI-Gateway and processed through the TRAK care system. Interpreting data extracted from TRAK in the context of this needs assessment presented some challenges as it was not immediately clear which specialty patients were 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

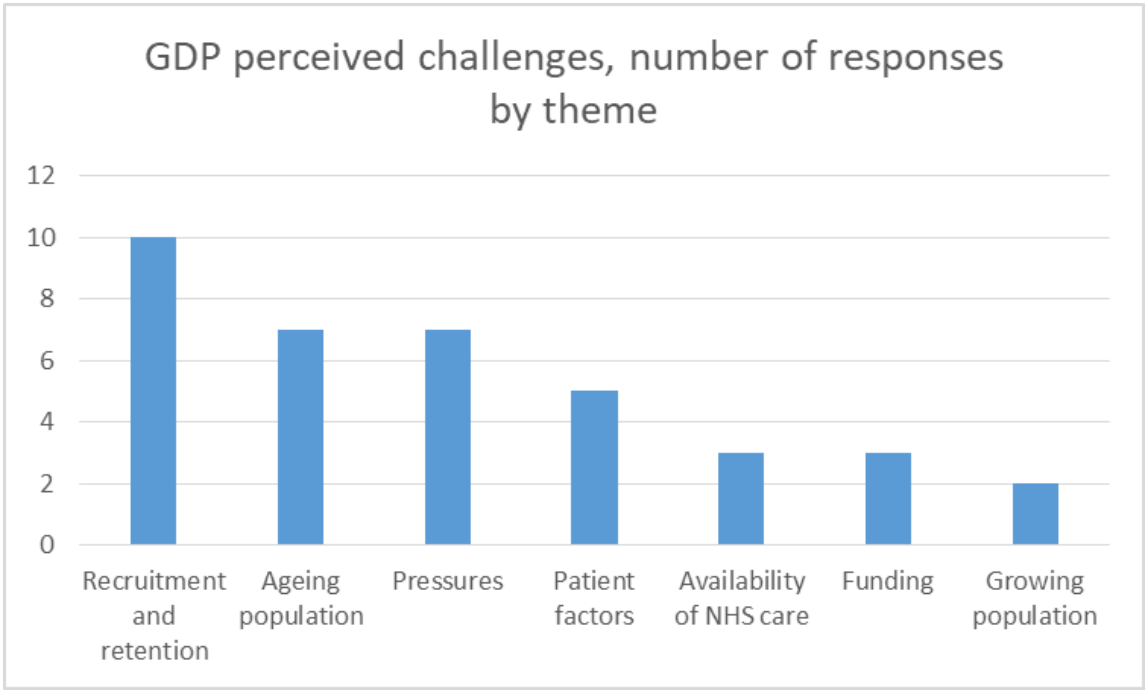
and a paediatric trauma clinic. One dentist would like to see services available to provide complex treatments such as post removal, endodontics and oral and maxillo-facial surgery, while another would like a local service providing “everything that EDI offers”

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?

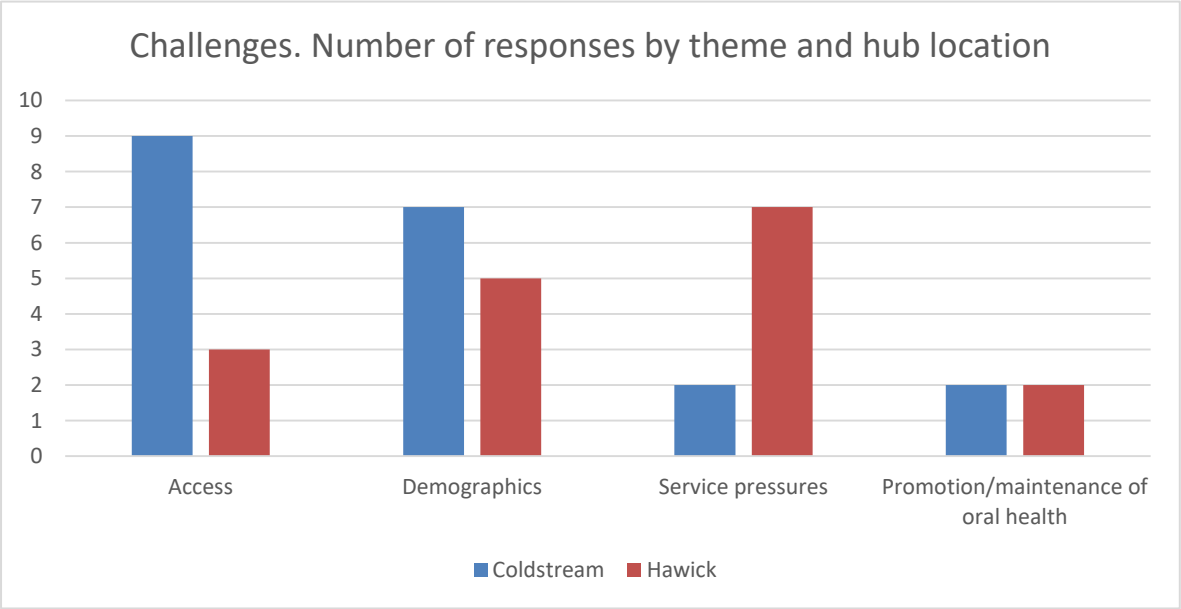
Participants discussed their answers to each question in small groups before feeding back to the wider meeting. Responses from each small group were collated and common themes identified.

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.

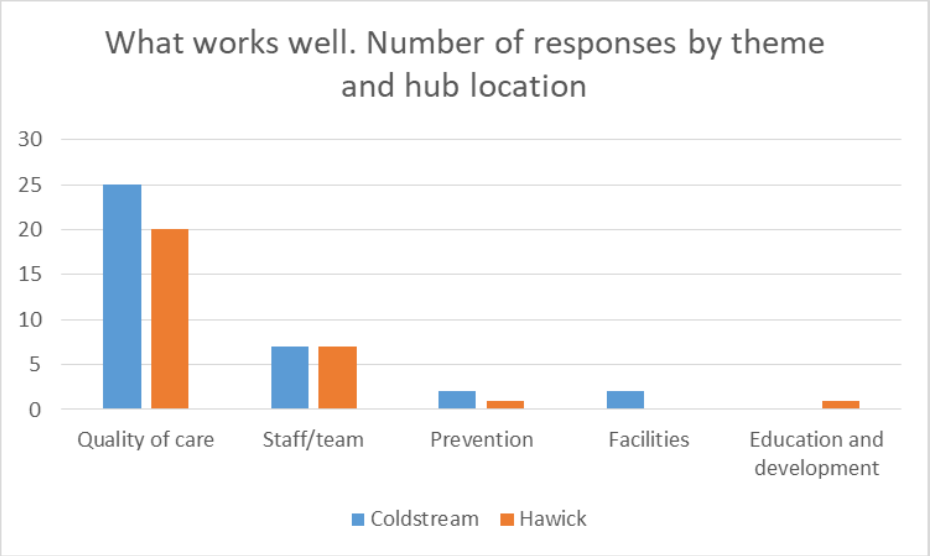
In the Hawick hub, it was suggested that there was a lack of capacity for dental access patients. It was also noted that there had been an increase in the number of children requiring dental treatment under general anaesthetic, and that there seemed to have been an increase in the complexity of the children 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.

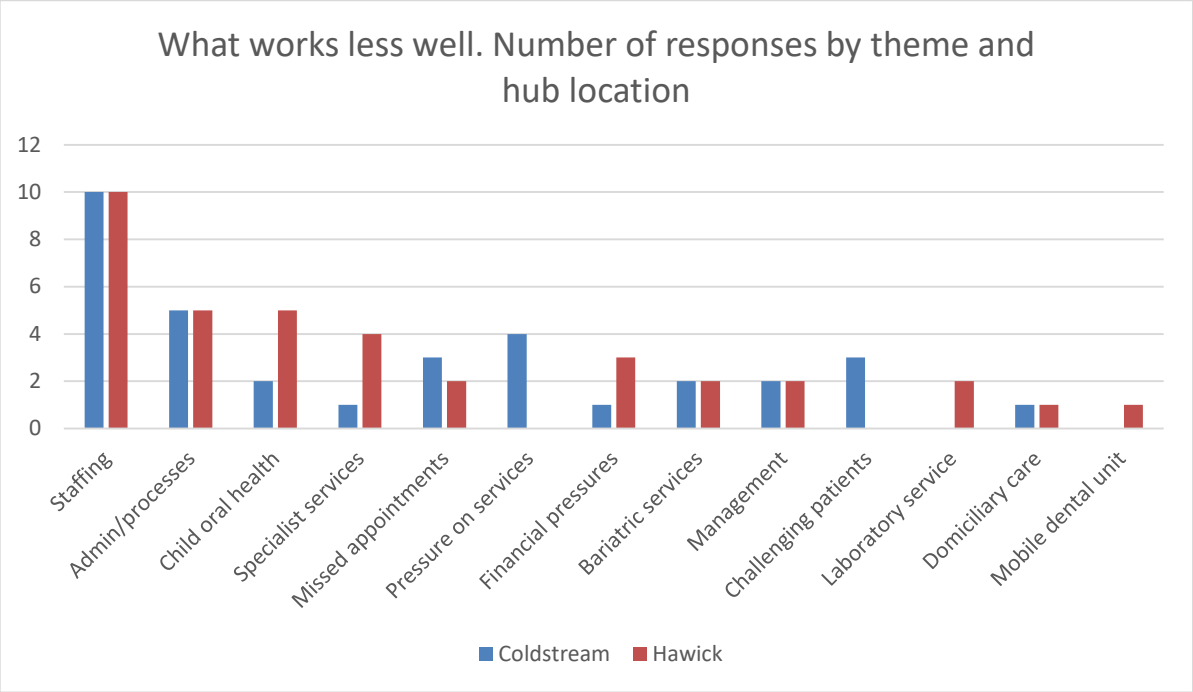
Education and Development

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

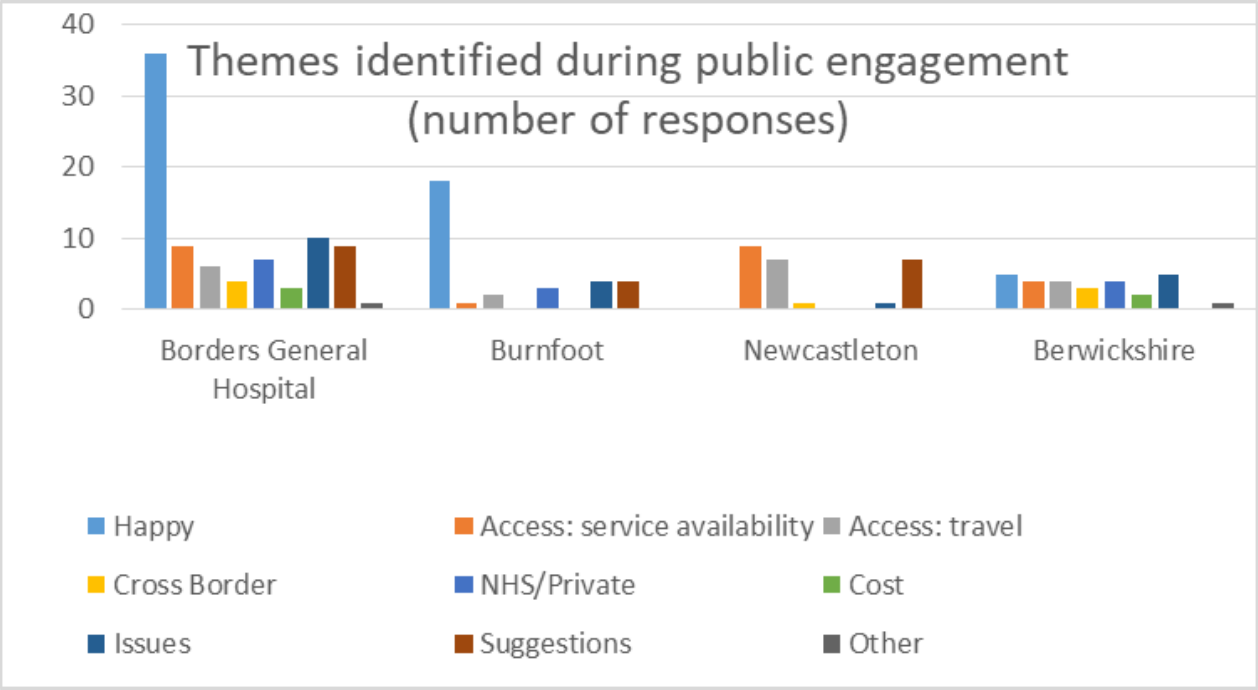
What matters to you about oral health and dental services in the Borders?

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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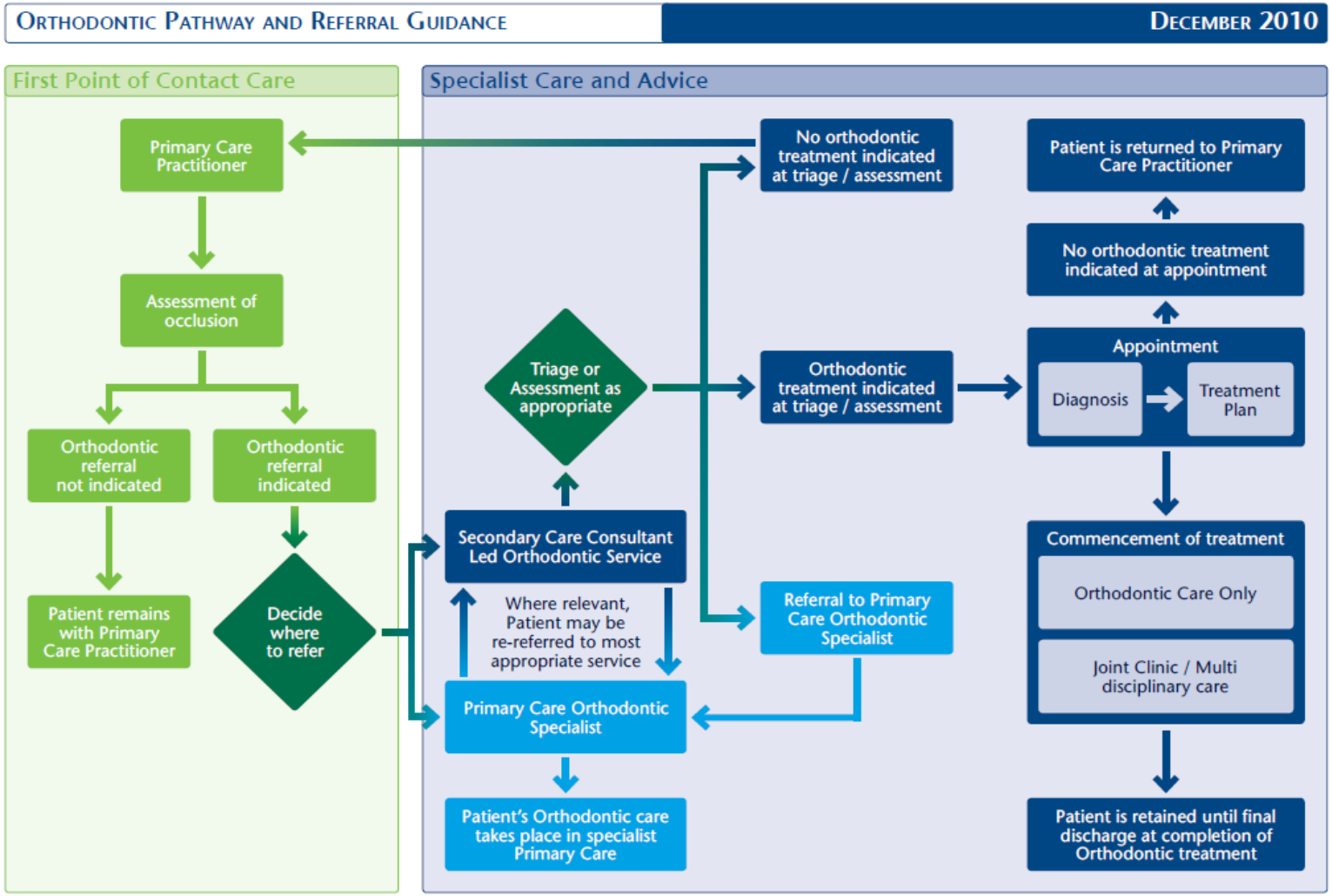
Glossary

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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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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Scottish Borders
Health and Social Care
PARTNERSHIP

Pharmacy service to support Social Care service users

Business Case

Version 3.1

May 2022

Version Control

Version	Date	Author	Reason for changes
Draft 0.1	28/01/22	Adrian Mackenzie	Initial Draft
Draft 0.2	01/02/22	Adrian Mackenzie	Update formatting, typographical errors
Draft 0.3	02/02/22	Adrian Mackenzie	Incorporating feedback from Alison Wilson
Draft 0.4	08/02/22	Adrian Mackenzie	Incorporating feedback from Chris Myers, Mairi Struthers and Rachel Mollart.
Version 1.0	10/02/22	Adrian Mackenzie	Formatting changes, incorporating further feedback form Alison Wilson
Version 2.0	25/04/22	Adrian Mackenzie	Update following feedback from Stephen Fotheringham and discussions with stakeholders
Version 2.1	12/05/22	Adrian Mackenzie	Updated following feedback from members of the H&SCP SMT meeting
Version 3	17/05/22	Adrian Mackenzie / Chris Myers	Update following feedback from Chris Myers and discussion with Meriel Carter.
Version 3.1	27/05/22	Adrian Mackenzie	Feedback on Version 3.0 from stakeholders incorporated.

Executive Summary

The Scottish Borders Health and Social Care Integration Joint Board (IJB) Strategic Implementation Plan for 2018-23 identified the need to provide polypharmacy support to social care service users to prevent medication-related admissions and improve the quality of disease management. Upto this financial year there has been no funding identified to mainstream this work and support integration.

An IJB funded project ran from Nov 2017 to April 2019 working with social care teams. Through this joint working and the development of joint training and guidelines it was demonstrated that many of the issues for carers are around medicines. The project demonstrated that advice from a member of pharmacy staff who understands the issues related to care providers is necessary to reduce risk to patients and staff administering medicines.

It has been recognised over the last few years that there is a need to provide strategic and operational input by a pharmacist and pharmacy technician into service users requiring health and social care partnership (H&SCP) assistance with their medicines.

The pressure on H&SCP services is also felt by Pharmacy; the increasingly elderly population on multiple medications results in more patients who require assistance to take their medicines and support reablement, promote independence and self-care. Many patients receive social care visits to assist them with their medicines. Currently there is no review of patient's medicines which may lead to a reduction in the number and/or need for visits and the length of visits due to the number of medicines.

The team would work primarily with Care at Home patients however they would also work with Care Homes patients on appropriate pieces of work.

The key aims of this team are presented below:

<table>
<tr><th>Primary Aims</th><th>Outcomes (National Health and Wellbeing Outcome indicators)</th><th>Measure</th><th>Financial Impact</th></tr>
<tr><td rowspan="3">Improved outcomes for individuals receiving Social Care input by undertaking risk assessment to avoid medication issues and increased safety by reducing the risk of harm to them from their medicines and the resultant admissions to hospital care.</td><td>People are able to look after and improve their own health and wellbeing and live in good health for longer</td><td rowspan="3">Reduction in estimated risk of harm to patients from their medicines using NPSA matrix.</td><td rowspan="3">It is estimated by the University of Dundee that approx 4.5% of hospital admissions are due to preventable hospital admissions, this translates to cost avoidance of £136K per year</td></tr>
<tr><td>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.</td></tr>
<tr><td>People who use health and social care services are safe from harm</td></tr>
<tr><td>Reduce the need for carer visits - With a proper assessment and review of patients the burden on health and social care can be reduced.</td><td rowspan="2">Resources are used effectively and efficiently in the provision of health and social care services</td><td rowspan="2">Number of carer visits that have been avoided</td><td rowspan="2">It is estimated that 38% of patients can have their care package reduced following a comprehensive review, this translates to over 150,000 carer visits per year and a cost avoidance of almost £98K per year.</td></tr>
<tr><td>Work with other H&SCP staff to deliver integrated care. This team would support workstreams for example 'Home First', 'Reducing delayed discharges', maximising capacity of care at home staff and contribute to the management of what were once considered winter pressures however now seem to be all year round.</td></tr>
</table>

Where capacity permits with the agreement of the IJB, the team may also be able to support the following outcomes.

Secondary Aims	Outcomes (National Health and Wellbeing Outcome indicators)	Measure	Financial Impact
Reduce the use of compliance aids – to allow reablement, promote self-care, and reduce the burden on both health and social care services. As well as releasing community pharmacy time	People are able to look after and improve their own health and wellbeing and live in good health for longer 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..	% of patients with a package of care that includes medicines who have a compliance aid.	No assigned financial saving, contributes to reducing burden on health and social care.
Actions around promoting independence and reablement through the use of assistive technology to enable patients to take their medicines and reduce the burden on both health and social care services.	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.. Resources are used effectively and efficiently in the provision of health and social care services.	% of patients assessed as to whether assistive technology would support them to safely take their medicines.	No assigned financial saving, captured under reduction in care visits
Work with other stakeholders to ensure consistency of training and education to staff across all Care at home and Care Home providers in relation to medicines related policies and procedures.	People who use health and social care services are safe from harm. 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.	All care providers to be made aware of the support available in relation to the development of policies and procedures.	No assigned financial saving, reduction in harm captured under reduced admissions.
Link with Realistic Medicines work within Borders H&SCP to deliver quality improvement approaches to patient care.	Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services	% of patients who receive social care assistance with their medicines who have also received a realistic medicines review.	It is estimated that reviewing 150 patients in year 1 will deliver £18K in drug savings per year.

Summary

The meeting is asked to support the proposal that a pharmacy based team be employed to work across all localities within the Scottish Borders H&SCP at a cost of £150K comprising of Pharmacy Technicians and a Pharmacist to deliver on the objectives identified above with an indicative likely benefit opportunity when applied across the Borders of £102K of net savings.

Integration Planning and Delivery Principles

Integration Planning and Delivery Principle	**How the service will ensure that these are met:**
Make the service more integrated from the point of view of service users	Integrated assessments of needs and sharing of information.
Take into account the needs of different service users	Holistic review processes to ensure 'what matters to me' is given prominence.
Take into account service user needs in different parts of the area in which the service is being provided	Working in locality areas will enable responses to be much better targeted at a local level.
Take into account particular characteristics and circumstances of service users	Provide tailored interventions based on an individual level of need and circumstances.
Respect the rights of service users	Ensure all assessments and interventions are underpinned by a human right based approach
Take into account the dignity of service users	Ensure that vulnerable service users have their rights and wishes respected
Take into account participation of service users in the community they live	Provide advice on medicines administration that supports service users to be active within their communities.
Protect and improve the safety of service users	Undertake medicines reviews that work to reduce the risk of harm from taking medicines and ensure all staff administering medicines are well trained
Improves the quality of service	Service will work closely to review any medicines related incidents to identify learnings and support actions to reduce recurrence.
Is planned and led locally in a way that is engaged with the community (service users, carers and those providing services)	Support a learning culture within all health and social care services to ensure continual service improvement
Best anticipates needs and prevents them arising	Provide advice and solutions that are flexible to changes in service users conditions.
Makes the best use of available facilities, people and resources	Will ensure effective use of health and social care resources to deliver care.

1. Introduction

The Scottish Borders Health and Social Care IJB Strategic Implementation Plan for 2018-23 identified the need to provide polypharmacy support to social care service users to prevent medication-related admissions and improve the quality of disease management. Upto this financial year there has been no funding identified to mainstream this work and support integration.

It has been recognised over the last few years that there is a need to provide strategic and operational input by a pharmacist and pharmacy technician into patients requiring health and social care partnership (H&SCP) assistance with their medicines. This team would support workstreams for example 'Home First', 'Reducing delayed discharges', maximising capacity of care at home staff and contribute to the management of what were once considered winter pressures however now seem to be all year round.

The team would work primarily with Care at Home patients however they would also work with Care Homes patients on appropriate pieces of work.

2. Background

An IJB funded project which ran from Nov 2017 to April 2019 enabled a Pharmacy Technician (1FTE) and a Social Care Manager (0.4FTE) to work with social care teams. The project had aimed to recruit a pharmacist in place of the Social Care Manager however recruitment to this post was unsuccessful. Through this joint working and the development of joint training and guidelines it was demonstrated that advice from a member of pharmacy staff who understood the issues related to care providers is required to reduce risk to patients and staff administering medicines. The full report is included in Appendix 1.

Across the H&SCP, our frailest patients outside of the Hospital environment are looked after either in their own homes or in Care Homes yet these are locations where patients may not receive regular face to face pharmaceutical care input tailored to them as an individual.

The implementation of the Pharmacotherapy service in the Scottish Borders provided an opportunity to continue elements of the IJB funded project providing Pharmacy input to the H&SCP. This was achieved through 1 WTE band 5 pharmacy technician providing medicines management advice and support to GP practice staff routinely & to social care staff for complex cases. Currently the role acts as a specialist support role to the practice based teams and provides a first point of contact for any medicines management issues that would otherwise be directed to practice based teams or social care some examples are:

- Queries from practice based teams around care packages e.g current level of medicine support, medicine tasks, care provider, visit timings etc
- Queries from care providers & social care around medication administration
- Prompting changes to medication to reduce care visits
- Resolving issues with care packages
- Providing medicines management advice for example:
    - covert administration
    - crushing medicines
    - managing swallowing issues and identifying alternative products or methods of administration
- Responding to medication administration errors

A decision has been made by the PCIP Executive that this post, while important, does not fit directly with Level 1-3 pharmacotherapy tasks in reduction of GP workload in relation to PCIF spend and will cease to fund the role after June 2022. However they recognise the critical importance of the role and are supportive of this bid for funding.

The pressure on H&SCP services is also felt by Pharmacy; the increasing elderly population on multiple medications results in more patients who require assistance to take their medicines and support reablement, promote independence and self-care. A survey undertaken in the Scottish Borders during the Summer of 2020 identified that two-thirds of the 11 out of 29 pharmacies who responded to the survey were at or close to full capacity for production of compliance aids. Many patients receive social care visits to assist them with their medicines and currently there is no planned reviews of patient's medicines, which may lead to a reduction in the number and/or need for visits and the length of visits due to the number of medicines.

Blister packs are widely regarded as a panacea for people living at home who have problems with their medicines. Their use is, however, not evidence based, with practice largely based on the beliefs of professionals and carers, rather than a patient centred approach. Medical and Nursing staff are the most likely to request the use of an aid, which is usually given without an assessment of the individual patient's needs in terms of medicine management.

Such needs depend on the patient's motivation, type of medicine regime, and physical and cognitive ability. Work done in the IJB funded project in 2019 where 202 patients currently receiving compliance aids were re-assessed, identified that for 49 patients out of 202 (24%) a blister pack was not the most appropriate method of support. Reducing the number of aids supplied, through proper assessment, would release pharmacy capacity to ensure that the needs of this vulnerable group of patients are better met.

The availability of compliance aids is a significant issue across the Scottish Borders in that pharmacy contractors in some areas do not have any further capacity to produce blister packs. The production of these aids requires considerably more pharmacy time (approx. 30 min/pt/month) with no additional funding provided. In the last 6 months, challenges have been identified in trying to source a pharmacy to provide a compliance aids in the following areas: Galashiels, Kelso, Duns, Eyemouth and Hawick. The issue is more significant in the Kelso as at the time writing no pharmacy has the capacity to take on additional patients and both pharmacies have a waiting list in place.

There is also a related medicines governance issue in that due to the removal of products from the manufacturer`s protective packaging they are exposed to light and moisture which are common reasons for drug degradation, reduced effectiveness and safety. The first step should always be to try to simplify the medicine regimen by polypharmacy review. If that is not sufficient, then a reminder chart may be tried. If a blister pack is then deemed appropriate, the device chosen should itself match the abilities of the patient - different aids require varying manipulative skills. Such an approach historically has not been common practice. Blister packs remove independence by taking away a key link between the patient and their medicines, which then become just a collection of tablets and capsules. Blister packs also make it difficult for social care and health staff to identify medication that may be discontinued or needs to be taken at certain times.

3. Management Case

The key aims of this team will be to deliver on the outcomes below:

Primary Outcomes

Primary Aim 1	
Improved outcomes for individuals receiving Social Care input by undertaking risk assessment to avoid medication issues and increased safety by reducing the risk of harm to them from their medicines and the resultant admissions to hospital care. This translates to cost avoidance of £131K per year.	
Outcomes (National Health and Wellbeing Outcome indicators)	People are able to look after and improve their own health and wellbeing and live in good health for longer
	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
	People who use health and social care services are safe from harm
Measure	Reduction in estimated risk of harm to patients from their medicines using NPSA matrix. Example in Appendix 2

Commentary:

Work done by University of Dundee estimated that approx 6.5% of all hospital admissions were medicines related, and that two-thirds (4.5%) of medicines related hospital admissions were preventable. This represents a significant impact on older patients spending time in hospital rather than their preferred care environment or own home. For example if care at home staff or patients were better aware through care plans of the need to stop water tablets (diuretics) when patients have diarrhoea and or vomiting this would significantly reduce the risk of an admission due to kidney failure.

A 25% reduction in the estimated 4.5% of BGH emergency admissions hospital admissions for patients aged over 75 years due to preventable medicines related hospital admissions translates to £136K
(*Based on a reduction of 25% in 4.5% of 4237 emergency admissions being avoidable medicines related admissions for over 75s in Borders in 2019/20 at £2852 per admission. Data taken from PHS Statistical release for 2018/19 and agreed with NHS Borders Planning & Performance Team).* https://www.isdscotland.org/Health-Topics/Finance/Publications/2019-11-19/Costs_R300s_2019.xlsx

Risk assessment and appropriate risk management could reduce issues and errors and lead to increased safety if undertaken during the initial social care assessment/review. Work done in 2019 within Waverley Transitional Care reduced medication errors from 37 in a year to 8.

The admission savings are based on reduced care required as a result of medicines related harm e.g. falls, adverse events from medication like bleeds, confusion, and overdose. The impact of this reduction in workload cannot be

underestimated as we look to reduce pressure on health and social care resources as part of the recovery from the impact of COVID, for example on waiting time lists and missed preventative screening. Work done in NHS Borders on 2014 supports the frequency of this level of outcome; an evaluation done following a polypharmacy review showed that the risk of harm to patients from their medicines can be reduced significantly. Further details can be found in Appendix 2.

Primary Aim 2

Reduce the need for carer visits - With a proper assessment and review of patients the burden on health and social care can be reduced this translates to over 150,000 carer visits per year and a cost avoidance of almost £98K per year.

Outcomes (National Health and Wellbeing Outcome indicators)	Resources are used effectively and efficiently in the provision of health and social care services
Measure	Number of carer visits that have been avoided.

Commentary:

It is estimated that 38% of patients can have their care package reduced following a comprehensive review, this translates to over 150,000 carer visits per year and a cost avoidance of almost £98K.
(38% of the 150 patients reviewed can have 1 visit less per day at £5 per visit).

With a proper assessment and review of patients the burden on health and social care can be reduced. For example, a patient receiving 4 visits a day to administer medicines, there is the potential that if the medicines are reviewed that they could be changed so that the patient requires fewer visits a day either by reducing the medicines they take or changing the medicines given. Pilot work done in 2019 identified that over a third of patients (38%) following a medication assessment could have a reduction in medication tasks by carers. This would release carer capacity to care for more individuals or to provide a greater scope of care to existing patients.

Information gathered by SBCares for w/c 9th May 2022 shows the challenges facing social care providers in providing care.

Patient Group	Patients Impacted	Hours of care
Hospital Waiting	34	472
Community Package unmet	125	902
Home First package unmet	16	76
Awaiting Increase in package	36	122
Total	**211**	**1,572**

Primary Aim 3

Work with other H&SCP staff to deliver integrated care. This team would support workstreams for example 'Home First', 'Reducing delayed discharges', maximising capacity of care at home staff and contribute to the management of what were once considered winter pressures however now seem to be all year round.

Outcomes (National Health and Wellbeing Outcome indicators)	Resources are used effectively and efficiently in the provision of health and social care services
Measure:	Number of people awaiting changes to their packages of care or new packages of care.

Commentary:

A support team focused on supporting the wider H&SCP teams rather than the more focused scope of the pharmacotherapy funded role in supporting GP practices. This would deliver a service wide approach to tackling the multifactorial issues around the provision of patient centred care involving Social Care providers, 3rd Sector and Healthcare staff

Local and National evidence suggests that this approach is an efficient use of resources, maximising the impact of interventions and minimising the use of resources. The key drivers are to improve the independence of individuals within a framework of an ageing population and financial controls, minimise medicines burden and maximise benefit Between 1998 and 2020 According to National registrar of Scotland data the Scottish Borders the 65 to 74 age group saw a 51.2% increase (versus 31.6% for Scotland) and the 75+ age group saw a 39.6% increase (versus 35.4 for Scotland).

Secondary Outcomes

Where capacity permits with the agreement of the IJB, the team may also be able to support the following outcomes.

Secondary Aim 4	
Reduce the use of compliance aids – to allow reablement, promote self-care, and reduce the burden on both health and social care services. As well as releasing community pharmacy time.	
Outcomes (National Health and Wellbeing Outcome indicators)	People are able to look after and improve their own health and wellbeing and live in good health for longer
	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..
Measure	% of patients with a package of care that includes medicines who have a compliance aid.
Commentary: It is estimated that for 24% of patients a blister pack was not the most appropriate method of support. As many pharmacies have over 100 blister pack patients this could eliminate waiting lists where the support is required and assessed as appropriate. Compliance aids are viewed by many as a panacea to assist patients, when other ways of supporting them will better assist reablement, promote self-care, and reduce the burden on both health and social care services. The use of compliance aids also makes it very difficult for carers to identify medication if some items are not to be administered. It is proposed that this project would support healthcare and social care staff to ensure they better understand the options available and give them the skills to make an assessment and choose the most appropriate method of medicines support. The benefit for patients of this approach to improvement assessment for patients will be supporting independence, reablement and reducing deskilling of activities of daily living e.g. managing their own medicines ordering, collection and administration. For example a patient with low vision could have a colour dot applied to the medicines pack to allow them to differentiate between different medicines.	

Secondary Aim 5	
Actions around promoting independence and reablement through the use of assistive technology to enable patients to take their medicines and reduce the burden on both health and social care services.	
Outcomes (National Health and Wellbeing Outcome indicators)	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..
	Resources are used effectively and efficiently in the provision of health and social care services.
Measure	% of patients assessed as to whether assistive technology would support them to safely take their medicines.
Commentary: Assistive technology is a much more cost-effective way of supporting suitable patients for example the monthly cost of an Ethel device to support medicines administration is £30/month compared with a medication prompt visit of £5 per visit.	

Secondary Aim 6	
Work with other stakeholders to ensure consistency of training and education to staff across all Care at home and Care Home providers in relation to medicines related policies and procedures.	
Outcomes (National Health and Wellbeing Outcome indicators)	People who use health and social care services are safe from harm.
	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.
Measure	All care providers to be made aware of the support available in relation to the development of policies and procedures.
Commentary:	

Work with other stakeholders to ensure consistency of training and education to staff across all Care at home and Care Home providers in relation to medicines related policies and procedures. It is not anticipated that the team would deliver routine training to staff as this would be their employer's responsibility.

Develop links with Social Care and Care homes to ensure consistency of training and education, supporting early discharge and self-care. Consideration should be given as to how to best support training to all care at home providers which focuses on outcome of screenings/assessments, definitions of prompt, assist and administer and levels of need. This will ensure consistency of approach with medicines management across Borders H&SCP. Given the challenges due to COVID and the wide geographical dissemination of staff, exploration of the efficacy of various training delivery approaches are needed from in person live events, through to live interactive remote learning using TEAMS through to non interactive online learning with complete flexibility around access and timing of training

Secondary Aim 7	
Link with Realistic Medicines work within Borders H&SCP to deliver quality improvement approaches to patient care.	
Outcomes (National Health and Wellbeing Outcome indicators)	Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services
Measure	% of patients who receive social care assistance with their medicines who have also received a realistic medicines review. It is estimated that reviewing 150 patients in year 1 will deliver £18K in drug savings.

Commentary:

There is strong evidence in pharmacy literature that as the number of medicines increases the risk of the patient being harmed by their medicines also increases. By undertaking a medicines review this risk can be managed or reduced. Work done by University of Dundee in the 2016 EFIPPS trial showed that the number of vulnerable patients with high risk prescribing can be reduced from 6.2% to 4.6% through feedback and awareness raising with prescribers. The reduction is medicines prescribed in other similar work has not been significant in terms of drug costs, the benefits are around the reduction in the use of medicines that may lead to drug related reasons for admission.

The team could support the administration of OPAT (Outpatient Parenteral Antibiotic Therapy) to patients receiving care at home and reduce the need for an admission or support earlier discharge. Based on prescribing data for the year to Feb 2022 a third of our care home residents received at least one treatment for a UTI, this team could make sure that such treatments were clinically appropriate in line with local antimicrobial guidance. This work would also support delivery of Standard 5 "Antimicrobial Use" in the HIS Infection Prevention and Control Standards for Health and Social Care settings.

Evidence in the project supports benefits to patients following a joint Health & Social Care approach to the assessment of patient's needs in relation to medicines management focusing on independence and self care. The role of a pharmacy technician in the project was critical to achieving best outcomes for individuals. To continue with this role across Borders, would require the employment of 2 FTE of technicians to ensure patients are screened/assessed in a timely manner.

It is proposed that the team would sit under the existing H&SCP structure for Care Management so that the team are fully embedded and can maximise the outcomes. Recruitment would take place by the Lead Pharmacist supported by Senior NHS Pharmacy staff and other H&SCP Colleagues. The aim would be to secure permanent funding for the posts as experience with recruitment has highlighted that success in recruiting to fixed term posts even through secondment has been very challenging.

Initial thoughts for the division of the technician staff would be one based in each of the following, with the hours worked based on the anticipated workload South (Based around Hawick and Jedburgh), East (Based around Berwickshire and Kelso) and West (based around Galashiels and Peebles). The pharmacist would work across all areas.

4. Financial Case

The cost of the provision would be offset by 3 factors:

1. Improved outcomes from Social Care interventions,
    a. Reduction in patients awaiting new packages of care or changes to packages of care.
    b. Increased efficiency around staff resource
2. Reduction in medicines related harm and associated admissions/ additional care needs.
3. Reduction in Medicines spend.

A evaluation of a similar intervention in East Devon in 2014 demonstrated savings of £255K for an investment of £156K, delivering net savings of £100K across a population of 145,000. With the exception of the Medication costs the savings would release capacity that could be used elsewhere. In the East Devon study 57% of patients referred to the pharmacy service we aged 80 years or over this compares to 67% of patients who are receiving input from SBCares in April 2022 who are aged over 80 this may mean that greater savings could be made.

https://pharmaceutical-journal.com/article/research/pharmacy-at-home-service-for-frail-older-patients-demonstrates-medicines-risk-reduction-and-admission-avoidance

Whilst it is difficult to compare savings due to differences in factors like population size, economies of scale, location and demographics. The Devon project provides support to the Scottish Borders estimates as detailed below:

Factor	Value	Cost Avoidance / Saving
Use of Social Care resources	£ 98K	Cost Avoidance
Reduced Admission from Medicines Harm	£ 136K	Cost Avoidance
Medicines Spend	£ 18K	Saving
Total	**£ 252K**	**Mainly cost avoidance**

This would deliver net savings of £102K, based on £252 savings/cost avoidance for a staffing investment of £150K.

5. Options

Option 1

Description
Do nothing – Maintenance of the Status Quo
Cost
£ Nil
Advantages
• No additional costs incurred
Disadvantages
• Maintaining the Status Quo is not possible since the existing model with support provided by a specialist pharmacy technician will end on 30th June 2022. • Queries from practice based teams around care packages would be directed to social care • Queries from care providers / social care regarding medication administration will be directed to practice based teams. • No advantage in terms of reduced care visits due to prompting changes to medication. • Issues raised regarding care packages will be directed to practice based teams placing more pressure on resources. • Medicines managewment advice e.g. covert administration, crushing medicines and managing swallowing issues and identifying alternative products or methods of administration etc. will be directed to practice based teams placing more pressures on existing resources. • Responding to medication administration errors will be directed to practice based teams again increasing pressure on existing resources.

Options 2 and 3 are based on the Pharmacist acting as the lead for the team; this role could also be undertaken by a B6 pharmacy technician. The time needed for his role is estimated at 0.2 FTE. If this were to happen then the team

workforce would be 1 FTE B6 Pharmacy Technician, 1.2 FTE B5 Pharmacy Technician, and 0.8 FTE Band 7/8A Pharmacist. The financial impact of this would be to increase costs by £4-6K

Option 2

Description
Creation of an HSCP Pharmacy Team with a Band 7 Pharmacist and 3 Band 5 Pharmacy Technicians totalling 2 FTE
Cost
Based on 2021 Payscales this would cost £137K per year excluding travel costs, increasing to £143K if Band 6 technician was the lead.
Advantages
• All of the additional pressures listed as disadvantages for Option 1 above being directed to practice based teams will be AVOIDED with those activities being directed to the new HSCP Pharmacy Team. • Existing examples of similar teams show that the costs of resourcing such a team are significantly outweighed by savings to Health and Care services from the avoidance of additional hospital admissions, health interventions and care visits. • Patient Safety will be significantly improved via proactive review of individual patient medication reviews. • Cost savings to both Health and care Services are unlikely to be cashable but WILL release capacity and resources to be used elsewhere.
Disadvantages
• The cost of establishing the recommended additional roles. • Establishing a role for a Band 7 rather than a Band 8 Pharmacist will mean that person is not as experienced and will not be able to act with the same level of autonomy. That in turn will mean this individual will have to seek advice, support and authorisation for some activities from existing services in Health and Care which are likely to already be under significant resource pressures.

Option 3

Description
Creation of an HSCP Pharmacy Team with a Band 8 Pharmacist and 3 Band 5 Pharmacy Technicians totally 2 FTE
Cost
Based on 2021-22 Payscales this would cost £146K per year excluding travel costs, increasing to £150K if Band 6 technician was the lead
Advantages
• All of the additional pressures listed as disadvantages for Option 1 above being directed to practice based teams will be AVOIDED with those activities being directed to the new HSCP Pharmacy Team. • Existing examples of similar teams show that the costs of resourcing such a team are significantly outweighed by savings to Health and Care services from the avoidance of additional hospital admissions, health interventions and care visits. • Patient Safety will be significantly improved via proactive review of individual patient medication reviews. • Cost savings to both Health and care Services are unlikely to be cashable but WILL release capacity and resources to be used elsewhere. • This Option is best placed to maximise the improved outcomes associated with the proactive review and administration of often complex patient medication regimes.
Disadvantages
• This is a more expensive option.

6. Recommendation

The meeting is recommended to approve the following:

Option 3 is the recommendation of this paper. The initial investment to establish the team is not insignificant BUT the benefits to be realised in terms of patient safety, better patient outcomes outweighs those costs. The avoidance of significant costs in terms of reduced hospital admission, reduced requirement for health interventions and reduced requirement for care visits should significantly exceed the upfront investment costs. . These cost avoidance outcomes are unlikely to take the form of cashable savings but WILL release significant capacity and resource which can then be used more effectively elsewhere.

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Consultees
Rachel Mollart – PCIP Exec member, Vice-Chair of Borders GP Sub
Paul McMenamin – Deputy Director of Finance / Finance Partner IJB, NHS Borders
Mairi Struthers – PCIP Pharmacotherapy Service Co-ordinator, NHS Borders
Health and Social Care Partnership Senior Management Team

Appendix 1 – Final Project Report IJB Funded Pharmacy Project.

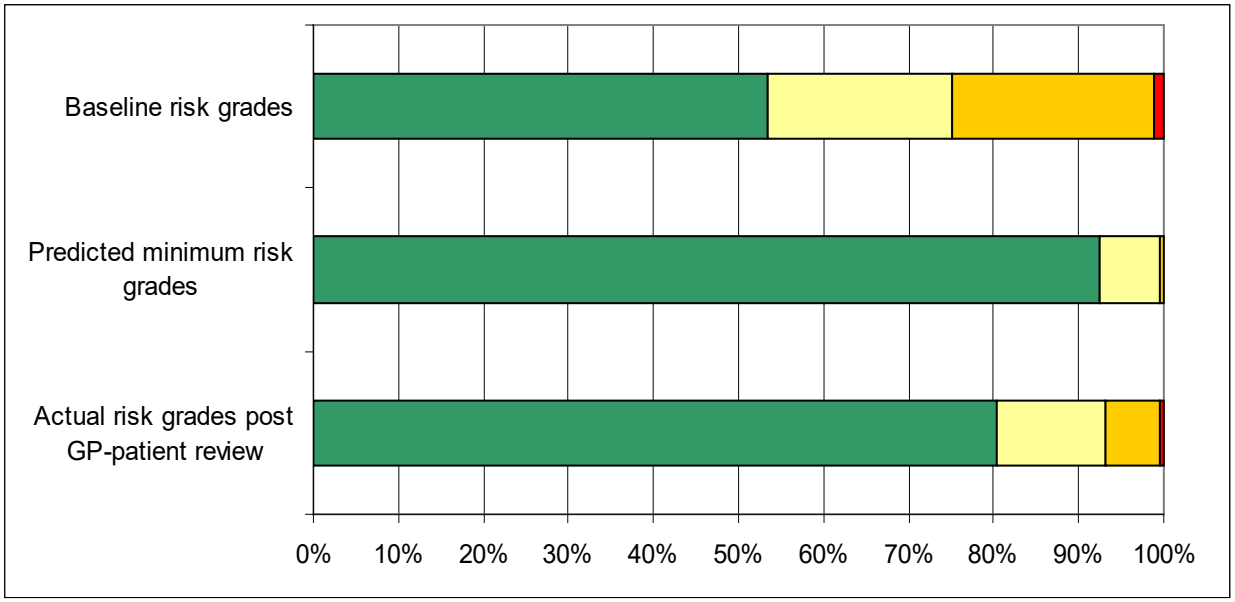
Final Project Outcome Report.pdf

Appendix 2 – NPSA Risk Matrix

The chart below demonstrates the effect based on the National Patient Safety risk matrix. Data is based on a review of 82 patients that gave a representative sample of the Borders GP practice populations.

The top line shows the risk of harm prior to medication review
The middle line shows the theoretical minimum risk post review
The bottom line shows the actual risk post medication review

Key
Red - very high risk of harm/admission
Amber- moderate risk,
Yellow – medium risk
Green – low risk)



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-150622-3 Pharmacy Support
Direction title	Pharmacy Support to Social Care service users
Direction to	NHS Borders and Scottish Borders Council
IJB Approval date	TBC – Direction to be considered by Integration Joint Board on 15 June 2022
Does this Direction supersede, revise or revoke a previous Direction?	No
Services/functions covered by this Direction	Pharmacy services, adult home care and residential care services
Full text of the Direction	To work in partnership to develop an integrated polypharmacy support service for all adult social care service users, provided by all providers. It is expected that an integrated impact assessment will be undertaken prior to commencing work on this initiative, to inform the development of the programme. It is expected that any associated savings as a result of this commission are identified and flagged to the Integration Joint Board Chief Financial Officer. The Integration Joint Board will determine at a later stage how the productivity gains from this development should be used, and whether they be recycled and used to increase capacity in the system, or used to contribute to a further reduction in the delegated services budget. Decisions about the recurrence of this initiative will be made following 2 reviews of the initiative by the Integration Joint Board Audit Committee and a review by the Integration Joint Board.
Timeframes	To commence as soon as possible
Links to relevant SBIJB report(s)	The Health & Social Care Integration Joint Board Strategic Plan 2018 – 2023 indicated that in order to reduce admission to hospital, improve health and wellbeing and reduce demand for statutory services: • "Pharmacy teams are taking on new responsibilities within GP surgeries in line with the new GMS contract pharmacotherapy service. This includes case management, supporting long term conditions (particularly respiratory disease and diabetes), care homes and polypharmacy reviews. The work should help prevent medication-related admissions and improve the quality of disease management." • "A project (using a project manager and pharmacy technician) is testing pharmacy input to patients receiving care packages" As the national parameters and scope of the Primary Care Improvement Plan have changed, it is recognised that the intended benefits and outcomes for social care service users can not been met by following the original plan. As a result, due to the expected benefits of this initiative, this Direction has been developed on a 2 year non-recurrent basis, as a test of change to ensure that the outcomes intended can be appropriately realised.
Budget / finances allocated to carry out the detail	2 year non-recurrent revenue to NHS Borders: £150,000 per annum
Outcomes / Performance Measures	It is expected that detailed information will be collected collaboratively by NHS Borders and the Scottish Borders Council to evidence improvements against the national health and wellbeing outcomes listed below, the integration planning and delivery principles, along with the measures and secondary aims:

Secondary Aims	Outcomes (National Health and Wellbeing Outcome indicators)	Measure
Reduce the use of compliance aids – to allow reablement, promote self-care, and reduce the burden on both health and social care services. As well as releasing community pharmacy time	People are able to look after and improve their own health and wellbeing and live in good health for longer 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..	% of patients with a package of care that includes medicines who have a compliance aid.
Actions around promoting independence and reablement through the use of assistive technology to enable patients to take their medicines and reduce the burden on both health and social care services.	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.. Resources are used effectively and efficiently in the provision of health and social care services.	% of patients assessed as to whether assistive technology would support them to safely take their medicines.
Work with other stakeholders to ensure consistency of training and education to staff across all Care at home and Care Home providers in relation to medicines related policies and procedures.	People who use health and social care services are safe from harm. 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.	All care providers to be made aware of the support available in relation to the development of policies and procedures.
Link with Realistic Medicines work within Borders H&SCP to deliver quality improvement approaches to patient care.	Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services	% of patients who receive social care assistance with their medicines who have also received a realistic medicines review.

It is also expected that evidence will also be captured on the quantum provided in the following areas. As part of this it is essential that the baseline is captured:

Factor	Type of gain
Use of Social Care resources	Outcomes / Productivity gain
Reduced admission from medicines Harm	Outcomes / Productivity gain
Medicines Spend	Saving

Date Direction will be reviewed	March 2023 Integration Joint Board Audit Committee, followed by further review at the Integration Joint Board Audit Committee in March 2024

Scottish Borders
Health and Social Care
Integration Joint Board

SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD

2021-22 ANNUAL PERFORMANCE REPORT & 2022-23 COMMISSIONING PLAN

Message from Chief Officer

In my first five months as Chief Officer, I have heard from many people who use our services, from unpaid carers, and from people delivering health, social care and adult social work services that the pressures they are experiencing are unlike anything that they have ever faced before. This certainly also rings true from my perspective.

The prolonged impacts of Covid-19 have unfortunately been felt by everyone in the Scottish Borders, and this is reflected in our health and wellbeing outcomes. It has also led to pressures in the health, social care and adult social work services commissioned by the Integration Joint Board.

Whilst recognising that there is a lot that needs to be done; within this challenging context that has gone on for a prolonged time, much progress has been made to best respond to these pressures, to sustain services and to support the health and wellbeing of people in the Scottish Borders.

I would like to express my deepest gratitude to everyone who works in health, social care and social work services; to all of the unpaid carers in the Scottish Borders; to all of our partners; and to everyone who has used health, social care, or adult social work services during this extremely challenging time.

I would also like to thank all Integration Joint Board members for their support including our former Chief Officer, Rob McCulloch-Graham, our outgoing Chair, Councillor David Parker, and to our former Elected Members for their leadership and support to the Integration Joint Board.

In addition to Covid-19, we are faced with meeting increased levels of need and dependency, in the context of significant financial challenges and workforce challenges for those who deliver health and social care.

One of the key take home messages from the pandemic, is that even in the most challenging circumstances, that by working together, everyone achieves more. Integration in its purest sense is about forming and developing partnerships and co-production to improve services and outcomes. I firmly believe that by moving together in the same direction with all of our partners with the common goal of improving outcomes, we can do better.

The Integration Joint Board will continue to renew its focus on partnerships, on engagement and on working with our communities to enhance how we strategically commission to best improve the outcomes for people living in the Scottish Borders, in these challenging times. By taking this approach, the Integration Joint Board will support improved outcomes while supporting a sustainable future health, social care and adult social work landscape, with the people of the Scottish Borders at the front and centre of everything we do.

Chris Myers
Chief Officer, Scottish Borders Health and Social Care Integration Joint Board
June 2022

TABLE OF CONTENTS

1. About the Health and Social Care Integration Joint Board

1.1. Broad Aims

The Scottish Borders Health and Social Care Integration Joint Board is a Public Authority which is focused on delivering improvements against the nine National Outcomes for Health and Wellbeing, and to achieve the core aims of integration:

- To improve the quality and consistency of services for patients, carers, service users and their families;
- To provide seamless, integrated, quality health and social care services in order to care for people in their homes, or a homely setting, where it is safe to do so; and
- To ensure resources are used effectively and efficiently to deliver services that meet the needs of the increasing number of people with long term conditions and often complex needs, many of whom are older.

The Integration Joint Board is responsible for the strategic planning of the functions delegated to it and for ensuring the delivery of those functions through the directions issued by it. It does this by developing a needs-based and outcomes-focused Strategic Commissioning Plan, and by commissioning our partners in line with the Integration Planning and Delivery Principles. The Integration Joint Board then reviews progress against this plan and on improvements in outcomes. This annual report forms one important part of this review process.

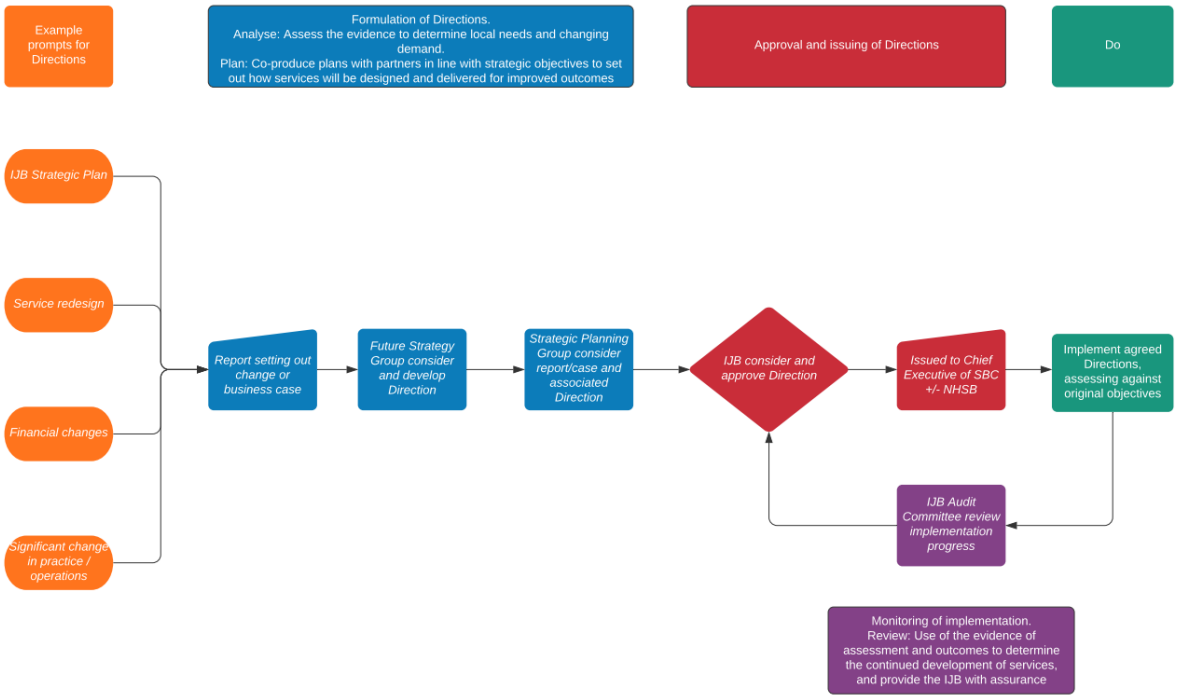
1.2. Delegated services

The following services have been delegated to the Integration Joint Board to strategically oversee and commission in line with our local priorities, the core aims of integration and the National Health and Wellbeing Outcomes. The delivery of these services have also been delegated into the Scottish Borders Health and Social Care Partnership which is provided by NHS Borders, the Scottish Borders Council; along with other delivery partners in line with the integration delivery principles.

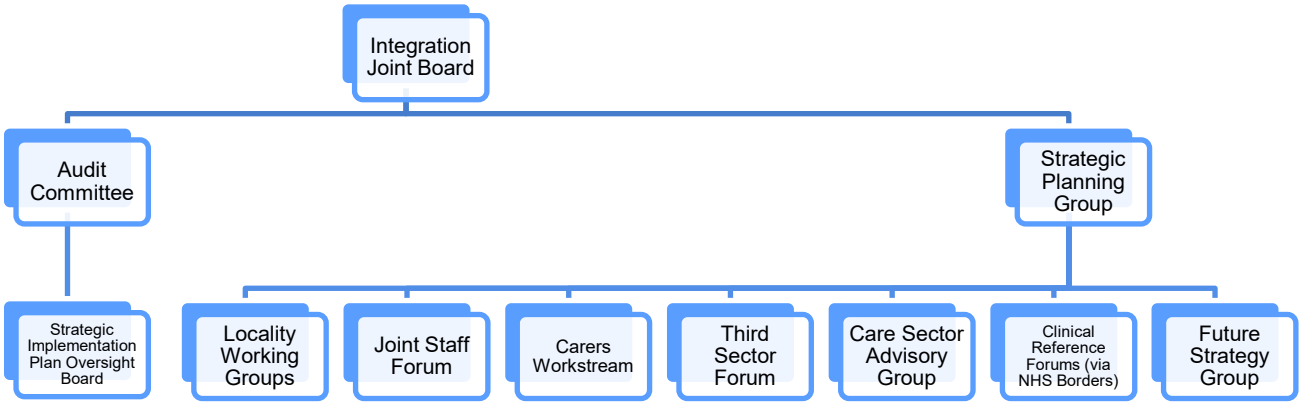
*Adult Social Care Services for adults aged 18 and over.
*Acute Health Services for all ages – adults and children.
*Community Health Services for adults aged 18 and over, excepting those marked with an asterisk (*), which also include services for children.

1.3. Our Commissioning Process and Structure

The responsibility for decisions about the planning and strategic commissioning of all health and social care functions that have been delegated to the Integration Joint Board sits wholly with the Integration Joint Board as a statutory public body. Commissioning in the Scottish Borders Health and Social Care Integration Joint Board is needs based and outcomes focused. It involves significant levels of engagement and consultation with our stakeholders. The diagram below summarises our high-level approach to commissioning (and de-commissioning).



The diagram below outlines the internal structure of the Integration Joint Board. The Audit Committee reviews the delivery of the Integration Joint Board and of its Directions. The Strategic Planning Group develops new plans and directions following consultation and engagement with relevant stakeholders, and its subgroups represent the diversity of partners. The Strategic Planning Group works to ensure a continued focus on outcomes and the delivery of the Integration Planning and Delivery Principles.



1.4. Membership of the Integration Joint Board

The Public Bodies (Joint Working) (Membership and Procedures of Integration Joint Boards) (Scotland) Order 2014 ("the Order") sets out requirements about the membership of an Integration Joint Board. This includes minimum required membership, and provision for additional members to be appointed.

The Integration Joint Board is a distinct legal entity that binds the Health Board and the Local Authority together in a joint arrangement. The membership of an Integration Joint Board reflects equal participation by the Health Board and Local Authority to ensure that there is joint decision making and accountability. The Order requires that the Local Authority and Health Board put forward a minimum of three nominees each.

The Integration Joint Board makes decisions about how health and social care services are planned and delivered for the communities within their areas. To do this effectively, they will require professional advice, for example, to ensure that the decisions reflect sound clinical practice. It is also essential that Integration Joint Boards include key stakeholders within the decision making processes to utilise their advice and experience.

To ensure this, the Order sets out a minimum further membership, but allows local flexibility to add additional nominations as Integration Joint Boards see fit. In addition to Health Board and Local Authority representatives, the Integration Joint Board membership must also include:

- The Chief Social Work Officer of the constituent Local Authority
- A General Practitioner representative, appointed by the Health Board
- A Secondary Medical care Practitioner representative, employed by the Health Board
- A Nurse representative, employed by the Health Board
- A staff-side representative
- A third sector representative
- A carer representative
- A service user representative
- The Chief Officer of the Integration Joint Board
- The Section 95 Officer of the Integration Joint Board

The Scottish Borders Health and Social Care Integration Joint Board goes beyond the minimum requirements outlined in the Order and the membership in 2021/22 and in the current year is outlined below.

1.4.1. Integration Joint Board Members: 1 April 2021 to 31 March 2022

Name	Designation	Membership status
Ms. Lucy O'Leary From 01.04.2021	Non-Executive Director, NHS Borders (Vice Chair)	Voting member
Mr. Malcolm Dickson Until 31.07.2021	Non-Executive Director, NHS Borders	Voting member
Mrs. Harriet Campbell From 15.12.2021	Non-Executive Director, NHS Borders	Voting member
Ms. Karen Hamilton	Non-Executive Director, NHS Borders	Voting member
Mr. John McLaren	Non-Executive Director, NHS Borders	Voting member
Mr. Tris Taylor	Non-Executive Director, NHS Borders	Voting member
Cllr. David Parker	Elected Member, Scottish Borders Council (Chair)	Voting member
Cllr. Shona Haslam	Elected Member, Scottish Borders Council	Voting member
Cllr. John Greenwell Until 28.07.2021	Elected Member, Scottish Borders Council	Voting member
Cllr. Jenny Linehan From 28.07.2021	Elected Member, Scottish Borders Council	Voting member
Cllr. Elaine Thornton-Nicol	Elected Member, Scottish Borders Council	Voting member
Cllr. Tom Weatherston	Elected Member, Scottish Borders Council	Voting member
Mr. Stuart Easingwood	Director of Social Work and Practice	Chief Social Work Officer
Dr. Kevin Buchan	Chair of GP Subcommittee	General Practitioner
Dr. Lynn McCallum	Executive Medical Director	Secondary Care Medical Practitioner
Mrs. Nicky Berry Until 01.06.2021	Director of Nursing, Midwifery and Operations	Nursing representative
Ms. Sarah Horan From 01.06.2021	Director of Nursing and Midwifery and Allied Health Professionals	Nursing representative
Mr. David Bell	Unite	Staff-side
Ms. Vikki MacPherson /Ms. Gail Russell	Partnership NHS	Staff-side
Ms. Jenny Smith	Borders Care Voice	Third Sector representative
Ms. Juliana Amaral From 15.12.2021	Berwickshire Association of Voluntary Services and Borders Third Sector Interface	Third Sector representative
Ms. Lynn Gallacher	Borders Carers Centre	Carer representative
Ms. Linda Jackson	LGBTQ+ representative	Service User representative
Mrs. Morag Low Until 28.07.2021	-	Service User representative
Mr. Nile Istephan	Chief Executive, Eildon Housing Association	Social Housing representative
Dr. Tim Patterson	Joint Director of Public Health	Public Health representative
Mr. Rob McCulloch-Graham Until 30.10.2022	Chief Officer and Joint Director of Health and Social Care	Integration Joint Board Chief Officer representative
Mr. Chris Myers From 01.11.2022	Chief Officer and Joint Director of Health and Social Care	Integration Joint Board Chief Officer representative
Vacant (Role undertaken by Andrew Bone, Director of Finance, NHS Borders and David Robertson, Chief Financial Officer, Scottish Borders Council)	Chief Financial Officer	Section 95 Officer of the Integration Joint Board

1.4.2. Integration Joint Board Members: Current Membership (as of June 2022)

Name	Designation	Membership status
Ms. Lucy O'Leary	Non-Executive Director, NHS Borders (Chair)	Voting member
Ms. Harriet Campbell	Non-Executive Director, NHS Borders	Voting member
Cllr. Jane Cox	Elected Member, Scottish Borders Council	Voting member
Ms. Karen Hamilton	Non-Executive Director, NHS Borders	Voting member
Mr. John McLaren	Non-Executive Director, NHS Borders	Voting member
Cllr. David Parker	Elected Member, Scottish Borders Council	Voting member
Cllr. Robin Tatler	Elected Member, Scottish Borders Council	Voting member
Mr. Tris Taylor,	Non-Executive Director, NHS Borders	Voting member
Cllr. Elaine Thornton-Nicol	Elected Member, Scottish Borders Council	Voting member
Cllr. Tom Weatherston	Elected Member, Scottish Borders Council	Voting member
Mr. Stuart Easingwood	Director of Social Work and Practice	Chief Social Work Officer
Dr. Kevin Buchan	Chair of GP Subcommittee	General Practitioner
Dr. Lynn McCallum	Executive Medical Director	Secondary Care Medical Practitioner
Ms. Sarah Horan	Director of Nursing and Midwifery and Allied Health Professionals	Nursing representative
Mr. David Bell	Unite	Staff-side
Ms. Vikki MacPherson	Unite	Staff-side
Ms. Juliana Amaral	Berwickshire Association of Voluntary Services and Borders Third Sector Interface	Third Sector representative
Ms. Jenny Smith	Borders Care Voice	Third Sector representative
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Ms. Linda Jackson	LGBTQ+ representative	Service User representative
Mr. Nile Istephan	Chief Executive, Eildon Housing Association	Social Housing representative
Dr. Tim Patterson	Joint Director of Public Health	Public Health representative
Mr. Chris Myers	Chief Officer, and Joint Director of Health and Social Care	Integration Joint Board Chief Officer representative
Vacant (Role currently being undertaken by Andrew Bone, Director of Finance, NHS Borders and David Robertson, Chief Financial Officer, Scottish Borders Council)	Chief Financial Officer	Section 95 Officer of the Integration Joint Board

2. Core Suite of Indicators

2.1. Health and Wellbeing Outcomes

This section provides an overview at a glance of our local performance against the National Health and Wellbeing Outcomes, compared to national performance in 2018/19 and 2019/20, which is the most up to date available information. These are derived from survey feedback.

Unfortunately, within the Scottish Borders, it is worth noting that in line with national data, we have seen a deterioration in our National Health and Wellbeing Outcomes.

Within the Scottish Borders, the latest data indicates that over this period, we performed better than the national benchmarks in the following areas:

- More people than the national average reported that they are able to look after their health very well or quite well
- More adults who were supported at home agreed that they are supported to live as independently as possible
- More adults receiving care than the national average would rate the care they receive as excellent or good
- More people had a positive experience of care at their GP practice than the national average
- Slightly more adults supported at home than the national average agreed that their services and support had an impact on improving or maintaining their quality of life

Within the Scottish Borders, we performed worse than the national benchmarks in the following areas:

- Fewer adults supported at home agreed that they had a say in how their help, care or support was provided
- Fewer adults supported at home agreed that their health and social care services seemed to be well co-ordinated
- Fewer carers felt supported to continue in their caring role
- Fewer adults supported at home agreed they felt safe

Over 2022/23, the Integration Joint Board Strategic Planning Group and its subgroups will focus on how the Integration Joint Board can promote improvements in all areas, with a focus on driving improvements in the areas where we performed worse in the Scottish Borders than the national benchmarks.

	Indicator	Title	Scottish Borders rate			Scotland rate		
			2015/16	2017/18	2019/20	2015/16	2017/18	2019/20
Outcome indicators	NI - 1	Percentage of adults able to look after their health very well or quite well	95.58%	94.34%	94.29%	94.51%	92.91%	92.85%
	NI - 2	Percentage of adults supported at home who agreed that they are supported to live as independently as possible [1]	-	-	81.1%	-	-	80.8%
	NI - 3	Percentage of adults supported at home who agreed that they had a say in how their help, care, or support was provided [1]	-	-	69.6%	-	-	75.4%
	NI - 4	Percentage of adults supported at home who agreed that their health and social care services seemed to be well co-ordinated [1]	-	-	70.0%	-	-	73.5%
	NI - 5	Percentage of adults receiving any care or support who rate it as excellent or good [1]	-	-	85.0%	-	-	80.2%
	NI - 6	Percentage of people with positive experience of care at their GP practice	88.7%	88.5%	82.3%	85.3%	82.6%	78.7%
	NI - 7	Percentage of adults supported at home who agree that their services and support had an impact on improving or maintaining their quality of life [1]	-	-	80.1%	-	-	80.0%
	NI - 8	Percentage of carers who feel supported to continue in their caring role	41.0%	36.1%	32.1%	40.0%	36.5%	34.3%
	NI - 9	Percentage of adults supported at home who agreed they felt safe [1]	-	-	80.5%	-	-	82.8%

Further detailed information on the National Health and Wellbeing Outcomes is included in Annex A.

2.2. Quantitative Indicators

This section provides an overview at a glance of our local performance against the national integration data indicators, compared to our local and national performance in 2018/19, 2019/20 and 2020/21, which is the most up to date available information. These are derived from national data sources.

The latest data indicates that over 2021/22, we performed better than the national benchmarks in the following areas:

- There was a lower premature mortality rate in the Scottish Borders than the national average
- There was a lower emergency admission rate in the Scottish Borders than the national average
- There was a lower spend on hospital stays where the person was admitted due to an emergency
- There was a lower rate of falls in the Scottish Borders than the national average
- There was a higher proportion of care services graded as good or better in Care Inspectorate inspections

Within the Scottish Borders, our performance was in line with the national average in the following area:

- The number of emergency readmissions to hospital within 28 days of discharge

Within the Scottish Borders, we performed worse than the national benchmarks in the following areas:

- There were a lower number of adults with intensive care needs in the Scottish Borders receiving care at home, compared to the national average
- There were a higher number of occupied bed days in hospital associated to emergency admissions in the Scottish Borders, compared to the national average
- A lower proportion of people in their last 6 months of life spent this at home or in a community setting in the Scottish Borders, compared to the national average
- There was a higher rate of bed days spent in hospital for people who were ready to be discharged in the Scottish Borders, compared to the national average

Over 2022/23, the Integration Joint Board Strategic Planning Group and its subgroups will focus on how the Integration Joint Board can promote improvements in all areas, with a focus on driving improvements in the areas where we performed worse in the Scottish Borders than the national benchmarks.

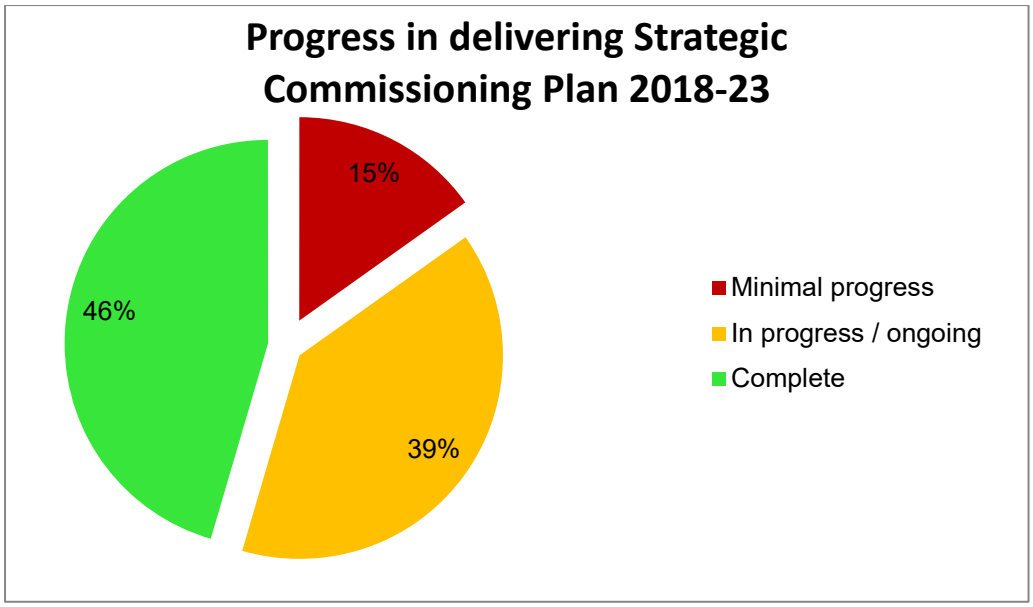
	Indicator	Title	Scottish Borders rate			Scotland rate		
			2018	2019	2020	2018	2019	2020
Data indicators	NI - 11	Premature mortality rate per 100,000 persons	388	315	367	432	426	457
	NI - 18	Percentage of adults with intensive care needs receiving care at home	62.2%	63.6%	59.6%	62.1%	63.0%	62.9%
			2018/19	2019/20	2020/21	2018/19	2019/20	2020/21
	NI - 12	Emergency admission rate (per 100,000 population)	12,425	12,181	10,248	12,279	12,525	10,951
	NI - 13	Emergency bed day rate (per 100,000 population)	131,471	119,798	105,790	119,986	118,552	100,710
	NI - 14	Emergency readmissions to hospital within 28 days of discharge (rate per 1,000 discharges)	109	107	120	103	105	120
	NI - 15	Proportion of last 6 months of life spent at home or in a community setting	85.5%	86.0%	89.6%	88.0%	88.3%	90.3%
	NI - 16	Falls rate per 1,000 population aged 65+	18.7	21.1	18.1	22.5	22.8	21.7
	NI - 17	Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections [2]	78.5%	85.7%	90.1%	82.2%	81.8%	82.5%
	NI - 19	Number of days people spend in hospital when they are ready to be discharged (per 1,000 population)	761	656	588	793	774	484
	NI - 20	Percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency	21.7%	20.2%	18.3%	24.1%	24.3%	21.0%

3. Progress in delivering the current Strategic Commissioning Plan

The Scottish Borders Integration Joint Board is responsible for setting the strategic direction for the delivery of delegated health, social care and adult social work services by developing a Strategic Commissioning Plan, based on need, focused on outcomes and in line with the integration planning and delivery principles.

The Integration Joint Board then commissions its partners by issuing Directions to implement this Strategic Commissioning Plan, and evaluates progress within its Audit Committee and through regular quarterly and annual review. A formal review against progress was undertaken in March 2022 by the IJB Audit Committee, and then in April 2022 by the Integration Joint Board Strategic Planning Group.

The chart below provides a breakdown of the current progress relating to the delivery of the actions detailed in the Strategic Implementation Plan 2018-22.



There has been significant work undertaken by the Integration Joint Board and its partners to deliver the Strategic Implementation Plan. The delivery actions that have been fully implemented include:

- Review of community hospital and day hospital provision
- Appointment of GP Cluster Leads
- Roll out of the Distress Brief Intervention Service
- Increasing the provision of housing with care and extra care housing
- Developing discharge to assess and home based intermediate care
- Development of Community Link Worker and Local Area Coordination services
- Funding of the Borders Carers Centre to undertake carer's assessments
- Extending the scope of the Matching Unit to source care and respite care at home

- Development of hospital inpatient pharmacy services to optimise outcomes, reduce re-admissions and length of stay
- Implementation of the Transforming Care After Treatment Programme for people with cancer
- What Matters Hubs are now operational in all 5 localities of the Scottish Borders

The delivery actions which are in progress include:

- Fully embedding transitional care / home based intermediate care as a model (Home First has capacity issues)
- Developing step up across all intermediate care services (Home First and the 4 Community Hospitals have this in place, but work is ongoing in Garden View to develop this)
- Full implementation of the Primary Care Improvement Plan Pharmacotherapy service
- Further increasing post diagnostic support rates for people with dementia – while the service is meeting demand, the referral rate is low (this also relates to an action in red)
- Progress in ongoing to improve uptake for Self Directed Support
- There are many examples of best value in the commissioning and delivery of health and social care, and the design and implementation of cost-effective alternatives to traditional costly models of care, but these need to continue to be progressed and reported upon
- There has been good uptake in the use of telecare and telehealthcare, however there remains further potential and in the context of workforce pressures and Covid-19, a real need to further increase uptake
- There has been redesign of day services with a focus on early intervention and prevention in line with national policy and legislation, and a redesign of learning disability day services, however concern has been raised about the provision of older adults day services. As a result, the IJB Carers workstream is co-producing a further needs assessment to develop an updated position on day supports.
- Work has progressed in realigning resources to deliver our strategic priorities and disinvest from services not required (e.g. the closure of Cauldsheils and the repatriation of individuals from out of area into the Millar House Integrated Community Rehabilitation Service), however due to system and covid-19 pressures, there is further work that can be undertaken
- There is work in progress to develop a re-ablement approach for care at home services. This needs to be considered in the context of the Home First service, and the potential for integration of services
- Community pharmacy services have been developed significantly and work is ongoing

The delivery actions that have not been progressed significantly include:

- Increasing the referral rate for people with dementia to post diagnostic support services
- Developing the Buurtzorg model of care and integrated locality management
- Providing polypharmacy support to social care service users to prevent medication-related admissions and improve the quality of disease management

Prioritised areas of focus for 2022-23 are outlined in section 7.

4. Financial Overview

The figure below provides an overview of IJB commissioned budget of by service area (£M) in 2021/22, excluding the unallocated NHS Borders savings requirements of £5.83M. Whilst this represents budget by service area, as a number of areas deliver a number of functions, it does not represent budget by function or service user group. The total IJB budget in 2021/22 was £178.4M.

From 2022/23, the IJB will work to develop a financial recovery plan to support financial sustainability. In addition, the new Strategic Commissioning Plan for 2023-26 will also work towards financial sustainability.

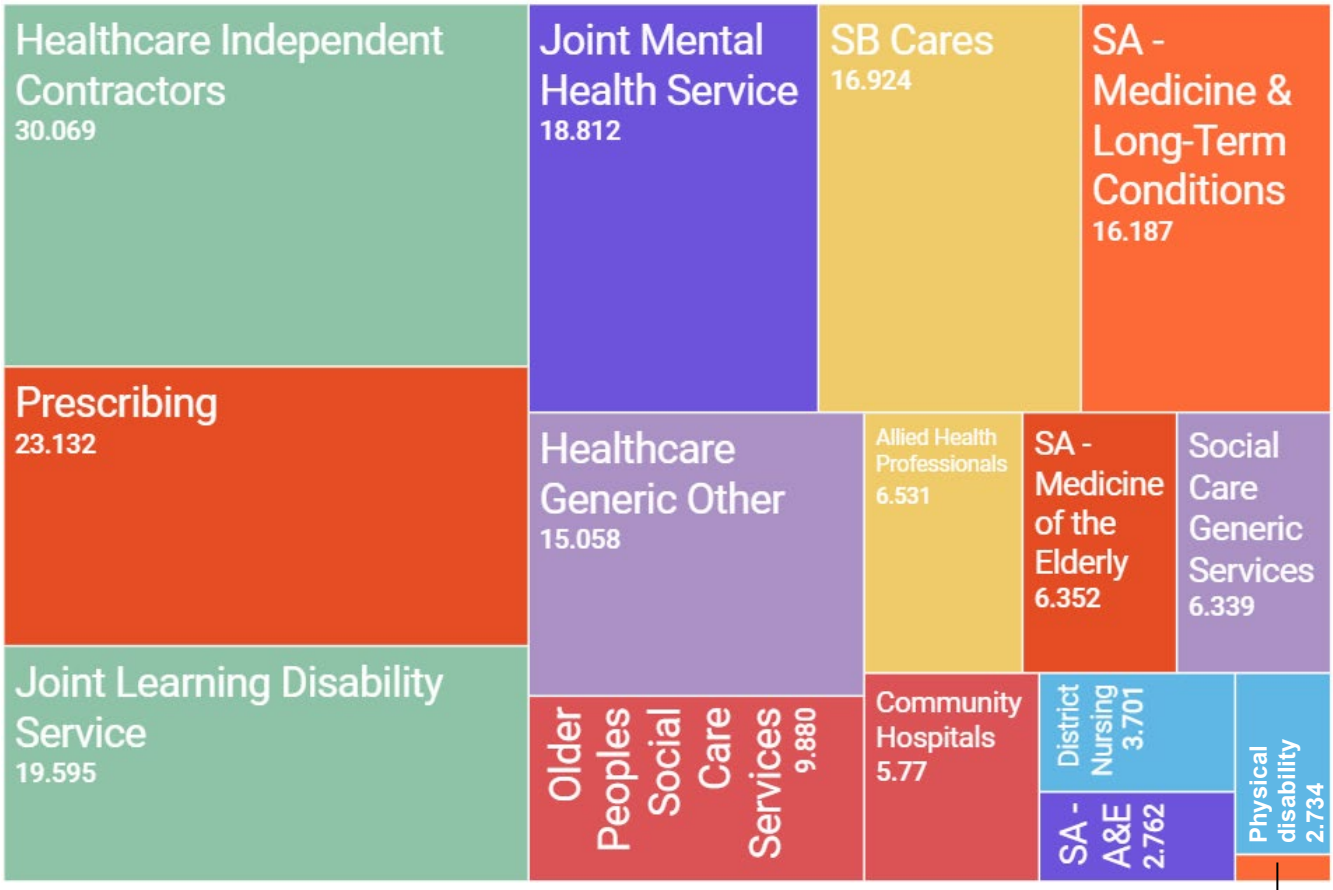


Figure 1 2021/22 Budgets by service area (£M) Excludes £5.83M savings requirement. SA denotes hospital set-aside. Total budget £178,415,000

The Integration Joint Board continues to face significant financial challenges and both of its partners are facing challenges in meeting the demand for health and social care services within the financial quantum available. This, going forward, will have a direct impact on the levels of funding provided to the Integration Joint Board. The key barriers to managing the financial position arises from demographic pressures of demand, together with capacity to plan and deliver required levels of transformation and efficiency savings. The significant growth anticipated in the number of older people and their need for suitable services, requires innovative solutions to allow services to be provided within funding levels available and, the ability of the partnership to transform services to help meet this demand.

The partnership faced a number of risks which required management and mitigation in 2021/22. Going forward, these continue to be prevalent:

- The 2022/23 Financial Plan does not currently address all historic and existing pressures;
- The Partnership's Delegated and Set-Aside Budgets remain under considerable pressure in 2022/23 as a result of the additional spend requirement of responding to the Covid-19 situation during the first half of the financial year, the additional costs of remobilisation and recovery, slippage in Transformation Programme workstreams and the inability across partner organisations to deliver required efficiency savings on which the Financial Plan is predicated;
- In respect of planned savings, there remains a significant shortfall between the level of planned efficiency savings requirement and those identified, particularly from a NHS Borders perspective. This is despite a non-recurring freeze on the allocation of any further efficiency savings requirement to delegated functions by NHS Borders beyond those brought forward from 2021/22;
- The Integration Joint Board holds a significant reserve in respect of COVID19 funds. This is expected to be utilised in 2022/23 in line with Scottish Government guidance to offset the overall costs of the Scottish Borders Health and Social Care COVID response. At this stage it is not anticipated that there will be any further allocations made available to support this expenditure in the next year.
- The Integration Joint Board has now mainstreamed the services previously provided under its Transformation Programme by permanently base-lining its supporting recurring budget. In turn, this means that any future transformation activity that the Partnership wishes to undertake will require additional supporting resources to now be identified beyond the small level of historic resource carried forward;
- With pressures across all health board and council functions as a result of the Covid-19 pandemic, both delegated and non-delegated, there is a risk going forward that if these are not funded by the Scottish Government in full, neither partner will be in a position to make additional contributions to top-up the budget delegated to the IJB or Set-Aside as it has in previous financial years. Accordingly, the Partnership may be at risk of over-spend, without mitigating solutions, at the end of the financial year;
- The financial challenges facing NHS Borders is expected to result in a requirement for further brokerage in 2022/23 to enable it to meet its statutory obligations, including funding any over-spend incurred by the IJB;
- The partnership's Strategic Plan covers the 4 years from 2018/19 to 2021/22. Similarly, its Strategic Implementation Plan runs from 2019/20-2023/24. Both NHS Borders and Scottish Borders Council currently receive only a 1-year financial settlement;
- Prescribing remains a high risk area due to the forecast level of spend and volatility of price and supply. Whilst there was a significant downturn in the level of prescribing and resultant expenditure levels in 2021/22 due to Covid-19, as primary care services remobilise, this trend is not expected to continue;
- There is an ongoing risk in relation to the sustainability of the workforce both internally and with our external care partners;

- Further cost pressures within core operational services may emerge during 2022/23 that are not yet projected or provided for within either partner's financial plans, nor the resources delegated to the IJB;
- The risk of loss of service provision as a result of market failure would result in additional costs as alternative supply is transitioned.

Going forward, delivering financial balance will require the Integration Joint Board to increase its focus on identifying and delivering a greater level of savings in year and on a permanently recurring basis. Monitoring of existing actions to mitigate emerging pressures will further support a reduction in spend required to address the pressures it experienced during 2021/22 and previous financial years. In setting its strategic agenda for the medium-term and planning the outcomes and new health and care services, the Health and Social Care partnership must target financial efficiency benefits and strive for overall affordability reducing in time, the requirement for Scottish Government brokerage.

5. Audit Committee

The remit of the IJB Audit Committee is to have high-level oversight of the IJB's framework of internal financial control, corporate governance, risk management systems and associated internal control environment.

The IJB Audit Committee has met 4 times on a virtual basis during the financial year on 14 June, 20 October and 9 December 2021, and 14 March 2022 to consider reports pertinent to the audit cycle.

To fulfil this remit, it sought assurance through material it received from Internal Audit, External Audit, other external scrutiny and audit bodies, and from Management, it placed reliance on the Partners' governance arrangements and assurance frameworks and considered relevant national reports that give rise to introducing best practice arrangements or lessons learned.

The Minutes of IJB Audit Committee meetings were presented for noting by the IJB following their approval by the Committee, and the Committee referred any exceptional items to the IJB in accordance with its Terms of Reference.

6. Strategic Planning Group

The role of the Strategic Planning Group is to develop the Integration Joint Board's strategic commissioning approach in line with the National Health and Wellbeing outcomes, and to achieve the core aims of integration.

Over 2021/22, the Integration Joint Board's Strategic Planning Group has informed the development of the Integration Joint Board's strategic commissioning and engagement approach. They have also influenced the development of local policy and formal directions.

In acknowledgement of the level of work that the Integration Joint Board needs to undertake to develop a new Joint Strategic Needs Assessment, including a thorough review of population health needs, and public engagement, the Integration Joint Board supported the development of the Future Strategy Group as a subgroup to the Strategic Planning Group.

As part of their discussions, the Strategic Planning Group have considered the following areas:

- How to better address health and care inequalities
- Progress on improving cancer journeys
- How to develop meaningful conversations with communities
- The approach to the development of a workforce strategy
- The next steps for the Oral Health Needs Assessment
- How the Integration Joint Board should respond to the outputs from the Alliance Scotland/ Third Sector interface event, exploring service provision in the Scottish Borders ‘20 Years into the Future’
- How to take the findings from discussions at the Strategic Planning Group about engagement and co-production to inform the Integration Joint Board's commissioning approach
- How the Integration Joint Board should respond to the 'A Change is as Good as a rest' report from the Borders Carers Centre
- Modelling residential and nursing care bed demand
- The potential impacts of the National Care Service in the Scottish Borders
- All Directions issued from 2022 onwards

Through the development of the Integration Joint Board's refreshed approach to Commissioning, all new plans or formal directions that are for consideration by the Integration Joint Board must be considered and approved by the Strategic Planning Group before getting onto the agenda for the Integration Joint Board. This ensures that the Strategic Planning Group have an enhanced scrutiny role in relation to new plans for the

Integration Joint Board, to ensure they appropriately align to the Integration Planning and Delivery Principles, and the National Health and Wellbeing Outcomes.

7. Progress over 2021/22

The work of the Integration Joint Board reduced due to the ongoing pressures associated to the pandemic. Within 2021/22, the Integration Joint Board:

- Supported the response to the pandemic, as a Category 1 responder, developing a Critical Functions Framework in partnership with the Scottish Borders Health and Social Care Partnership
- Developed its strategic commissioning approach, including the development of a Directions Policy and Procedure, aligned to the National Health and Wellbeing Outcomes, the Integration Planning and Delivery Principles and best practice
- Improved its approach to collaboration, engagement and co-production with service users, unpaid carers, staff, the third sector, the independent sector and delivery partners
- Co-produced our vision and needs based approach to better support and improve outcomes for unpaid carers with the Carers Workstream and Borders Carers Centre
- Commissioned care home modelling
- Worked with the Third Sector to support the development of the Community Mental Health and Wellbeing Fund

Oversaw the development of:

- The Primary Care Improvement Plan
- Integration of Community Health and Social Care services, and social prescribing through the Pathway 0 workstream
- The Older People's Acute Hospital and Intermediate Care Pathways
- The Autism workstream to improve supports for people with autism
- The Dementia Strategy Group
- The Alcohol and Drugs Partnership

Issued formal directions in areas including:

- The development of a Health and Social Care Integrated Workforce Plan, to support ongoing workforce sustainability and immediate workforce pressures from our partners
- Support for the development of the Strategic Commissioning Plan 2023-26
- Development of the Millar House Integrated Community Rehabilitation Service, and;
- The scoping and development of business cases for Care Villages in Tweedbank and Hawick

8. Commissioning Plan 2022/23

Based upon the National Health and Wellbeing Outcomes, the financial and workforce situations within the Scottish Borders, the focus on the Integration Joint Board in 2022/23 will explore how it can prioritise most of the actions from its Strategic Implementation Plan 2018-23, with a focus on the following areas:

- Better integration and co-ordination of community health and social care services
- Ensuring a person-centred approach to service delivery across health and social care
- Reducing the number of people waiting for care in our communities and in hospital
- Continuing to develop support for unpaid carers
- Enhanced support for people with intensive needs receiving care at home, e.g.
    - Technology Enabled Care
    - Pharmacy support for social care service users
    - Developing Community Geriatric provision, with the potential for service transformation
    - Consideration of the Hospital at Home model as a transformation initiative
- Developing community palliative care services, with the potential for service transformation
- Promoting financial and workforce sustainability

Due to the need to ensure good foundations for a number of the actions outlined in the Strategic Implementation Plan, it is recommended that the following Strategic Implementation Plan 2018-23 actions continue to be progressed over 2022/23, but that the expectation is for implementation in future years:

- Developing step up across all intermediate care services
    - Work needs to be progressed on the continued development of intermediate care and medical pathways to ensure that step up can be delivered appropriately.
- Developing best value in commissioning for both health and social care
    - A review of strategic commissioning has been undertaken for Social Care. Consideration needs to be put into the approach for the commissioning of delegated health services
- Developing the Buurtzorg model of care
    - The Kings Fund note that this can take 5 years to cultivate genuinely new ways of working and to appreciate the benefits. Whilst we must maintain this

aspiration, there is much work to do and we should focus on developing our approach in line with the Framework for Community Health and Social Care Integrated Services in the first instance to establish a good base for further change.

- Shifting resources from acute health and social care to community settings
    - This is a key requirement of integration. It is expected that the Integration Joint Board will work with its partners to identify further transformation programmes which support this ambition. The new Integration Joint Board Chief Financial Officer will develop a supporting framework to facilitate this, and the Integration Joint Board will work closely with its partners to develop an appropriate approach to support this aim.

During 2022-23, broadly speaking the Integration Joint Board will also consider the following areas:

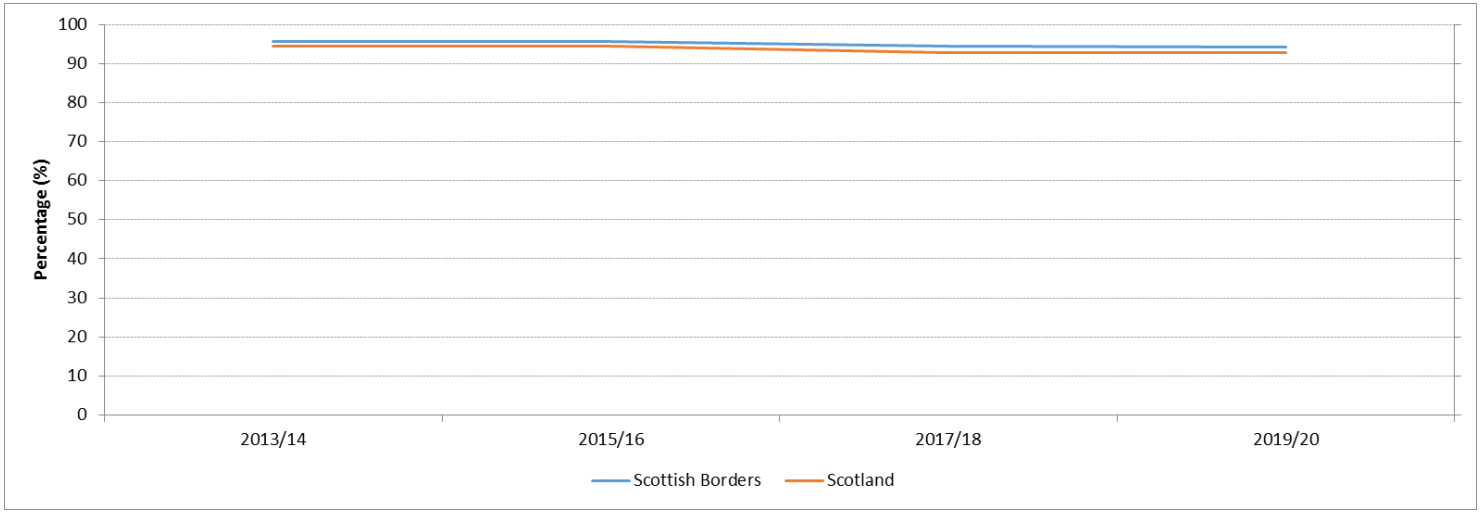
- Working with partners to reduce the pressures associated to Covid-19
- Continuing to refine and improve its commissioning approach, including a focus on continuous improvement within the Integration Joint Board structure
- Developing the Integration Joint Board's focus on Equalities and Human Rights, including the development of the Partnership's Equality Outcomes and Mainstreaming Action Plan
- Developing the partnership and engagement approach of the Integration Joint Board with its communities, including service users, carers, staff, the independent sector, third sector, localities, and other key strategic partners
- Undertaking a Joint Strategic Needs Assessment, underpinned by public engagement, in order to develop a new Strategic Commissioning Plan for 2023-26
- Responding to national policy, including the development of the National Care Service and Community Health and Social Care Boards

Annex A: National Health and Wellbeing Outcomes

National Indicator 1 Percentage of adults able to look after their health very well or quite well

Time series for - **Scottish Borders**

	2013/14	2015/16	2017/18	2019/20
Scottish Borders	95.7%	95.6%	94.3%	94.3%
Scotland	94.5%	94.5%	92.9%	92.9%

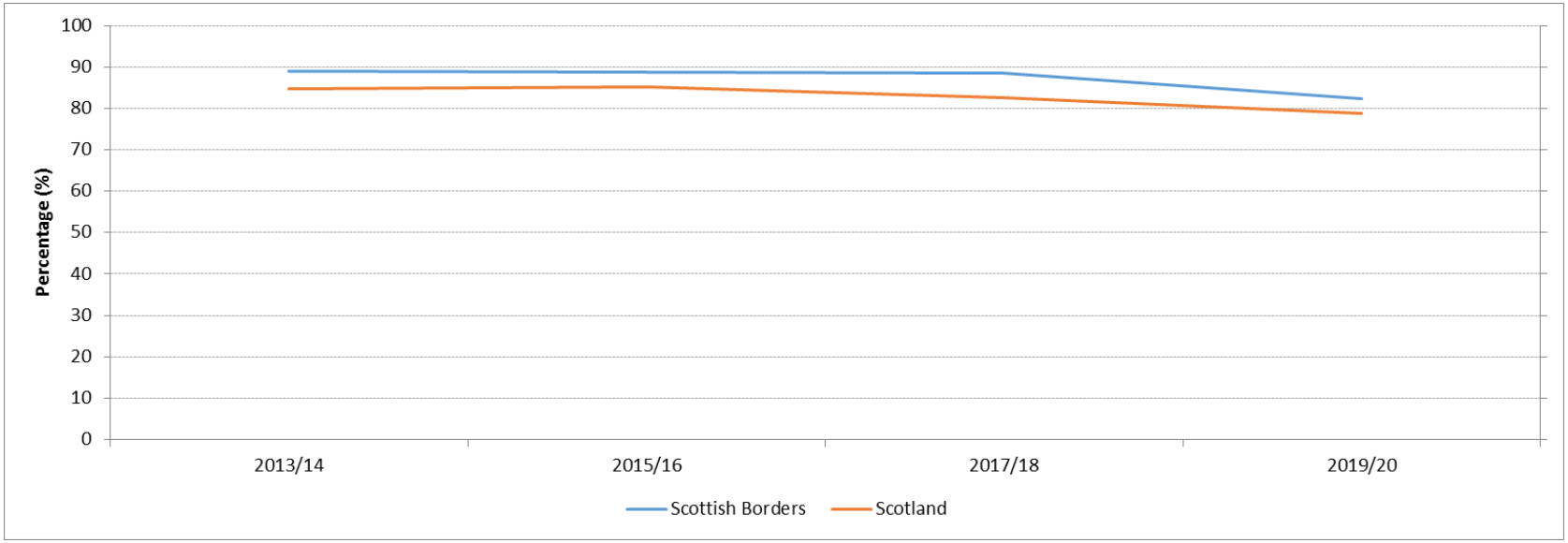


Source: Q52 - 2013/14 Health and Care Experience Survey, Q51 2015/16 Health and Care Experience Survey, Q40 2017/18 Health and Care Experience Survey, Q34 2019/20 Health and Care Experience Survey

National Indicator 6 Percentage of people with positive experience of care at their GP practice

Time series for - **Scottish Borders**

	2013/14	2015/16	2017/18	2019/20
Scottish Borders	89.0%	88.7%	88.5%	82.3%
Scotland	84.8%	85.3%	82.6%	78.7%

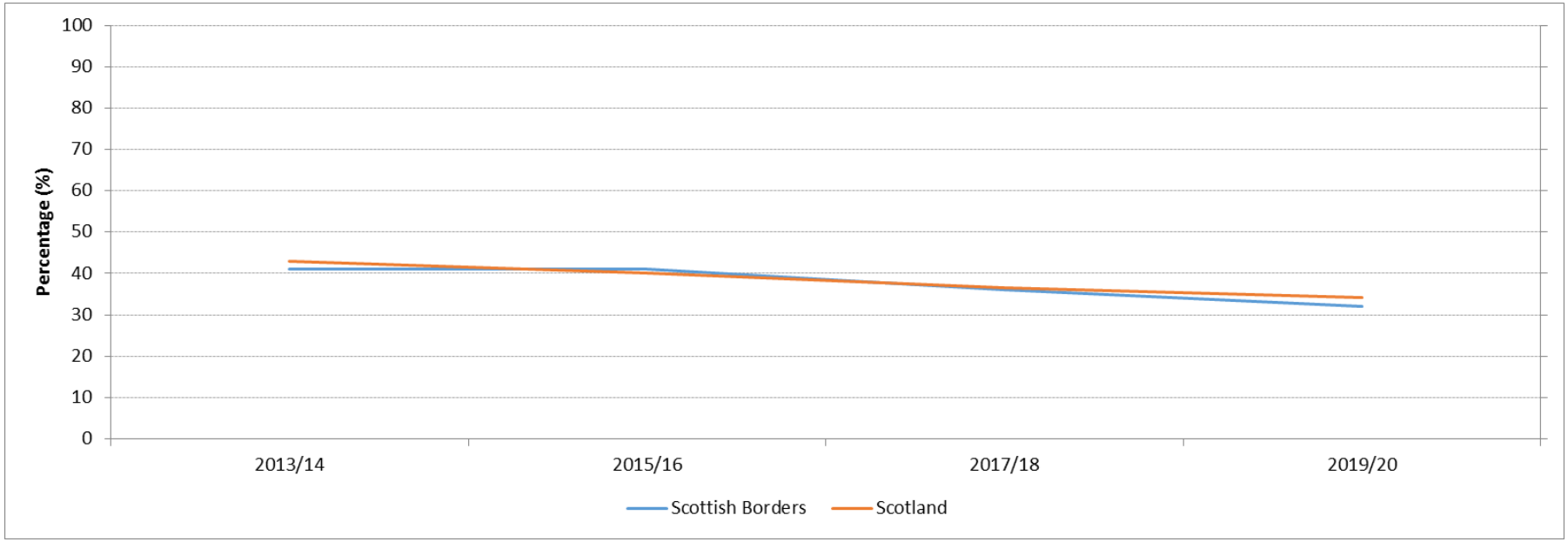


Source: Q27 - 2013/14 Health and Care Experience Survey, Q25 2015/16 Health and Care Experience Survey, Q8d 2017/18 Health and Care Experience Survey, Q10 2019/20 Health and Care Experience Survey

National Indicator 8 Percentage of carers who feel supported to continue in their caring role

Time series for - **Scottish Borders**

	2013/14	2015/16	2017/18	2019/20
Scottish Borders	41.0%	41.0%	36.1%	32.1%
Scotland	43.0%	40.0%	36.5%	34.3%



Source: Q45f - 2013/14 Health and Care Experience Survey, Q45e 2015/16 Health and Care Experience Survey, Q32e 2017/18 Health and Care Experience Survey, Q32e 2019/20 Health and Care Experience Survey

Notes for National Indicators 1, 6 and 8:

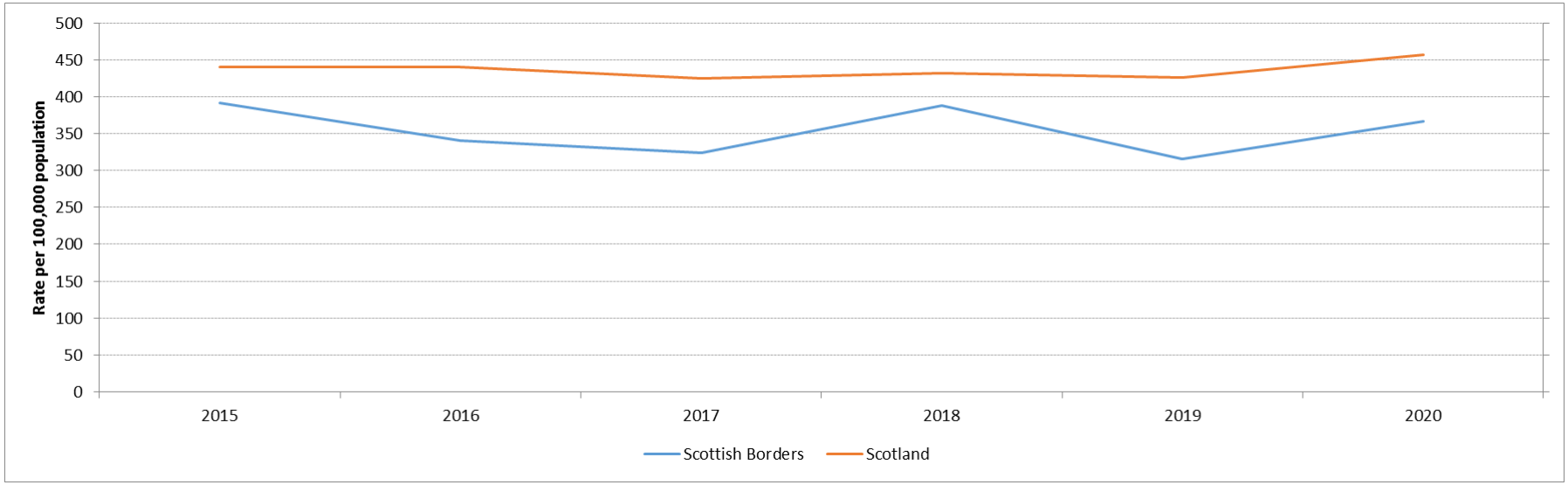
1. The Health and Care Experience Survey is a sample survey of people aged 17+ registered with a GP practice in Scotland. The results are therefore affected by sampling error. The effect of this sampling error is relatively small for the national estimates, however the sampling error will be greater when looking at small sub-sets of the population and the results are based on a smaller sample size. Care should be taken when comparing results, the effects of sampling error should be taken into account by the use of confidence intervals and tests for statistical significance.

2. Weighting - categories with no responses - Results are weighted to try and make them more representative of the overall population. To calculate weighted results, responses are grouped into categories by age, sex and service use, but responses may not have been received for some of these categories (especially at GP practice level, presented in the HACE publication but not here). Where this is the case, this category is not represented in the weighted result and this may impact on its representativeness.

National Indicator 11 Premature mortality rate per 100,000 persons; by calendar year

European age-standardised mortality rate per 100,000 for people aged under 75.
Death rates (per 100,000 population) for Local Authorities: age-standardised using the 2013 European Standard Population

	2015	2016	2017	2018	2019	2020
Scottish Borders	391	340	324	388	315	367
Scotland	441	440	425	432	426	457



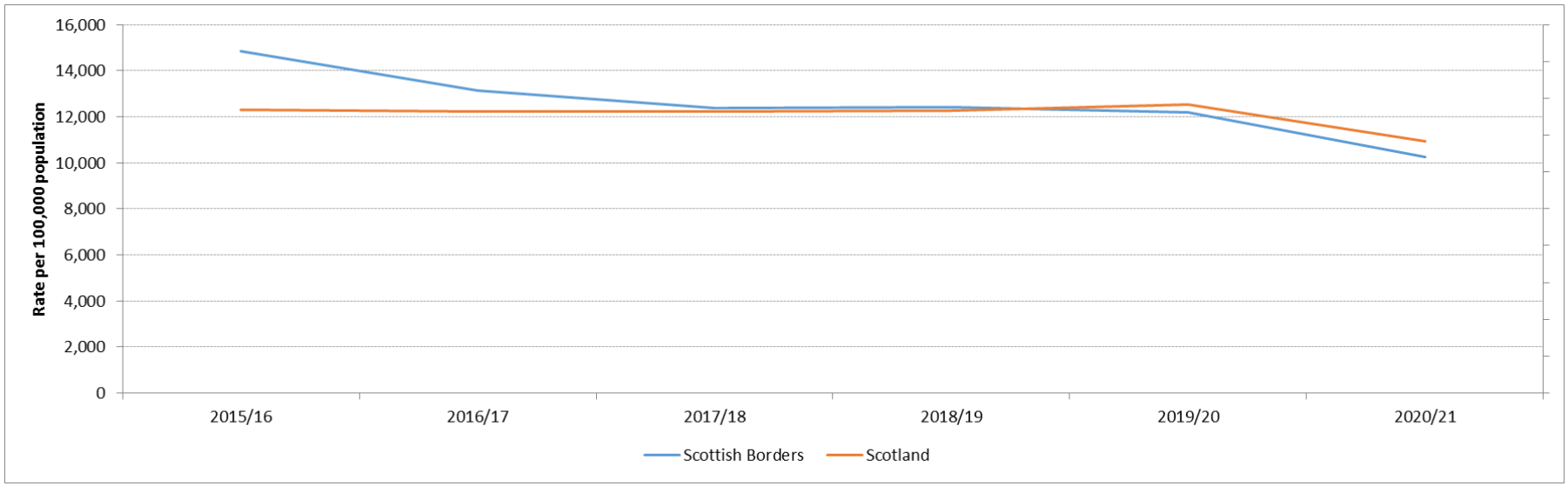
Source: National Records for Scotland (NRS)

1. Age-standardised using the 2013 European Standard Population

National Indicator 12 Emergency admission rate

Rate of emergency admissions per 100,000 population for adults (18+).

	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21
Scottish Borders	14,833	13,135	12,382	12,425	12,181	10,248
Scotland	12,295	12,229	12,210	12,279	12,525	10,951



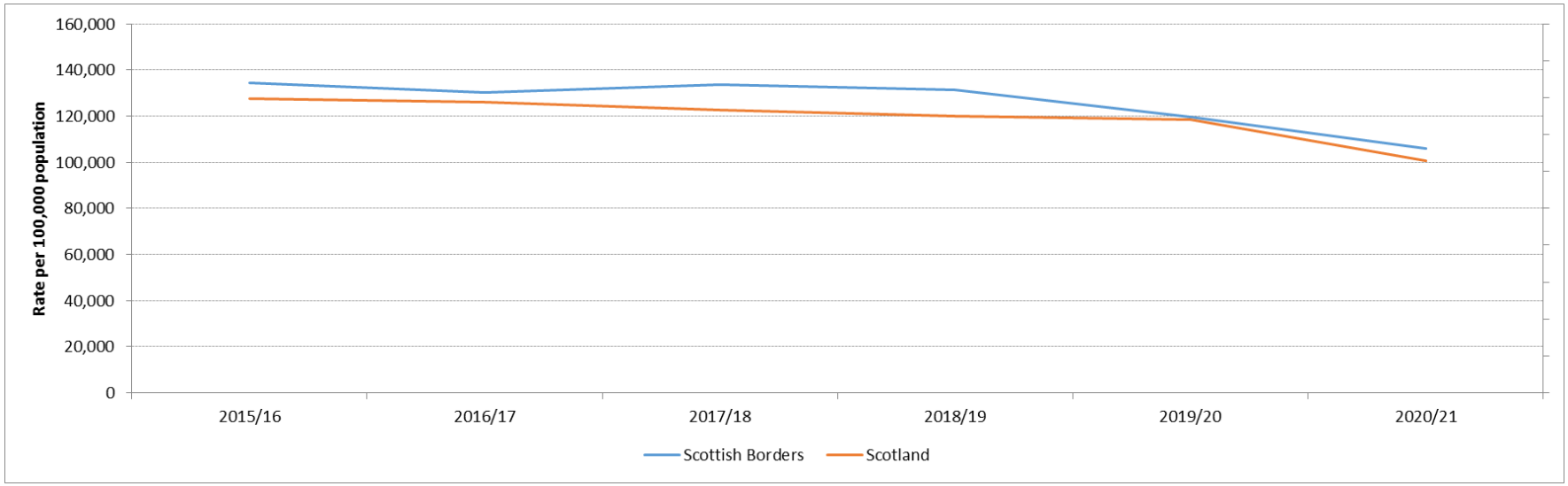
Source: PHS - SMR01 (acute discharges from non-obstetric/non-psychiatric NHS hospitals in Scotland), including Geriatric Long Stay (GLS) discharges
SMR04 (mental health inpatient records from NHS hospitals in Scotland

Notes:
1. Includes emergency admissions to all hospital specialties (acute, geriatric long stay and mental health) occurring within the selected year.
2. A hospital stay is selected if an emergency admission occurred in the first episode of the stay.
3. 2020 population estimates have been used to calculate rates from 2020 onwards. For data relating to years prior to this, population estimates for the corresponding year have been applied.

National Indicator 13 Emergency bed day rate

Rate of emergency bed day per 100,000 population for adults (18+).

	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21
Scottish Borders	134,442	130,181	133,824	131,471	119,798	105,790
Scotland	127,609	126,007	122,541	119,986	118,552	100,710



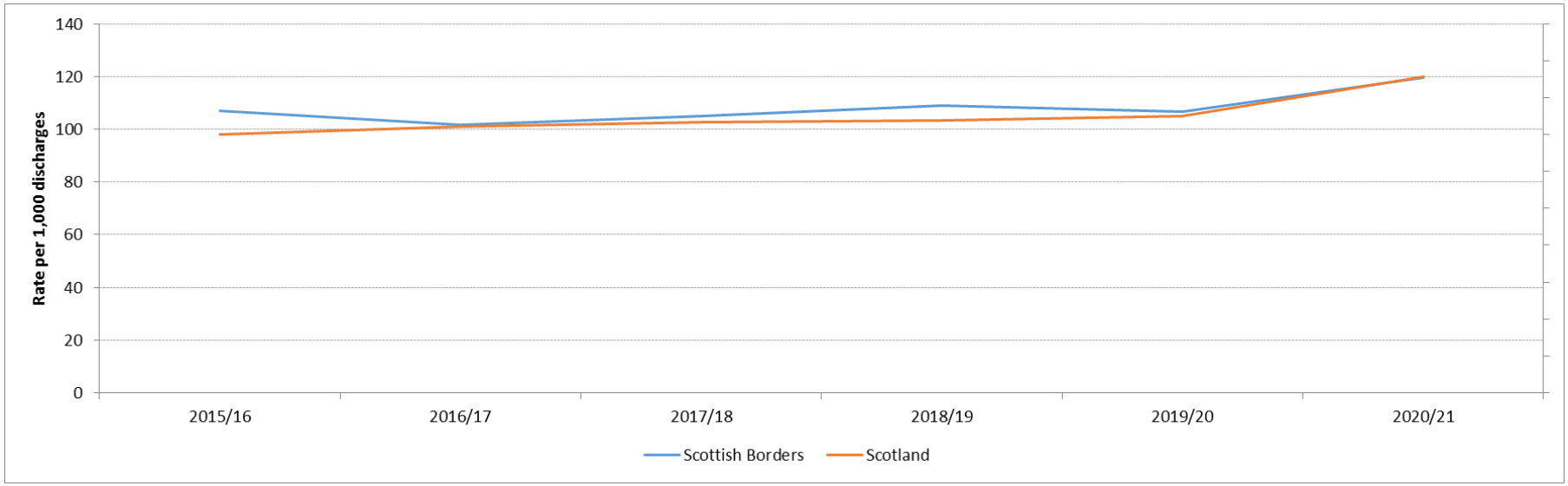
Source: PHS - SMR01 (acute discharges from non-obstetric/non-psychiatric NHS hospitals in Scotland), including Geriatric Long Stay (GLS) discharges
SMR04 (mental health inpatient records from NHS hospitals in Scotland

Notes:
1. Includes emergency admissions to all hospital specialties (acute, geriatric long stay and mental health) occurring within the selected year.
2. A hospital stay is selected if an emergency admission occurred in the first episode of the stay.
3. 2020 population estimates have been used to calculate rates from 2020 onwards. For data relating to years prior to this, population estimates for the corresponding year have been applied.

National Indicator 14 Readmission to hospital within 28 days

Emergency readmissions to hospital for adults (18+) within 28 days of discharge (rate per 1,000 discharges)

	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21
Scottish Borders	107	102	105	109	107	120
Scotland	98	101	103	103	105	120



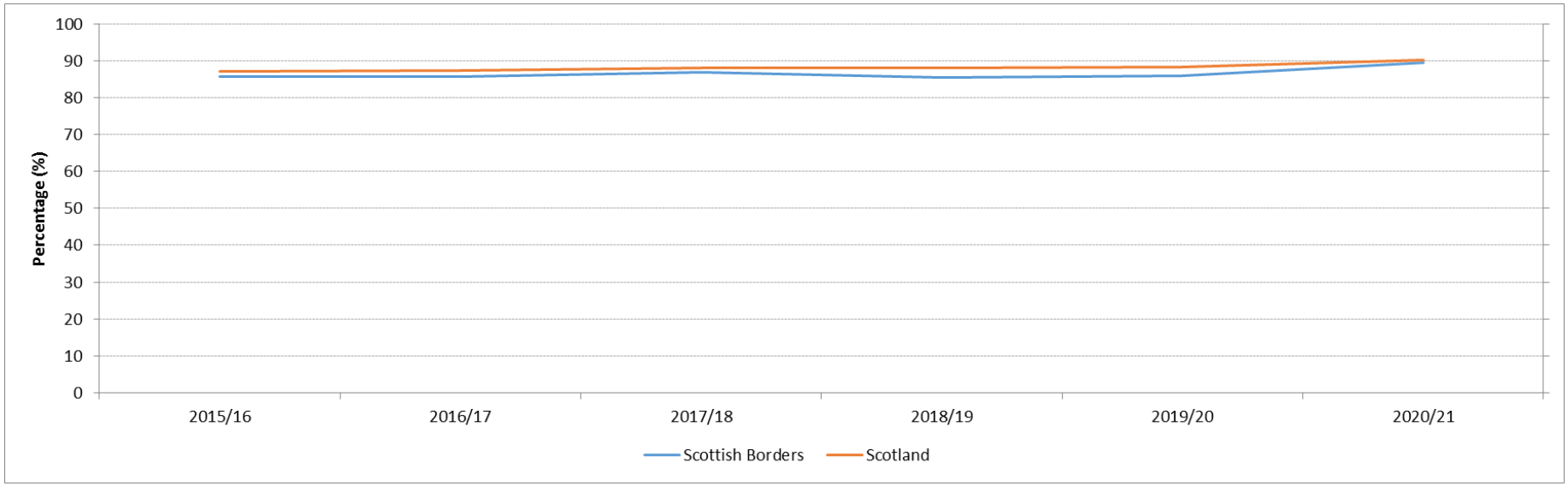
Source: PHS - SMR01 (acute discharges from non-obstetric/non-psychiatric NHS hospitals in Scotland), excluding Geriatric Long Stay (GLS) discharges

1. An emergency readmission is where the subsequent admission is an emergency and occurs up to and including 28 days from the initial admission. The initial admission can be of any type but must end within the time period of interest.

National Indicator 15 Proportion of last 6 months of life spent at home or in a community setting

This indicator measures the percentage of time spent by people (all ages) in the last 6 months of life at home or in a community setting.

	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21
Scottish Borders	85.6%	85.6%	86.9%	85.5%	86.0%	89.6%
Scotland	87.0%	87.4%	88.0%	88.0%	88.3%	90.3%



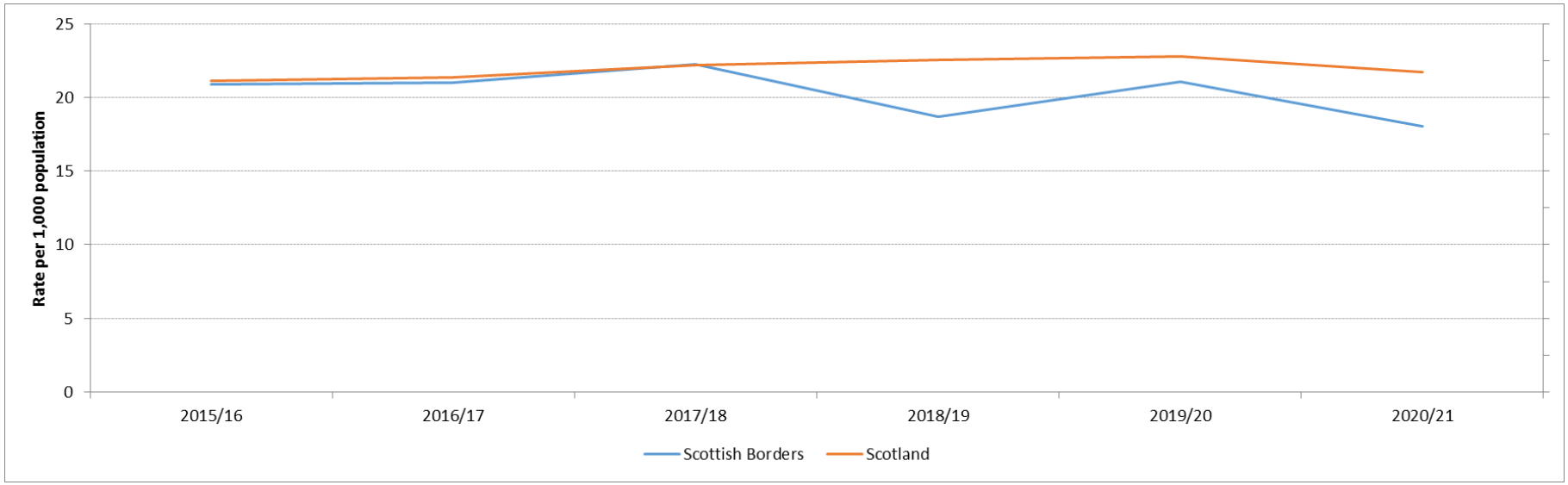
Source: PHS - SMR01 (acute discharges from non-obstetric/non-psychiatric NHS hospitals in Scotland), including Geriatric Long Stay (GLS) discharges
SMR04 (mental health inpatient records from NHS hospitals in Scotland
National Records for Scotland

Notes:
1. Patients who died where an external cause of death is coded (V01-Y84) on the death registration have been excluded from the analysis.
2. Patients who died where a fall is coded on the death registration are included within the cohort; W00-W19 Falls.
3. Based on the above criteria, any person that died within the time period of interest is selected. The possible number of bed days that these people could have spent in hospital in a six month period is calculated by multiplying the total number of deaths by 182.5. The actual bed days these people spent in hospital is then deducted from that total and the remainder calculated as a percentage of all possible bed days.
4. Care homes are excluded from the analysis.

National Indicator 16 Falls rate per 1,000 population aged 65+

The focus of this indicator is the rate per 1,000 population of falls that occur in the population (aged 65 plus) who were admitted as an emergency to hospital.

	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21
Scottish Borders	21	21	22	19	21	18
Scotland	21	21	22	23	23	22



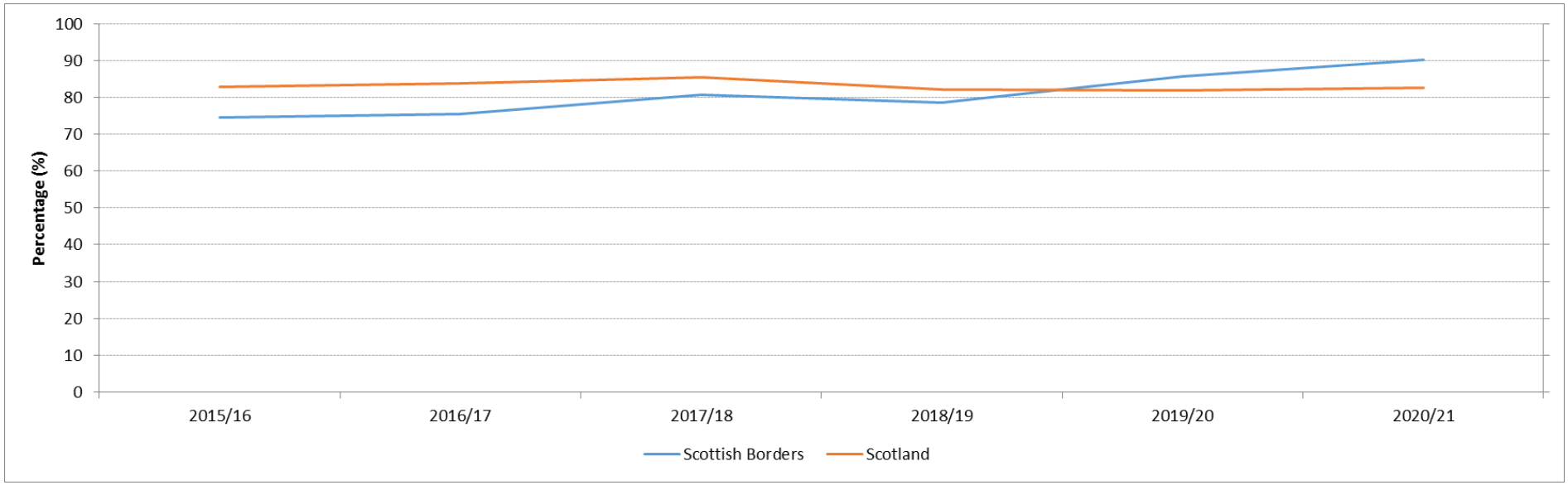
Source: PHS - SMR01 (acute discharges from non-obstetric/non-psychiatric NHS hospitals in Scotland), excluding Geriatric Long Stay (GLS) discharges

Notes:
1. Emergency admissions code 33-35 have been used and ICD10 codes W00 - W19.
2. 2020 population estimates have been used to calculate rates from 2020 onwards. For data relating to years prior to this, population estimates for the corresponding year have been applied.

National Indicator 17 Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections

The Care Inspectorate have advised that this indicator is developmental.

	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21
Scottish Borders	74.6%	75.4%	80.7%	78.5%	85.7%	90.1%
Scotland	82.9%	83.8%	85.4%	82.2%	81.8%	82.5%


100
90
80
70
60
50
40
30
20
10
0
Percentage (%)
2015/16
2016/17
2017/18
2018/19
2019/20
2020/21
Scottish Borders
Scotland

Source: Care Inspectorate

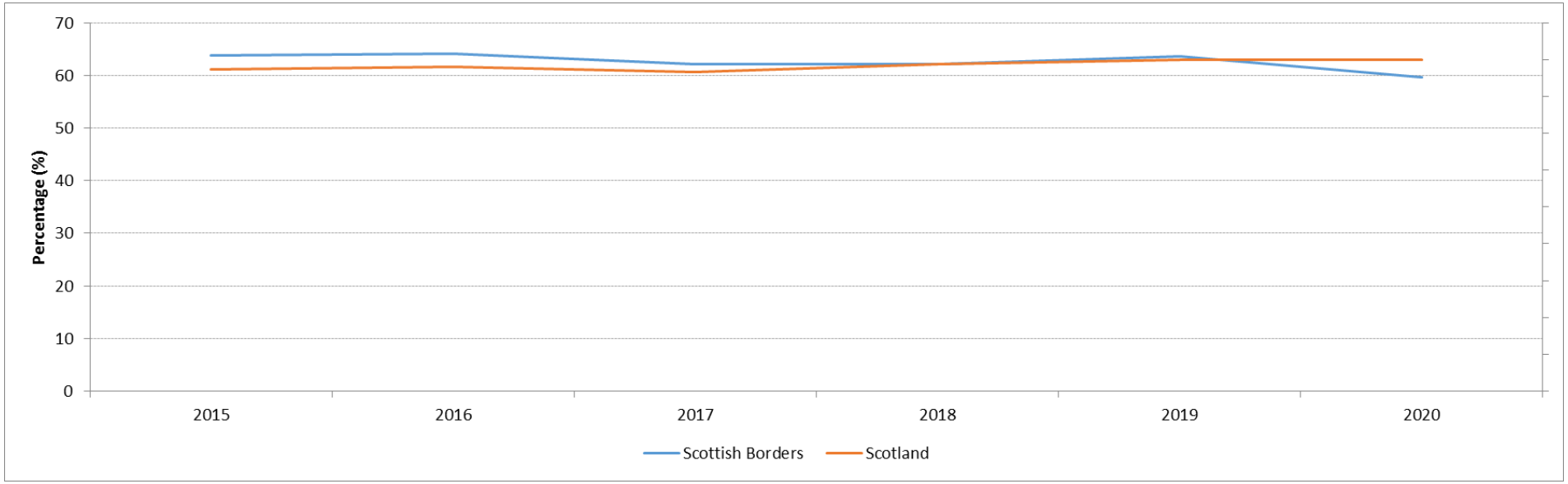
Notes:

1. Data presented in 2020/21 - Advice from directors of Public Health in Scotland was that inspection visits would present a real risk of introducing and spreading COVID-19 in Scotland's care homes. Therefore, to limit the spread of COVID-19, and with agreement from Scottish Government the Care Inspectorate restricted their presence in services unless necessary. This approach resulted in the majority of services not being graded as normal and instead retaining the grades they had last received. Instead the Care Inspectorate intensified oversight using a range of remote and virtual approaches to ensure services were supported and operating well throughout the pandemic.
2. Data are provisional.
3. Based on services registered with the Care Inspectorate as at 31 March of each year. Grades are those published on the CI website, also at 31 March in each year.
4. The information about the Local Authority in which the service provides care has been taken from the Care Inspectorate Annual Returns, and relates to 31 December in each year.
5. Some services that are not premises based (Housing Support and Support Services - Care at Home) might provide a service in several Local Authorities.
6. For care services that provide a service in more than one Local Authority there are duplicate entries - one entry for each Local Authority. Therefore the total number of services does not match the overall number of services registered, as published by the Care Inspectorate in the Annual Report and other publications.
7. For services that did not submit an annual return or registered after 31 December 2020 only the Local Authority where the service is based is used to determine where the service is provided.
8. Combined housing support and support services - care at home only submit one annual return (usually under the housing support service). The information contained in the one annual return has been applied to the other part of the service and is displayed in the data.
9. For those services that did not mention the Local Authority that they are based in as a Local Authority that they provide a service in, this Local Authority was added as one where they provide a service.

National Indicator 18 Percentage of adults with intensive care needs receiving care at home

The number of adults (18+) receiving personal care at home or direct payments for personal care, as a percentage of the total number of adults needing long-term care.

	2015	2016	2017	2018	2019	2020
Scottish Borders	63.8%	64.1%	62.2%	62.2%	63.6%	59.6%
Scotland	61.2%	61.6%	60.7%	62.1%	63.0%	62.9%



Source: PHS Source Social Care Database, PHS Continuing Care Census, Scottish Government Hospital Based Complex Clinical Care Census, Scottish Government Quarterly Monitoring, Survey, Scottish Government Social Care Survey

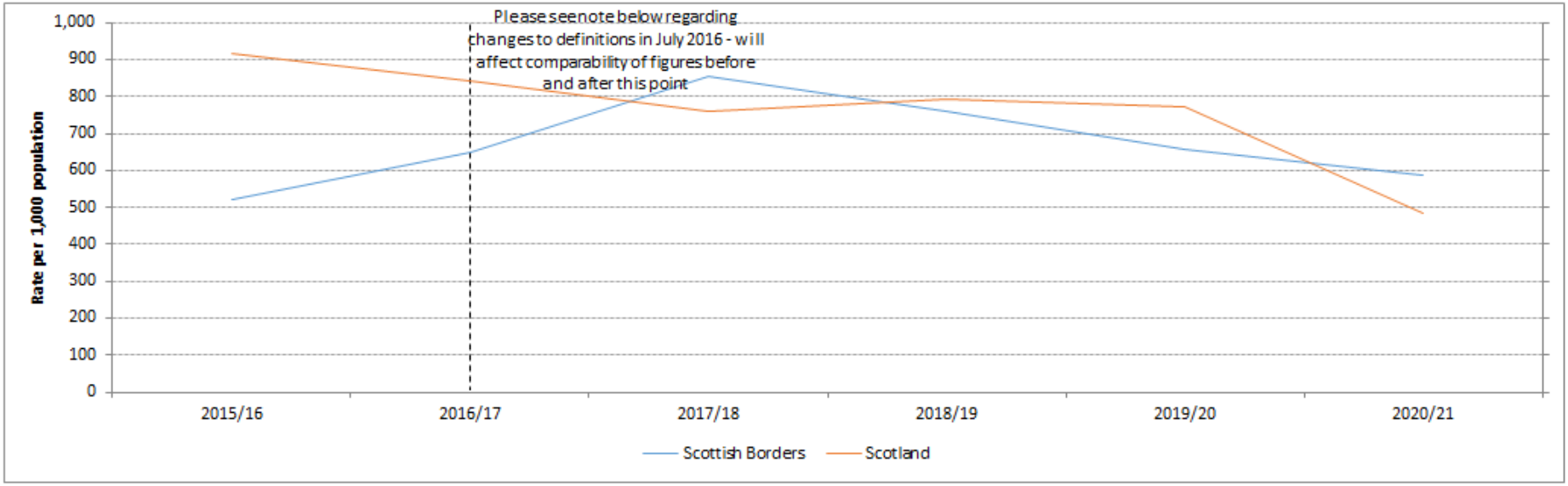
Notes:

1. The total number of adults needing long-term care includes those receiving personal care at home, long stay care home residents and those in receipt of Continuing Care/Hospital Based Complex Clinical Care (HBCCC). Please see the publication for more detailed information.
2. Previous guidance (CEL 6 (2008)) on NHS Continuing Care was replaced on the 1st June 2015 with DL (2015)11 - Hospital Based Complex Clinical Care. As a result, the previous NHS Continuing Care Census was ended in June 2015 and replaced by the Hospital Based Complex Clinical Care publication from 2016.
3. The definition of HBCCC changed between the 2016 and 2017 Census. The figures here for 2017 and 2018 use a similar methodology to 2016 for comparison purposes.
4. The HBCCC publication is returned by NHS Health Boards. Local Authorities have been mapped using the home post code of the patient returned by the NHS Health Board. In those cases where this was unavailable, the post code of the patient on the date of the census was used, where available. Not all patients can be mapped to Local Authority, therefore totals may be higher than summed Local Authority data.
5. Personal Care at home information includes those aged 18 years and over with personal care needs assessed through Self-directed Support Direct Payments. This was previously captured as part of the Scottish Government Social Care Survey. Figures for 2018, 2019 and 2020 are from PHS Source Social Care Database.
6. For 2019, as Aberdeenshire have not broken down services to personal and non-personal care, all clients under the age of 65 have been recorded as receiving non-personal care, except those with Multi-Staff Input who have been recorded as receiving personal care
7. Care Home information for the following was not returned - East Renfrewshire - 2015, 2016, 2017 and 2018; Orkney Islands - 2016, 2017 and 2019; East Ayrshire, North Ayrshire, South Lanarkshire - 2018; Eilean Siar 2019 and 2020; Aberdeen City 2020 - previous years figures have been used as a proxy to maintain comparability.
8. SDS information for the following was not returned; South Ayrshire 2020; Aberdeen City - previous years figures have been used as a proxy to maintain comparability.
9. Home Care information for the following was not returned - Aberdeen City; Orkney Islands 2019; Aberdeen City 2020; Only aggregate Home Care data was provided by Glasgow City for 2018 - previous years figures have been used as a proxy to maintain comparability.
10. In line with the 'PHS Insights into Social Care in Scotland' publication, statistical disclosure control has been applied to protect patient confidentiality. Therefore, the figures presented here may not be additive and may differ from previous publications.

National Indicator 19 Number of days people aged 75+ spend in hospital when they are ready to be discharged, per 1,000 population

The number of bed days due to delay discharge that have been recorded for people aged 75+ resident within the Local Authority area, per 1,000 population in the area.

	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21
Scottish Borders	522	647	855	761	656	588
Scotland	915	841	762	793	774	484



Source: PHS Delayed Discharge data collection

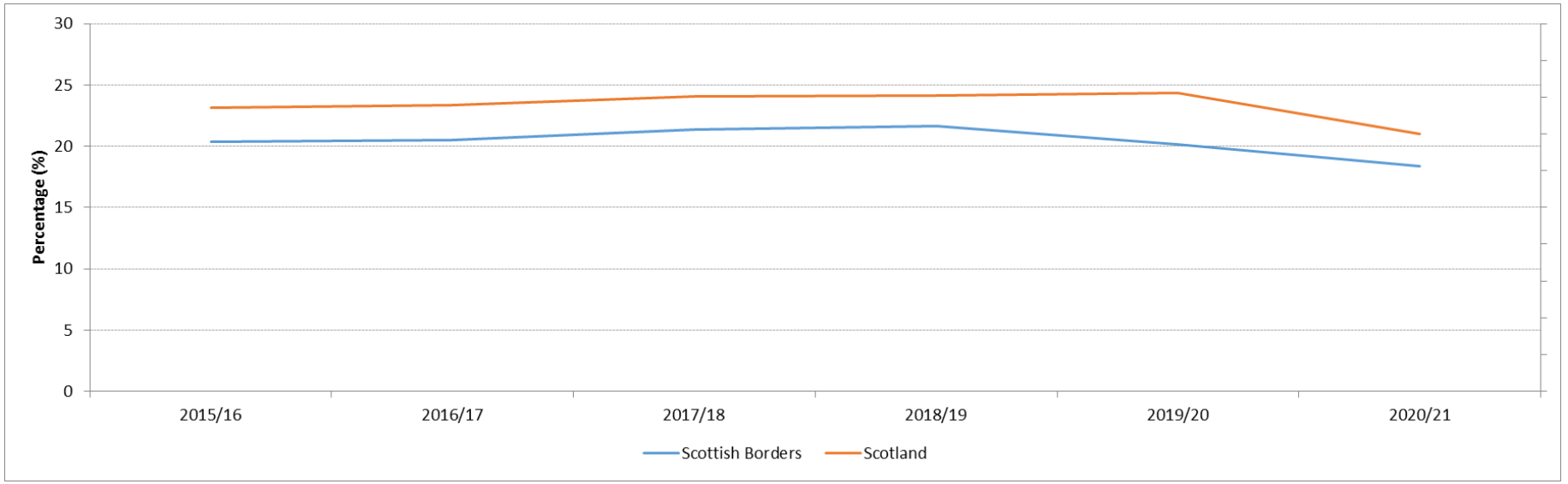
Notes:

1. Please note definitional changes were made to the recording of delayed discharge information from 1 July 2016 onwards. Delays for healthcare reasons and those in non hospital locations (e.g. care homes) are no longer recorded as delayed discharges. In this indicator, no adjustment has been made to account for the definitional changes during the year 2016/17. The changes affected reporting of figures in some areas more than others therefore comparisons before and after July 2016 may not be possible at partnership level. It is estimated that, at Scotland level, the definitional changes account for a reduction of around 4% of bed days across previous months up to June 2016, and a decrease of approximately 1% in the 2016/17 bed day rate for people aged 75+.
2. 2020 population estimates have been used to calculate rates from 2020 onwards. For data relating to years prior to this, population estimates for the corresponding year have been applied.

National Indicator 20 — Percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency

Cost of emergency bed days for adults (18+).

	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21
Scottish Borders	20.4%	20.5%	21.4%	21.7%	20.2%	18.3%
Scotland	23.2%	23.3%	24.1%	24.1%	24.3%	21.0%



Source: PHS - SMR01 (acute discharges from non-obstetric/non-psychiatric NHS hospitals in Scotland), including Geriatric Long Stay (GLS) discharges
SMR04 (mental health inpatient records from NHS hospitals in Scotland
Scottish Government Local Financial Return (LFR) 03

Notes:

1. The numerator includes emergency admissions to all hospital specialties (acute, geriatric long stay and mental health) occurring within the selected year.
2. Associated bed day costs are counted in the numerator if an emergency admission occurred in the first episode of the stay.
3. For health activity in the numerator, 2019/20 costs have been used as a proxy for costs in subsequent years with a 1% uplift to account for inflation. For health and social care activity in the denominator, 2018/19 costs have been used as a proxy for subsequent years with a 1% uplift to account for inflation (aside from 2019/20 where a 1.9% uplift has been applied to match the uplift used during the 2019/20 PLICS process - please see Notes tab for more detail).
4. Total expenditure includes all health and social care activity and is published in the IRF publication by financial year. Please see the publication link for more detailed information regarding this.
5. Cost information derived using the patient level costing (PLICS) methodology has been included in this indicator. Please see this link for more detail https://www.isdscotland.org/Health-Topics/Health-and-Social-Community-Care/Health-and-Social-Care-Integration/Analytical-Outputs/Method-Sources.asp.
6. Please note that 2018 unit costs for C3 specialty (Anaesthetics) in NHS Ayrshire and Arran were extremely high and impacting the numerator within the rates presented. 2017 costs have therefore been used for this specialty instead. The PHS Costs team has contacted the NHS Board for more details to clarify the issue for future updates.

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Scottish Borders Health & Social Care Integration Joint Board

Scottish Borders Health and Social Care PARTNERSHIP

Meeting Date: 15 June 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
INTEGRATION JOINT BOARD 2022/23 FINANCIAL PLAN	
Purpose of Report:	The purpose of this paper is to present the Joint Financial Plan for 2021/22 to the IJB for approval.
Recommendations:	The Health & Social Care Integration Joint Board is asked to: a) Approve the 2022/23 budget in line with resources agreed with the partners. b) Endorse the approach to development of an HSCP Recovery plan to address savings targets and the status of work towards this plan. c) Note the risks described in the paper.
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 2022/23 will be reported to the Integration Joint Board.
Carers:	*N/A*
Equalities:	The equalities impact of the contents of this report are not known at this stage. As the detailed outcomes of the settlements become apparent equalities impact assessments will be carried out.
Financial:	No resourcing implications beyond the financial resources identified within the report. The report draws on information provided in the finance reports presented to NHS Borders and Scottish Borders Council. Both partner organisations' Finance functions have contributed to its development.
Legal:	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:	To be 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.
Direction required:	No Direction required.

IJB FINANCIAL PLAN 2022/23

1 Introduction

1.1 The paper presents the IJB financial plan and budget settlement for 2022/23 for approval. The draft budget was presented at the IJBs meeting on 2nd March 2022. There are no changes to the final budget presented below.

1.2 The budget settlement outlines resources of £189.5m in relation to functions delegated to the Health & Social Care Partnership. Of this, £70.2m is in relation to Social Care functions and £119.3m is in relation to NHS functions. Further resources of £28.1m are *Set Aside* for Large Hospital functions. The overall settlement represents an increase of 7.7% over baseline recurring budgets.

1.3 The plan includes a requirement for savings of £7.1m required to deliver a balanced financial plan for the IJB. Savings plans remain in development and an outline timescale for development is included within the paper.

1.4 Delivering a balanced financial plan for 2022/23 requires a number of assumptions to be made in relation to the level of resource provided, notably in relation to public sector pay policy and inflationary pressures. In both cases the assumptions made are based on partner bodies planning assumptions and consistent with Scottish Government advice, however economic forces at a national and international continue to present challenge to these planning assumptions.

1.5 The risks relating to assumptions made within the plan are highlighted within the paper and the IJB must be clear that it accepts these risks in approving the budget allocations from both Partners.

1.6 Regular reporting will ensure the IJB is kept informed of any changes affecting the assumptions made.

2 Background

2.1 General Principles

2.1.1 The Scheme of Integration (SOI) for Scottish Borders Integrated Joint Board requires that the IJB agree its budget annually with Scottish Borders Council and NHS Borders in line with joint financial planning arrangements.

2.1.2 Resources available to the IJB are based on historic agreed budgets amended for items agreed through the financial plans of partner organisations, including share of local government financial settlement and the uplift to the NHS Board Revenue Resource Limit, as well as any further items directed as a result of national policy or otherwise agreed by partner bodies.

2.1.3 Savings targets are determined based on any shortfall against the level of resources available to the IJB and its agreed investments, including historic baseline expenditure.

2.1.4 The IJB is expected to deliver the outcomes identified within its strategic commissioning plan from within the totality of resources available. In some cases additional resources may be made available during the year to meet strategic priorities not included within the original plan. This includes allocation of additional resources by Scottish Government through partner bodies, where resources are directed at functions delegated to the IJB. Partners are expected to pass on these resources in full.

2.1.5 The IJB has the ability to hold ring-fenced reserves to retain planned underspends. Within Scottish Borders IJB there are significant accumulated reserves held on a ring fenced basis in relation to COVID recovery, Scottish government health portfolio commitments, and legacy balances retained from historic transformation funds. The COVID recovery reserve is held on a whole system basis (including non-delegated functions) in line with Scottish Government guidance. These reserves are discussed further in section 6 of the report.

2.1.6 Where there is a forecast overspend across the budgets set for delegated functions "the Chief Officer and the Chief Financial Officer of the Integration Joint Board must agree a recovery plan to balance the overspending budget" (Scottish Borders Scheme of Integration, Section 8.6).

2.1.7 The Scheme of Integration (SOI) makes provision for partner organisations to provide additional resources to the IJB where its recovery plan has been unsuccessful in a given year. Under the terms of the SOI amounts provided to meet this gap are repayable to the partners in future periods. This issue is discussed further in section 7, below.

2.2 Financial Planning Context

2.2.1 The Scottish Government (SG) announced its budget on the 9th December 2021, notifying Health Boards and Local Authorities of their resource allocations for 2022/23. The budget was approved by parliament on 10th February 2022.

2.2.2 The SG budget outlined resource commitments for a single year pending the medium term spending review in May 2022. The Integration Joint Board (IJB) budget is therefore presented on a one year basis in line with SG planning assumptions.

2.2.3 Both NHS Borders (NHSB) and Scottish Borders Council (SBC) have incorporated the impact of the 2022/23 resource allocations as notified by SG within their budget allocations to the IJB for the delegated functions.

2.2.4 Scottish Borders Council approved its budget at its meeting on 22nd February 2022.

2.2.5 NHS Borders approved its budget at its board meeting on 7th April 2022.

2.2.6 A draft budget was presented to the IJB at its meeting on 2nd March. Following approval of the budget by each partner this budget is now presented to the IJB for final approval.

2.2.7 There are no changes to the draft budget presented in March 2022.

2.2.8 The IJB will work with partners to develop its medium term financial plan aligned to the revised IJB strategic commissioning plan in line with Scottish Government and local authority planning timescales.

3 Delegated Resources 2022/23

3.1 Table 1, below, summarises the funding agreed with partner bodies for the functions delegated to the IJB for 2022/23.

Table 1 – Allocations to the IJB from partner bodies 2022-23

Proposed Resources	Council	Health		TOTAL
		IJB Delegated	Set Aside	
	£m	£m	£m	£m
Recurring Base Budgets	61.9	120.3	26.9	209.2
Recurring Savings Targets	(1.3)	(4.7)	(1.0)	(7.1)
Net Baseline	60.6	115.6	25.9	202.1
Additional Recurring Resources	9.6	3.7	1.4	14.6
Additional Non-Recurring Resources	0.0	0.0	0.8	0.8
Proposed Resource Allocations	**70.2**	**119.3**	**28.1**	**217.5**
Uplift	**15.8%**	**3.2%**	**8.4%**	**7.7%**

3.2 The 2021/22 budget approved by the IJB in March 2021 identified total resources of £194.4m. Since this time, the overall budget has increased as a result of additional in year allocations not included within the budget approved at March 2022. This has resulted in a revised (net) baseline of £202.1m.

3.3 The additional resources allocated to the delegated functions are above the level of uplift received by partner bodies and represent their commitment to funding the pressures and statutory commitments which will impact on the delegated functions in 2022/23. They include uplift to the Social Care Fund, the Transformation Fund and Resource Transfer.

3.4 Any further increase to allocations in relation to delegated functions which are received by partner bodies during 2022-23 will be passed on. This will include elements of the Programme for Government (PfG) resource to NHS Boards as described in Appendix 2 to this report.

4 Funding Requirement

4.1 The impact of known and expected costs and pressures has been modelled across the partner's services to identify the level of funding the IJB requires for 2022/23 to fully fund commissioned services.

a) Pay pressures have been calculated on the basis of SG pay policy guidelines for 2022/23 although it should be noted that pay negotiations continue.

b) Non pay inflation has been estimated in line with partner body and national guidance. Inflationary increases are modelled at 2.0% except where separately identified. This is in line with partner body and national planning guidance. The impact of macro-economic factors on general inflation will remain a risk to partner organisations and will be considered further via quarterly reviews.

c) Prescribing costs are assumed to be in line with estimates provided by NHSB.

d) Known increases relating to the Scottish Living Wage, the uprating of Free Personal and Nursing Care payments, and the ongoing implementation of the Carers Act have also been built into the funding required.

e) The impact of known and expected pressures relating to demographic increases in demand for services are also reflected as budget growth within the Council budget – specifically in relation to Older People and Learning Disability Social Care services.

4.2 The financial implications of additional costs and pressures included in the plan are summarised below in comparison to the resources NHSB and SBC have provided for 2022/23:

Table 2 – Scottish Borders IJB - Forecast Outturn 2022-23

Forecast Outturn	Council	Health		TOTAL
	£m	IJB Delegated £m	Set Aside £m	£m
Expenditure Commitments				
Baseline	61.9	120.3	26.9	209.2
Projected Increase	9.6	3.7	2.2	15.5
Total Expenditure Commitments	**71.5**	**124.0**	**29.1**	**224.6**
Resources Provided	**70.2**	**119.3**	**28.1**	**217.5**
Required Savings	*(1.3)*	*(4.7)*	*(1.0)*	*(7.1)*
Delivery of Financial Balance	1.3	4.7	1.0	7.1
Forecast (Over)/Under spend	**0.0**	**0.0**	**0.0**	**0.0**

4.3 Table 2 identifies the gap that exists between the anticipated expenditure commitments and the resources provided, which totals (£7.1m). Actions required to address this gap are discussed in section 5, below.

4.4 It should be noted that the savings target delegated by NHSB is based on accumulated non-delivery of prior year savings targets allocated to the IJB. The Health Board has deferred any consideration of increased savings targets to offset new investments pending development of its medium term (three year) financial plan in summer 2022.

4.5 A summary of the budget by service is provided in Appendix 1.

5 Delivering Savings

5.1 As identified in Table 2 there is a projected requirement for £7.1m of savings delivery during 2022/23. A detailed HSCP Recovery plan has been commissioned by the Chief Officer and timescales for preparation of this plan are outlined below:

Milestone(s)	Date
Confirm individual business unit targets for in year delivery	31st May
Draft Recovery plan	30th June
Phase I implementation (early implementers)	1st July+
Final Recovery Plan	31st July
Phase II implementation (full implementation)	30th September

5.2 Whilst the plan remains in development it is clear that focus will be required to establish increased grip & control on existing budgets, as well as implementation of service reviews of those areas where spend is out of alignment with benchmarked performance. The IJB will require support from partners to ensure that there is efficient contracting across goods & services, as well as to drive programmes such focussed on improvement and realistic medicine/prescribing.

5.3 The Strategic commissioning plan will give opportunity to align financial improvement with the IJBs overall strategic direction and it is expected that transformational change will provide a significant component of the financial recovery actions. This will take time and it is unlikely that significant savings will be achieved in 2022/23. To deliver this change the IJB will seek to establish a transformation fund to support transitional costs and project support across programmes of work.

5.4 The HSCP Recovery plan will also need to align to individual savings plans developed within partner organisations and much of what is achieved in 2022/23 will be reliant on the delivery of these workstreams.

5.5 ***Scottish Borders Council.*** Within Social Care services transformational change and resultant savings is being supported through the Council's Fit for 2024 programme. 2022/23 will continue to see significant focus on digital transformation in line with the Council's Digital Strategy.

5.6 ***NHS Borders.*** The Health Board is currently developing its transformation programme approach under the overarching NHS Borders Quality & Sustainability programme. Within this, financial savings are expected to be delivered through a combination of local improvement plan**s** and whole system workstreams. Further detail is awaited on how this will be delivered.

5.7 The key actions required to deliver financial balance will be managed operationally through the Health & Social Care Partnership (HSCP), with accountability for performance aligned to the partner bodies.

6 IJB Reserves

6.1.1 The IJB holds significant non-recurring reserves in relation to balances committed not spent on ring-fenced allocations.

6.1.2 The reserves balance as at 31st March 2022 will be finalised following completion of the IJB Annual Audit, however draft figures suggest that this balance will be c.£30m, of which the majority will be held in relation to NHS allocations.

6.1.3 A full review of the reserves balance will be undertaken in advance of Quarter One review with a view to identifying any flexibility available to the IJB to support its strategic commissioning plan, and to offset non-delivery of savings.

6.1.4 The Scottish Government has indicated that it is reviewing its portfolio commitments in light of current economic pressures. It is likely that slippage on prior year investments against some areas of SG priority will be expected to be utilised to address current year commitments before any additional funding is made available. An assessment of the risk against this position will be undertaken as part of the Q1 review.

6.1.5 COVID reserves are held by the IJB in relation to additional SG funds made available in February 2022 and with expectation that these funds will be ring-fenced to offset ongoing COVID expenditure. No further COVID funds are expected to be available to SG through UK government consequentials and therefore this is the only resource available to support COVID plans. Further advice is awaited from SG on how this funding can be utilised.

6.1.6 Given the significant financial challenges faced by the IJB and its partners, consideration will need to be given to how the IJB reserves may contribute to the overall financial balance of the IJB in 2022/23. This issue is discussed further in section 7, below.

7 Delivering Financial Balance

7.1 Should the HSCP recovery plan be unable to identify or deliver savings to the value required, the IJB will be unable to present a balanced financial position in 2022/23.

7.2 The IJB Chief Finance Officer will be expected to develop a financial strategy for how the IJB manages any gap on delivery in 2022/23 as quickly as possible following their commencement in post.

7.3 The conditions under which support from partner bodies may be available are described below. Any support may be conditional and it will be essential that the IJB explores all possible options to mitigate this gap before seeking support from partners.

7.4 A potential mitigation to address in year shortfall may include consideration of how the IJB can release funds held as ring-fenced by reviewing phasing of commitments, i.e. borrowing from its own reserve in current year with expectation that this will be paid back through release of savings in future periods. This strategy presents significant risk and deployment of this approach will need agreement of partner organisations and the IJB.

7.5 In line with the Scheme of Integration, the IJB can request additional contributions from partner bodies to offset any gap in proportion to their share of this gap. Partner bodies are required to provide this support, however the Scheme of Integration sets out the conditions under which this support is provided as follows:

> "The Integration Joint Board should make repayment in future years following the same methodology as the additional payment. If the shortfall is related to a recurring issue the Integration Joint Board should include the

issue in the Strategic Commissioning Plan and financial plan for the following year".

7.6 NHS Borders and Scottish Borders Council have not exercised this condition in relation to financial support issued in previous years. Total support to the IJB in 2021/22 is expected to be c.£4m (subject to final audit). No conditions have been advised by partners in relation to this support.

7.7 It should be noted that NHS Borders holds a commitment to repay £8.3m brokerage to Scottish Government in relation to support received in 2019/20. This figure includes support made available to the IJB. The IJB has not been advised of any expectations that it will contribute to the repayment of this brokerage.

8 Risk

8.1 There is a high degree of uncertainty within the current operating environment across Health & Social Care delegated functions, with significant volatility in relation to financial planning assumptions.

8.2 The impact of global events (e.g. Russia-Ukraine war) on macro-economic factors has introduced rapid inflationary pressures on fuel, utilities and general costs of living. Variation from planning assumptions will be closely monitored during 2022-23.

8.3 Public sector pay deals have not yet been finalised for key staff groups and any increase above estimates will result in cost pressure unless accompanied by additional allocation following the May 2022 spending review.

8.4 Financing of ongoing expenditure on the local COVID response plans is likely to reduce during 2022-23 and will require reduction in additional services on a phased basis in order to manage within available resources. New variants or other drivers for increased outbreaks may cause disruption to these plans.

8.5 The transition from pandemic to remobilisation of services is likely to be slow and there are significant challenges within the operating environment across Health & Social Care. These challenges will includes pressure on staff and providers which will limit the pace of change and have already manifest in disruption to services during the early part of 2022.

8.6 The financial plan which underpins the level of resources provided by NHSB to the IJB has not yet been approved by Scottish Government. This plan identifies an in year shortfall of £12.2m. There is a risk that the SG requires NHSB to take additional actions to reduce the projected deficit and that this in turn impacts on the level of resource available to delegated functions. It is likely that any support available to offset this deficit will be made available on a repayable basis (i.e. brokerage).

8.7 As in previous years, there is a risk that new pressures will emerge during the course of 2022-23. This will require identification of mitigating actions by the HSCP and partner bodies.

9 Recommendations

9.1 The Integrated Joint Board is requested to:-

9.1.1 **Approve** the 2022/23 budget in line with resources agreed with the partners.

9.1.2 **Endorse** the approach to development of an HSCP Recovery plan to address savings targets and the status of work towards this plan.

9.1.3 **Note** the risks described in the paper.

Author(s)

Andrew Bone	David Robertson
Director of Finance	Director of Finance/Chief Officer
NHS Borders	Scottish Borders Council

Appendices
Appendix 1 – Scottish Borders IJB Budget 2022/23
Appendix 2 – Key Messages from SG Budget Announcements

Appendix 1

IJB FINANCIAL PLAN

Summary	2022/23			
	HSCP Social Care £'000	**HSCP NHS £'000**	**Hospital Set Aside £'000**	**Total Budget £'000**
Joint Learning Disability Service	**18,146**	**3,599**	**0**	**21,745**
Joint Mental Health Service	**1,803**	**18,910**	**0**	**20,713**
Joint Alcohol & Drugs Service	**150**	**423**	**0**	**573**
Older People Services	**27,303**	**0**	**0**	**27,303**
SB Cares	**14,519**	**0**	**0**	**14,519**
Physical Disability Service	**2,491**	**0**	**0**	**2,491**
Prescribing	**0**	**23,132**	**0**	**23,132**
Generic Services				
Independent Contractors		31,708	0	31,708
Primary Care Improvement		1,053	0	1,053
Community Hospitals		6,254	0	6,254
Allied Health Professionals		7,507	0	7,507
District Nursing		4,102	0	4,102
NHS directed funds (social care)		12,960	0	12,960
Generic Other	7,106	14,375	0	21,481
	7,106	**77,958**	**0**	**85,064**
Large Hospital Functions				
Accident & Emergency			3,366	3,366
Medicine & Long-Term Conditions			18,012	18,012
Medicine of the Elderly			6,932	6,932
Winter Planning			800	800
			29,110	**29,110**
Targeted Savings	**(1,339)**	**(4,739)**	**(1,046)**	**(7,124)**
Total	**70,179**	**119,284**	**28,063**	**217,527**

Appendix 2

Key Messages from SG Budget Announcements

1 The Scottish Government published its draft budget on 9th December 2021 and approved this budget on 10th February 2022. A Resource Spending Review was published on 31st May 2022 which takes a medium term forward look over the lifetime of the parliament.

2 The key aspects of the SG budget announcements and their implications for NHSB and SBC are summarised below:

2.1 Health

2.1.1 NHS Health Boards will receive an uplift of 2.0% on baseline resources. This equates to £4.5m for NHS Borders.

2.1.2 Additional resources are made available to offset the impact of increased national insurance employer contributions in respect of the Health & Social Care Levy. Funding equates to £1.3m to NHS Borders (share of £70m nationally).

2.1.3 Adjustment of a further £2.7m to the Health Board's base budget to maintain parity within 0.8% of the NHS Scotland formula for population-weighted resource allocation (NRAC).

2.1.4 Increased investment in Programme for Government (PfG) priorities expected to flow on a population-share basis during 2022/23, including:

a) Primary Care investment (£262.5m nationally, £12.5m increase on previous year).
b) Mental Health & CAMHS (£246m nationally, £14.9m increase on previous year). This delivers the £120m Recovery & Renewal fund announced in 2021/22.

c) Drug Deaths policy (£61m nationally, no change to previous year).

d) Recurring impact of £300m 'winter' funds announced in 2021/22, including additional resources for HSCPs across both NHS and Social Care.

e) Commitment to provide additional resources to offset the financial impact of measures taken in response to the Covid-19 pandemic.

2.1.5 In line with previous years, NHS Boards are directed to provide a minimum level of uplift to IJBs in line with the Health Board's own uplift (2.0%); and to pass on this uplift in full to any funds directed to Social Care.

2.2 Local Authority

2.2.1 The Health and Social Care Portfolio will transfer a total of £554m to Local Government to support social care and integration, which recognises the recurring commitments on adult social care pay and on winter planning arrangements.

2.2.2 Within this total, £235.4 million is made available to support retention and improve pay terms & conditions. This includes increase to a £10.50 minimum pay settlement for adult social care workers in commissioned services, in line with the equivalent commitment being made in the public sector pay policy. Funding also includes provision for increases to FPNC and the Carers Act.

2.2.3 Funding is expected to be additional to each Council's recurring 2021-22 budget with the expectation that this delivers an increase of £554m above baseline budgets for Social Care in 2022-23.

2.2.4 Social Care fund of £7.888m (uplifted by 2.0% from 2021/22 funding) is once again transferred from NHS to the Council via the Integration Joint Board (IJB). This funding has previously been delegated on a permanent recurrent basis to the Council's Social Care function by the IJB.

2.3 **Update on Scottish Government *Resource Spending Review***

2.3.1 The Scottish Government published its Resource Spending Review (RSR) on 31st May 2022. This report outlines public sector spending plans to 2026 against key priorities in relation to child poverty, the climate emergency, recovery from COVID and growing a fairer economy.

2.3.2 The report emphasises the impact that global factors will have on the Scottish economy, including current inflationary pressures. Despite this, it emphasises an ongoing commitment to deliver on previously announced investment priorities, including the increase to overall resources in health and social care, including establishment of the National Care Service.

2.3.3 In order to finance these changes the report acknowledges that there will need to be public sector reform. Key messages within this domain include the need to deliver a minimum of 3% savings per annum across all public sector organisations, and to consider how shared service infrastructure can be used to best effect, including rationalisation of the public sector estate through increased joint working.

2.3.4 The report does not set out any specific changes to Public Sector pay policy however it identifies a strategic aim to manage total pay costs within the levels of spend incurred in 2022/23 "while returning the overall size of the public sector to broadly pre-COVID-19 levels". This is intended to provide flexibility to support pay increases within an overall balanced position.

2.3.5 The RSR is not a budget; it provides a framework for government spending and outlines the economic forces which will influence this programme. It is clear that there will be increased constraints on public spending as a result of the issues described in the report and that investment will be made within the context of enhanced drive to deliver efficiencies from within existing resources in order to finance this investment.

2.3.6 A fuller assessment of the impact of these issues on the IJBs ability to deliver against its financial plan will be prepared through the quarterly review process.

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-150622-4 Budget
Direction title	2022-23 Budgetary framework
Direction to	NHS Borders and Scottish Borders Council
IJB Approval date	TBC – Direction to be considered by Integration Joint Board on 15 June 2022
Does this Direction supersede, revise or revoke a previous Direction?	No
Services/functions covered by this Direction	All delegated and set aside services
Full text of the Direction	The Scottish Borders Health and Social Care Integration Joint Board commissions NHS Borders and the Scottish Borders Council to deliver services within the budgets and under the framework outlined in Item 5.7 of the 15 June 2022 Integration Joint Board. NHS Borders and the Scottish Borders Council are expected to work in partnership with Scottish Borders Health and Social Care Integration Joint Board Chief Financial Officer and Chief Officer to facilitate the development of an HSCP Recovery plan to address savings targets, and to share progress against the Recovery plan with the Integration Joint Board. In addition NHS Borders and the Scottish Borders Council are expected to work to develop an integrated transformation projects and a wider programme in line with the detail noted in the Delivery Plan outlined in the 2022/23 Annual Report (Item 5.6 of the 15 June 2022 Integration Joint Board), and the new developing Strategic Commissioning Plan. It is expected that all new transformation plans will be brought to the Integration Joint Board via its Strategic Planning Group to ensure that they are appropriately consulted upon and align to the aims of integration and outcomes that are being sought by the Integration Joint Board.
Timeframes	To commence with immediate effect
Links to relevant SBIJB report(s)	Items 5.6 and 5.7 of the 15 June 2022 Integration Joint Board
Budget / finances allocated to carry out the detail	As outlined in the item.
Outcomes / Performance Measures	It is expected that detailed information will be collected by NHS Borders and the Scottish Borders Council to evidence progress against budget and on savings plans. This will need to be reported to the Integration Joint Board Chief Financial Officer. It is expected that savings plans proactively take cognisance of any impacts on the National Health and Wellbeing outcomes, and that all plans are developed in line with the Integration Delivery Principles. It is expected that where possible, plans will work in line with the 'Triple Aim' (i.e. Improving Population Health, Improving Value for Money and Improving Service User Experience).
Date Direction will be reviewed	September 2023 Integration Joint Board Audit Committee, followed by further review at the Integration Joint Board Audit Committee in March 2024. There will be more regular review by the Integration Joint Board Chief Financial Officer.

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Scottish Borders Health & Social Care Integration Joint Board

Scottish Borders Health and Social Care PARTNERSHIP

Meeting Date: 15 June 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
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MONITORING AND FORECAST OF THE HEALTH AND SOCIAL CARE PARTNERSHIP BUDGET 2021/22 AT 31 MARCH 2022	
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 2021/22 based on available information to the 31 March 2022.
Recommendations:	The Health & Social Care Integration Joint Board is asked to: a) **Note** the actual performance of the Partnership was a combined favourable variance of £0.913m for the year to 31 March 2022; b) **Note** that all costs identified in relation to Covid-19 have been funded by the Scottish Government; c) **Note** that the position includes additional funding to offset non-achievement of savings made available by Scottish Government, as well as virement to the Health and Social Care Partnership by Scottish Borders Council to offset pressures within social care functions from efficiencies identified across non-delegated functions; **d) Note** that no additional contribution from partners is required to achieve a breakeven position as a result of additional Scottish Government support to meet the costs of COVID19, and to offset non-delivery of savings, made available during 2021/22.
Personnel:	There are no resourcing implications beyond the financial resources identified within the report.
Carers:	N/A
Equalities:	There are no equalities impacts arising from the report.
Financial:	Financial resources and their deployment are described within the body of 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.
Direction required:	No Direction required

Background

1.1 The report relates to the Month 12 actual outturn 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").

1.2 The outturn 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 variance from budget as at 31 March 2022.

Overview of Monitoring and Forecast Position at 31 March 2022

2.1 The paper sets out the consolidated financial performance for the period to end of March 2022 (month 12).

2.2 At the end of month 12, functions delegated to the partnership are reporting a favourable position of £0.913m and the large hospital budget retained and set-aside is reporting a breakeven position (£0m). This position includes additional support detailed below.

2.3 The health delegated functions within the partnership are reporting an adverse pressure of (£0.021m) which is fully offset by underspend against delegated functions within Social Care. Social Care functions are reporting an underspend of £0.934m. It should be noted that this position includes virement of additional budget by Scottish Borders Council made in prior periods to offset financial pressures incurred at that time.

Efficiency Savings

3.4 The IJB is reporting a shortfall of £6.565m on savings plans during 2022/23, however additional support has been made available by Scottish Government to offset the anticipated impact of COVID19 on delivery of savings. Total offset of £6.269m is described below, leaving a residual £0.296m shortfall.

	Targeted Savings per Financial Plan	Shortfall before Support	SG Support	Final Position Mar-22
	£m	£m	£m	£m
Healthcare Functions	(4.740)	(4.739)	4.623	(0.116)
Social Care Functions	(3.356)	(0.780)	0.780	0.000
Set-Aside Functions	(1.090)	(1.046)	0.866	(0.180)
	(9.186)	(6.565)	6.269	(0.296)

3.5 The residual shortfall arises due to slippage on in year savings projected to be delivered in 2021/22. This position relates exclusively to NHS functions, including Set Aside, and is offset by slippage on core budgets within these areas such that the overall reported performance is broadly breakeven.

3.5 Where savings plans have not been delivered recurrently in 2021/22 these will form the basis of expected savings for 2022/23 and beyond. This issue is discussed further by separate paper (Financial Plan 2022/23).

Year End Outturn

Healthcare functions

3.5 After support to non-delivery of savings, delegated healthcare functions are reporting an overall breakeven position (£0.021m overspent). This position includes a number of financial pressures reported in line with previous forecasts, including: high cost individual Learning Disabilities out of area placements; use of premium rate staffing to cover medical workforce gaps within Mental Health services. In addition, prescribing volumes and price indicators suggest an increased spend within primary care in the period January to March. AHP services are underspent after non-recurring support to offset pressure in Home First, and further slippage on dental services contributes to the overall position.

Social Care functions

3.7 At 31 March, Scottish Borders Council is reporting an improved position against forecast on Social Care functions, an underspend of £0.934m. This is mainly due to both Older People and Learning Disability experiencing higher than expected client income and lower client/care costs. A further benefit is realised in Mental Health due to reduced staff and care package costs. It should be noted that this position includes additional support to the partnership through virement from non-delegated functions to offset financial pressures identified in prior periods, together with the additional support to non-delivery of savings in 2021/22 provided by Scottish Government.

Large Hospital functions retained and set-aside

3.9 Accident and Emergency continues to experience significant pressures due to additional staffing to manage increased demand. This is offset by underspend in hospital prescribing with reduced activity against long term conditions and General Medicine. Vacancy gaps against a number of key medical staffing posts have provided further offset which mitigates the slippage in delivery of savings and

supports the achievement of an overall breakeven position, after additional SG support.

COVID-19

3.10 Additional expenditure of £4.386m was incurred across the partnership in relation to COVID-19 response. This included £0.540m within healthcare functions and £3.846m within Social care functions. This expenditure was fully funded in 2021/22 through additional Scottish Government funds. Additional support to hospital Set Aside functions was similarly funded as part of the wider NHS board COVID plan.

3.11 The IJB holds a reserve of c.£11m against unutilised COVID19 funds provided in 2021/22. Scottish Government have highlighted a significant shortfall in funds available to support COVID19 activities identified within financial plans for 2022/23 and IJBs are expected to work with local partners and Scottish Government to develop revised plans as part of a national programme of COVID cost improvement actions. This includes review of Vaccination plans and other directed services, including Test & Protect, and the expected wind-down of schemes to support social care provider sustainability and other support across hospital and community services. An update on this position will be developed as part of the IJBs quarter one forecast.

Annual Accounts 2021/22

3.10 The position reported above remains provisional pending audit of the IJBs Annual Report and Accounts for the period to 31st March 2022.

Appendices

Appendix 1 – Monthly Management Revenue Report at 31st March 2022

MONTHLY REVENUE MANAGEMENT REPORT

Scottish Borders Health and Social Care PARTNERSHIP

Summary	2021/22	At end of Month:	March

	Base Budget £'000	Actual to Date £'000	Revised Budget £'000	Projected Outturn £'000	Outturn Variance £'000
Joint Learning Disability Service	19,595	23,257	22,782	23,257	(475)
Joint Mental Health Service	19,211	22,201	21,976	22,201	(224)
Older People Service	9,880	9,477	9,997	9,477	520
SB Cares	16,924	15,768	15,655	15,768	(113)
Targeted Savings net of support	(4,740)	0	(116)	0	(116)
Physical Disability Service	2,734	2,573	2,558	2,573	(15)
Prescribing	23,132	23,552	23,132	23,552	(419)
Generic Services	67,468	89,639	91,394	89,639	1,756
Large Hospital Functions Set-Aside	24,211	27,451	27,451	27,451	0
Total	178,415	213,917	214,830	213,917	913

MONTHLY REVENUE MANAGEMENT REPORT

Delegated Budget Social Care Functions	2021/22	At end of Month:	March

	Base Budget £'000	Actual to Date £'000	Revised Budget £'000	Projected Outturn £'000	Outturn Variance £'000	Summary Financial Commentary
Joint Learning Disability Service	16,122	18,826	19,187	18,826	361	Learning Disability: Lower than anticipated net client care costs including higher than forecast client income (£41k) and reducing client expenditure (£237k). Lower than anticipated impact of Care provider Pay Uplift (1 December - £83k)
Joint Mental Health Service	2,196	2,060	2,174	2,060	114	
Older People Service	9,880	9,477	9,997	9,477	520	Mental Health: £59k staffing underspend in Local Area Co-Ordinators as well as general and Galashiels Resource Centre staffing teams. Lower than forecast client care package costs (£54k).
SB Cares	16,924	15,768	15,655	15,768	(113)	Older People:£290k higher than anticipated client residential care income. £81k lower than anticipated Social Care Provider Pay Uplift costs. £149k lower than anticipated care provision costs at Dovecot due to Housing Support not being provided by provider and lower than forecast TUPE and core care costs.
Physical Disability Service	2,734	2,573	2,558	2,573	(15)	
Generic Services	6,339	7,227	7,294	7,227	67	SB Cares: Higher than anticipated net operating costs relating to Garden View care home.
						Physical Disability: Higher than forecast locality based client care package costs.
						The year end position is £0.934m under budget. This is mainly due to both Older People and Learning Disability experiencing higher than expected client income and lower client/care costs. Mental Health is also under budget due to reduced staff and care package costs.
Total	54,195	55,931	56,865	55,931	934	

MONTHLY REVENUE MANAGEMENT REPORT

Delegated Budget Healthcare Functions	2021/22	At end of Month:	March

	Base Budget £'000	Actual to Date £'000	Revised Budget £'000	Projected Outturn £'000	Outturn Variance £'000	Summary Financial Commentary
Joint Learning Disability Service	3,473	4,431	3,595	4,431	(836)	Learning Disability: Pressure attributable to 2 additional complex hospital placements with discharge delayed and a small number of clients in private settings requiring enhanced care provision during the year due to deteriorating health conditions.
Joint Mental Health Service	16,616	19,220	18,882	19,220	(338)	Mental Health: Medical staffing budgets are £528k overspent, a small favourable movement from the position previously reported. 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. Nursing budgets are reporting overspends of £97k at M12. These costs include agency nurse support out with core budgets at a cost of £64k.
Joint Alcohol and Drugs Service	399	920	920	920	0	
Prescribing	23,132	23,552	23,132	23,552	(419)	Prescribing: A forecast adverse pressure in Primary Care Prescribing is also reported (£420k) due to an increased number of items and forms issued over the last quarter. Again, there has also been an increase in the average unit cost per item dispensed. Final prescribing information has yet to be received for M12 so accruals are currently based on local intelligence assumptions. Any deviation from assumptions will be accounted for in 2022/23.
Targeted savings	(4,740)	0	(4,739)	0	(4,739)	Targeted Efficiency Savings: Planned savings within NHS Borders that are forecast not to be delivered due to CV-19. SG support included within HB support line.
Allocated Non Recurring Savings Projects	0	0	0	0	0	
Health Board Support (including brokerage)	0	0	4,623	0	4,623	
Generic Services						
Independent Contractors	30,069	34,764	34,760	34,764	(4)	
Community Hospitals	5,770	5,856	5,940	5,856	84	
Allied Health Professionals	6,531	7,268	7,579	7,268	311	
District Nursing	3,701	4,162	4,324	4,162	162	
Generic Other	15,058	30,362	31,498	30,362	1,136	Generic Services: is also forecasting an underspend position across Community Hospitals (£84k), AHP services (£311k) 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. 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).
Total	100,009	130,535	130,514	130,535	(21)	

MONTHLY REVENUE MANAGEMENT REPORT

Large Hospital Functions Set-Aside	2021/22	At end of Month:	March

	Base Budget £'000	Actual to Date £'000	Revised Budget £'000	Projected Outturn £'000	Outturn Variance £'000	Summary Financial Commentary
Accident & Emergency	2,762	4,233	3,740	4,233	(493)	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 has been 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	18,008	18,149	18,008	141	
Medicine of the Elderly	6,352	6,076	6,608	6,076	532	General Medicine: Within Medicine and Long-Term conditions, the adverse position is entirely attributable to increased drugs spend.
Targeted Savings	(1,090)	0	(1,046)	0	(1,046)	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.
Allocated Non Recurring Savings Projects	0	0	0	0	0	
Health Board Support (including brokerage)	0	0	0	0	0	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.
Health Board - Set Aside resource limit	0	(866)	0	(866)	866	
Total	24,211	27,451	27,451	27,451	0	

Scottish Borders Health & Social Care Integration Joint Board

Scottish Borders Health and Social Care PARTNERSHIP

Meeting Date: 15 June 2022

Report By:	Chris Myers, Chief Officer Health & Social Care
Contact:	Jill Stacey (Chief Officer, Audit and Risk) Emily Elder (Corporate Risk Officer)
Telephone:	Jill Stacey – 01835 825036 Emily Elder -01835 824000 Ext: 5818
SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD STRATEGIC RISK REGISTER UPDATE	
Purpose of Report:	The purpose of this report is to provide Members of the Board with an update of the most recent review of the IJB Strategic Risk Register as it is important that the Board is kept informed of the IJB's key risks and the actions undertaken to manage these risks.
Recommendations:	The Health & Social Care Integration Joint Board is asked to: a) **Note** the progress made to reframe the IJB Strategic Risk Register to reflect the remit of the IJB; b) **Note** that the previous risks contained in the IJB Strategic Risk Register have been archived as they focus on partnership risks; c) **Note** that a further risk update will be provided in September and December 2022.
Personnel:	In line with the role and responsibilities, the IJB's Chief Officer carried out a review of the IJB Strategic Risk Register on 6th December 2021 and on 25th March 2022 and since then has been reframing the IJB Risk Register to better reflect the role and remit of the IJB, supported by SBC's Corporate Risk Officer.
Carers:	There are no direct carers' impacts arising from the report.
Equalities:	There are no equalities impacts arising from the report.
Financial:	There are no direct financial implications arising from the proposals in this report.
Legal:	Good governance will enable the IJB to pursue its vision effectively as well as underpinning that vision with mechanisms for the control and management of risk.
Risk Implications:	Risk Management arrangements will assist the IJB making informed business decisions and provide options to deal with potential problems in line with its agreed Risk Management Strategy within its governance arrangements.

Background

2.1 The IJB, as strategic commissioner of health and social care services, gives directions to NHS Borders and Scottish Borders Council for delivery of the services in line with the Strategic Plan. The Scheme of Integration sets out how the managerial arrangements across the integrated arrangements flow back to the IJB and the Chief Officer. These arrangements are further supported by the IJB's Local Code of Corporate Governance.

2.2 Compliance with the principles of good governance requires the IJB to adopt a coherent approach to the management of risks that it faces in the achievement of its strategic objectives. A new Risk Management Policy and refreshed Risk Management Strategy were approved by the IJB on 19 August 2020.

2.3 In accordance with the Risk Management Policy and Strategy, the IJB Chief Officer carries out a review of the IJB Strategic Risk Register on a quarterly basis.

2.4 While the Risk Management Policy and Strategy states that six monthly risk reviews should be presented to the Board in June and December each year, the disruption caused by Covid-19 during 2020 and ongoing into 2021 meant that the first formal report of 2021 was presented to the Board on 22nd September 2021, delayed from June 2021. In line with the agreed structure the second most recent report was presented on 15th December 2021, and is followed by this report on 15th June 2022.

Summary

3.1 It is important that the IJB has its own robust risk management arrangements in place because if objectives are defined without taking the risks into consideration, the chances are that direction will be lost should any of these risks materialise. The identification, evaluation, control and review of the IJB's strategic risks is a Management responsibility. However, knowledge of the strategic risks faced by the IJB and associated mitigations will enable the Board members to be more informed when making business decisions.

3.2 The previous IJB Chief Officer carried out a management review of the risk register in February, May and August 2021 and the new IJB Chief Officer carried out a review in December 2021 and most recently on 25th March 2022. At this most recent review the decision was taken to reframe the IJB Strategic Risk Register to better reflect the role, remit and strategic objectives of the IJB rather than focusing on risks which are essentially partnership considerations. Work has been underway since March 2022 to develop a new suite of risks which will support and underpin the objectives of integration while continuing to take into consideration the impacts of Covid-19 and, furthermore, give reference to key policy revisions that will ultimately have a positive bearing on governance, commissioning and service delivery arrangements. This work continues to be undertaken by the IJB's Chief Officer in line with his role and responsibilities, supported by SBC's Corporate Risk Officer and it should be noted that reframing the risk register with the inclusion of new risks takes significantly more time than it does to review existing risks.

3.3 Building on the last report to the IJB in December 2021 the potential impacts for the IJB and delegated services arising from the Scottish Government's consultation on the National Care Review continue to be a consideration when evaluating the IJB's

risk landscape. The same is true of the ongoing impacts of the Covid-19 pandemic and the UK's exit from the EU e.g. the increasing demand for H&SC services (partly attributed to a build-up of need during Covid-19 lockdowns and restrictions) and the decreasing workforce pool that can be utilised by partners to achieve the objectives of the IJB (partly, attributable to the UK's exit from the EU and the demand for staff in other sectors such as hospitality). Furthermore, the IJB Chief Officer continues to remain alert to risks being faced by Scotland's other IJBs to ensue awareness of the types of risks that may threaten the objectives of the SBIJB.

3.4 The Risk Management Policy Statement states that: "The IJB will continue to systematically identify, analyse, evaluate, control and monitor those risks that potentially endanger or have a detrimental effect upon its people, property, reputation and financial stability…" Part of this systematic and continuous process involves revisiting the Strategic Risk Register at regular intervals to assess its continued relevance and where appropriate make changes to ensure that it remains reflective of the IJB's aims and objectives and captures and manages those risks that threaten their achievement. In the same vein this continuous process requires that risks which are no longer relevant should be retired but retained to ensure that an effective audit trail is maintained.

3.5 A summary of the progress made to reframe the IJB's Strategic Risk Register (which sets out the strategic risks associated with the achievement of objectives and priorities within the IJB's Strategic Plan) is presented below in addition to those risks which are to be archived as they have a stronger focus on partner considerations rather than the role and remit of the IJB as a separate entity. Although nearing its final stages, work to reframe the Strategic Risk Register is still in progress and as such it is intended that a second report is presented to the IJB at its meeting on 21 September 2022 at which point a more detailed summary of those risks will be provided.

3.6 Seven new risks have been identified and where relevant have carried forward aspects of the original ten risks in the form of risk factors, consequences, internal controls and mitigating actions.

3.7 The previous suite of ten IJB Strategic Risks, identified in 2018, which have been archived are as follows:

Risk Title	Risk Description	Risk Score
Cultural Change	If the required change in culture is not achieved then the delivery of the Partnership's strategic objectives may be delayed or may not be fully met.	4 Major – Remote 
Resources	If we do not ensure that an effective Commissioning Plan is agreed, and the required resource are directed by the IJB and allocated by NHSB and SBC then we may not secure the expected outcomes or achieve best value.	12 Moderate – Likely 
Future Market for Care	If the future market for care is insufficient to meet increasing demand then there may be gaps in service provision and poor outcomes/choices	16 Major – Likely 
Stakeholder Engagement	If we do not ensure that we have a partnership approach when communicating and engaging with stakeholders then we may fail to get them to play	12 Moderate – Likely 

	their part in delivering the partnership's strategic objectives.	
Delegated Budget	If both Partners do not sufficiently and rigorously plan and manage their Efficiency and Savings Programmes then the delegated budget may continue to overspend leading to inability to commission sufficient services to deliver the strategic objectives.	16 Major – Likely
Workforce	If we do not have a workforce fit for purpose now and in the future then the Partnership may fail to deliver on the strategic objectives leading to poor outcomes.	16 Major – Likely
Supplier Failure	If a significant supplier was unexpectedly unable to fulfil their contract then there may be a serious gap in service provision leading to risk of harm and reputational damage.	20 Catastrophic – Likely
Harm to Service Users	If someone under the care of the IJB comes to harm because of a failure attributed to the Partners then this may result is significant reputational damage.	8 Major - Unlikely
Programmes/Projects Management	If we fail to manage and appropriately resource major programmes/projects undertaken simultaneously then we may be unable to achieve objectives	9 Moderate – Possible
Data Breach	If the Partners lose sensitive data or use data inappropriately then we may be in breach of data protection legislation resulting in fines and reputational damage.	4 Minor – Unlikely

3.8 A reframed suite of IJB Strategic Risks have been identified along with the risk causes/factors, consequences, internal controls and mitigating actions. As risk management is an iterative process these will continue to be developed, managed, monitored and presented to the IJB in line with agreed reporting arrangements, the risks are as follows:

Risk Title	Risk Description	Risk Score
Strategic Objectives	Failure to deliver the SBIJB strategic objectives could lead to the inability of the IJB to deliver the intended health and wellbeing outcomes and achieve the core aims of integration for the Scottish Borders population.	9 Moderate – Possible
Budget	If we fail to ensure the effective delivery of outcomes/delegated services within the available budgets then it could lead to poorer outcomes and an inability to deliver the Strategic Commissioning Plan.	20 Major – Almost Certain
Issuing of Directions	If the Directions issued by the IJB are unclear or are not implemented by partners then it may adversely impact on outcomes, resources and on the principles of integration.	12 Major – Possible
Operating as a Separate Entity	If the IJB does not operate effectively as a separate entity then it could result in a failure to deliver the principles of integration and achieve its objectives.	16 Major – Likely

Infrastructure	If the IJB lacks the professional, administrative and technical infrastructure to operate effectively it could result in failures of planning, governance, scrutiny and performance arrangements.	16 Major – Likely 
Resources	If the IJB fails to make best use of the expertise, experience and creativity of its communities then it could result in negative impacts to the delivery of its strategic outcomes and poor relationships with its communities.	12 Major – Possible 
Legislative/Regulatory Compliance	If the IJB fails to comply with legislative and regulatory requirements it could lead to legal breaches and result in fines and/or prosecution.	10 Catastrophic – Unlikely 

3.9 This report and the IJB Strategic Risk Register are intended to provide the Board with assurance that the strategic risks associated with the achievement of objectives and priorities within the IJB's Strategic Plan are being effectively identified, managed and monitored.

3.10 Reliance is placed on the risk management arrangements within the partner organisations in respect of the operational delivery of commissioned services. As stated in the IJB Risk Management Strategy, any of these risks that significantly impact on the delivery of the IJB Strategic Plan will be escalated to the Chief Officer for consideration.

3.11 The IJB Strategic Risk Register will continue to be reviewed alongside the implementation of the Strategic Plan by the IJB's Chief Officer on a quarterly basis with support from SBC's Corporate Risk Officer. A further update will be presented to the Board in September 2022 along with a summary of the reframed IJB Strategic Risk Register and then in December 2022 (reflecting the six monthly reporting arrangements as detailed in the IJB's Risk Management Policy and Strategy).

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Scottish Borders Health & Social Care Integration Joint Board

Scottish Borders Health and Social Care PARTNERSHIP

Meeting Date: 15 June 2022

Report By:	Cathy Wilson, General Manager, Primary and Community Services
Contact:	Cathy Wilson, General Manager, Primary and Community Services Dr. Kevin Buchan, Chair of GP Sub Committee Paul Mcmenamin, Deputy Director of Finance Dr. Tim Young, Associate Medical Director, Primary Care and Community Services
Telephone:	01896 826 455

PRIMARY CARE IMPROVEMENT PLAN UPDATE

Purpose of Report:	The purpose of this report is to provide an update to the Scottish Borders IJB on progress with the implementation of the Primary Care Improvement Plan, along with a note on the risks relating to the delivery of the programme.
Recommendations:	The Scottish Borders IJB is asked to **note** the report, the risks, and actions being undertaken to reduce these risks.
Personnel:	Circa 70 WTE new posts will be established across a number of clinical and support services. Each workstream is established at a level which enables provision for a 50 week service throughout the year through sufficient additional resource to cover annual leave and sickness absence.
Carers:	Possible impacts on carers will be considered when the Healthcare Inequalities Impact Assessment will be undertaken.
Equalities:	A Healthcare Inequalities Impact Assessment for the whole PCIP programme has been undertaken. For new workstreams, service specific Healthcare Inequalities Impact Assessments will be undertaken to ensure that the services appropriately ensure that the new services are not discriminating in their approach, that they widen access to opportunities, and promote the interests of people with protected characteristics.
Financial:	For 2022/23, no allocation in respect of Primary Care Improvement Fund has yet been made to the Scottish Borders Partnership. Whilst it is hoped that an increased allocation will be made across all partnerships in order to meet the additional funding requirements national delivery of PCIP now requires, it has been assumed for now that the 21/22 ring fenced resource allocation level of £3.2m will continue as a minimum. Now that the PCIP workstreams become more fully operational,

	there is financial risk to the Partnership and its PCIP as a result of currently insufficient recurrent funding allocation against forecast expenditure of delivery all of the mandatory workstreams of the PCIP this financial year. Should these workstreams not be delivered, NHS Borders will be required to compensate GPs to deliver activity that will no longer be contractually obliged, at rates yet to be negotiated by the BMA and Scottish Government. Scottish Government issued an updated Memorandum of Understanding (MOU 2) to Health Boards in July 2021. The revised MoU for the period 2021-2023 recognises what has been achieved but also reflects on the fact that there is still a way to go to fully deliver the GP Contract Offer commitments as originally intended by April 2021. This revised MoU 2 acknowledges both the early lessons learned as well as the impact of the Covid-19 Pandemic and that the delivery of the GP Contract offer requires to be considered in the context of Scottish Government remobilisation and change plans. The MoU 2 officially runs until March 2023. In November 2021, the Scottish Government recognised that partial implementation of the Pharmacotherapy and Community Treatment and Care (CTAC) service, on a national level would require additional support for general practices. As such, it was agreed to allocate a sustainability payment to all practices covering 2021-22 and 2022-23.
Legal:	The delivery of PCIP is part of the national GP Contract (2018) through a Memorandum of Understanding between BMA and Scottish Government (Health and Integrated Authorities)
Risk Implications:	• Financial risk • Availability of accommodation for staff • IT infrastructure • Recruitment issues

Page 326

Primary and Community Services
Cathy Wilson, General Manager

SCOTTISH BORDERS INTEGRATED JOINT BOARD

PRIMARY CARE IMPROVEMENT PLAN OPERATIONAL AND FINANCE UPDATE

1. Executive Summary

The Scottish Borders IJB is asked to note the report, the risks, and actions being undertaken to reduce these risks.

The purpose of this report is to provide an update to the Scottish Borders IJB on progress with the implementation of the Primary Care Improvement Plan, along with a note on the risks relating to the delivery of the programme.

2. Background

2.1. GMS Contract

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

The nationally agreed General Medical Services contract 2018, and the Memorandum of Understanding, set out the need to refocus the role of the GPs as expert medical generalists. This role builds on the core strengths and values of General Practice – expertise in holistic, person-centred care – and involves a focus on undifferentiated presentation, complex care, and whole system quality improvement and leadership.

The aim of the GMS Contract (2018) is to enable GPs to do their job to the top of their license and enable patients to have better care. This refocusing of the GP role requires some tasks currently carried out by GPs to be carried out by members of an enhanced Primary Care Multi-Disciplinary Team, where it is safe, appropriate, and improves patient care.

The key priorities developed in order to develop the broader Primary Care Multi-Disciplinary Team, are managed through individual workstreams under the Primary Care Improvement Plan Executive Committee. The following workstreams were agreed to transfer from General Practitioners to the developing Health and Social Care Partnership Primary Care Multi-Disciplinary Teams as part of the National Memorandum of Understanding:

- Pharmacotherapy Services
- Urgent Care Services
- Community Treatment and Care Services
- Vaccination Services
- Additional Professional Roles:
    - Community Link Workers
    - First Contact Practitioner Physiotherapists
    - Community Mental Health Services

2.2. Joint letter SG/SGPC letter of December 2020

In December 2020, the Cabinet Secretary for Health and Wellbeing and the Chair of the BMA Scotland circulated a letter to Health and Social Care Partnerships and NHS Boards, noting an updated position in relation to the timescales for the implementation of the transfer of the priority

services from GPs to enhanced Primary Care Multi-Disciplinary Teams. In addition, this noted the contractual footing of the non-delivery of these workstreams.

Whilst the implementation order changed, the Cabinet Secretary and Chair of BMA Scotland were clear that NHS Boards and Health and Social Care Partnerships, and the public at large, to ensure the changes proposed here are done in ways that remain true to the Contract Offer commitments. We understand that this means that funding cannot be vired out of services that have been developed in line with the contract offer in 2018, even if they are not reflected in the updated deadlines on contractual delivery.

2.3. Revised Memorandum of Understanding of July 2021

The Scottish Government then issued an updated Memorandum of Understanding (2) (MoU) to Health Boards in July 2021. The revised MoU for the period 2021-2023 recognises what has been achieved but also reflects on the fact that there is still a way to go to fully deliver the GP Contract Offer commitments as originally intended by April 2021. This revised MoU acknowledges both the early lessons learned as well as the impact of the Covid-19 Pandemic and that the delivery of the GP Contract offer requires to be considered in the context of Scottish Government remobilisation and change plans. The MoU runs until March 2023.

All six MoU areas remain priority in scope as commitments for the MoU signatories. Following the joint SG/SGPC letter of December 2020, the parties acknowledged that the focus for 2021-22 should be reprioritised to the following three services with revised timescales:

- Vaccination Transformation Programme (VTP) – October 2021-April 2022
- Pharmacotherapy (Level One) – April 2022
- Community Treatment and Care Services (CTAC) – 2022-23

2.3. Community Treatment & Care Services and Pharmacotherapy – GP Sustainability Payment letter of November 2021

In November 2021, the Scottish Government recognised that partial implementation of the PCIP's Community Treatment and Care (CTAC) and Pharmacotherapy services was creating difficulties for GPs. This problem was highlighted nationally across several Health Boards. As a result, SG provided sustainability funding to make up for the delay in delivering these PCIP services.

Along with the sustainability funding, SG also extended both CTAC and Pharmacotherapy workstream delivery. Both workstreams are currently in its planning stage and will be delivered by the end of March 2023.

3. Updated deadlines for implementation of workstreams

This is summarised in the new chronological order associated to the updated deadlines for implementation in the table below:

Workstream	Implementation deadline (local delivery RAG)	Contractual implication of non-delivery	Local commentary
Vaccination Services: Childhood and travel	1 October 2021 (Green)	Historic income from vaccinations will transfer to the Global Sum 2022-23 including that from the five vaccination Directed Enhanced Services Should Practices continue to	VTP complete as of 1st April 2022. Insufficient recurring funding for future planning.
Vaccination Services: All other	April 2022 (Green)		

		provide vaccinations, a new Transitionary Service will apply (to be negotiated by SGPC and the Scottish Government), and payments will be made to practices providing these services from 2022-23	
Pharmacotherapy Services: Level One	April 2023 (Amber)	Transitionary Service for practices without a Level One Pharmacotherapy service	New service plan agreed by PCIP Exec on 5th May. Additional project support needed to support successful delivery
Community Treatment and Care Services	2022-23 (Amber)	Transitionary Service for practices without access to the Community Treatment and Care Service	Amber for delivery and recurrent financial risk. Non-recurrent funding available for 2022/23, but insufficient recurrent funding once implemented.
Urgent Care Services	2023-24 (Green)	Legislation will be amended so that Boards are responsible for providing an Urgent Care service to practices for 2023-24	ANP recruitment challenges, but green overall for delivery and service is funded
Additional Professional Roles: • Community Link Workers • First Contact Practitioner Physiotherapists • Community Mental Health Services	2021-2022 (Green)		Services are in place and are funded

3.1. Operational progress

3.1.1. Vaccination

The Vaccination Transformation Programme can be divided into 6 different work streams:

1. pre-school programme
2. school based programme
3. travel vaccinations and travel health advice
4. influenza programme
5. at risk and age group programmes (shingles, pneumococcal, hepatitis B)
6. COVID-19 programme

The Vaccination Transformation Programme was successfully complete within the contractual timescale (1st April 2022). The service was delivered in parallel with the COVID-19 booster programme, and with an expanded influenza vaccination programme.

178,000 vaccinations have been given by NHS Borders' Vaccination Service since VTP transition started in October 2021.

There remain a number of uncertainties in the final budget in terms of recurring costing for the final vaccination programme, therefore there will likely be a need will need to revisit VTP's expenditure estimates as we obtain more clarity on recurring funding from the Scottish Government.

3.1.2. Pharmacotherapy

A vote of no confidence letter was sent on 30th January 2022 from GP Sub to the Medical Director of NHS Borders regarding the Pharmacotherapy Programme. The letter outlined concerns around delivery of the 2018 GMS GP Contract stipulated Level 1, 2 and 3 pharmacotherapy tasks to a level where it would make a significant difference to reducing GP workload.

A reply from the Board was received on 11th February 2022. One of the actions from the reply was to survey all GP practices to establish what their priorities are within the outlined level 1-3 work. A thorough engagement and consultation survey exercise was sent to all practices. All 23 practices replied by the end of March 2022 and information was collated and analysed.

The message was clear; GP Practices prioritised level 1 work being completed by the General Practice Clinical Pharmacy team (GPCP).

An SBAR around this was presented at PCIP Exec Meeting on 5th May 2022 and the focus on delivery of a Level 1 service was formally agreed in a clearly outlined plan

Work is currently underway in reallocating GPCP staff sessions fairly (linked to list size) across all 23 practices. Regular communication with General Practice staff is place in recognition that the updated plan falls short of removing the bulk of pharmacotherapy workload away from GPs. There is acknowledgment nationally that the GMC contract is underfunded.

As mentioned earlier, the delivery deadline has been extended to April 2023. There is significant work associated to the development of the service, and as a result additional project support is currently being sought to support this workstream in meeting its target.

3.1.3. Community Treatment and Care Services

Responsibility for the delivery of CTAC services will transfer from GP Practices to the Health Board by 31st March 2023 in order to release GP capacity, reduce GP risks associated with delivering CTAC services (such as the employment of the required clinical workforce) and enable a more resilient service to be provided across the Scottish Borders.

The Health Board aims to deliver a robust, efficient and sustainable CTAC service which will enable people to live safely and confidently in their own homes and communities, supporting them and their families and carers to effectively manage their own conditions whenever possible. A project plan

NHS Borders currently operate 10 Treatment Rooms in a number of different Health Centres and Community hospitals. All services currently provided in these Treatment Rooms will move to being provided within CTACs with the current Health Board funding and staffing continuing, and additional CTAC services being offered as part of the PCIP work stream.

Services to be provided by the Health Board in CTACs by 31st March 2023:

- Catheterisation
- Ear care
- Medication administration
- Minor Injuries
- Monitoring of chronic conditions (ECG/BP/Blood tests/Height/Weight etc)
- Phlebotomy
- Wound management
- Continence (where unable to be seen by Bladder and Bowel Service)

NHS Borders organisational change process is continuing with new profiles of CTAC services developed in preparation for staff engagement sessions. Progress with this element of the project is dependent on approval to use proposed workforce plan.

TUPE has been confirmed as the correct legal framework for managing any transfer of staff from GP practice to NHS Borders employment.

Agreement to utilise proposed workforce model to allow for progression with internal organisation change process, recruitment and TUPE of practice staff is needed. However, due to a lack or recurring expenditure, it is not clear that the workforce model can be progressed. There is significant work associated to the development of the service, and as a result a Project infrastructure is being recruited to with non-recurrent funding to support this.

3.1.4. Urgent Care Services

The Advanced Nurse Practitioner (ANP) role is a unique integration of nursing and medical knowledge which has facilitated new ways of working and fostered greater collaborative working. ANP's deliver multi-professional models of service delivery and work in parallel with medical staffing to generate sustainable solutions to workforce planning challenges. ANPs support the PCIP's urgent care pathway to provide a service to GP practices for on the day presentations, including home visits, therefore, releasing the GP to take on a more holistic view of patient care.

The role of the ANP is to assess, diagnose, treat and formulate management plans including onward referral to acute care. They are autonomous practitioners and manage the comprehensive clinical care of their patients. Non-medical prescribing is an integral component of this which aims to: improve quality without compromising safety, allow easier and quicker access to medications for patients, increase patient choice in accessing medication and contributes to more flexible team working across the health service by making better use of the skills of health professionals.

ANPs are a sustainable solution to help meet the changing demands on the health service.

Workforce summary:

- Lead Clinical Nurse Manager is in post since April 2022.
- 10 trainee ANPs are currently in post with one fully qualified ANP.
- Three of the trainees will qualify in Dec 2022.
- Recruitment for four additional ANPs is in progress – aiming to recruit qualified if possible.
- Seven are registered non-medical prescribers and the remaining five will qualify in Aug 2022.

As the ANP model develops, the key areas of evaluation are that services remain safe, person centred, efficient and effective. The baseline data to be gathered and analysed:

- Activity analysis-case load and case type, prescribing activity;

- Adverse events;
- Stability of service;
- Patient satisfaction; and
- Performance against national targets/outcomes quality assurance.

3.1.5. Additional Professional Roles

The Additional Professional Roles comprise Community Link Workers, First Contact Physiotherapy and Community Mental Health Services (Renew). All three services are currently operational.

Community Link Workers

The Community Link Worker (CLW) programme has been operational & available to all practices in the Borders since March 2020. Whilst far from ideal given the impact of the pandemic to be launching a new service, the CLW service continued to operate and be open to new referrals throughout the Coronavirus pandemic the navigating the associated restrictions on the service & communities.

The programme is delivered by the Mental Health Local Area Co-ordination Team. The Local Area Co-ordination Team (LAC) provide a service to adults who are isolated in their community due to the impact of learning disability, mental ill-health, physical disability or older age; and provide support to encourage and enable individuals to live an active, more connected and purposeful life in their community.

The team comprises Local Area Co-ordinators (LAC) and Community Link Workers (CLW) covering the entire Borders area, in locality teams. The team provide flexible individualised support to clients to enable them to build the skills & confidence to engage/re-engage in the local community. This includes the provision of direct support for a period of time with an agreed plan for the gradual withdrawal of this support to the point where the individual can continue independent of LAC team support. This is fundamental to the LAC model and crucial in ensuring client progression through the service.

There is a single referral route for the LAC service, referral form asks for main area affecting on individuals' quality of life. This is not about categorising individual by condition/area, collaborative working is embedded across team. Particularly many referrals for older adults and adults with a physical disability are passed to CLW programme as the main area is to address low mood.

First Contact Physiotherapy

First Contact Physiotherapy (FCP) service was implemented in the Borders in 2019 with 2.2 WTE Physiotherapists and has since grown to a full complement of staff of 9.2 WTE from February 2022.

The team is well integrated in all 23 of the GP practices within the Borders. The FCP work-stream is currently changing the delivery model from a silo working system to a hybrid central diary system to answer to the MOU key priorities.

The team has been working continuously on developing various pathways across the Multi-Disciplinary Team for better patient care, early access and "right time-right care-right practitioner". FCP pathways currently established is linked with:

- MSK teams;
- Orthopaedics;
- Community link workers incl. Mental Health;
- OT/Speech and Language therapist;

- Podiatry; and
- Third party vendors e.g. Live Borders.

Community Mental Health Services (Renew)

Community Mental Health Services (affectionately and branded known as 'Renew') aims to work with individuals and families in assessing their mental health needs - providing evidence based treatment to low mood, anxiety and mild depression.

This service has been another PCIP success with GPs regularly reporting on an increase in confidence in trusting their patients under Renew's care and in turn considerably reducing their GP workload.

3.2. Finance

3.2.1 Recurrent funding

The Integration Authority received its annual PCIP funding letter for 2021/22 from the Scottish Government on 29 June 2021. This letter outlined an earmarked-recurring allocation to the Scottish Borders of £3.296m for 2021/22. The annual funding letter for 2022/23 has yet to be received and it can be assumed that in line with last year's timescales it will be around a month from now before any confirmation is received.

There is significant forecast financial pressure on the PCIP should there be no increase in PCIF allocation for 2022/23. This is detailed further below and is in line with the position across other partnerships nationally.

A summary of 2022/23 funding, investment and forecast expenditure position on the Partnership's PCIP is detailed below:

Workstream	PCIP 3-Year Recurring Investment £'000	Actual Expenditure to 01 April 2022 £'000	Forecast Expenditure to 31 March 2023 £'000	Surplus / Slippage / (Deficit) at 31 March 2023 £'000
VTP	16	0	16	0
Pharmacotherapy	879	75	888	(9)
CTAC	121	0	121	0
Urgent Care	883	59	792	91
FCP	528	46	545	(17)
Mental Health	669	52	618	52
Community Link Workers	150	13	150	0
Central Costs	49	0	40	9
Total Expenditure	**3,296**	**245**	**3,170**	**126**
Funded by:				
2.13% of £155m	(3,296)			
Drawn Down Share			(3,170)	(126)
Total Funding Requirement	**(3,296)**		**(3,170)**	**(126)**

The table above provides an update to the financial plan for 2022/23 as to how the total PCIF funding allocation is being used to deliver the requirements of the MoU contained in the new GMS Contract (2018).

The PCIP workstreams are underpinned by a full year recurring investment plan of £3.296m to support delivery of the PCIP three year plan. Funding of £3.296m has yet to be confirmed by the Scottish Government via the Annual Funding Letter and it is hoped that the level of funding will substantially increase from the £3.296m assumed in order that the full recurring cost of both Vaccine Transformation and Community Treatment and Care can be fully funded (see 3.7 below).

PCIP Executive has fully allocated the assumed 2022/23 Scottish Government earmarked recurring PCIP allocation of £3.296m.

Actual Expenditure at 30 April 2022 is £0.245m. Forecast expenditure to 31 March, excluding the full recurring (and currently unaffordable cost of VTP and CTACs) is £3.170m. Forecast drawdown of funding allocation required to meet this at outturn therefore is also £3.170m. Against the total assumed 2022/23 earmarked recurring PCIF funding allocation which has now been fully directed by the PCIP Executive therefore, total forecast slippage on the PCIP is £0.126m.at the end of M01. This may change as the funding level position becomes clearer going forward.

PCIP Executive has directed £0.121m of earmarked recurring resource to Community Treatment and Care Services (CTCS) and £0.016m to Vaccine Transformation Programme (VTP). In addition, further non-PCIF funding has been made available on a non-recurrent basis from within the vaccination programme and winter plan budget to support these workstreams. To date however, minimal expenditure has been incurred in relation to only CTCS in 2021/22 in respect of the Project Manager, a post which since the start of the financial year has remained vacant and work continues in order to better inform both workstreams' scope, component elements, workforce model and in turn, likely resource requirements.

This will inform the further planning, direction and management of these workstreams going forward, together with their likely resource requirements which will continue to be reported to the Scottish Government. Given that PCIP Executive has fully allocated all 2022/23 assumed funding with only £0.137m combined allocated to VTP and CTCS, there is financial risk associated to insufficient recurrent funding for NHS Borders to either deliver all of the mandatory workstreams of the PCIP and / or a significant affordability gap as a direct result. Whilst delivery models for both VTP and CTAC workstreams are currently being further developed, indicative indications are that on a permanently recurring basis minimum investment of around £0.736m and £1.724m is required respectively for these workstreams, although the full delivery models for each of these functions are currently being re-scoped.

Should there be no increase to PCIF allocation in 2022/23 or in the financial years thereafter, taking account of pay inflation and incremental drift across other PCIP workstreams also, it is forecast therefore that overall there will be a recurring funding gap of £2.511m therefore.

3.2.2. Non-recurrent funding

As previously reported, Scottish Government Health Directorate Finance wrote to all NHS Boards in February 2021 to notify them of an allocation of funding being made to Intergration Authorities in respect of outstanding balances on the Primary Care Improvement Fund. The allocation respresents unused funding accumulated over the three years of the MoU 2018 to 2021. For NHS Borders this additional allocation was £1.097m which is non-recurring. This has been supplemented by slippage on the recurring allocation in both 2020/21 and 2021/22 which may also

be used on a non-recurring basis to further deliver the PCIP. At 01 April 2022 therefore, the total combined non-recurring resources remaining available for direction is £1.184m.

As a result of its non recurring nature, this supplementary allocation therefore cannot be used to fund permanent staff or any other recurring expenditure. The funding is ringfenced to support enabling works to deliver PCIP priorites in full and as such cannot be used by health boards to offset slippage on the delivery of Financial Plan savings or meet pressures on expenditure across any other non-PCIP services or workstreams.

The confirmed PCIP carry forward included within the Health and Social Care Partnership Earmarked Reserve at 31 March 2022 as reported totals £1.523m which is expected to be carried forward to 2022/23 via the Earmarked IJB General Reserve.

Expenditure against the non-recurring supplementary PCIP allocation is accounted for separately from that recurring funding relating to workstreams funded by the main annual allocation and reported to the PCIP Executive Group, Scottish Government and Health and Social Care Partnership.

A summary of commitments made by the PCIP Executive Group against the non-recurring allocation is summarised in the table below:

Commitments	Resource Directed £	Actual Expenditure to 30 April 2022 £	Forecast Expenditure to 31 March 2023 £	
ANP Training	82	2	82	*1
CTCS Programme Management	54	0	54	*2a
CTCS Admin Support	15	3	15	*2b
CTCS General Allocation	545	7	545	*3
PCIP Project Management	72	0	72	
PCIP Comms / Engagement	25	0	25	
VTP	200	0	200	*4
System Acquisition & Installation	276	0	276	*5
Provision for 22/23 pay inflation and drift	254		254	*6
Total Commitments	**1,523**	**12**	**1,523**	
Funded by:				
Additional NR Allocation	(1,097)		(1,097)	
Non-Recurring Carry Fwd	(426)		(426)	
Total Funding	**(1,523)**		**(1,523)**	
Remaining for Direction	**0**			
Total Forecast Slippage / Uncommitted			**0**	

Notes	
1	ANP modular training to date has to date been funded by slippage within the Urgent Care recurring workstream.
2	CTCS is currently being scoped. New Project Manager being recruited and will be funded from recurring allocation currently. No admin requirement yet identified.
3	CTCS non-recurring allocation to fund part-year initial phase of programme in latter part of 2022/23
4	VTP non-recurring allocation to fund part-year initial phase of programme in latter part of 2022/23.
5	Systems: Commitment to OrderComms per PCIP Executive September 2021. Potentially Albasoft also.
6	Balance of uncommitted NR allocation. Hold in reserve for now - should recurring plan be fully spent, will be required to fund pay inflation and incremental drift.

In total £1.523m is available non-recurrently this year of which £0.338m relates to slippage on the recurring allocation last year and £1.184m the balance on the previous year's non-recurring plan. Of this, £0.254m remains uncommitted at the end of M01.

3.2.3. Anticipated required funding by workstream, 2021-22

The table below outlines the forecast full-year expenditure, required by PCIP at current prices, for it to be fully delivered:

Workstream	PCIP 3-Year Recurring Investment £'000	Full-Year Required Investment £'000
VTP	16	736
Pharmacotherapy	879	966
CTAC	121	1,724
Urgent Care	883	943
FCP	528	1,237
Mental Health	669	
Community Link Workers	150	150
Central Costs	49	51
Total Expenditure	**3,296**	**5,807**
Funded by:		
2.13% of £155m	(3,296)	(3,296)
Potential Forecast Shortfall*		**2,511**

**Dependent on level of 2022/23 PCIF allocation yet to be confirmed*

As can be seen from the above, unless the 2022/23 and future years' PCIF allocations are significantly increased, there is likely to be a funding shortfall of £2.511m on the plan, primarily as a result of VTP and CTAC not being funded to the level required, increasing financial risk on the partnership and compromising the delivery of the plan within required and agreed timescales.

4. Recommendations

The Scottish Borders IJB is asked to note the report, the risks, and actions being undertaken to reduce these risks.

Scottish Borders Health & Social Care Integration Joint Board

Scottish Borders Health and Social Care PARTNERSHIP

Meeting Date: 15 June 2022

Report By:	Simon Burt, General Manager Mental Health & Learning Disabilities Services
Contact:	Simon Burt, General Manager Mental Health & Learning Disabilities Services
Telephone:	Simon.Burt@borders.scot.nhs.uk
MENTAL HEALTH AND WELLBEING IN PRIMARY CARE SERVICES	
Purpose of Report:	To present for noting the submission made to Scottish Government around the initial funding and implementation plan for improving Mental Health and Wellbeing Services within Primary Care.
Recommendations:	The Health & Social Care Integration Joint Board is asked to: a) **Note** for reference this 4-year programme.
Personnel:	A conceptual workforce plan is underway – however this will be informed through co-production, and flexible enough, to adapt to any iterations of the model.
Carers:	We are currently working with our Public Engagement and Communications teams to develop a 4-year strategy plan that will ensure we have the right expertise to facilitate and inform this critical part of this process.
Equalities:	HIIA is currently being conducted and will be annually reviewed.
Financial:	Scottish Government Mental Health Recovery and Renewal Fund - NRAC Allocation – see paragraph 14
Legal:	N/A
Risk Implications:	The following are a list of key risks that we feel are critical at this stage of submission to bring to your attention: • Recruitment and retention, particularly within the Mental Health sector in Scottish Borders, is at a challenging point and will impact implementation plans should recruitment campaigns take longer than anticipated • Patient care and safety must be considered above all else and therefore plans and models will need to be agile and iterative to support this • The remote and rural set-up of health care within Scottish Borders does pose additional challenges that we may not have anticipated yet due to infrastructure and limited

	funding • Financial allocation based on NRAC may be insufficient to support our deliverables of developing real change • Funding beyond 2024-25 is subject to approval by future Scottish Governments. Our intention to treat this funding as recurrent as and when plans are approved by Scottish Government on an annual basis presents a limited financial risk • Availability of infrastructure and space will impact the service roll out and will need to be accounted for as we further develop plans •
Direction required:	No Direction required

Briefing Paper

1. Initial funding had been made available to improve Mental Health and Wellbeing Services within Primary Care Services.

2. We are being asked to: '*work with Primary Care partners to improve capacity for mental health assessment, care and support within Primary and Community Care settings. This will build on examples of good practice already implemented through the Primary Care Improvement Plan, and through our work on Action 15 of the Mental Health Strategy. This will include the interface with specialist services to ensure that people receive the right care in the right place. This will ensure that there is a clear pathway to mental health services for those who need them*.'

3. The funding that being provided is to be used by Integration Authorities (IAs) to support the planning process for the establishment of multi-disciplinary MHWPCS, within GP clusters or localities, to provide assessment, advice, support and some levels of treatment for people who require mental health, distress or wellbeing support.

4. Building resilience within our Primary Care teams is pivotal for an integrated mental health system and key in developing and sustaining a system that supports the population with improved mental health and wellbeing. Our overarching vision is that wherever and whenever a person is in touch with the system - they will be listened to and helped to reach the most appropriate place for them - there is no wrong door.

5. For us to achieve this vision we have four key targets and supporting requirements. These are:

- Establish an ageless service
- Build on local services/successes through additionality
- Maximise the use of digital technology and resources
- Ensure inclusive access for all

6. Where we see the biggest unmet need in our Health Board, is the provision of Tier 2 Services for under 18s. We have a huge demand on our CAMHS service at present as there is a significant gap between what CAMHS can offer and that of the local commissioned services that supports children and young people. From our initial consultations, almost all agree that this area is where real progress and change can occur.

7. Our plan therefore will be implemented in two phases:
Phase 1 will focus on the Under 18s gap between Tier 2 and 3 Services where we feel the biggest unmet need and risk is; and will be our primary focus for Years 1 and 2. The development of a core service for under 18's (recognising a cohort of 16-25 transitions) closely linked to GP Practices and school will work with key stakeholders to further identify demand, establish care/treatment pathways, explore the use of technology, and build a clear picture of demand – this will be expanded within Year 3.

8. Phase 2 will look to address the gap between our Adult Primary Care service and our Secondary Care service and will be the focus across Year 3 and 4. Further stakeholder engagement will allow us to further define the gaps, demand and care/treatment pathways and the additional staffing model required. We envision that this will build on our current Renew service while addressing the gaps identified with people with more complex needs who present in primary care; the establishment of a trauma treatment pathway and supporting over 65s.

9. We believe that by developing our existing services, Scottish Borders will ensure equity and inclusivity to all ages looking to access mental health support for those with mild to moderate mental health conditions

10. NHS Borders prides itself in its co-production approach to service design and implementation. We know that collaboration with people with lived experience is key in understanding and evidencing what works. It will result in invaluable guidance; improved outcomes and a stronger evidence-based model of care/support. Therefore, we are currently working with our Public Engagement and Communications teams to develop a 4-year strategy plan that will ensure we have the right expertise to facilitate and inform this critical part of this process.

11. Using quality improvement principles, proper collaborative engagement (particularly with children and young people) and conducting a successful recruitment campaign will lay a solid foundation for years 2 -4 and the development of more detailed plans.

12. The additionality provided by our 2026 vision will be:

1. Phase 1 will be to establish services in primary care to under 18's focussing upon anxiety and low mood. Scoping of demand and capacity will allow us to ensure that we provide the correct resource level, assessment, and support.
2. Phase 2 will focus upon the gaps in support to over 18's and how we can redesign and coordinate effectively existing services to ensure that we meet unmet need. Our early consultation indicates that we will need to focus upon supporting those presenting frequently within primary care settings, those with neurodevelopmental disorders and increasing the take up of services for over 65's.
3. Our mental health primary care services will be easily accessible and more streamlined, wherever possible providing a single point of access. We aim to provide no wrong front door and to ensure people reach the right place at the right time avoiding "rejected" requests for support.
4. We will maximise the use of digital options and look to reduce the accessibility of these types of interventions. This will include digital hubs within localities and increased accessibility to online self-help and information resources.

5. Our model focussing upon a centralised resource, maximising digital access wherever possible, will allow us to flexibly meet demand, including the anticipated increased demand from deprived areas of the community.
6. Services will be strategically planned and evaluated effectively. Our local oversight group will continue to support us to plan services together with our stakeholders. We will be further developing engagement with people with lived experience to ensure meaningful involvement and co-production. Years 1 and 2 will include a strategic review of the existing landscape of services including those funded through action 15 and the PCIP to ensure that we provide an integrated and aligned range of service provision avoiding duplication and overlap wherever possible.
7. Our fundamental model for developing services will follow a quality improvement approach. This will be underpinned by effective gathering and analysis of data and the establishment and measurement of key outcomes targets/data.
8. Service delivery and accessibility will be delivered within a trauma informed framework as a minimum standard.

13. Funding is based on NRAC allocation and has been indicated as follows:

2022-2023	£204,537.20
2023-2024	£408,436.56
2024-2025	£823,676.85
2025-2026	TBC

Scottish Government have stated that ongoing funding beyond 2024-25 is "…subject to the approval of future Scottish budgets by the Scottish Parliament". As such we are treating funding as recurring for recruitment and planning purposes.

14. Next steps:
    a. Awaiting feedback from National Oversight Group on our submitted plan
    b. Planning and scoping of various workstreams e.g. Under 18s, Digital, Public Engagements etc
    c. Review of Current Primary Care Mental Health Provision (see Appendix 1 for supporting information)

Appendix 1 - The Renew Service – Report on the first 18 months

01 June 2022

Introduction

1. The Renew service was established in NHS Borders in October 2020 utilising funding from PCIP and Action 15 with the aim of offering a “see and treat” model for mild to moderate anxiety and depression using evidence based psychological therapies in primary care. The aim was to reduce GP Mental Health workload as well as increase the capacity and access to psychological therapies. This report outlines the service’s development, performance, current state, and development issues going forward.

Background

2. Historically psychological therapy and mental health services for adults in NHS Borders have been accessed via the Community Mental Health Team (CMHT) in secondary care. This has led to long waits, rejected referrals and GP’s needing to support people with mild to moderate mental health difficulties.

3. Changes to GP contracts and the PCIP have created the opportunity to revisit this and resulted in the development of an innovative collaboration between with GP’s, Mental Health, and Psychology Services to establish a centralised primary care mental health service where assessment and treatment is offered under one service.

4. This in itself is innovative, as traditionally models of mental health support in primary care are aimed at distress management with onward referral to other services e.g., psychology should this be needed.

5. Psychology Services in NHS Borders have been under resourced pre 2018 and had the smallest workforce per 100,000 for a mainland Board. Resource has been largely focused on secondary care services, but in adult mental health this resulted in very long waiting times and the inability to widen access to psychological therapies or meaningfully address these capacity issues or cater for people who needed evidence based psychological treatment for mild to moderate mental health issues, but who did not meet the criteria for secondary care services.

6. Through audit and discussions with GP’s, it became clear that many patients were seeing GPs on a regular basis who fell into the category of mild to moderate mental health issues with the only option GPs could consider being medication or wellbeing services which did not necessarily meet the treatment need.

7. Following discussions with GP’s it was agreed that to fill this gap and reduce the workload on GP’s, that offering a “see and treat” model of psychological intervention in situ, may be a solution.

Initial Pilot

8. It was agreed to pilot this approach in one GP Practice. This took place between October and December 2019 where referrals for mild to moderate anxiety and depression were assessed and treatment started “under one roof” as opposed to an initial period of distress reduction and then onward referral to psychology waiting lists. This approach proved popular and reduced GP return mental health referrals considerably.

Scaling Up

9. It was agreed to investigate scaling up the model in 2 GP Clusters in 2020. However, this did not come to pass due to Covid as well as logistical issues. It was agreed that Psychology Services would support primary care by offering psychological first aid training and enhancing the Wellbeing service during this time.

10. Following the first lockdown, in July 2020, an options appraisal to reconsider scaling up the primary care mental health service for adults took place. Of the options considered, the preferred option was for a centralised service offering a range of evidence based psychological interventions delivered digitally using a combination of PCIP and Action 15 funding.

11. A SLA was agreed and the Renew Service started in October 2020 with a much reduced staff complement while recruitment continued for CAAPs (Clinical Associates in Applied Psychology), Mental Health Practitioners and Assistant Psychologists. The service was at full staffing complement by April 2021.

12. Interventions offered include computerised CBT, internet enabled CBT (IESO), anxiety and low mood courses, guided self-help (121) and one to one psychological therapy. It was agreed that a comprehensive assessment would be undertaken a quickly as possible so that people could be directed to /choose the best treatment for them.

13. As mentioned earlier, the service was offered without a physical base, with all practitioners (except the admin team) operating from home using Near Me and telephone to offer interventions.

Page 63 of 116

Performance

14. When the initial SLA was signed, 4 KPI's were agreed with the agreement that these would be reviewed annually. (It has not always been possible to collect data on all these KPI's which will be discussed.)

KPI 1: Demand for the service

15. Renew has been a popular service with all GP practices in the Borders using the service. Since the starting there have been over 5000 referrals which is a high referral rate. The following graphs outline referral numbers and sources.

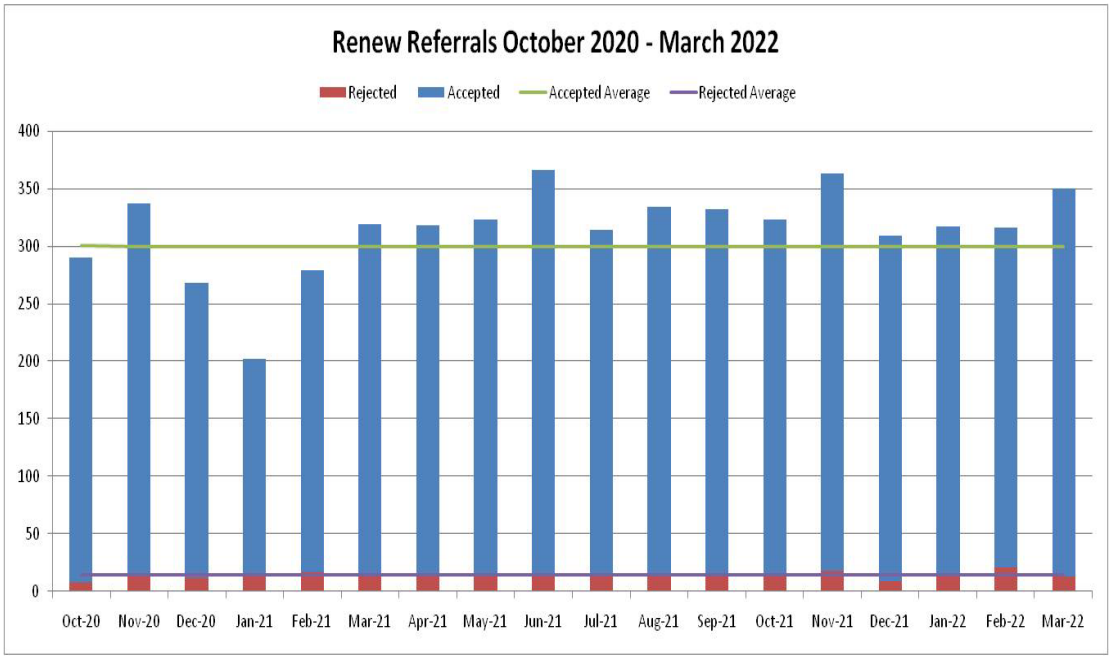


Figure 1: Renew Referrals October 2020- March 2022

16. All GP Practices in the Borders have referred to Renew, although some have referred higher numbers than others.

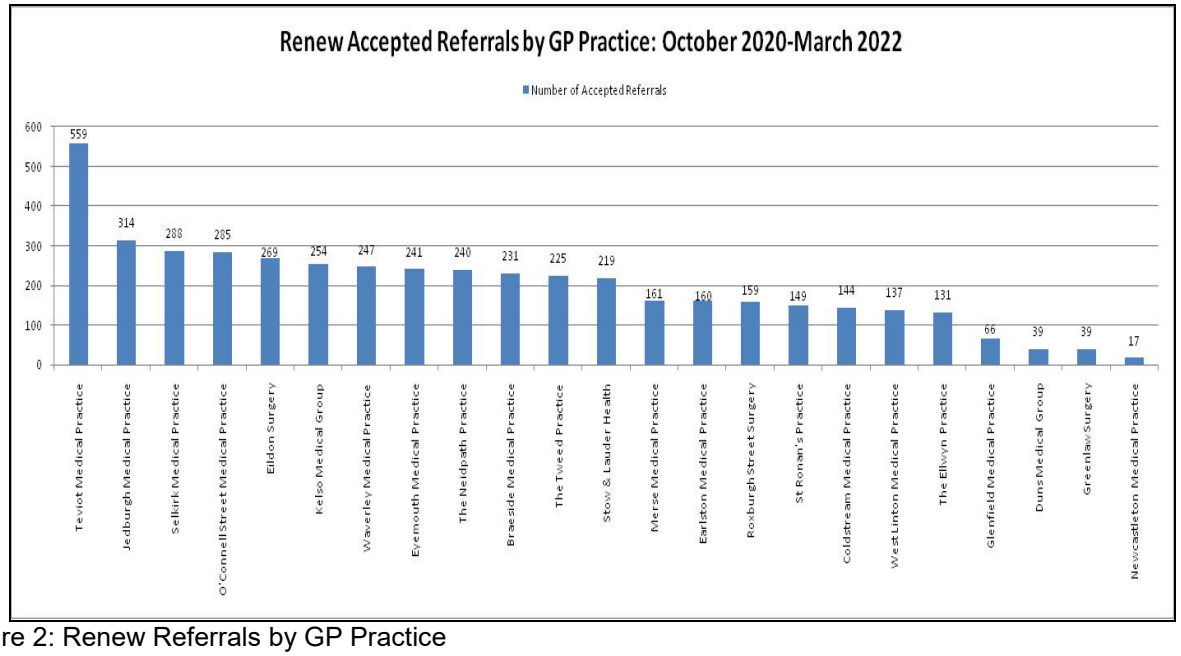


Figure 2: Renew Referrals by GP Practice

17. Renew accepts referrals from other services including Mental Health, DBI and Wellbeing.

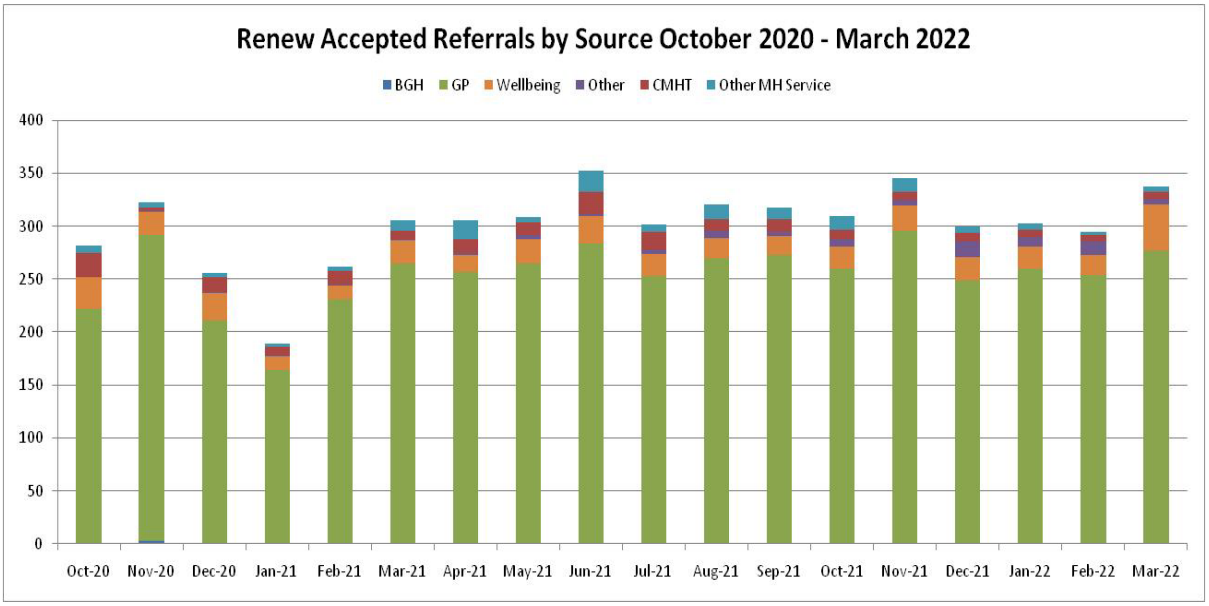


Figure 3: Renew Referrals by Source: October 2020 – March 2022

KPI 2: Speed of Access/Service Efficiency to see and treat

a) Assessment

18. One of the initial priorities with Renew was to ensure that a comprehensive assessment takes place as soon as possible, and our target has been to assess new referrals within two weeks. On average we have completed 210 assessments per month and complete these assessments within an average of 12 days.

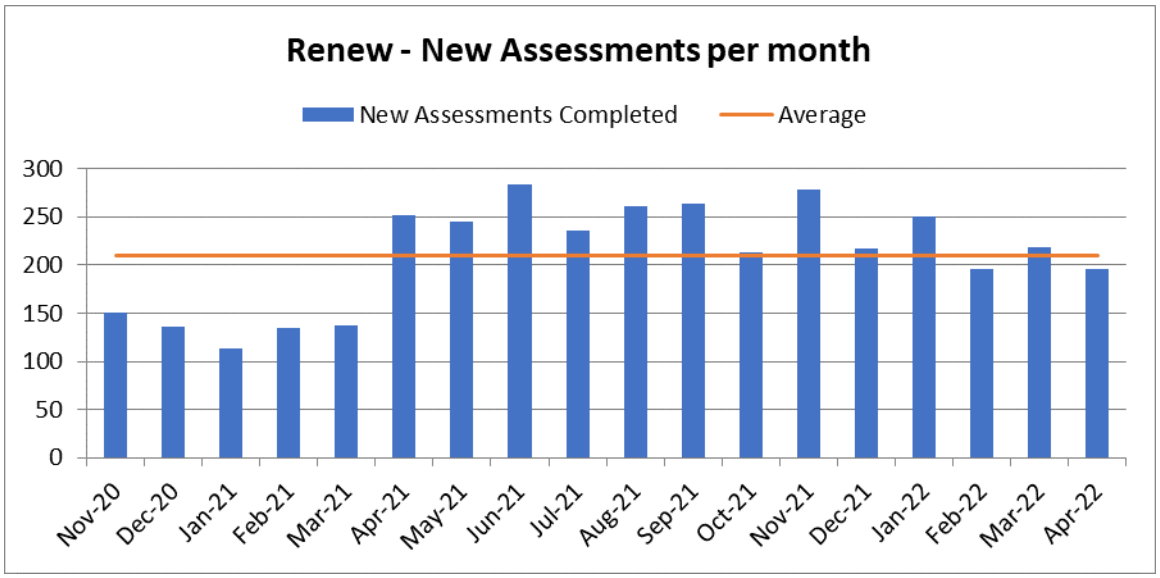


Figure 4: Renew Service – Number of Assessments completed per month, November 2020-April 2022

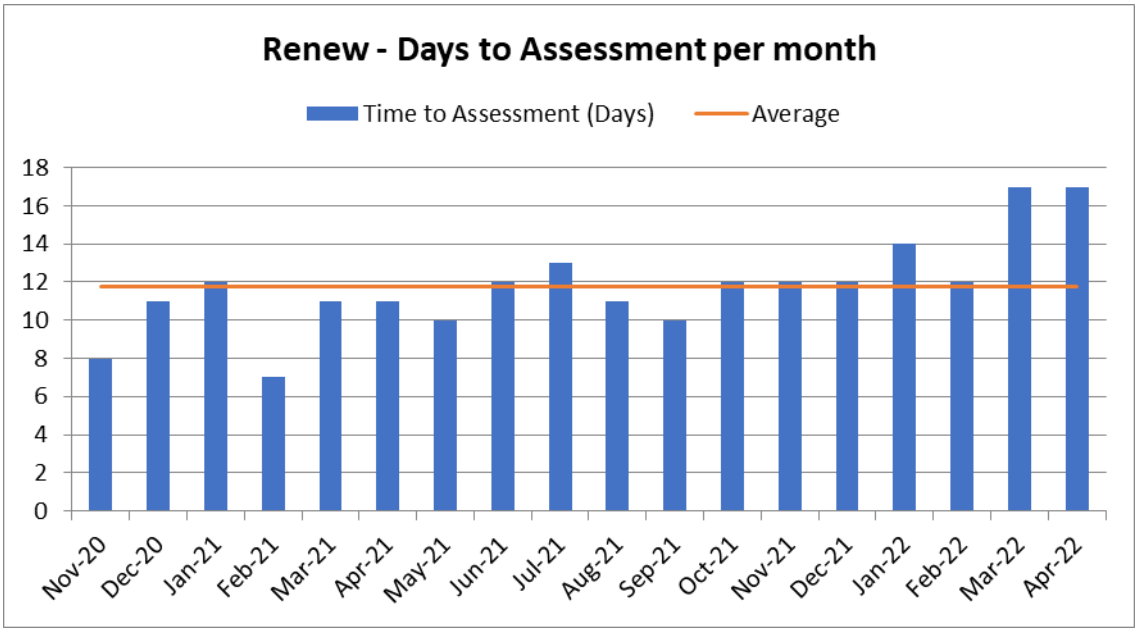


Figure 5: Renew Service -Time to Assessment per month November 2020- April 2022

19. Keeping assessments and treatments in balance is something we need to consistently monitor.

b) Treatment

20. For treatment, we aim to start treatment with the majority of people referred within 18 weeks and on average have 105 new treatment starts per month. It is clear from this data, that there has been some variance in terms of new treatment starts which is due to a number of factors, including data issues, shifting the main mode of treatment to courses that start every 8 weeks (from August 2021) and service adaptations during Covid to manage staff absence while maintaining flow.

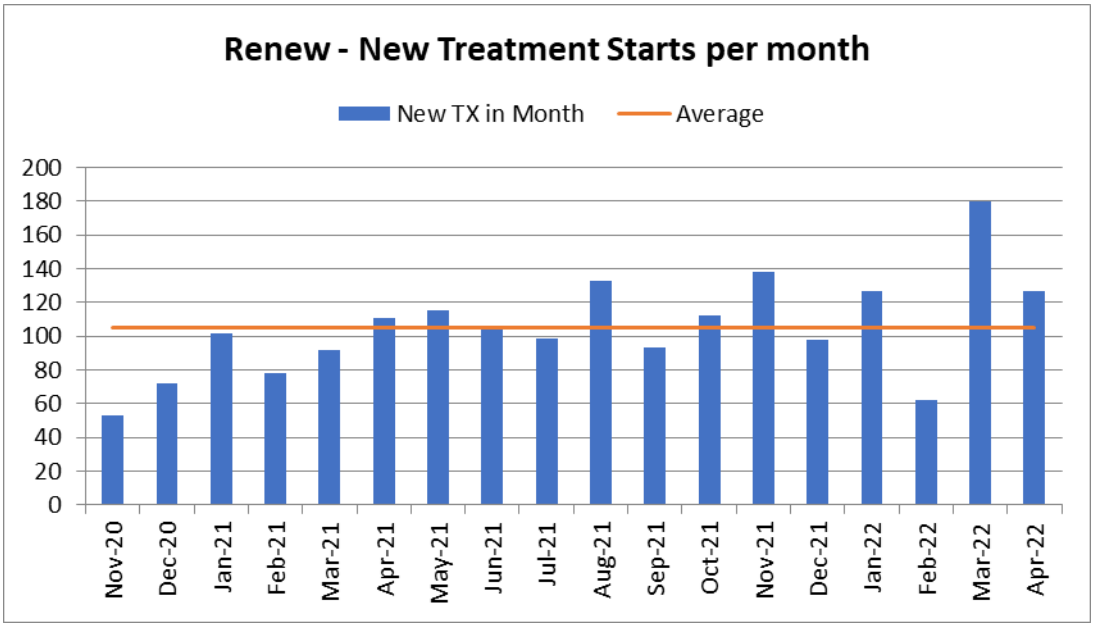


Figure 6: Renew: Number of new treatment starts per month November 2020- April 2022

21. In general, Renew has consistently started treatment for over 80% of all referrals within 18 weeks. Since October 2021 there have been a few delays which have been caused by staff sickness due to Covid and delays with courses or 121 treatment starts as the model has shifted to more courses. However, we monitor this closely and are currently working on plans to flow, reduce the backlog, and smooth out the courses schedule so that courses are offered more regularly than every 8 weeks.

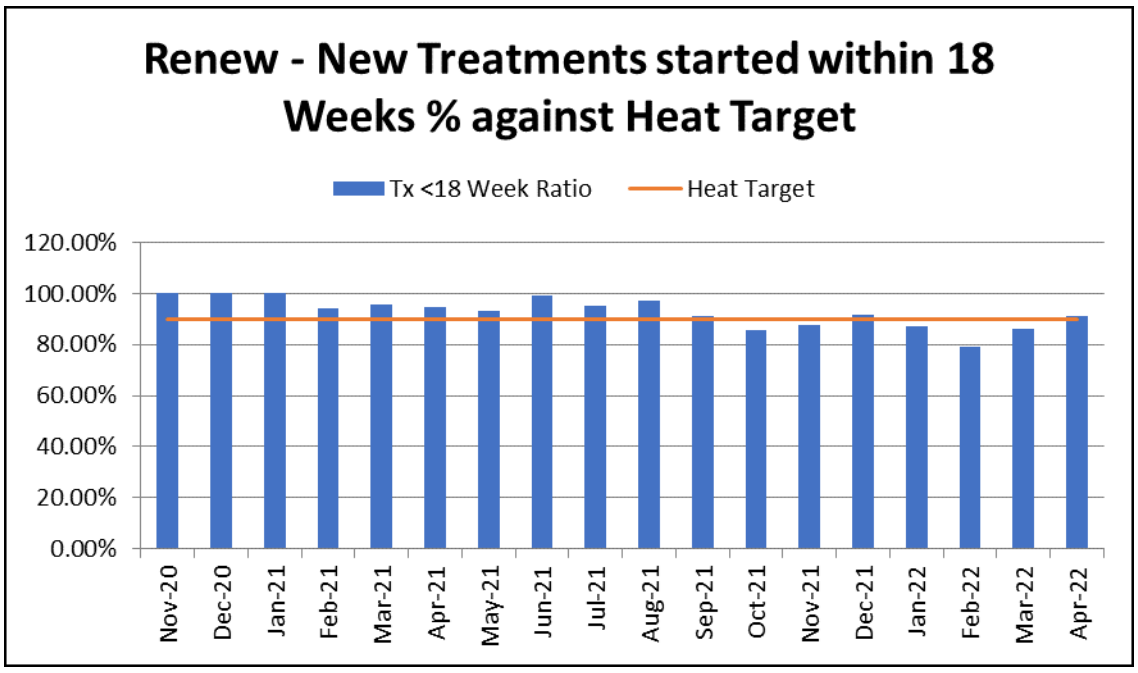


Figure 7: Renew: Number of new treatment starts within 18 weeks November 2020- April 2022

c) Current Waits

22. Renew started with a third of the agreed staff complement and inherited open cases and psychological referrals that were waiting to be seen as part of the enhanced Wellbeing Service were moved over to Renew in October 2020. Renew has therefore always had a “tail” and this coupled with strong demand has needed careful monitoring of the focus of capacity and treatment types to ensure flow through the system. We are currently reviewing our queue to focus on ways of reducing this “tail” and bringing the service into balance.

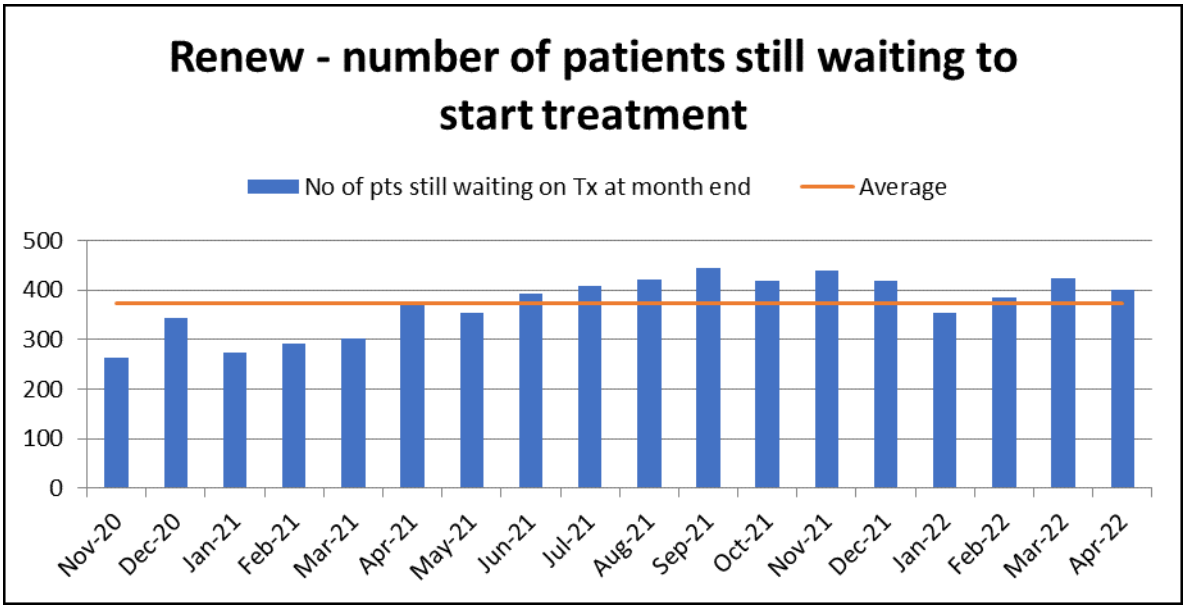


Figure 8: Renew: Number of new treatment waits 18 weeks November 2020- March 2022

KPI 3: Service Outcomes – service valued by GP's and patients and treatments effective

a) GP Satisfaction

23. All GP Practices in the Borders have referred into Renew and at a recent audit of GP satisfaction with Renew, results show that 35% GPs rated Renew as Excellent, 53 % Very Good, 8% Good, 4% fairly Good/Poor.

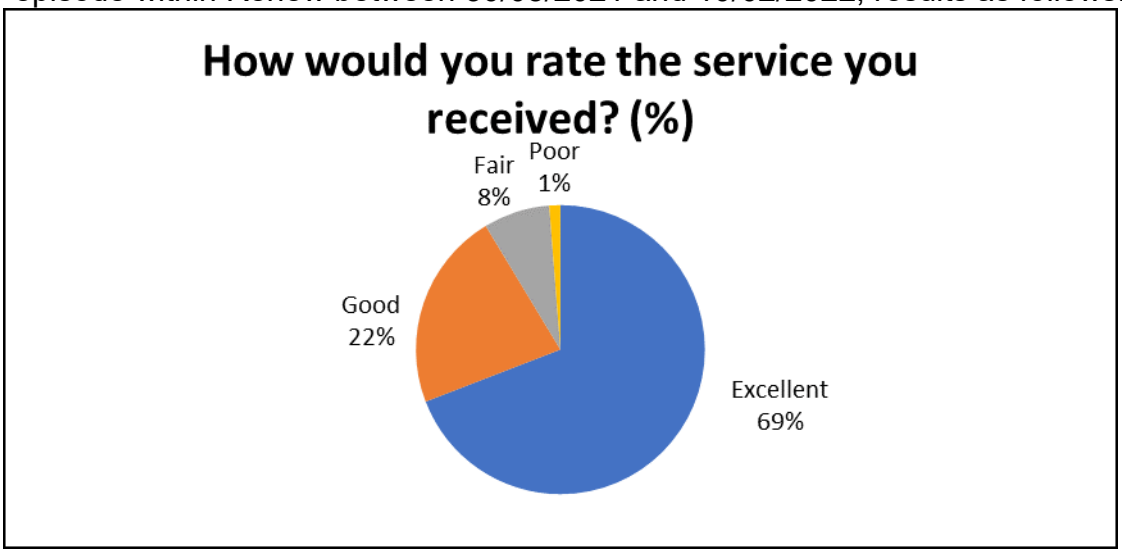
Some of their comments about the service are:

- *Encouraging lack of hoops for us to jump through - we can leave assessment to our more expert colleagues*
- *We previously had a massive gap in MH provision in Borders and I believe Renew has filled this gap well.*
- *Before it was very confusing to keep up with what services were still available and what were not.*
- *I found single point of referral for triage to different treatment modalities works really well.*
- *Patient feedback and I have also noticed that they have an initial consultation quickly to discuss problems and develop a plan about most appropriate approach and I think the patients find this discussion and choice helpful and empowering.*

b) Patient Satisfaction

24. We routinely collect data from people who have been through the service using the CSQ-8, a validated tool to assess patient feedback in primary care mental health services which provides us with both qualitative and quantitative data. Feedback from a sample of these is as follows:

25. Eighty-one patients completed the CSQ-8 following completion of their treatment episode within Renew between 30/08/2021 and 10/02/2022, results as follows:



84% *of all respondents received the kind of service they wanted from Renew*
93% *of respondents would recommend the Renew Service to a friend*
89% *of respondents were satisfied with the amount of help they received in Renew*

88% *of respondents felt that services they received within Renew had helped them to deal more effectively with their problems*
93% *of respondents would come back to Renew if they needed to seek help in future*

c) Efficacy of Treatment

26. We collect routine outcome measures throughout all our treatments. This has helped us to measure the effectiveness of the service in terms of symptom reduction, recovery, and client satisfaction.

27. To capture this data, we collected self-reported information each treatment session using the Patient Health Questionnaire-9 (PHQ-9) as a general measure of depression, the Generalised Anxiety Questionnaire-7 (GAD-7) as a general measure of anxiety, and other measures around specific phobias and functioning.

28. Data indicates that all treatment interventions are showing good efficacy in terms of symptom reduction.

KPI 4: Balancing Measures: Ensuring the effect of the service is positive and not creating more work for GP's or Mental Health Services.

a) GP Mental Health Appointments

29. When we did our test of change, an audit on one GP Practice, revealed that for every new GP Mental Health consultation, there were three times as many return appointments. This pointed to the "revolving door" where there was no effective, evidence-based treatment available and was one of the main reasons why we tested out and adopted a "see and treat" model as opposed to usual models of distress management in primary care.

30. With this KPI, we sought to measure whether by establishing Renew, those GP's who referred to Renew had a drop in mental health appointments, especially return appointments.

31. Unfortunately, in spite of extensive discussions, no mechanism has been found to be able to measure GP mental health appointments and as such we have not been able to measure this KPI and recommend we remove this as a KPI unless suitable technology is developed.

b) Anti-depressant Prescribing

32. Our assumption was that with different treatment options, that GPs would rely less on prescribing anti-depressant medication. We therefore proposed to monitor anti-depressant medication prescribing.

33. This however, also proved to be difficult on a number of levels. When we consulted experts in this area, the consensus was that even if there was a drop (or increase) in anti-depressant medication, there was not current technical ability to attribute this change to Renew. We therefore did not continue with this KPI and recommend we review this.

c) Impact on Mental Health Services

34. At the time, we considered a balancing measure to be that there was not an increase in referrals to other mental health services, namely the CMHT. In order to monitor this, we have looked at two pieces of data – total referrals from GP's to CMHT's and referral data between Renew and the CMHT.

d) Referrals from GP's to CMHT

35. Data shows that there has been a significant reduction of over 30% in referrals from GPs to the CMHT from 2020 to current times. This is an interesting trend to note, and clearly there has not been an increase in referrals to the CMHT from GP's since Renew was established. However, it is important to note that this period coincided with Covid which could have impacted on referral trends.

	Fin Yr. 2019/20	**Fin Yr. 2020/21**	**Fin Yr. 2021/22**
GP to CMHT	951	639	687

Table 1: Referrals from GP's to CMHT

e) Referrals between Renew and the CMHT

36. When Renew was established there was concern expressed from CMHT colleagues that this would result in an increase in their workload.

37. Data shows that referrals have been going either way from the CMHT to Renew with no negative impact on the CMHT. This data also shows the excellent collaboration between the CMHT and Renew to ensure that referrals get to the right treatment option and that this can be done without referrals having to go back to GPs for redirection.

38. It is also important to note that there is currently no mechanism for stepping up referrals from Renew to more advanced psychological interventions apart from referring via the CMHT. It is planned to address this, as this is creating unnecessary duplication in referrals and additional work for the CMHT.

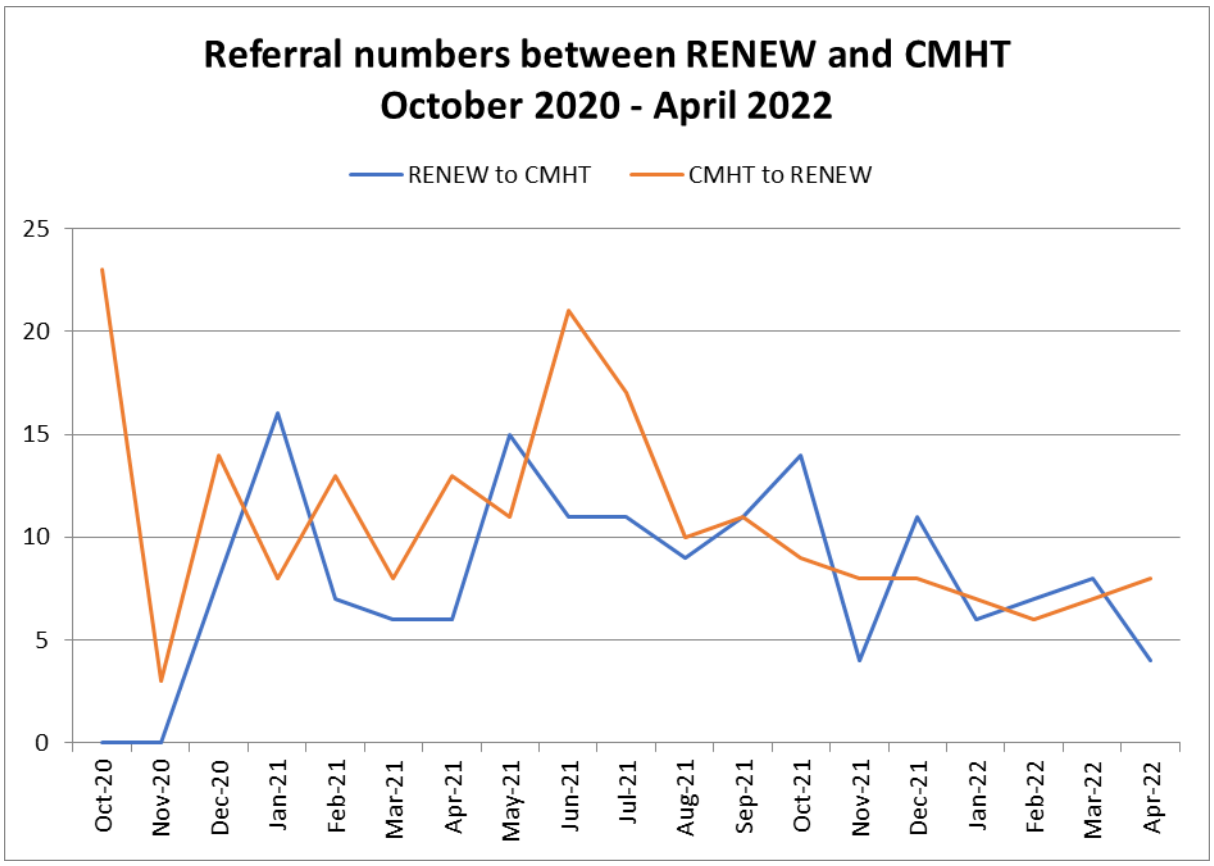


Figure 9: Referrals between Renew and the CMHT, October 2020 – April 2022.

	Mean	Median
RENEW to CMHT	8.4	8
CMHT to RENEW	10.8	9

Table 2: Mean and Median Referrals between Renew and CMHT

	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	Total
RENEW to CMHT	0	8	16	7	6	6	15	11	11	9	11	14	4	11	6	7	8	4	6	160
CMHT to RENEW	23	3	14	8	13	8	13	11	21	17	10	11	9	8	8	7	6	7	8	205

Table 3: Referrals by month between Renew and CMHT

Summary and Recommendations

39. In general, given its origins and the conditions it has operated under Renew has been a successful service. It is still relatively new and from a clinical perspective there is work to be done to ensure the model, flow and treatment options fit the demand.

40. The centralised model has worked well, especially with courses as previously there had been resistance to face to face courses or groups due to the rural nature of the Borders and people knowing each other – with the centralised model this ensures a wider group and mix of people attending the groups.

41. Given the Scottish Government's investment in primary care services, it is important to review and take learning from the Renew experience to help us in this wider development and ensure that we build on our successes, while continuing to allow Renew to develop and mature.

42. The following recommendations are proposed:

- Review Renew KPI's to ensure they are deliverable (especially KPI 4)
- Review SLA in the light of future primary care developments. Future service developments should not negatively impact on the delivery of psychological therapies and pathways.
- Continue to monitor flow and reduce treatment backlogs and ensure model, flow and treatments fit demand
- Consider how to meet gaps that have come to light between Renew and the CMHT e.g., trauma treatment
- Enhance the digital therapeutic offering (e.g., cCBT) by establishing a digital team
- Establish a more permanent administrative base, and scope out clinical options for Near Me Hubs
- Establish a website that will provide referrers and those referred with service details and links
- Review the pathway for GSH via Wellbeing
- Review and improve the pathway for ongoing referrals to other psychology services
- Collaborate closely with proposed primary care developments to ensure that pathways are improved, and developments work seamlessly.

Dr Caroline Cochrane
Clinical Lead: Renew
June 2022

Scottish Borders Health & Social Care Integration Joint Board

Scottish Borders Health and Social Care PARTNERSHIP

Meeting Date: 15 June 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 2 February 2022.
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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Scottish Borders
Health and Social Care
PARTNERSHIP

Minutes of a meeting of the **Scottish Borders Health & Social Care Strategic Planning Group** held on **Wednesday 2 February 2022** at **10am** via Microsoft Teams

Present:
Lucy O'Leary, Non-Executive NHS Borders (Chair)
Chris Myers, Chief Officer
Gerry Begg, Housing Strategy Manager
David Bell, Staff Representative, SBC
Stuart Easingwood, Chief Social Work Officer
Lynn Gallacher, Borders Carers Centre
Caroline Green, Public Member
Susan Holmes, Principal Internal Audit Officer
Clare Oliver, Communications Manager, NHS
Gail Russell, Partnership Support Staff Side NHS
Debbie Rutherford, Borders Carers Centre
Morag Walker, Executive Officer, The Bridge
Cathy Wilson, General Manager, P & CS

In Attendance:
Laura Prebble, Minute Taker
Keith Allan, Public Health
Hayley Jacks, Planning & Performance Officer
Kathleen McGuire, Lead Commissioner for Borders Care Village Programme
Morag McQuade, Clinical Director Dental Services
Morag Muir, Consultant in Public Dental Health, Public Health

1. APOLOGIES AND ANNOUNCEMENTS

Apologies received from Wendy Henderson, Colin McGrath, Tim Patterson, Jenny Smith and June Smyth. The Chair confirmed the meeting was quorate. Chris Myers to Chair today's meeting as Lucy O'Leary is unwell. Keith Allan attending for Tim Patterson.

2. MINUTES OF THE PREVIOUS MEETING

The minutes of the previous meeting held on 3 November 2021 were approved.

3. MATTERS ARISING

Action Tracker: All items complete.

The **STRATEGIC PLANNING GROUP** noted the Action Tracker as complete.

4. CHANGE IS AS GOOD AS A REST - PRESENTATION – Debbie Rutherford

Debbie Rutherford was welcomed to the meeting to present the report that was circulated prior to the meeting.

Caroline Green noted that carers seemed very unhappy about current respite provision and noted that the report did not look at future need. It was clear that carers were looking for building based respite provision where they can leave their loved one for a few hours. Caroline also noted that many people live out with Galashiels and so would need transport to attend any central service which is an additional cost to be considered. Lynn Gallacher added that they are in the process of scoping the wider need and the Carers Workstream group will be looking at this in more detail. Lynn confirmed there is a real need for building based day care and this is being looked at. Chris Myers noted that the IJB are updating their strategic plan which should include a section on carers so care services can be prioritised. Support for carers is measured annually on a national perspective. It is the requirement of the IJB to scope the broader area and to then co-produce a vision and implement it as a group, i.e. to understand the need and then act.

Lucy O'Leary asked about the attendance rate of carers and professionals to see how their views differed. Lynn Gallacher was unsure of the exact breakdown but noted that the professionals held the same views as the carers. They recognised the need for building based day care. Kathleen McGuire noted that day care would be included in the model for the new care village development, along with the facility for respite and step up/down services. Engagement has not yet started but this is a real opportunity to work together with carers. Lynn Gallacher welcomed that. However, Lynn noted a dis-satisfaction by carers that consultation had not taken place with them before decisions had been made. Kathleen advised that the Care Villages Programme Board was aware of the journey to date and there will be real and full engagement with carers going forward and Kathleen will be in contact with the Carers Workstream group. Chris Myers noted that the first Care Villages Programme Board will be meeting for the first time soon. There is an outline business case for a care home in Hawick as well as Tweedbank. There will be consultation with all partners as part of this process.

David Bell noted that paid carers are also burnt out. Staff are leaving and they are struggling to recruit staff. This is a national issue. Staff are needed to be able to provide services. Chris Myers agreed and noted that it has been agreed that paid carers workforce would be out of scope of the Carers Workstream but following on from the integrated workforce planning update at the last IJB and the significant workforce pressures being experienced, that in recognition of the role of the workforce, it was expected that the IJB would commission its first formal direction to the Scottish Borders Council and NHS Borders calling for an integrated workforce plan. This would be both for the medium to long term development of the workforce, but also to help manage the immediate workforce sustainability issues

Keith Allan also noted that carers need more recognition and to be held in higher esteem to encourage people into the role. Lynn Gallacher noted that some carers only have a break from caring for the short time a carer is in to support their loved one to get washed/dressed. Carers are burnt out due to the lack of respite for higher need cases and, as a result, people are being admitted to hospital or care homes sooner. Lynn noted that organisations are sitting on budgets but there are no carers to recruit to posts. Chris Myers added that it had been highlighted that the positive SDS ambition is challenged by the availability of workforce, and can mean that there is minimal support available as a result. The Carers Workstream is moving forward with this.

Conversations have been opened and all services, including building based services are being considered as part of this.

The **STRATEGIC PLANNING GROUP** noted the report and thanked Debbie Rutherford for her presentation. It was agreed to keep the Carers Workstream on the action tracker.

5. REVIEW OF SCHEME OF INTEGRATION FOR NOTING – Chris Myers

Chris Myers circulated a link to this document prior to the meeting. It is a legal requirement to review the scheme of integration, in agreement with SBC and NHSB, to ensure the IJB functions as it should. In light of the pandemic and the National Care Service the Scottish Government has agreed to a light touch review. Consultation will be done widely with all stakeholders. All feedback is welcomed. Chris Myers asked member of this group to reply individually via the link and asked if the group would like to submit a joint response. It was agreed that a joint response was not needed.

Clare Oliver asked if there was an easy read version available and Chris noted that there was not. Chris added that all IJB documentation should have an easy read version so it is accessible to all. **Action**: Clare Oliver to contact Iris Bishop to discuss for future documentation. Keith Allan agreed and suggested that opinions could be gathered using another method so the opinions of all were gathered. This would achieve a better product.

The **STRATEGIC PLANNING GROUP** noted the report.

6. 1. NEW IJB STRATEGIC COMMISSIONING PROCESS - Chris Myers

Following on from the last SPG meeting, Chris Myers updated the discussion paper to go to the IJB – circulated prior to the meeting. The paper has also been to the Audit Committee who were supportive of the paper. The finalised paper circulated reflects the SPG discussion to ensure the IJB commission in the right way, with good co-production at the core of how the IJB commissions in line with the steer provided by the SPG. This will also support the planning work going on over the next few years, including the new needs assessment, public engagement and the development of the National Care Service.

2. STEER FROM SPG ON THE FUTURE STRATEGY GROUP MEMBERSHIP AND REMIT – Chris Myers

Chris Myers noted that the Future Strategy group will report into the SPG. The proposed remit will be to analyse and plan for commissioning as part of the strategic commissioning process. Chris Myers asked the group if they were supportive of the proposed remit and there were no objections. Caroline Green asked if the independent sector providers (ISP) group included only paid carers and asked if a representative from Marie Curie should be included to represent the voluntary sector. Chris Myers noted that the SPG was the route in for the independent sector providers, however the SPG has the right to ask for a different approach if it would add value. Caroline Green noted the need for a professional from Marie Curie to be invited to attend rather than a volunteer/nurse who is unable to contribute strategically. Caroline added that is we are unable to employ carers then maybe consider other options such volunteers or befriending schemes to provide respite care. Morag Walker noted her apologies for the last few meetings as the representative

for the Third sector on this group. Morag noted that she has met with Brian Paris and Health representatives about the re-commissioning of services and will forward information for circulating. Chris Myers noted how pivotal the work between the IJB and the Third Sector will be to a successful way of working for the IJB that best meets needs. He asked Morag to contact him if she needs help with anything. Lynn Gallacher replied to Caroline Green's suggestion of using volunteers to confirm volunteers are being used for low level care needs but the gap is where there is a specialist high level care need.

Membership – Gerry Begg suggested housing was represented from both the local authority and social landlord sector. Chris Myers agreed to discuss this further with Gerry. Kathleen McGuire suggested a representative from Digital be included. June Smyth and Jen Holland would cover this area. Lynn Gallacher suggested including unpaid carers and Chris noted that he was keen that the Future Strategy Group did not to replicate the SPG. The Future Strategy Group would be developing the detail which the SPG could scrutinise and steer. David Bell suggested a representative from HR from SBC and NHSB. Caroline Green suggested a medical director for their views on feasibility. A clinical services representative was proposed by Kathleen McGuire.

Next steps – Chris will have further discussions with individuals and put together terms of reference for this group to bring to the SPG to formalise.

The **STRATEGIC PLANNING GROUP** supported the remit and membership. Chris Myers agreed to consider the Housing representative, HR and clinical representation for the Future Strategy Group.

7. ORAL HEALTH NEEDS ASSESSMENT AND NEXT STEPS – Morag McQuade/Morag Muir

Morag McQuade and Morag Muir were welcomed to the meeting. Morag Muir shared the presentation on screen. Ten priority areas for action were identified prior to Covid but the impact of Covid has means there is a backlog of appointments and clinics are not yet running back at full capacity. Inequalities have been heightened. The service is looking to remobilise in a way that addresses these issues and asking for the SPG to endorse this and the IJB to ratify this approach. The request is to have oral health included in the new IJB plan as a priority to focus on. To commission the Health Board to develop a comprehensive strategic plan for oral health services.

Cathy Wilson supports the need for infrastructure and financial backing from the IJB as dentistry is an indicator of general health. The service is mobile and can go into care homes. Keith Allan also support this request and noted that the deprived are suffering disproportionately. Keith also added that this could be included in the review of integration that is under review to help the service and the residents of the Borders. However, funding for dental services comes directly from the Scottish Government but the IJB could have control over some aspects. Chris Myers noted that general and public dental services are within the scope of the IJB with the caveat that planning and direction come from Scottish Government. David Bell noted that the data is 2 years out of date and suggested that the data be updated before presenting to the IJB.

Chris Myers thanked Morag McQuade and Morag Muir for their presentation.

The **STRATEGIC PLANNING GROUP** ratified the report for publication and agreed to include oral health in the IJB strategic plan.

8. DIRECTIONS FOR CONSIDERATION – Chris Myers

Five direction documents were circulated prior to the meeting for consideration by the SPG prior to going to the IJB to seek support to issue these in line with the new Directions Policy and Strategic Commissioning Approach developed by the SPG, Audit Committee and IJB. Chris Myers asked the group for any feedback/ changes.

- Workforce strategy – this was in line with the discussion at the last IJB and the comments from David Bell in the SPG about the significant workforce pressures being experienced
- Tweedbank and Hawick Care Village Development/Workforce/Commissioning – Chris Myers noted there had been a lot of discussion at the IJB on the care village paper. Work was supported by the IJB on the basis of much more engagement and co-production, and an assessment of the need
- The Strategic Commissioning direction supports the work that will be undertaken by the IJB on developing a needs assessment and new strategic commissioning plan
- Oral Health Needs Assessment/Budgets – to be presented at the next IJB meeting. More detail to be added to the Budgets paper before submission.

Lucy O'Leary thanked Chris Myers for putting the papers together. The Directions formalise and provide clarity that the IJB's role is to commission and the SPG's role is to advise the IJB of the direction.

The **STRATEGIC PLANNING GROUP** supported the 5 Directions.

9. ANY OTHER BUSINESS

None.

10. DATE AND TIME OF NEXT MEETING

The Chair confirmed the next meeting of the Strategic Planning Group would be held on Wednesday 4 May 2022 at 10am to 12pm via Microsoft Teams.

Lucy O'Leary noted that local elections take place in May and so there may be a new Board by the next meeting date. The new Vice Chair of the IJB will be from the Council. Lucy is in discussion with David Parker on how to manage the Chair for the next meeting. Chris Myers noted that the IJB schedule is also being reviewed.

Meeting Dates 2022: 4 May 2022, 3 August 2022, 2 November 2022.

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