Borders NHS Board

A meeting of the **Borders NHS Board** will be held on **Thursday, 2 October 2025** at 10.00am in the Council Chamber, Scottish Borders Council and via MS Teams (HYBRID).

AGENDA

Time	No		Lead	Paper
10.00	**1**	**ANNOUNCEMENTS & APOLOGIES**	Chair	*Verbal*
10.01	**2**	**REGISTER OF INTERESTS**	Chair	*Appendix-2025-68*
10.02	**3**	**MINUTES OF PREVIOUS MEETING** 07.08.2025	Chair	*Attached*
10.03	**4**	**MATTERS ARISING** Action Tracker	Chair	*Attached*
10.05	**5**	**CHIEF EXECUTIVE'S REPORT**	Chief Executive	*Verbal*
10.10	**6**	**STRATEGY**		
10.10	6.1	Scottish Borders Health & Social Care Integration Joint Board update	Chief Executive	*Verbal*
10.12	6.2	Public Protection Report	Director of Nursing, Midwifery & AHPs	*Appendix-2025-69*
10.22	6.3	Primary Care Improvement Plan Annual Programme Report	Director of Urgent Care, Community Services & Mental Health	*Appendix-2025-70*
10.32	6.4	Policy on Prescribing Following Private Consultation	Director of Pharmacy	*Appendix-2025-71*
10.42	**7**	**FINANCE AND RISK ASSURANCE**		
10.42	7.1	Resources & Performance Committee minutes: 08.05.25	Board Secretary	*Appendix-2025-72*
10.43	7.2	Audit Committee minutes: 19.06.25; 26.06.25	Board Secretary	*Appendix-2025-73*
10.44	7.3	Finance Report	Director of Finance	*Appendix-2025-74*

10.55	**8**	**QUALITY AND SAFETY ASSURANCE**		
10.55	8.1	Clinical Governance Committee minutes: 23.07.25	Board Secretary	*Appendix-2025-75*
10.56	8.2	Quality & Clinical Governance Report	Director of Quality & Improvement	*Appendix-2025-76*
11.15	8.3	Infection Prevention & Control Report	Director of Nursing, Midwifery & AHPs	*Appendix-2025-77*
11.25	**9**	**ENGAGEMENT**		
11.25	9.1	Whistleblowing Quarter 1 Report	Director of HR, OD & OH&S	*Appendix-2025-78*
11.30	9.2	Whistleblowing Quarter 2 Report	Director of HR, OD & OH&S	*Appendix-2025-79*
11.35	**10**	**PERFORMANCE ASSURANCE**		
11.35	10.1	Integrated Performance Scorecard	Director of Planning & Performance	*Appendix-2025-80*
11.50	**11**	**GOVERNANCE**		
11.50	11.1	Scottish Borders Health & Social Care Integration Joint Board minutes: 16.07.25	Board Secretary	*Appendix-2025-81*
11.51	11.2	Board Business Plan 2026	Board Secretary	*Appendix-2025-82*
11.53	11.3	Annual Climate Change Report 2024/25	Director of Finance	*Appendix-2025-83*
11.58	11.4	Consultant Appointments	Director of HR, OD & OH&S	*Appendix-2025-84*
11.59	**12**	**ANY OTHER BUSINESS**		
12.00	**13**	**DATE AND TIME OF NEXT MEETING**		
		Thursday, 4 December 2025 at 10.00am in the Council Chamber, Scottish Borders Council and via MS Teams (HYBRID)	Chair	*Verbal*

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**2 October 2025**
Title:	**Register of Interests**
Responsible Executive/Non-Executive:	**K Hamilton, Chair**
Report Author:	**I Bishop, Board Secretary**

1 Purpose

This is presented to the Board for:

- Decision

This report relates to a:

- Government policy/directive

This aligns to the following NHSScotland quality ambition(s):

- Person Centred

2 Report summary

2.1 Situation

2.1.1 The purpose of this report is include the Declaration of Interests for P Williams, Non Executive Director into the formally constituted NHS Borders annual Register of Interests as required by Section B, Sub Section 4, of the Code of Corporate Governance.

2.2 Background

2.2.1 In accordance with the Board's Standing Orders and with the Standards Commission for Scotland Guidance Note to Devolved Public Bodies in Scotland, members are required to declare on appointment and annually any private interests which may be material and relevant to NHS business.

2.3 Assessment

The Register of Interests is made up of details received from members regarding any private interests which may be material and relevant to NHS business and constitute the Register of Interests.

The Register is made publicly available both through the NHS Borders website and on request, from the Board Secretary, NHS Borders, Headquarters, Education Centre, Borders General Hospital, Melrose TD6 9BD.

2.3.1 Quality/ Patient Care

Not applicable.

2.3.2 Workforce

Not applicable.

2.3.3 Financial

Not applicable.

2.3.4 Risk Assessment/Management

Regulatory requirement.

2.3.5 Equality and Diversity, including health inequalities

An HIIA is not required for this report.

2.3.6 Climate Change

Not applicable.

2.3.7 Other impacts

Regulatory requirement.

2.3.8 Communication, involvement, engagement and consultation

Not applicable.

2.3.9 Route to the Meeting

Not applicable.

2.4 Recommendation

The Board is asked to **approve** the inclusion of the Declaration of Interests for P Williams, Non Executive Director in the NHS Borders Register of Interests.

The Board will be asked to confirm the level of assurance it has received from this report:

- **Significant Assurance (recommended)**
- Moderate Assurance
- Limited Assurance
- No Assurance

3 List of appendices

The following appendices are included with this report:

- Appendix No 1, Register of Interests for P Williams, Non Executive Director.

Borders NHS Board

Register of Interests of Board Members

This register has been drawn up in accordance with the Standards Commission for Scotland, Standards in Public Life: Model Code of Conduct for Members of Devolved Public Bodies.

Board Member: PAUL WILLIAMS….. *(please insert your full name in capital letters)*

Registerable Interest	Members Interest
Remuneration Remuneration by virtue of being • employed or self employed • the holder of an office • a director of an undertaking • a partner in a firm • undertaking a trade, profession or vocation or any other work • allowances in relationship to membership of an organisation	NIL
Related undertakings Any directorships held which are not themselves remunerated, but where the company (or other undertaking) in question is a subsidiary of, or a parent company of, a company (or other undertaking) for which a remunerated directorship is held.	NIL
Contracts Any contract between NHS Borders and the member or a firm in which the member is a partner, or an undertaking in which the member is a director or has shares (as described below), under which goods or services are to be provided or works executed, which has not been fully discharged.	NIL
Houses, land and buildings Any right or interest owned by the member in houses, land or buildings which may be significant to, of relevance to, or bear upon, the work and operation of NHS Borders	NIL
Shares and securities Any interest in shares which constitute a holding in a company or organisation which may be significant to, of relevance to, or bear upon, the work and operation of NHS Borders and the nominal value of the shares is; greater than 1% of the issued share capital of the company or other body; greater than £25k.	NIL
Gifts and hospitality Any relevant gifts or hospitality received by the member or the members spouse or cohabitee, company or partnership.	NIL
Non financial interests Any non-financial interests which may be significant to, of relevance to, or bear upon, the work and operation of NHS Borders, such as membership or holding an office in other public bodies, clubs, societies and organisations, such as trade unions and voluntary organisations.	NIL

Signed…  …….. Date ……22.09.2025……...

Borders NHS Board

Minutes of the **Borders NHS Board** meeting held on Thursday, 7 August 2025 at 10.00am in the Council Chamber, Scottish Borders Council and via MS Teams (Hybrid).

Present:
F Sandford, Vice Chair (Chair)
L Livesey, Non Executive
J Ayling, Non Executive
D Parker, Non Executive
P Moore, Chief Executive
A Bone, Director of Finance
S Horan, Director of Nursing, Midwifery & AHPs
L McCallum, Medical Director
S Bhatti, Director of Public Health

In Attendance:
I Bishop, Board Secretary
J Smyth, Director of Planning & Performance
A Carter, Director of HR, OD & OH&S
O Bennett, Interim Director of Acute Services
G Clinkscale, Director of Acute Services
L Jones, Director of Quality & Improvement
M Clubb, Director of Pharmacy
S Whiting, Infection Control Manager
S Laurie, Senior Communications Officer
N Sewell, Health Improvement Lead
M Chalmers, Acacium Group
K Rodgers, Head of Finance, NHS Health Improvement Scotland
A McGillvray, Senior Reporter

1. Apologies and Announcements

1.1 Apologies had been received from K Hamilton, Chair, L O'Leary, Non Executive, and J McLaren, Non Executive.

1.2 The Chair welcomed a range of attendees to the meeting.

1.3 The Chair confirmed the meeting was quorate.

1.4 The Chair advised that where the Board might find it difficult to give an overall assurance rating to an item it would be asked to consider a split of assurance between Systems/Processes and Outcomes.

1.5 I Bishop advised that the election for a Chair of the Area Clinical Forum had been held and an appointment had been secured. The individual was currently on annual leave and the announcement would be released on their return.

2. Declarations of Interests

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

The **BOARD** noted there were no verbal declarations.

3. Minutes of the Previous Meeting

3.1 The minutes of the Extraordinary meeting of Borders NHS Board held on 26 June 2025 were approved.

4. Matters Arising

4.1 **Action 2024-5:** The election of a new ACF chair had been held and an appointment made. It was agreed to close the action.

4.2 **Action 2025-4:** It was noted the action remained live.

4.3 **Action 2025-5:** It was noted the action remained outstanding.

The **BOARD** agreed to close Action 2024-5.

The **BOARD** noted the Action Tracker.

5. Chief Executive's Report

5.1 P Moore provided an overview of the content of the report and highlighted: staff awards; retirements and the organisational strategy.

5.2 S Horan acknowledged the organisations' support for R Morrison who had been able to maintain membership of the Mountain Rescue Team.

5.3 The Chair recorded the congratulations of the Board to all those mentioned within the staff awards section the report.

The **BOARD** noted the report.

The **BOARD** confirmed it had received Moderate Assurance from the report.

6. Clinical Strategy Update

6.1 L McCallum provided an overview of the progress made with the clinical strategy and highlighted several key elements within it which included: the patient and the population of the borders placed at the centre of the strategy; challenges in relation to the process that had been undertaken in terms of time; locality based working and pathways; delivery of change and the need and desire to deliver; support of the planning and performance team; and changing the mindset of the public.

6.2 The Chair provided feedback on the session she had attended at Borders College.

6.3 Discussion focused on: financial strategy to support the clinical strategy; capturing the underlying causes and themes in terms of the actions developed; any case for

delay to enable better commitment from General Practice; draw in the 5 life stages into answers the 4 key questions from the organisational strategy; pump priming needed to transition from secondary care to primary care provision; themes will emerge; challenges around time and credibility; positive feedback from the sessions held; is conclusion by September feasible or should there be a short extension; the task force could replan the overall timeline if required; hundreds of clinicians had engaged with the process to date; credibility; continual change process; the infrastructure in place; and the other underpinning strategies of the Organisational Strategy.

The **BOARD** noted the work underway towards the development of NHS Borders Clinical Strategy.

The **BOARD** confirmed it had received Significant Assurance in terms of systems and processes and Moderate Assurance in terms of outcomes from the report.

7. Scottish Health & Social Care Integration Joint Board Update

7.1 P Moore provided an overview of the report and advised that the work of the partnership continued in the absence of a Chief Officer. He and D Robertson remained committed to the recruitment of a new Chief Officer and a revised job description had been jointly agreed. The timeline for a recruitment campaign would become clearer over the following weeks. A joint workshop was being organised between NHS Borders and Scottish Borders Council Executives to ensure partners were clear on the key priorities they both shared and continued to build on already successful integration work.

7.2 P Moore advised that he would provide a further update to the next meeting of the Board in October.

The **BOARD** noted the report.

The **BOARD** confirmed it had received Moderate assurance from the report.

8. Q4 Risk Report 24/25 – Annually

8.1 L Jones provided an overview of the report and highlighted that good progress continued to be made in regard to risk management and a new digital system “Inphase” had been introduced.

8.2 S Horan commented that she was supportive of the business as usual approach and enquired about progress.

8.3 L Jones confirmed that targeted training continued to take place and there appeared to be more of a focus on risk in service planning.

8.4 S Horan acknowledged the risk team contained a small number of topic specialists who carried a significant workload and wished the Board to acknowledge the pressure on that small team to deliver.

8.5 J Smyth commented that very high risks were discussed at the Operational Planning Group (OPG) where they were scrutinised and mitigated. She recorded her thanks to L Pringle for her significant input to the OPG.

The **BOARD** noted the report.

The **BOARD** noted the actions from the Audit and Risk Committee:

- Further internal work to be undertaken to improve compliance with risk management process particularly within support services.
- To investigate whether it is possible to include percentages within the training statistics and include in next report.
- Risk Management Strategy will be reviewed this year to come in line with the Organisational Strategy.

The **BOARD** confirmed it had received Significant Assurance in terms of systems and processes and Moderate Assurance in terms of outcomes from the report.

9. Finance Report

9.1 A Bone provided an overview of the content of the report and reminded the Board that the detailed scrutiny of finance was through the Resources & Performance Committee, however given the seriousness of the financial position he would continue to report to the Board as well.

9.2 A Bone reported that he had not yet received feedback from the Scottish Government on the Quarter 1 report. After 2 months the organisation was £3.13m overspent and if the trend continued there would be a £19m overspend at the end of the year. The financial plan trajectory had been £12.8m and many of the actions described in the financial plan had not yet impacted the forecast.

9.3 He further highlighted: the non delivery of £3m of savings; actual savings achievement to date; increase in agency use; unlikely to hit the Quarter 1 milestone targets or the Quarter 2 milestone target; and the underpinning challenge on level and pace of recurring savings.

9.4 Further discussion focused on the increase in medical agency spend due to a number of unexpected situations arising in small teams with vulnerability; greater efficiency savings; a need for further discussion at the Delivery Group; strategic reconfiguration of the organisation and it's assets; evaluation of savings schemes through the Financial Improvement Plan (FIP) programme; service reviews; and increase in the level of focus on financial recovery.

The **BOARD** noted the contents of the report which included:

YTD Performance	£3.13m overspend
Outturn Forecast at current run rate	£18.77m overspend
Projected Variance against Plan (at current run rate)	£5.97m adverse
Actual Savings Delivery (current year effect)	£0.84m (actioned)
Projected gap to FP Forecast	Best Case £12.80m (FP) Worst Case £18.77m (trend)

The **BOARD** noted the assumptions made in relation to Scottish Government allocations and other resources.

The **BOARD** confirmed it had received Moderate Assurance in terms of systems and processes and Limited Assurance in terms of outcomes from the report.

10. Clinical Governance Committee minutes: 14.05.25

The **BOARD** noted the minutes.

11. Quality & Clinical Governance Report

11.1 L Jones provided an overview of the content of the report and highlighted: the additional funding received for planned care; maintenance of a strong focus on both national standards and areas outwith the national standards; medication governance work and the lack of a HEPMA system; and feedback from the Deanery in regard to training concerns in general surgery.

11.2 S Horan commented that the lack of a HEPMA system impacted on anti-microbial stewardship as HEPMA was a key enabler in how to manage that.

11.3 The Chair commented that the Clinical Governance Committee were keen for the Board to understand the gravity of not having a HEPMA system and indeed being the only Board in Scotland not to have a HEPMA system.

11.4 L McCallum reinforced the point raised by S Horan and commented that the lack of a HEPMA system was a significant issue in regard to medical training, nurse and AHP training. There were students from various disciplines who worked on electronic systems and had never written paper prescriptions. The electronic systems enabled a higher level of patient safety and whilst there would be a significant financial impact it was now an imperative from a patient safety, training and governance perspective.

11.5 A Bone commented that whole system infrastructure planning was being progressed through a national planning network and he suggested a business case could be submitted, however there was a restriction on the number of cases Boards could submit so a prioritisation framework locally would be required.

11.6 Further discussion focused on: financial savings achieved by being more digitally enabled; the risk of harm in being an outlier with HEPMA; unannounced Health Improvement Scotland (HIS) inspection earlier in the week; hand hygiene compliance; and initial feedback from the unannounced inspection.

The **BOARD** noted the report.

The **BOARD** confirmed it had received Limited assurance from the report.

12. Infection Prevention & Control Report

12.1 S Whiting provided an overview of the content of the report and highlighted several key issues which included: hand hygiene good practice observed by the HIS unannounced inspection; *Staphylococcus aureus* Bacteraemia (SAB) remained off

target; *Clostridioides difficile* infection (CDI) had increased in Quarter 1; in reviewing the cases there was no cross contamination; the absence of HEPMA was a limitation in reviewing decisions that may have impacted those areas; crude data on deaths which relied on coding and did not distinguish between acute and community deaths; and E.coli were 50% community associated.

12.2 Discussion focused on: revised format of the report; plotting of cluster issues into a chart to explore the possibility of linkages; capture and report on the blocked empty beds for outbreaks; and recognition of the incredible work taken forward with hand hygiene compliance.

The **BOARD** noted the report.

The **BOARD** confirmed it had received Moderate assurance from the report.

13. Managing Introduction of GLP-1 RA Medication in NHS Borders

13.1 M Clubb provided an overview of the content of the report and referred to the various medications for weight loss which had prices agreed through the SMC mechanism and had been agreed by the East Region Formulary. It had also been agreed at the East Region that the route for prescriptions would be through the Weight Management Service as it could provide the after care that would be required. He further commented that there was an intention to increase the number of dietetic supplementary prescribers.

13.2 L McCallum commented that the evidence emerging around the weight loss drugs was that they were neuro protective, whilst also being very expensive.

13.3 Discussion focused on: surge planning to manage obesity and prescribing GLP-1 medications; additional workforce in the dietetic and lifestyle services; obesity strategy; challenges in affording changes in clinical practice; new medicines funding for NHS Borders is £5.5m and that has already been exceeded; already 400 patients attend the weight management service and it was expected that some would be eligible for treatment; patient led demand was unknown; suspected about 2,000 people were accessing the treatment privately; and when people come off GLP1 there is a tendency for weight gain, so support is required to maintain that weight loss.

The **BOARD** approved the recommendations in the paper to provide the SMC approved medicines through the weight management service with additional staffing.

The **BOARD** confirmed it had received Moderate assurance from the report.

14. Staff Governance Committee minutes: 17.04.25

14.1 L Livesey enquired why the Whistleblowing Quarter 1 report (April-June) had not been presented to the Board.

14.2 I Bishop confirmed that due to annual leave the report had not been finalised in time for the meeting and would be presented to the next meeting of the Board in October.

The **BOARD** noted the minutes.

15. NHS Borders Performance Scorecard

15.1 J Smyth presented the standard performance scorecard to the Board meeting. She advised that an updated narrative on Treatment Time Guarantee had been received and the revised report would be circulated to the Board after the meeting.

15.2 O Bennett provided the Board with some salient points in regard to acute services and highlighted: progress in terms of reducing elective waits; waits over 2 years were isolated to 1 speciality, dermatology; there were a handful of cases where patients were unavailable or medically unfit; significant progress in new treatment and out patient waiting times with no patients over 52 weeks to be seen or treated; from cancer perspective there had been a 19% improvement in performance; unscheduled care remained challenging with many performance issues linked to flow; and delayed discharge performance had improved but not at the scale expected.

15.3 P Moore commented that the progress with elective performance was impressive and especially the eradication of 52 week waits. He noted that the level of delayed discharges remained unacceptable and that there were still challenges across the system. He remained keen to focus on closing those areas of greatest risk to patients.

The **BOARD** noted the report for performance as at the end of June 2025.

The **BOARD** confirmed it had received Moderate assurance from the report.

16. Scottish Borders Health & Social Care Integration Joint Board minutes: 19.03.25

The **BOARD** noted the minutes.

17. Consultant Appointments

The **BOARD** noted the report.

The **BOARD** confirmed it had received Significant Assurance from the report.

18. Any Other Business

The **BOARD** noted there was no further business for discussion.

19. Date and Time of next meeting

19.1 The Chair confirmed that the next scheduled meeting of Borders NHS Board would take place on Thursday, 2 October 2025 at 10.00am in the Council Chamber, Scottish Borders Council and via MS Teams (hybrid).

Borders NHS Board Action Point Tracker

Meeting held on 3 October 2024

Agenda Item: NHS Borders Performance Scorecard

Action Number	Reference in Minutes	Action	Action to be carried out by:	Progress (Completed, in progress, not progressed)
2024-5	16	The **BOARD** noted that the ACF Chair would progress linking the ACF through the Clinical Governance Committee in terms of activities across independent practitioners.	**ACF Chair**	**In Progress: Update 05.12.24:** Mrs Laura Jones advised that Dr Kevin Buchan, Mrs Sandford and herself had met and discussed linkages between the ACF and Clinical Governance Committee. Some issues required a more operational reporting line and it was agreed to keep the item open on the Action tracker whilst further discussions took place. **Update 06.02.25:** The Chair advised that the Chair of the ACF had resigned and an election would be held for a replacement. Mrs Fiona Sandford commented that it was important for the Board to receive a strong voice from independent practitioners particularly GPs. **Update 26.03.25:** The Chair of the GP Sub election was required to take place before the election of the Chair of the ACF. The election for the Chair of the GP Sub was scheduled for 31.03.25. **Update 18.06.25:** Election to take place at ACF meeting on 23.06.25. **Update 26.06.25:** An election was held and an appointment was not made. A further election would take place over the following 2

				weeks. The **BOARD** agreed to close Action 2024-5.

Meeting held on 26 June 2025

Agenda Item: Health & Care (Staffing) (Scotland) Act 2019 - Annual Report

Action Number	Reference in Minutes	Action	Action to be carried out by:	Progress (Completed, in progress, not progressed)
2025-4	21	The **BOARD** noted the report and demitted it to the Staff Governance Committee to review and represent to the Board with assurance that it was evidencing compliance with the Act.	**Andy Carter / Sarah Horan**	**In Progress:** The report had been scheduled for the Staff Governance Committee meeting to be held on 16 October 2025.

Agenda Item: Code of Corporate Governance sectional refresh

Action Number	Reference in Minutes	Action	Action to be carried out by:	Progress (Completed, in progress, not progressed)
2025-5	24	The **BOARD** agreed that the Area Partnership Forum Terms of Reference be reviewed and resubmitted.	**Iris Bishop / John McLaren**	**In Progress:** John McLaren to represent the APF ToR to the next APF meeting for review and onward submission to the Board for formal approval.

Agenda Item:

Action Number	Reference in Minutes	Action	Action to be carried out by:	Progress (Completed, in progress, not progressed)
2025-6				

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**2 October 2025**
Title:	**Public Protection Report**
Responsible Executive/Non-Executive:	**S Horan Director of Nursing, Midwifery & AHPs**
Report Author:	**R Pulman, Nurse Consultant Public Protection**

1 Purpose

This is presented to the Board for:

- Awareness

This report relates to a:

- Legal requirement

This aligns to the following NHSScotland quality ambition(s):

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

Adults with complex care needs and frailty are at increased risk of harm due to delayed discharges, extended Emergency Department (ED) stays, and boarding. Risks include deconditioning, institutional harm, and missed safeguarding opportunities.

ASP themes are being linked to key safety indicators such as pressure damage, nutrition, frailty, documentation, and transitions of care.

Need to ensure that Adult Support and Protection continues to be integrated within existing quality and assurance processes to support early identification and response to ASP and understanding of themes and trends across areas.

Priorities include continuing to strengthening staff confidence and understanding of roles and responsibilities in relation to public protection and safeguarding, improving data capture, and embedding learning into daily practice all of which are essential to ensure patient safety and effective Public Protection.

Public Protection is integral to high-quality care and patient safety and NHS Borders remains committed to maintaining robust oversight and ensuring compliance with national legislation, standards, and guidance. We continue to prioritise continuous improvement in practice to safeguard children, young people, and adults from harm, reinforcing our commitment to supporting the vision of the Scottish Borders Public Protection Committee; *"Everyone in the Scottish Borders has the right to live free from abuse, harm, and neglect."*

Public Protection encompasses Adult Support and Protection, Child Protection, Violence Against Woman and Girls, MAPPA (multi-agency public protection arrangements for offenders) and has links to the Prevent duties.

Public Protection is a shared responsibility across all services. The consequences of failing to protect vulnerable individuals are significant and far-reaching. NHS Borders continues to strengthen its role as a key partner in public protection through learning, and a developing a culture of safety and prevention. The report reflects our commitment to continuous improvement, partnership working, and learning from instances where harm has occurred.

2.2 Background

Public protection in Scotland is underpinned by a strong legislative and policy framework aimed at safeguarding children (including unborn babies), young people, and adults at risk of harm. NHS Borders, as part of the wider health system, plays a critical role in identifying, responding to, and preventing harm through multi-agency collaboration and continuous improvement.

NHS boards have a duty to co-operate with local authorities when they are making enquiries to protect children, young people and adults and NHS employees have a duty to take appropriate action when we are concerned that a child (including an unborn child), young person or an adult is at risk of harm, abuse or neglect.

Children and Young People (Scotland) Act 2007 outlines duties around child protection, wellbeing, and Getting It Right For Every Child (GIRFEC) framework.

Section 4 ASP Act 2007 (Scottish Government 2007), Scottish Government (2021) and Scottish Government (2022). Section 5 (3) of the ASP Act 2007 places a legal duty on NHS staff to 'report' to Social Work colleagues when an adult is known or believed to be at risk of harm Section 5(3) ASP Scotland Act 2007.

National guidance and Standards such as the National Guidance for Child Protection in Scotland (2021) and The Code of Practice for Adult Support and Protection (2022) provide comprehensive detail in respect to the practical application of day-to-day practice to support development of local procedures.

The approach to addressing violence against women and girls (VAWG) is supported by comprehensive framework of guidance aimed at prevention, protection and provision of services.

There is also specific legislation and practice guidance that directs and supports NHS Boards to fulfil their duties in relation to MAPPA and PREVENT.

NHS Boards have responsibilities in relation to assessing and managing the risks of certain offenders by virtue of Sections 10 and 11 of The Management of Offenders etc. (Scotland) Act 2005. These are the statutory partnership working arrangements known as Multi-Agency Public Protection Arrangements (MAPPA). Health board have key statutory responsibilities as a **Duty to Cooperate** agency (where the focus is on information sharing and other supports to partners). They also have statutory responsibilities as **Responsible Authorities** where MAPPA arrangements relate specifically to Restricted Patients.

Human Rights Act 1998 and UNCRC (Scotland) Act 2024 outline duties to ensure that rights promote
and protected.

Key Issues of Significance

- Consistent and systematic capture and dissemination of learning from Learning Reviews, ensuring that insights—whether from formal or alternative processes—are effectively shared across NHS Borders to strengthen practice and prevent future harm.
- Evolving complexity- public protection agenda continues to be substantial and complex, shaped by multi-faceted factors.
- Complex practice scenarios and emotional demands on health professionals working directly with individuals affected by harm, abuse and neglect.
- Consistent communication and information sharing, particularly at transition points between NHS services and multi-agency working; silo working.
- Need for on-going cultural change to promote shared ownership of safeguarding responsibilities across staff levels and services.
- Ongoing work pressures and competing demands risk gaps in Public Protection training compliance and capacity to engage in multi-agency processes.

The Scottish Borders Public Protection Committee is committed to the continued development of consistent and co-ordinated approaches to Public Protection that ensure that all children, Young People and adults at risk of harm are protected from harm. Key objectives include:

- Promoting early intervention.
- Enhancing multi-agency collaboration, assessment, planning and information sharing.
- Promoting Supervision and Support for staff.
- Promoting a culture of continuous learning and development.
- Promoting person-centred care- rights of the individual.

The functions of the NHS Borders Public Protection Service Are:

- Provision of professional clinical expert leadership
- Provision of learning and education
- Quality assurance
- Public Protection policy, procedures and guidance

2.3 Assessment

NHS Borders has established a strong foundation for Public Protection through strategic leadership, multi-agency collaboration, and structured governance. The co-located Public Protection Unit (PPU), active participation in strategic and operational multi-agency forums that support the functions of Public Protection agenda including MAPPA, and implementation of national frameworks such as the Public Protection Assurance Toolkit reflect a proactive approach to safeguarding.

The Public Protection Team has a key role in the provision of leadership, professional expertise and support to a wide range of stakeholders. The team comprises a Public Protection Nurse Consultant, Public Protection Nurse (Adults), x2 WTE Public Protection Nurse Advisors (Child) and administration support. There is an identified Lead Paediatrician for Child Protection.

In response to partial retirement within the team and the evolving needs of the service, succession planning has become a strategic priority. This includes proactive workforce development, mentoring, and role transition planning to ensure continuity of expertise and leadership. The team is actively reviewing its structure and capacity to remain responsive to emerging public protection challenges, legislative changes, and the increasing complexity of safeguarding across both adult and child services.

The Public Protection Team provides;

- Advice, support and supervision to staff to help encourage reflective and improved practice for risk assessment and decision making.
- Timely medical assessment and examinations as part of multi-agency processes including Forensic examination.
- Develops and delivers single and multi-agency public protection learning and education opportunities, which aligns with professional and national standards to support staff fulfil their roles and responsibilities to protect unborn babies, children, young people and adults from risk of harm.
- Participates in learning reviews and dissemination of learning.
- Supports inspection processes and associated improvement plans.
- Participates in collating and interpretating data on child and adult support and protection through quarterly Public Protection Committee Performance Reports.
- Provides guidelines and policies for staff to help them execute their public protection responsibilities.
- Contributes to the development of local multi-agency procedures and guidance.
- Contributes to national, policy and guidance direction.
- Supports escalation and dispute resolution.
- Ensure robust information sharing systems and alerts are in place; **NB**: The number of different patient management systems in place across NHS Borders

continues to present a challenge in ensuring relevant and proportionate information is shared/documented across all these systems.
- Promotes collaborative multi-agency partnership working.

Nurse Consultant PP is an active participant in a range of national groups where they continue to contribute to the business and development of consistent Public Protection Practice across Scotland. This includes work related to Public Protection Assurance Framework, bench marking activity in relation to Public Protection resource provision in NHS Boards and initial evaluation of implementation of NHS accountability framework.

Public Protection data is regularly reported and scrutinised via quarterly Public Protection Committee Performance reports. The Public Protection Committee also has a risk register that is regularly scrutinised and updated.

A Dissemination process is in place to ensure that communications about Public Protection training is disseminated across the organisation and arrangements are in place to deliver single and multi-agency training on Public Protection across NHSB.

Mandatory Public Protection awareness e-learning module for August 25 is **82%**.

Areas for development

- **Policy implementation versus Practice Consistency**;
  While policies are in place, ensuring consistent application across all care settings remains a challenge. Variability in staff understanding and confidence in procedures can pose risks to patient safety.
- **Learning Dissemination and Action**
  Although learning from reviews and near misses are identified and acted upon, the effectiveness of dissemination and integration into daily practice must be continuously monitored to avoid recurrence of issues.
- **Data Capture and Assurance**
  There are planned improvements to enhance data capture and response in relation to Public Protection across NHS Borders. However, until fully implemented, there may be limitations in real-time visibility of training compliance and concerns and trends. Leadership, Clinical teams, Public Protection Team, and governance bodies must be engaged in ongoing commitment to training and quality and assurance processes.

Adult Support and Protection

Operational Pressures- delayed discharged, extended ED stay and Boarding:
- Adults with complex care needs and/or frailty are at heightened risk of harm due to prolonged hospital stays, including deconditioning and increased exposure to institutional harm risks.

Current Good Practice:
- A Standard Operating Procedure (SOP) is in place, including a flowchart, outlining the process for notifying Patient Safety, Clinical Nurse Managers, and the Director of Nursing/ADoNs regarding Adult Support and Protection (ASP) investigations involving NHS Borders.

- ASP cases with patient safety implications are promptly shared with the Patient Safety Team, Clinical Nurse Manager, and ADoN for the relevant clinical area.
- Outcome summaries and recommendations from ASP investigations are disseminated to Patient Safety Clinical Nurse Managers, ADoN's to support learning and continuous improvement.
- Health representatives are identified to assist Council Officers during ASP investigations. Their clinical expertise ensures accurate interpretation of health information.

This approach aims to enables:

- Timely clinical risk assessments
- Compliance with Duty of Candour
- Embedding ASP recommendations into broader patient safety systems

Areas for Improvement:

- Strengthen feedback mechanisms to provide assurance to the Public Protection Committee regarding the implementation of Adult Support and Protection recommendations.
- Establish a consistent and transparent approach that evidences ongoing improvement and impact.

Themes linking Public Protection to Quality and Safety Indicators/Care Assurance System and delivery programme:

- **Pressure Damage-** poor pressure damage prevention can be both clinical safety concern and in some cases a safeguarding issue.
- **Food and nutrition** – links exist between poor nutritional care in hospital or community setting s and increased vulnerability to risk of harm.
- **Frailty**: Frailty often interacts with ASP concerns- increased susceptibility to abuse
- **Documentation-** Gaps in recording patient condition concerns, or decision making. Adult with incapacity record can compromise both patient safety and the legal robustness of ASP investigations.
- **Transitions of care** risks include inadequate follow-up, poor discharge information and failure to ensure right services in place before discharge.
- **Capacity and consent issues** and assurance on compliance with the Adults with Incapacity (Scotland) Act 2000

Governance implications: By tracking these indicators within existing safety reporting, we can strengthen early identification of safeguarding concerns, improve cross-service awareness and embed safeguarding thinking into all quality and safety monitoring processes.

Action Recommendations

1. **Develop a Feedback Framework**
   Create a structured process for reporting back to the Public Protection Committee on how ASP recommendations have been actioned, including timelines and NHS responsible leads.
2. **Implement a Learning Tracker**
   Use a digital or dashboard-based tool to monitor ASP-related learning outcomes,

changes in practice, and evidence of improvement across clinical areas. (In development).

3. **Enhance Multi-Agency Collaboration**
   Formalise regular review meetings between Patient Safety, Clinical Leadership, and Public Protection leads to discuss ASP cases and shared learning.
4. **Audit and Review Cycle**
   Introduce periodic audits of ASP case outcomes to assess how recommendations have been embedded and identify areas for further development.

Workforce and training priorities:
Targeted training for staff in acute settings, particularly those in wards receiving 'boarded patients', to ensure safeguarding/ASP risks are recognised. Also, emphasise on recognising harm in patients experiencing extended stays in ED, delayed discharge or transitioning between care settings.

- Use Learning Reviews to provide focused' learning spotlights' for staff, to avoid information overload while reinforcing key practice points.
- To ensure Adult Support and Protection (ASP) investigations are robust and clinically informed, it is essential to strengthen both
  the processes and training that enable health professionals to effectively support Council Officers.

Complex Child Protection cases including those that have been actively managed within inpatient wards, involving suspected Non-accidental Injuries (NAI) and where children are required ongoing clinical care alongside multi-agency protection planning, has an impact on staff within acute clinical and community areas;

- Managing suspected child protection cases can be emotionally challenging and may cause distress among staff teams particularly where injuries are severe or where there is uncertainty about the child returning home.
- Increased staff time is required for case discussions, report preparation for Child Protection and Court processes and liaison with agencies involved- adding to workload pressures.
- Staff require increased supervision and emotional support to process the emotional impact and maintain standards of care and follow procedure.

Good Practice

- Structured post -case debriefs following high-impact cases
- Child Protection supervision is accessible to staff
- Group Supervision sessions have been established; promotes reflection/professional curiosity.
- The provision of supervision to the Family Nurse Partnership (FNP) service in line with the FNP licencing agreement.
- Child protection consultant paediatricians undertake medical examinations and provide expert opinions about children who have been abused or neglected as part of multiagency arrangements to protect children. We have a regular meeting to review Child Protection Cases and robust analysis of health role.

Practice example: Childrens ward staff were offered access to psychology-facilitated reflection and debrief session following involvement in complex and emotionally challenging case. This session provided a safe and structured space for staff to reflect on their experiences and emotional responses and process the impact of safeguarding work on their wellbeing.

Our Public Protection Service provides advice for Child and Adult Support and Protection concerns. And continues to be well used by a range of staff across NHS Borders.

Over the past year, NHS Borders has progressed work to strengthening its public protection practice through targeted developments in policy, multi-agency collaboration, and practitioner tools. These improvements reflect a proactive response to emerging risks and national expectations, particularly in relation to early intervention, child-centred planning, and adult support and protection.

- **Policy and Procedure Updates**:
  The revision of the *Bruising and Injury in Non-Mobile Infants and Children Procedure* and the approval of *Multi-Agency Pre-Birth Guidance* demonstrate a commitment to support practitioner to identify risk.
- **Enhanced Multi-Agency Collaboration**:
  Expansion of the *Pre-Birth Assurance Oversight Group* to include addiction, mental health, learning disability, and justice services has improved information sharing and consistency in decision-making.
- **Innovative Practice Development**:
  The implementation of adult chronologies within Learning Disability services and the redesign of the child's plan reflect a shift toward more holistic, rights-based, and outcome-focused approaches.
- **Improved Practitioner Tools**:
  The development of a new *Child Protection Report Template* supports clearer assessment and analysis, enhancing the quality of information shared in child protection processes.
- **Service Users and Families**:
  - A key area of practice development has been the leadership of a Short Life Working Group to review the current child's plan, resulting in a revised approach that is child-centred, strengths-based, rights-focused, and more effective in measuring improvements in outcomes for children—addressing previously identified gaps in planning and assessment.
- **Training and Development**
  Securing funding to deliver training that equips staff to assess risk in child protection, practice professional curiosity, and engage in effective supervision is essential to strengthening safeguarding practice across NHS Borders.
- **Enhancing IRD recording and decision making**
  Scottish Borders is strengthening their Inter Agency Decision Making process (IRD) through approval of a key recommendation from the Public Protection Committee, endorsed by Chief Operating Group (COG). To develop and introduce a joint recording system for IRD using the Social Work system, MOSAIC,. This electronic solution will ensure consistent documentation of critical assessment information, decision making and planning.
- **Links with GP practices**
  Delivered Public Protection Awareness to GPs and practice staff across Scottish Borders.

2.3.1 Quality/Patient Care

Positive

- Effective Public Protection processes and procedures reduce risk of harm to children, young people and adults and improve safety and wellbeing.
- Prompt recognition of concerns by staff can prevent escalation and improve outcomes.
- Trauma-informed and rights based approaches improve trust, engagement and outcomes.
- Multi-agency collaboration supports understanding of risk and continuity of care planning and breaks down silo working.
- Visible public protection practice and procedures builds community trust that NHS services are safe and protective environments.

Negative

- Lack of staff awareness about Public Protection/safeguarding can lead to uncertainty and inconsistency in recognising and responding to concerns.
- Time spent on child protection and adult support and protection processes can contribute to workload pressures impacting clinical availability for other aspects of caseload management.

2.3.2 Workforce

Public Protection Service Update: October 2024 – August 2025
The delivery of Public Protection work priorities and actions has been significantly impacted between October 2024 and August 2025 due to staffing capacity issues within the Public Protection team. These challenges stem from staff absences and a partial retirement, which have necessitated a focus on maintaining critical business functions.

As a result, service priorities were streamlined to ensure the continued delivery of essential activities, specifically responding to Interagency Referral Discussions (IRDs), critical business and providing consultation and supervision for staff managing complex cases

Work has been undertaken to review and develop the staffing model required to support the full scope of the service. This includes the recruitment of a Public Protection Nurse Advisor to fill the vacancy created by the partial retirement.

Ongoing discussions with the Director of Nursing and Midwifery are focused on succession planning to ensure future sustainability of the team.

It is important to acknowledge the emotional impact on staff involved in child and adult support and protection work. Exposure to distressing situations, formal reviews, or investigations can lead to stress, burnout, secondary trauma, and anxiety.

Clinical teams, safeguarding leads, and service managers must be supported to implement new procedures and actively contribute to ongoing evaluation efforts.

2.3.3 Financial

Public Protection is now reflected under one budget report which proves better understanding and scrutiny of finance related to this area (previously held across three different areas)

2.3.4 Risk Assessment/Management

Risk: Reduced Capacity to Deliver Full Service
Impact: Delayed responses, reduced participation in multi-agency processes, impact on quality improvement
Mitigation:

- Prioritisation of critical functions (e.g., IRDs and supervision for complex cases).
- Recruitment of a Public Protection Nurse Advisor to fill the vacancy.
- Review and redesign of the staffing model to support sustainable service delivery.

Risk: Inconsistent staff knowledge and confidence in identifying and responding to child protection and/or adult support and protection concerns.
Impact:

- Variation in practice and response across teams and services
- Potential harm to children, young people, and adults due to missed or delayed safeguarding interventions

Mitigations:

- **Accessible Training:** Public Protection training is available to all staff, with a clear training and development strategy and framework in place.
- **Regular Communication:** Training opportunities are routinely disseminated to staff, managers, and team leaders.
- **Booking System:** A dedicated training information and booking system is available via the intranet.
- **Guidance Access:** "What to do if concerned" guidance and referral information are easily accessible on the intranet.
- **Consultation Support:** Staff have access to consultation and advice from the Public Protection team.
- **Up-to-Date Resources:** Procedures, policies, and guidance are maintained and accessible via the intranet and the Right Decision Making app.
- **Mandatory Learning:** A mandatory Public Protection e-learning awareness module is in place to ensure baseline knowledge across the workforce.

Risk: Failures in information sharing across systems.
Impact:

- Incomplete understanding of individual risk factors
- Duplication or omission of care and safeguarding actions
- Potential for avoidable harm to children, young people, and adults

Mitigations:

- **Established Protocols:** Clear procedures and protocols are in place to guide effective and timely information sharing across relevant systems and agencies.
- **System Alerts:** Child Protection and Adult Support and Protection alerts are embedded within electronic systems to flag concerns and ensure visibility across services.
- **Communication Pathways:** Defined communication pathways exist to inform staff of Public Protection concerns, ensuring timely and appropriate responses.
- **Multi-Agency Engagement:** Health professionals actively participate in multi-agency meetings to share information, contribute to risk assessments, and coordinate care planning.

Risk: **Emotional impact on staff dealing with Child and Adult Support and Protection**
Impact: Burnout, stress and reduced effectiveness in clinical roles

Mitigation:

- Child Protection Supervision policy in place
- Access to supervision
- Access to consultation and advise
- Promotion of trauma informed staff frameworks

2.3.5 Equality and Diversity, including health inequalities

Public Protection practice plays a vital role in promoting equality, eliminating discrimination, and supporting inclusive, person-centred care. It contributes directly to:

- By ensuring protection responses are fair, unbiased, and sensitive to the diverse backgrounds and experiences of individuals.
- Public Protection supports equitable access to health and social care services, particularly for those at risk due to socio-economic disadvantage or marginalisation.
- Maintaining honest and open relationships with individuals and families is central to effective public protection.

Public Protection also supports efforts to reduce health inequalities by:

- Identifying and responding to risks that disproportionately affect vulnerable groups.
- Promoting access to services for individuals affected by gender-based violence, disabilities, and other protected characteristics under the Equality Act.
- Embedding trauma-informed practice, which ensures services are responsive to the needs of those who have experienced adversity, abuse, or neglect.

Public Protection approaches must recognising the unique needs of individuals and communities and promote dignity, respect, and equity in every interaction.

2.3.6 Climate Change

Not Applicable.

2.3.7 Other impacts

Not Applicable.

2.3.8 Communication, involvement, engagement and consultation

The Board has carried out its duties to involve and engage external stakeholders where appropriate.

2.3.9 Route to the Meeting

This has been previously considered by the following groups as part of its development. The groups have either supported the content, or their feedback has informed the development of the content presented in this report.

Clinical Governance Committee 10 September 2025.

2.4 Recommendation

- **Awareness** – For Members' information only.

The Board is being asked to note the contents of the Public Protection Report and to support ongoing efforts to build capacity, foster a culture of safeguarding, and ensure that all staff clearly understand their roles and responsibilities. This includes the ability to **Recognise, Respond, Report, and Reflect**—the four essential steps in safeguarding children, young people and adults from harm. Embedding these principles across our workforce enables individuals to act appropriately when they have concerns about someone's safety or well-being.

The Board will be asked to confirm the level of assurance it has received from this report:

- Significant Assurance
- **Moderate Assurance (recommended)**
- Limited Assurance
- No Assurance

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**2 October 2025**
Title:	**Primary Care Improvement Plan Annual Programme Report**
Responsible Executive/Non-Executive:	**G Clinkscale, Director of Urgent Care, Community Services & Mental Health**
Report Author:	**C Wilson, General Manager P&CS**

1 Purpose

This is presented to the Board for:

- Awareness

This report relates to:

- Annual Operational Plan/Remobilisation Plan
- Government policy/directive
- NHS Board/Integration Joint Board Strategy or Direction

This aligns to the following NHS Scotland quality ambition(s):

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

The purpose of this report is to provide a comprehensive overview of the achievements, challenges, and future goals pertaining to the delivery on the commitments outlined in the General Medical Services (GMS) 2018 contract, and Primary Care Phased Investment Programme demonstrator site.

2.2 Background

In 2018, a new GP contract was introduced. A new primary care model was to be rolled out to make it easier for people to access care from a wide range of healthcare

professionals. The New GMS GP Contract refocused the role of GPs as Expert Medical Generalists (EMGs) working within a Multi-disciplinary Team (MDT). The aim of this is to reduce GP and GP Practice workload. New staff were employed by Health Boards and work with practices and clusters.

The Health Board has been required to shift GP workload and responsibilities to members of a wider primary care multi-disciplinary team when it is safe and appropriate to do so, while also demonstrating an improvement for patient care.

It is a requirement of the MoU that Integrated Authorities develop and review a local Primary Care Improvement Plan (PCIP). The aim of the plan is to identify and integrate key areas to be transformed to achieve the GP contract goals with the expectation that reconfigured services will continue to be provided in or near GP practices.

SG issued an updated Memorandum of Understanding (MoU2) to Health Boards in July 2021. The revised MoU for the period 2021-2023 recognised what had been achieved on a national level but also reflected gaps in delivering the GP Contract Offer commitments as originally intended by April 2021.

SG advised that all 6 MoU service areas should remain in scope, however following the SG/SGPC letter of December 2020, they agreed that the following services should be reprioritised to the following three services:

- Vaccination Transformation Programme (VTP)
- Pharmacotherapy
- Community Treatment and Care Services (CTAC)

It is important to note that prior to the MoU2 announcement, other PCIP Borders workstreams were well underway and PCIF commitments attached.

NHS Borders applied to be a demonstrator site on the Scottish Governments Primary Care Phased Investment Programme over November and December of 2023. We were notified of our success, and the programme was kicked off by the Cabinet Secretary for Health in January 2025. The programme includes £4.3million in funding for a full CTAC service and steps to increase Pharmacotherapy provision over 18 months up to October 2025.This demonstrator site programme ends March 2026 with a programme outcome report expected January 2026.

2.3 Assessment

The attached report summarises progress on with both the PCIP programme and recent Primary Care Phased Investment demonstrator site programme.

2.3.1 Quality/ Patient Care

A Quality Improvement ethos and approach have been central to both the development of the PCIP programme and Primary Care Phased Investment Programme demonstrator site workstreams. NHS Borders has been working with Healthcare Improvement Scotland (HIS) to refine the QI approach taken as part of the demonstrator site programme.

2.3.2 Workforce

A mixture of both fixed term and substantive staff have been recruited to deliver the Primary Care Phased Investment demonstrator site programme. This has involved Tupe of relevant Primary Care staff into the CTAC operations team.

2.3.3 Financial

Programme finances are detailed within the annual report attached.

2.3.4 Risk Assessment/Management

A programme risk register is held by the Primary and Community Services operational team.

2.3.5 Equality and Diversity, including health inequalities

All stages of EHRIA are completed and attached. Stage 3 of the EHRIA has been sent to groups we have consulted with, following best practice, for their feedback we will the stage 3 after this feedback has been received if changes are required.

2.3.6 Climate Change

Reduced travel in provision of Pharmacotherapy and continued provision of CTAC locally in the community will mean reduced travel for associated staff and patients respectively. This will translate to Carbon reduction impacts and will also decrease impacts of transport on air quality.

2.3.7 Other impacts

N/A

2.3.8 Communication, involvement, engagement and consultation

The Board has carried out its duties to involve and engage external stakeholders where appropriate.

2.3.9 Route to the Meeting

This has been previously considered by the following groups as part of its development. The groups have either supported the content, or their feedback has informed the development of the content presented in this report.

- Integrated Joint Board 24th September 2025

2.4 Recommendation

- **Awareness** – For Members' information only.

The Board will be asked to confirm the level of assurance it has received from this report:

- Significant Assurance
- **Moderate Assurance**
- Limited Assurance
- No Assurance

If a single level of assurance cannot be determined Officers are asked to suggest a level based on the following split of assurance:

- **Systems and Processes**
- **Outcomes**

3 List of appendices

The following appendices are included with this report:

- Appendix No 1 Annual PCIP Report

PCIP Borders
Primary Care Improvement Plan

2025

Primary Care Improvement Plan

Annual Programme Report

PCIP Executive Committee Report

“

NHS Borders is in the process of developing its clinical strategy… moving care away from the hospital and into communities. It remains of vital importance that the investment is made to allow all members of the MDT to work to the top of their license allowing general practitioners to continue to concentrate on their expert medical generalist role.

”

- Dr Robert Duncan

GP Sub-Committee Chair

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Foreword

Notes from the PCIP Executive Chair – Cathy Wilson

Over the past year, the Primary Care Improvement Plan (PCIP) has continued to play a pivotal role in transforming how care is delivered across our communities. I have had the privilege of overseeing the implementation and evolution of this ambitious programme, which remains a key vehicle for realising our collective vision for modern, sustainable, and person-centred primary care.

A significant milestone this year has been our participation as a PCIP Demonstrator Site. This opportunity has provided the platform, resources, and flexibility to test new approaches and accelerate progress across two key workstreams. It has also enabled us to critically reflect on what is working, where variation persists, and how we can better align systems around the needs of both patients and multidisciplinary teams.

Through this work, we have strengthened our understanding of what it takes to embed sustainable change. We've also learned that pace must be balanced with partnership. Whether through improved MDT integration, redesigned CTAC & Pharmacotherapy services, or enhanced engagement with general practice, it is clear that transformation is most successful when it is locally owned and clinically led.

As we look ahead, the learning from our Demonstrator Site experience will continue to shape our future direction - not only for the Borders, but as a contribution to national thinking on the next phase of PCIP. I want to thank all those who have contributed to this year's achievements—particularly our practice teams and those across Primary Care Services who continue to innovate despite ongoing operational pressures.

This report provides a snapshot of the progress made and the impact we've delivered together. It also reflects the challenges we continue to navigate, and our shared commitment to ensuring that Primary Care in the Borders remains responsive, resilient, and relevant for years to come.

Notes from the Chair of GP Sub-Committee – Dr Robert Duncan

The Scottish Borders Primary Care Improvement Plan (PCIP) has continued to develop over the past 12 months. As mentioned in last year's update the Scottish Borders was selected by Scottish Government to be a demonstrator site which delivered extra resource to try and highlight what more fully funded aspects of the 2018 contract could look like in practice. Locally this has led to an increase in the pharmacotherapy services offered to practices and the further development of CTAC services. The CTAC team have successfully recruited to and are in the process of delivering CTAC services to all practices in NHS borders for the first time. The team are in the process of rolling out a central booking system and dealing with the IT challenges that come with this both for the CTAC service and the practices involved. It's hoped that roll out will be completed by the end of summer 2025. Unfortunately, there is still no indication of what funding will be available after the end of the demonstrator site payments which will come to an end in March 2026 making future planning uncertain. With the resource allocation to these services remaining uncertain, practices remain concerned both about the continuing nature of these services and the potential effect on other work streams.

Other work streams of Vaccinations (VTP), Urgent Care, Mental Health (Renew) and First Contact Physio (FCP) are mainstreamed and business as usual. These work streams are embedded within GP practices and are involved in day-to-day multidisciplinary team working. There has been no further movement on the pausing of Sustainability Loans by Scottish Government in May 2024, a scheme designed to stabilise practices by easing the financial risks of owning premises.

NHS Borders is in the process of developing its clinical strategy with a clear steer from the Chief Executive on moving care away from the hospital and into communities. It therefore remains of vital importance that the investment is made to allow all members of the MDT to work to the top of their licence allowing general practitioner to continue to concentrate on their expert medical generalist role.

Notes from the Chief Financial Officer of the Integration Joint Board – Lizzie Turner

The Primary Care Improvement Programme has continued to drive forward significant change in the last year despite the financial uncertainty facing the services implemented as a PCPIP Demonstrator Site. During 2024/25 we have recruited 54 new members of staff including the transfer of employment of 12 members of staff from GP Practices across the Borders demonstrating significant investment in centralising CTAC services and improving access to data in line with the feedback from our residents. With approved funding in place until March 2026 the projects will operate ‘at risk’ from 1st April unless future year funding is confirmed. The team continues to work closely with Scottish Government colleagues to confirm the ongoing funding available as soon as possible to allow us to permanently embed these valuable services.

“As we look ahead, the learning from our Demonstrator Site experience will continue to shape our future direction - not only for the Borders, but as a contribution to national thinking”

Cathy Wilson – Chair of PCIP Executive Committee

PCIP Timeline

In 2018, a new GP contract was introduced. A new primary care model was to be rolled out to make it easier for people to access care from a wide range of healthcare professionals.

Funding was to be provided for the streamlining of services and for new staff who would be employed by NHS Health Boards to help maximise the time GPs can spend for caring for those who require their expertise.

It was hoped that this transition would take place over the course of 3 years – this would be locally agreed through Primary Care Improvement Plans (PCIPs) .

2018

PCIP is part of the GP Contract. It is defined through an agreed national Memorandum of Understanding (MoU) between the Scottish Government (SG), the Scottish General Practitioners Committee of the British Medical Association (SGPC), Integration Authorities (IAs) and NHS Boards.

This MoU mandated the delivery of specific priorities aimed at supporting people to access more easily the most appropriate healthcare to meet their needs to in turn release GP Clinical time to allow GPs to focus on their role as Expert Medical Generalists.

SG funding to support the implementation of the MoU has been allocated to IAs through the Primary Care Improvement Fund (PCIF), and locally agreed PCIPs would set out in more detail how implementation of the 6 priority service areas will be achieved.

PCIP Executive April 2019

The PCIP Executive Committee (created in April 2019) is the body which overseas and directs the development and implementation of the PCIP programme in the Borders. Its membership is at senior level and represents the 3 partner organisations – a tripartite agreement between GPs, NHS Borders and the Integration Joint Board (IJB).

A revised version of the Borders PCIP Plan 2018-2021 would be published later in the year.

COVID-19 Pandemic

The PCIP Executive notes the impact of COVID on service delivery. GP Executives of the GP Sub Committee would work closely with NHS Borders to mitigate risks and focus on the recovery and remobilisation progress.

December 2021

Joint letter SG/SGPC

In December 2021, the Government issued a letter announcing an implementation change order of workstreams recognising which streams would be of more benefits to GP workloads, also the extended deadline for workstreams and also highlighting the contractual burden on Health Boards for non-delivery of these workstreams.

July 2021

MoU2

SG issued an updated Memorandum of Understanding (MoU2) to Health Boards in July 2021. The revised MoU for the period 2021-2023 recognised what had been achieved on a national level but also reflects gaps in delivering the GP Contract Offer commitments as originally intended by April 2021.

This revised MoU2 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.

SG advised that all 6 MoU service areas should remain in scope, however following the SG/SGPC letter of December 2020, they agree that the following services should be reprioritized to the following three services:

- Vaccination Transformation Programme (VTP)
- Pharmacotherapy
- Community Treatment and Care Services (CTAC)

It is important to note that prior to the MoU2 announcement, other PCIP Borders workstreams were well underway and PCIF commitments attached.

November 2021

GP Sustainability Payment

In recognition that nationally several HBs were struggling with the March 2022 deadline, a GP sustainability payment was offered to help cover costs- giving an additional year for implementation of both CTAC and Pharmacotherapy.

March 2022

Position

The position at the end of March 2022, against the three priority areas from MoU2, was as follows:

- Vaccination Transformation Programme (VTP) – delivered in full (supported by non-recurrent funding)
- Pharmacotherapy (level 1 Acute Prescriptions) – partially implemented
- CTAC – not yet implemented

Modelling and planning were complete for final implementation however this was paused pending confirmation of resources to support further investment.

August 2022

Scottish Government Annual Allocation

Scottish Government confirmed the 2022/23 PCIF allocation in August 2022. In common with the position across NHS Scotland, the level of funding available to primary care within Scottish Borders was insufficient to meet the projected costs outlined within the local PCIP.

At this stage a strategic review was undertaken which identified a revised CTAC Phase I model to deliver a minimum PCIP commitment. Discussions on implementation were predicated on use of non-recurrent resources held within the IJB reserves to bridge investment pending confirmation of future Scottish Government allocations.

March 2023

Adjustment to Health Board's Funding Allocation

In March 2023 Scottish Government made adjustment to the Health Board's RRL funding allocation to offset slippage on prior year PCIF allocations against funding allocated in 2022/23. This adjustment had the effect of reducing non-recurrent IJB reserves held for PCIP by £1.523m – this triggered a review of Scottish Borders' PCIP strategic plan.

July 2023

IJB and Health Board Approve PCIP Bundle for fuller GMS Contract Delviery

In July 2023 - PCIP Exec had their proposal approved to combine funding streams from a range of Health Board and PCIP sources as well as releasing savings from a Programme of Polypharmacy to bridge the gap between PCIF funding for GMS Contract implementation and what was agreed would be as close as we could achieve to full delivery of the contract.

January 2024

NHS Borders successful in bid to become a demonstrator site on the Scottish Governments Primary Care Phased Investment Programme.

NHS Borders applied to be a demonstrator site on the Scottish Governments Primary Care Phased Investment Programme over November and December of 2023. We were notified of our success and the programme was kicked off by the Cabinet Secretary for Health in January. The programme includes £4.3million in funding for a full CTAC service and steps to increase Pharmacotherapy provision over 18 months up to October 2025.

May 2024

Understand Phase Completed

NHS Borders submitted their delivery plan to the Scottish Government as a Demonstrator Site on the Primary Care Phased Investment Programme (PCPIP). This plan was accepted with delivery objective based on the data collection gathered in the previous 3 months of understanding.

June 2024

CTAC Phlebotomy in practices

NHS Border delivered its first objective as a demonstrator site which was to recruit, or transfer employment from practices, sufficient staff to ensure that all Phlebotomy was now delivered by staff employed by the Health Board.

December 2024

Pharmacy Hub Launched

We delivered our second objective: to moved non-patient facing Pharmacy staff out of practices and into a single location at Scottish Borders Council Old School Building in Newtown St Boswells. To provide a more resilient and reliable service to practices handling letters with medicines changes and action other prescribing tasks.

March 2025

All PCPIP Recruitment Completed

All recruitment for the final stages of CTAC (objectives 3 and 4) and the additional Pharmacy staff to run a High Risk Medicines monitoring service (objective 5) were recruited.

July 2025

Understand Phase Completed

Launch of CTAC Admin Hub at the first practice – a service for patients to call and book their appointments. An essential element of the model for delivering reliable and equitable access to CTAC services across the Borders.

PCIP Borders
Primary Care Improvement Plan

PCIP Vaccination

Delivered March 2022

Community PCIP Care & Treatment

PCIP Pharmacotherapy

Due since April 2022

MoU 2 Priorities

PCIP Community Mental Health

PCIP Urgent Care

PCIP Musculoskeletal

Community PCIP Links Worker Service

Additional Professional Roles

PCIP Premises

PCIP Communications

PCIP Data

} Enablers

Primary Care Phased Investment Programme

As already shown in the timeline, we were successful in our application to become a Demonstrator Site as part of the Primary Care Phased Investment Programme (PCPIP). This programme is being delivered locally in tripartite agreement between the Scottish Government, NHS Borders and Healthcare Improvement Scotland. The other demonstrator sites on the programme are Edinburgh City, Shetland and Ayrshire and Arran. The programme aims to evaluate fuller implementation of the 2018 GMS contract to inform the next steps for Scotland from 2026 onwards.

In the Scottish Borders the new services and models for provision that have been funded are as follows:

- A clinical workforce to provide all Phlebotomy to GP practices in the Scottish Borders (Objective 1)
- A centralised Pharmacy Hub to provide Pharmacy Technician Support to every GP practice in the borders 5 days a week. (Objective 2)
- A clinical workforce to provide the full list of treatments under Community Treatment and Care in each Health Centre in the Borders. (Objective 3)
- A centralised admin hub for the booking and administration of the CTAC service (Objective 4)
- A centralised High Risk Medicines Service to monitor all patients on a predefined list of medications – previously known as DMARDs. (Objective 5)

Working in collaboration with Healthcare Improvement Scotland, we are undertaking the change following quality improvement methodologies. Whilst being a proven way of developing sustainable and meaningful positive outcomes when implementing change, this will facilitate the collection of data on impact and outcomes of the increased GMS Contract implementation - helping to inform Scottish Government on where GMS contract implementation is bringing the best value for GP practices, patients and the public.

Our initial period of work with Healthcare Improvement Scotland was to 'Understand the System' this meant the collection of significant amounts of data to build up context and a baseline to compare against as we monitor the changes these new services bring. The culmination of this was a week of care audit across 9 practices in the Scottish Borders.

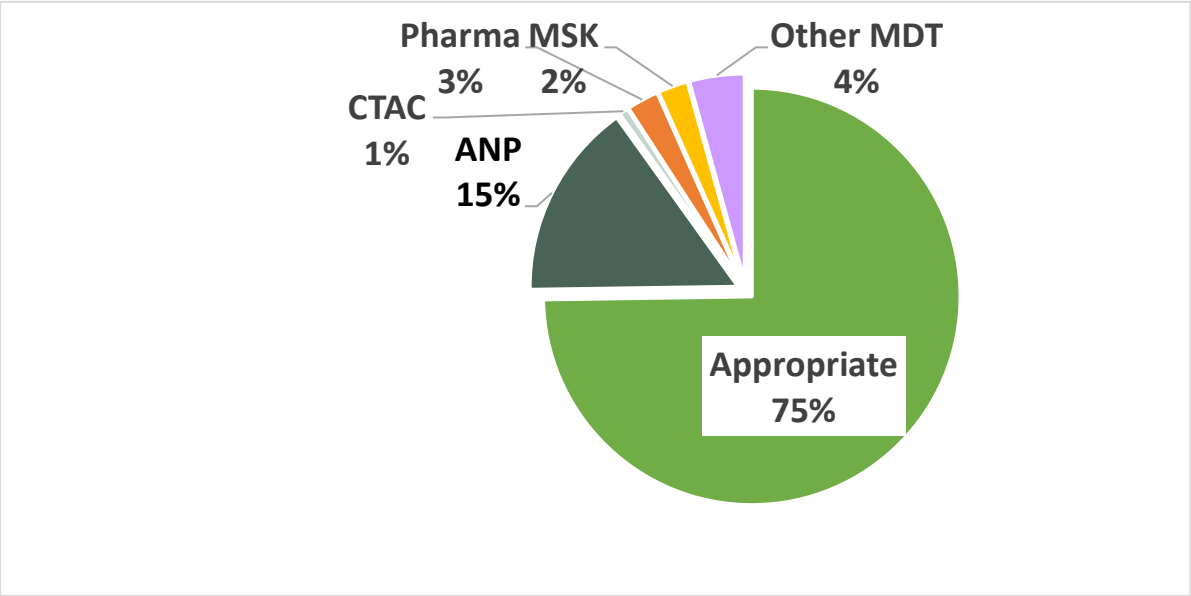
Week of Care Audit Summary

- **9 Practices collected data for 5 consecutive days each between 29th of July and the 18th of September 2024**
- This covers 56,774 registered patients – **46.7% of Borders registered patient population**
- Number from each practice cluster:
  - 3 Central
  - 3 East
  - 2 South
  - 1 West
  - Practices were selected for invitation to participate by HIS.
- Selection was based on trying to balance a range of variables - creating a **representative sample for the Borders.**

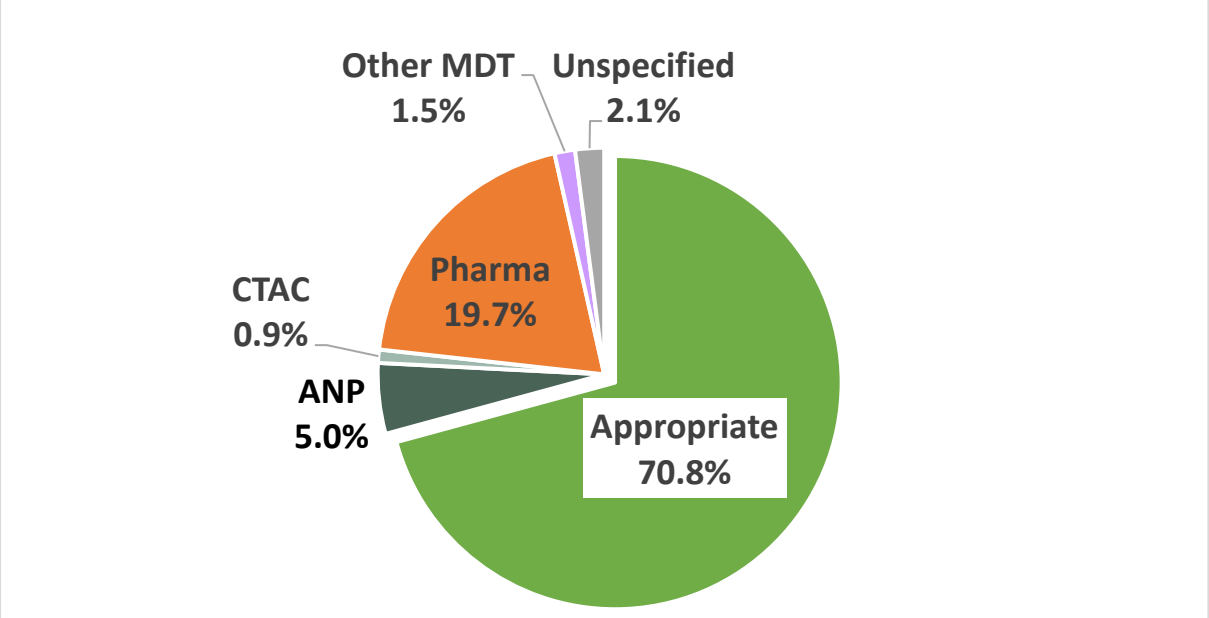
This Data collection exercise has allowed us to quantify hitherto unseen demand for Pharmacotherapy, CTAC and ANP Urgent Care for the first time as well as quantify time spent by GPs on tasks that could have also gone to mental health or to Physio.

This can be shown below for first Patient facing activity and then non patient facing activity. This data highlights some of the key services that are most likely to reduce GP's time on tasks appropriate for other professional groups.

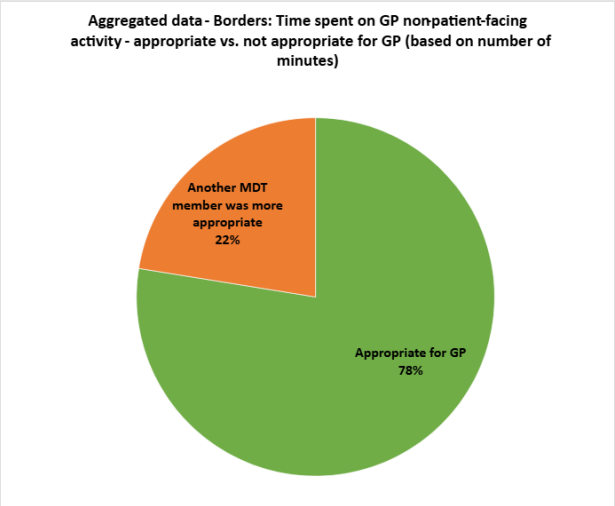
GP time spend in Patient Facing Activity – split by who the best person to see the patient would have been:

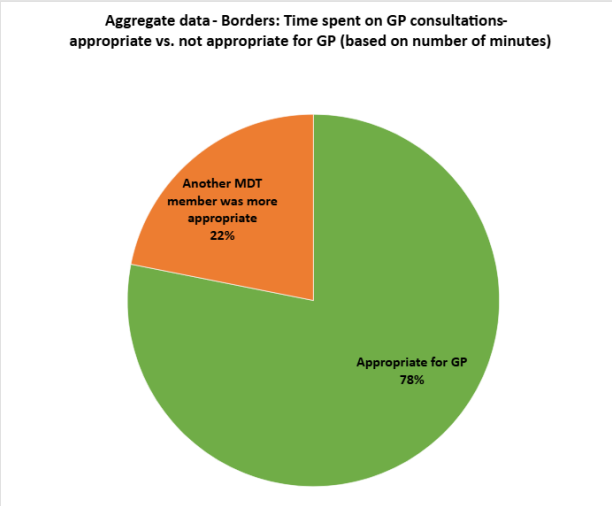


GP time spend in non- Patient Facing Activity – split by who the best person to see the patient would have been:



We have since repeated the data collection twice, once in March and once in June of 2025, with a smaller sample of 4 practices. **Comparing the data collected in March against last year's Week of Care Audit we can see indications of improvement in time spent by GPs on appropriate tasks from 75% to 78% of time spent on consultations being appropriate and 70.8% to 78% on time spent on non-consultation activity.**





This is an indication that we are on the correct path, and it is hoped the findings from the next two week of care audits will increase our confidence that these changes are due to the impact of increased support to practices from CTAC and Pharmacotherapy.

Next Steps in PCPIP

We are now approaching the end of the implementation and data collection phases of the Demonstrator site programme. Over the summer of 2025 we will continue to undertake improvement projects and collect data on the impact of the services introduced to provide more information for the evaluation of the programme by Healthcare Improvement Scotland. Data Collection will end in October 2025, but we will continue to focus locally on collecting data to inform further improvement within PCIP services in the Scottish Borders.

What we set out to deliver

The GMS Contract (2018), subsequent Memorandum of Understandings and the draft directions released in April 2023 outlined a commitment to the development of HSCP (Health and Social Care Partnership) led pharmacotherapy services to support GP workload. Acute prescribing makes up a significant part of day-to-day workload in primary care services and this programme provides solutions to support rapid sustainable improvement.

The programme aims to deliver improvements that:

- enable staff involved in prescribing to work together effectively, and
- enable pharmacotherapy and practice staff to fully utilise their skills sets.

Service Delivery

The original service plan in 2018 for Pharmacotherapy was for 28 whole time equivalent (WTE) completing work raging from the original Level 1 – 3 as per the GMS 2018 contract. NHS Board allocated staff funded prior to PCIP were later removed early on in the plan to refocus on efficiencies, reducing the workforce to 21 WTE with further funding cuts leading to a current workforce of 16.6wte (Pharmacists and Technicians).

In March 2022, faced with concerns around the delivery of Levels 1, 2 and 3, a survey was sent to all GP practices to better understand which areas could make a significant difference at reducing GP workload. The results indicated that GP Practices prioritised Level 1 work. A technician led service was organised mainly focusing on their supporting Level 1 prescribing for Pharmacists (level 2 and 3 for technicians), hospital discharge letters, clinic letters and repeat prescribing (increasing serial prescribing). This service has continued up until now.

The release of the draft directions in April 2023 and being successful with a bid submitted to Scottish Government and Health Improvement Scotland to become a demonstrator site, has prompted a change in direction of service delivery

The Pharmacotherapy service is now defined as ‘Management of all acute and repeat prescriptions, medicines reconciliation, performing polypharmacy reviews and serial prescribing (GP to only provide immediate care to prevent injury of a patient or the worsening of a patient’s clinical condition). Making available sufficient staff to ensure that an adequate service continues to be available, during annual leave, sickness absence or parental leave taken by the staff who routinely operate the service.’ This cover is only currently available for technicians by utilising the new Pharmacy Hub model.

Workforce

Based on our 2018 original plan we would have had 1wte member of pharmacy team per 5000 patients, with the reduction in funding available the ratio is now 1wte to 7500 patients. The team consists of staff ranging from Band 3 Pharmacy Support Workers to Band 8a pharmacists which provide a good spread of skill mix to complete the levels 1-3 pharmacotherapy work.

What has been achieved by October 2025

Workload

Data collection has been a focus of work. The project began by creating task sheets for staff members to use as a guide in completing assigned work. These sheets include the necessary read codes that need to be referenced. A new read code template includes all the codes required to record the daily work completed by each staff member to maximize the data collected for review.

We have used the software EMIS Enterprise, to automatically pull this data from the practices, and create dashboards, demonstrating the quantity of work completed by the team and allowing managers to oversee output and assess equity of service provision to practices.

We have learned that practice workload for Level 1 tasks is subject to wide variation (complexity of work assigned to the team, level of experience, skill mix and different practice demographics are key components of this). To minimise variation this is being addressed by standardisation of practice work using SOP's developed by the team and agreement of a Pharmacotherapy MOU.

Service Delivery

A wide variance in the work that each practice would like the team to complete, that is the skill set of the team and how work is completed in practice, has led to significant challenges in delivering an equitable service.

As part of the demonstrator site funding provided by Scottish Government/ HIS, premises for a Pharmacy Team HUB has been acquired. All the Pharmacotherapy Technicians and Pharmacy Support Workers will work here daily, completing Level 1 work and in particular increasing serial prescribing, while the Pharmacist remain in practice. The HUB working will provide a better Team ethos and peer support, while allowing work to be evenly shared across the team, rather than individuals being allocated to a practice on a session basis (based on list size)

In September 2024, GP practices were sent a survey again, asking what work within the practice they would like to be completed by the Pharmacist.

Acute Requests

Acute requests are in many practices the main workload assigned to the Pharmacists. Although difficult to ascertain exact numbers, the team are beginning to take active steps to reduce the quantity by utilising other services available, for example serial prescribing and use of limited repeats. We have taken steps to collaboratively work with Health Improvement Scotland to reduce the numbers, which will increase safety of prescribing and equity in the service.

Serial Prescriptions

Managing the medicines to treat chronic disease is part of the service delivery plan and serial prescribing is key to this. Work is continuing over 2025/6 to maximize the number of repeat medications that are managed via the serial prescribing route, currently we average at 5% over the Board. With the addition of two Band 3 Pharmacy Support worker to the team, this percentage should increase.

Workforce Development

Over the past 48 months, we have been developing our service and are continually reviewing skill mix. Recognising the lack of technician workforce at a national level. The 5 trainee technicians that were being trained within the team have now qualified, of these trainee pharmacy technicians, we have retained two within the team. The others have been employed in other sectors of pharmacy within NHS Borders.

The pharmacist team (8wte) consists of 3.5wte Band 8a pharmacists, of which 2.71wte are >55yrs old and 4.5 wte of Band 7 Pharmacists. The newly recruited 3.5 wte of Band 7 Pharmacists are employed on a remote working contract, to allow people from further afield to work in the Borders thus increasing the pool of Pharmacists we can recruit to.

Community Pharmacy

The links between practice teams and community pharmacy teams are very important. Community pharmacy provides supports to general practice in a number of areas (Pharmacy First and Pharmacy First plus) as well as working alongside the team to provide Serial prescribing.

Quality Improvement in Pharmacotherapy this year

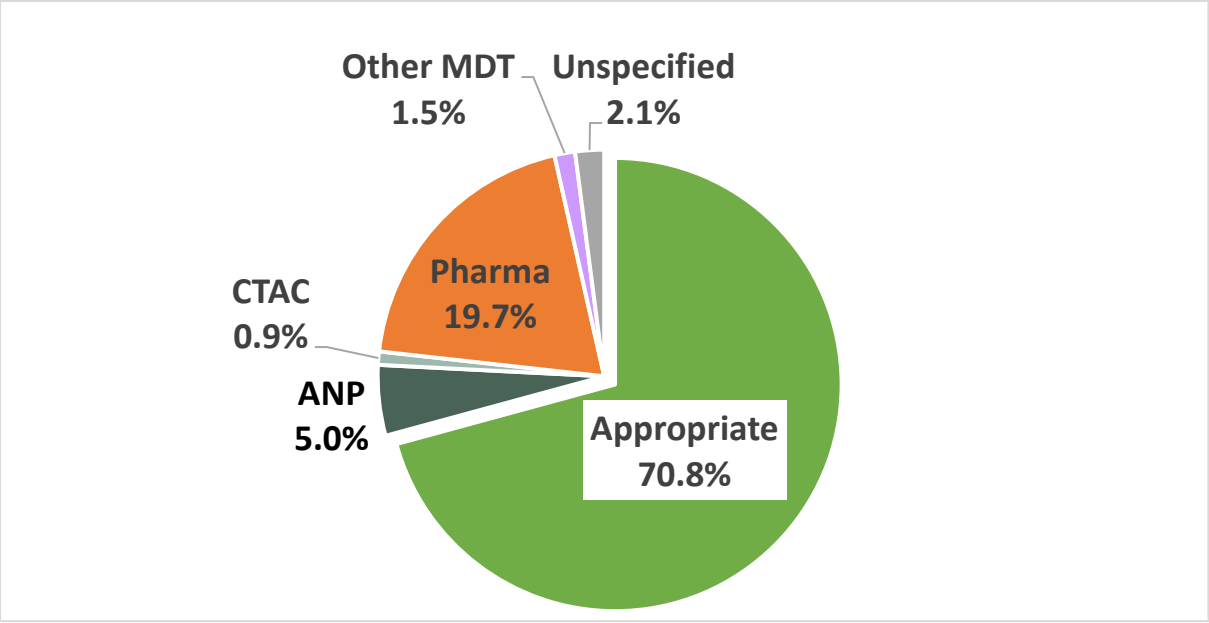
PCPIP Demonstrator Site and Pharmacy Hub

The announcement in January of 2024 that NHS Borders had been successful in our application to become a Demonstrator Site as part of the Primary Care Phased Investment Programme (PCPIP) meant the funding of the following models for provision of Pharmacotherapy or Practice Based Pharmacy:

- A centralised Pharmacy Hub to provide Pharmacy Technician Support to every GP practice in the borders 5 days a week.
- A centralised High Risk Medicines Service to monitor all patients on a predefined list of medications – previously known as DMARDs.

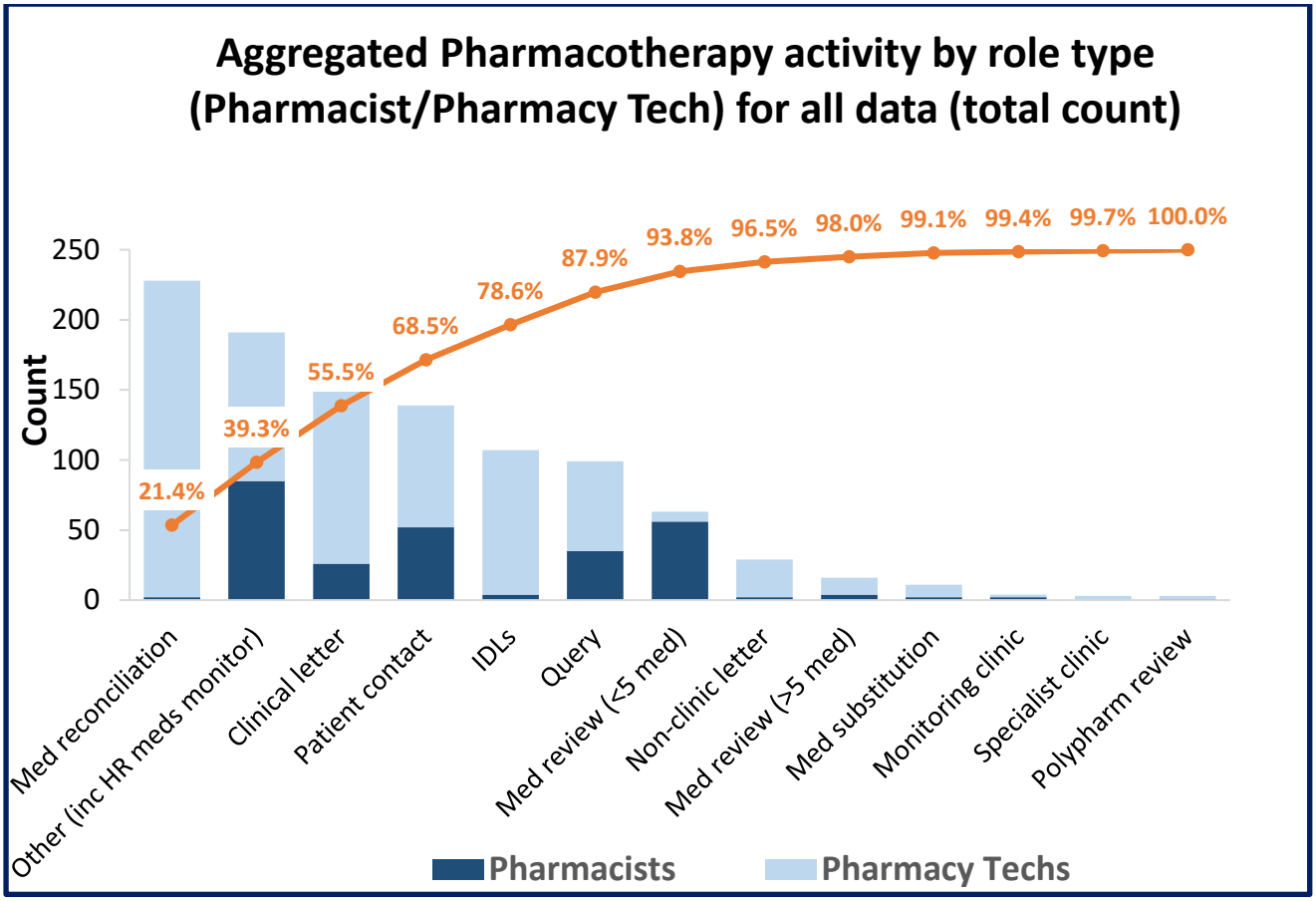
As covered in the introduction to PCPIP we captured the unseen demand for PCIP services for the first time in Borders practices in the summer of 2024. This showed the significant impact that Pharmacotherapy could still have on the amount of time GPs were spending on prescribing tasks when they weren't seeing patients in consultation:

GP time spend in non- Patient Facing Activity – split by who the best person to see the patient would have been:



As the figure above shows, Pharmacotherapy could provide a significant benefit to reducing GP workload if we were able to provide more capacity within the service – almost 20% of time spent on non-patient facing tasks could have been undertaken by Pharmacotherapy.

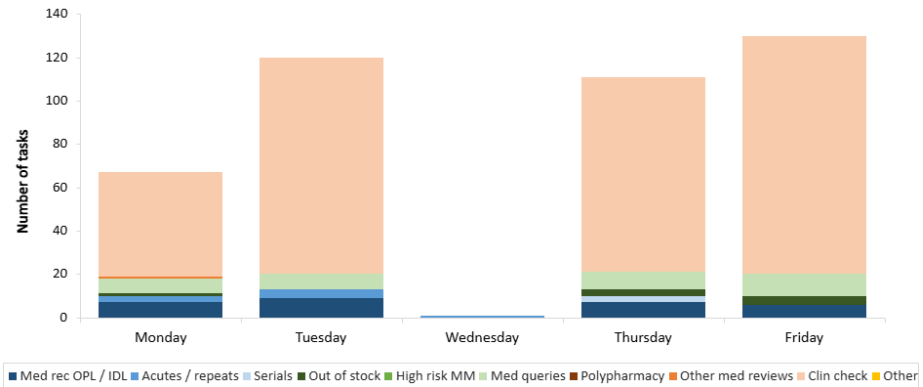
The Pharmacotherapy team also recorded their activity in practices:



In the above Pareto chart we see a breakdown of the workload of the pharmacotherapy team, split by Pharmacists and Pharmacy technicians. This clearly outlines that almost 100% of activity is being spent covering level 1 Pharmacist tasks (level 2 and 3 Pharmacist technician tasks) in the practices that took part in the Week of Care Audit.

With the implementation of a Pharmacy hub working we have been able to smooth out coverage from the pharmacy technicians to ensure that patients' prescriptions from discharges and outpatient appointments are actioned faster and therefore patient safety is improved. In the following graph you can see the activity undertaken by Pharmacy Technicians in a small practice in the Borders. This is in contrast to the sessional alloaction of hald a day a week previously when tasks for the Pharmacy technician would have had to wait up to seven days to be actions:

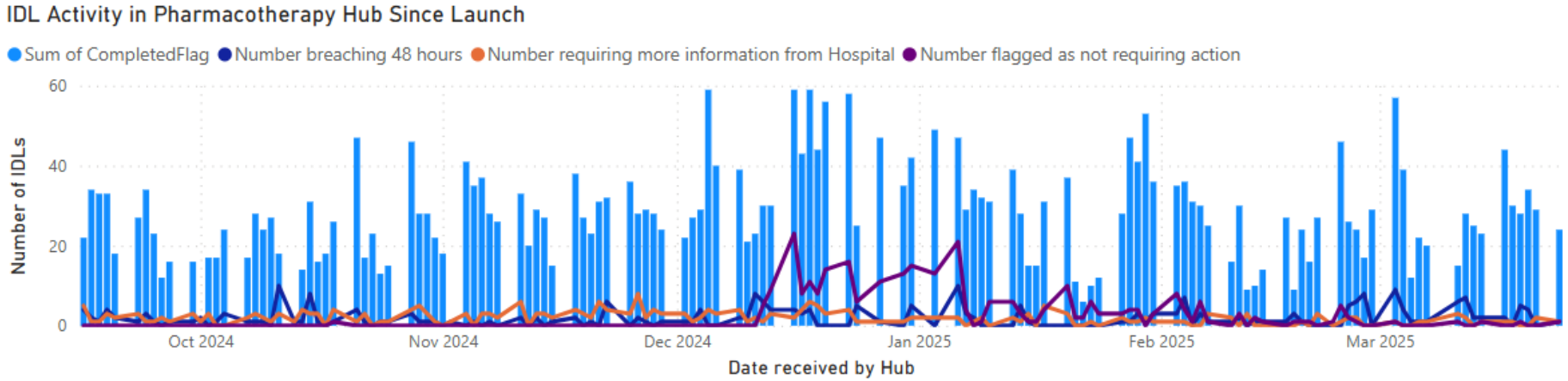
Distribution of activity across the week at a small Borders practice after Pharmacy Hub Implementation:



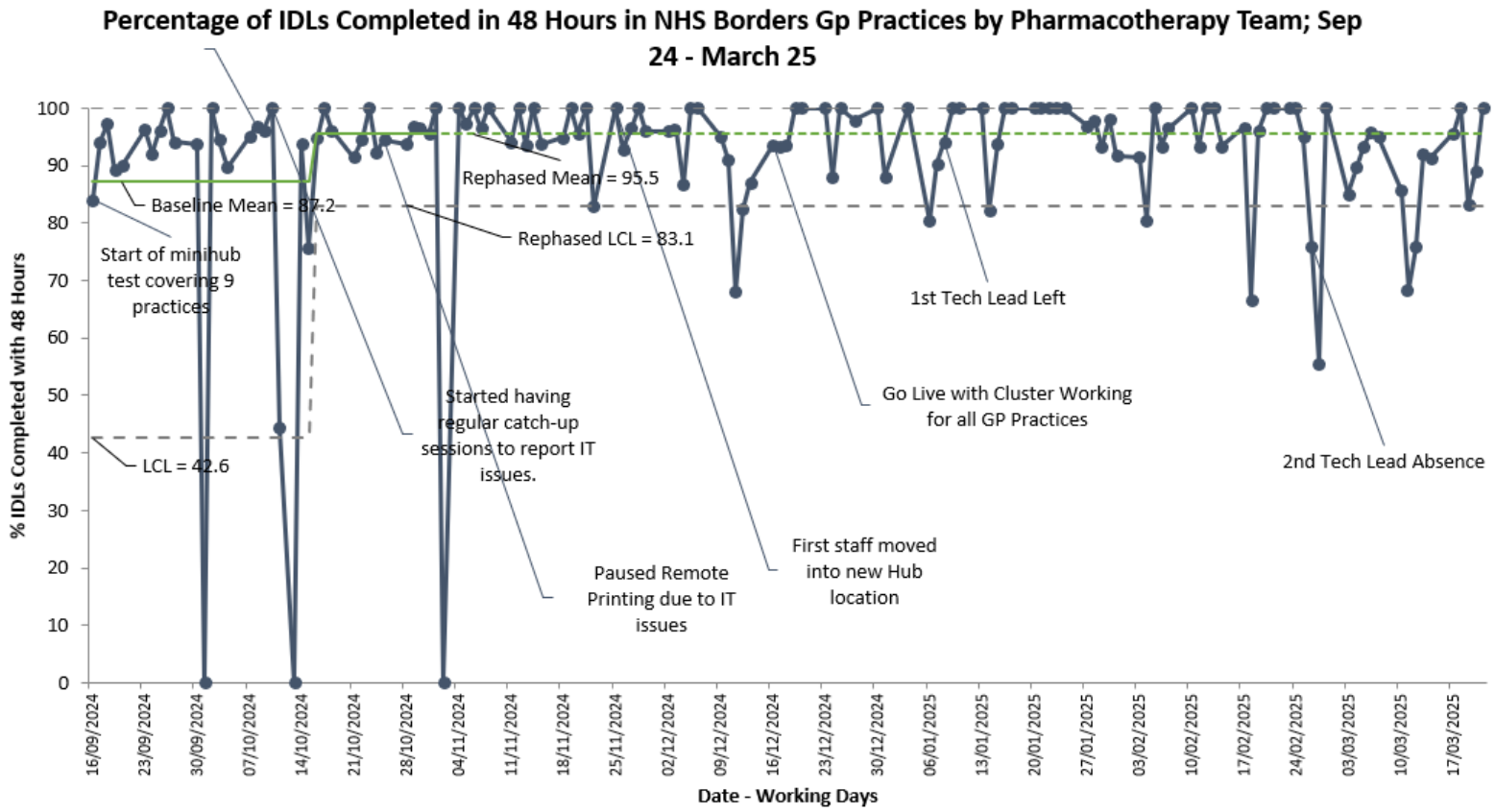
Data from the Implementation of the Pharmacotherapy Hub

Overall Hub Activity – Immediate Discharge Letters (IDLs)

In the below chart you can see the amount of activity recorded by the Hub on IDLs since we started piloting it in December 2024. The demand and thus activity is highly variable and having the team in one location in order to pool resource allows us to use time when demand is low to focus on other tasks or in practices where demand is higher whilst when demand is high we can focus and prioritise resources based on prioritisation of the workload.

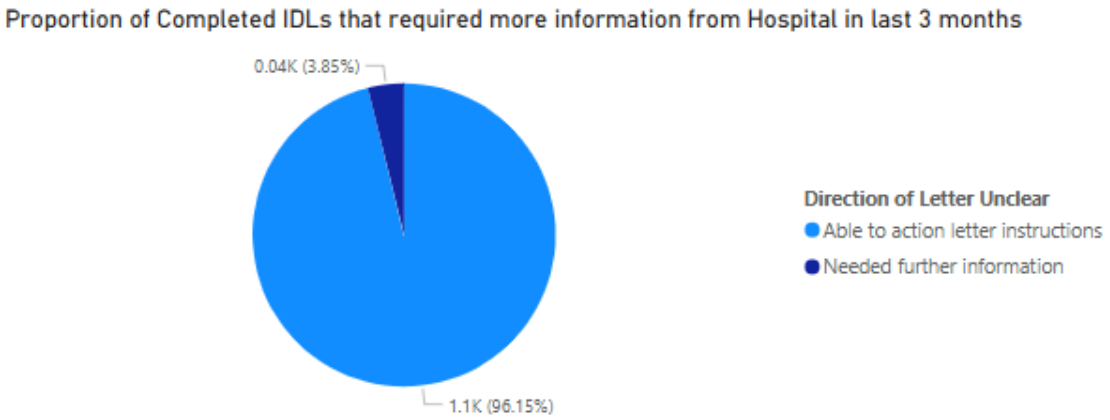


The key outcome measure of the project to move Pharmacy technicians to working in the hub was to meet the national target of 48 turnaround times for any Immediate Discharge Letters (IDLs) routed to Pharmacotherapy – this contributes to improving safety for patients – reducing the risk of patients running out of medications given at discharge or other medication associated harms. The below is an SPC chart from the start of testing the hub concept through to the 21st of March. The process stabilised at the end of the calendar year and we started to average 95% of IDLs completed with 48 hours. The team are currently managing extended absences and vacancies which explains higher variation over the last months and a decline in performance against this target, however this also speaks to the fact that as a hub we can now cover this temporarily diminished capacity without this disproportionately affecting certain patients at certain practices.

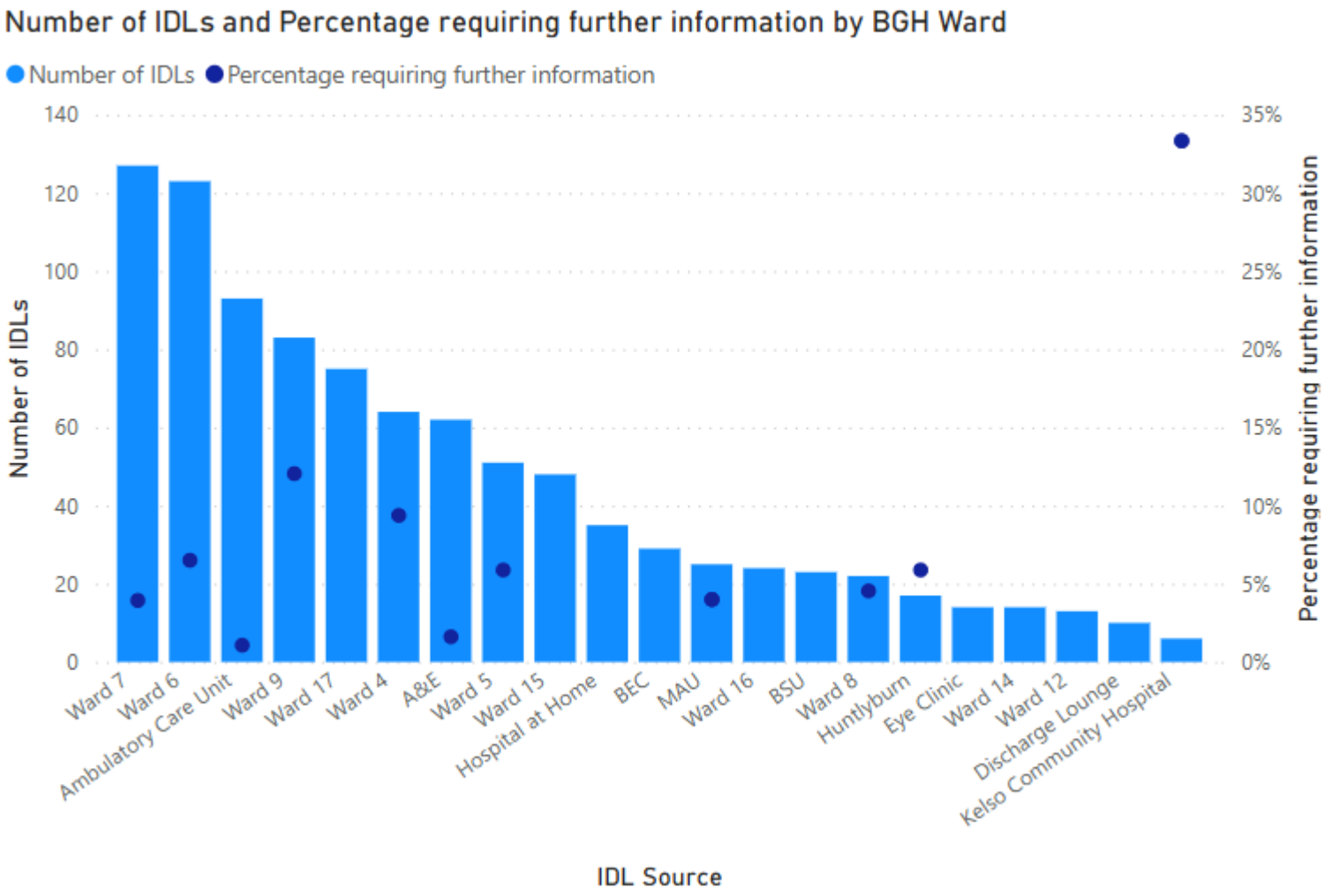

Percentage of IDLs Completed in 48 Hours in NHS Borders Gp Practices by Pharmacotherapy Team; Sep 24 - March 25
% IDLs Completed with 48 Hours
Date - Working Days
Baseline Mean = 87.2
Rephased Mean = 95.5
Rephased LCL = 83.1
LCL = 42.6
Start of minihub test covering 9 practices
Started having regular catch-up sessions to report IT issues.
Paused Remote Printing due to IT issues
First staff moved into new Hub location
Go Live with Cluster Working for all GP Practices
1st Tech Lead Left
2nd Tech Lead Absence

Challenges to meeting 48 Hour Target:

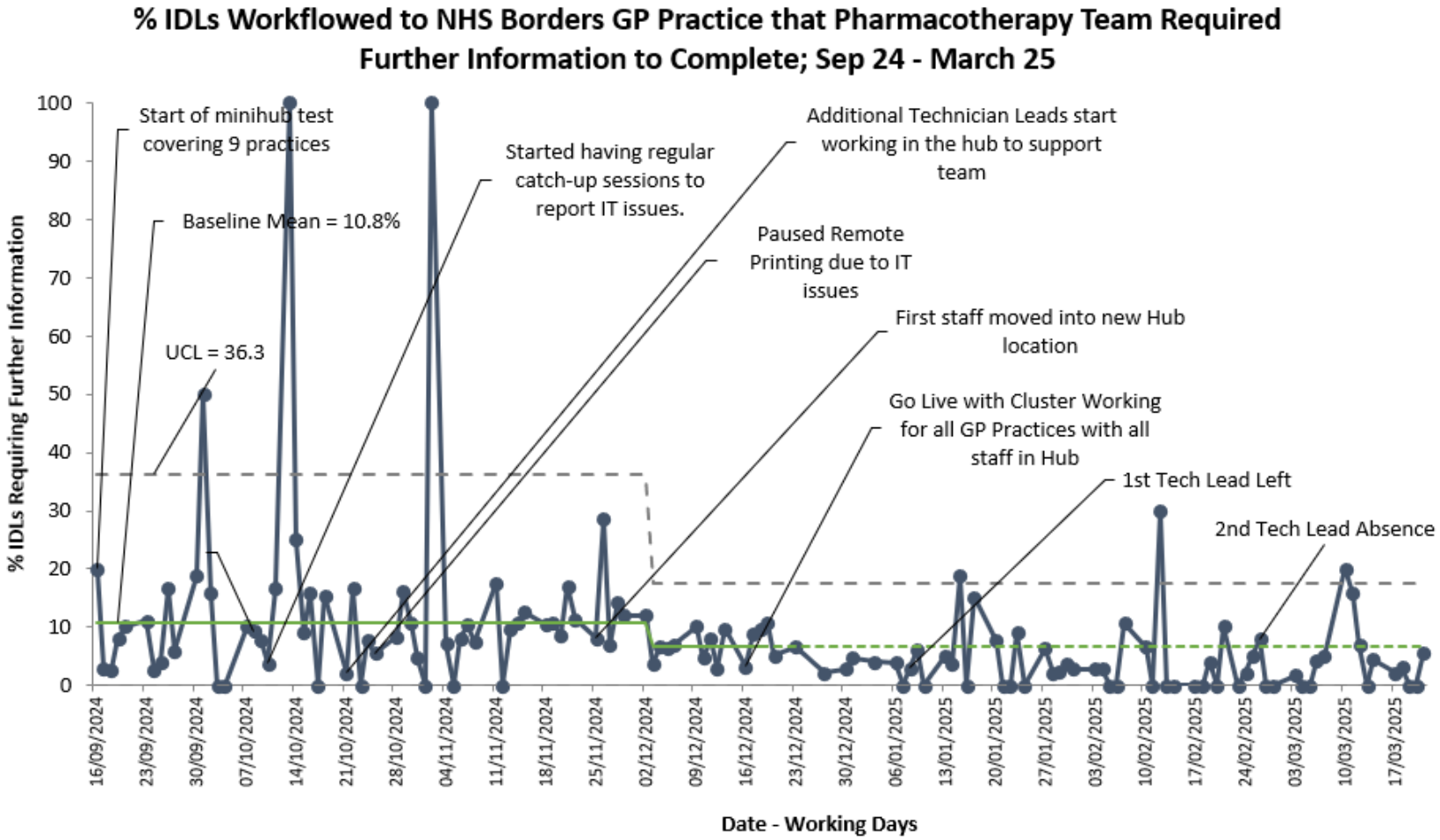
One of the principal challenges to delivering on our KPI of actioning Immediate Discharge Letters(IDLs) within 48 hours is the information and clarity of instruction in the discharge letter. Being able to capture quality issues in IDLs in one location and record the source of IDLs that have been difficult to resolve or action allows us to go to the source of letters and seek improvements to realise efficiencies across the system we have used the below information to run sessions in secondary care illustrating the impact of poorly written or incomplete letters and the wasted resource spent trying to unpick what the next steps are for a patient.



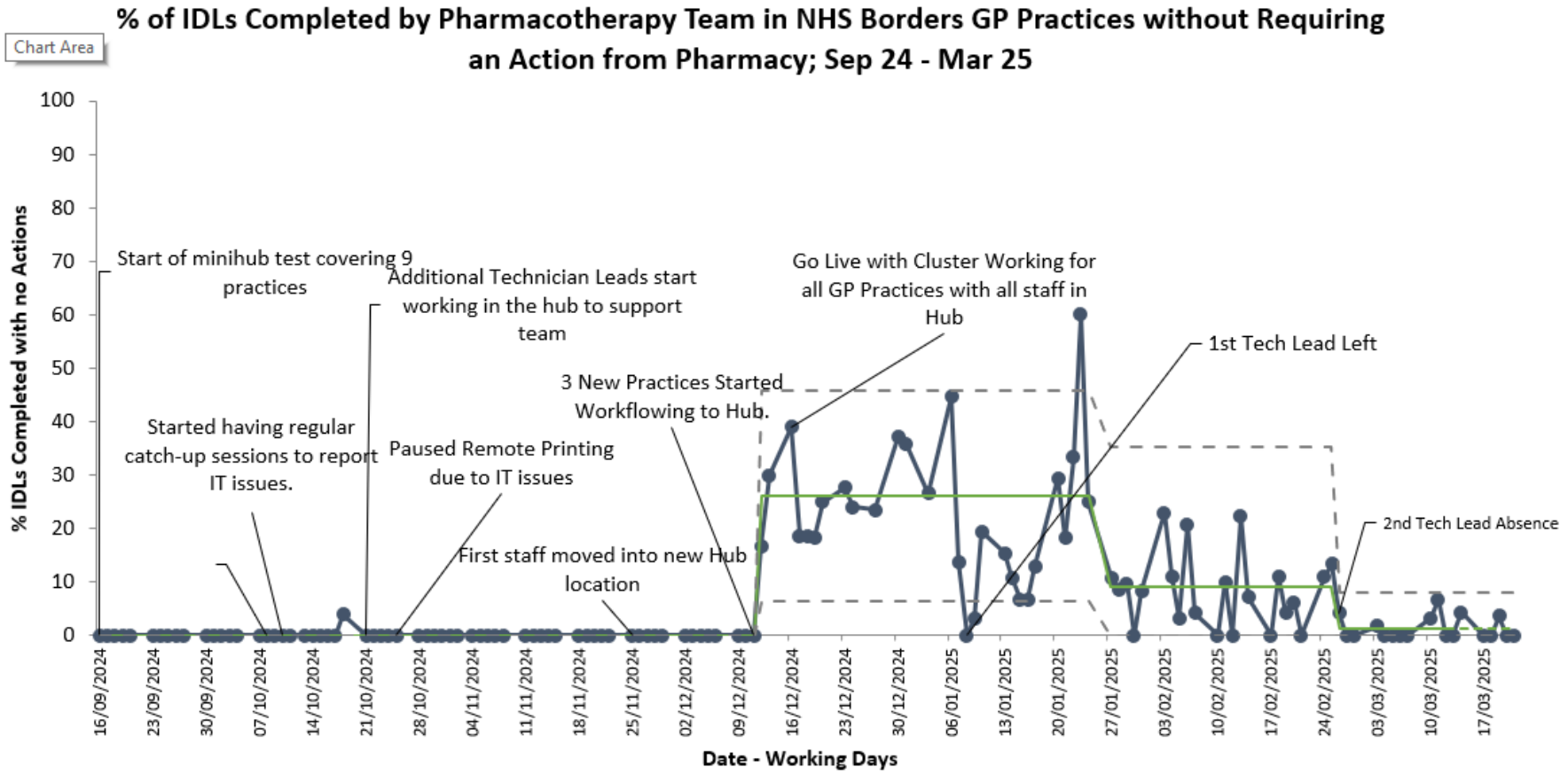
Sources of NHS Borders IDLs needing further information from January 2025 – March 2025:


Number of IDLs and Percentage requiring further information by BGH Ward
Number of IDLs
Percentage requiring further information
140
120
100
80
60
40
20
0
35%
30%
25%
20%
15%
10%
5%
0%
Number of IDLs
Percentage requiring further information
Ward 7
Ward 6
Ambulatory Care Unit
Ward 9
Ward 17
Ward 4
A&E
Ward 5
Ward 15
Hospital at Home
BEC
MAU
Ward 16
BSU
Ward 8
Huntlyburn
Eye Clinic
Ward 14
Ward 12
Discharge Lounge
Kelso Community Hospital
IDL Source

We also monitored this number as a process measure as it captures two factors that determine how quickly an IDL can be completed. The first is the information in the IDL and whether secondary care need to include more details to allow the technicians to complete the medicines reconciliation but it also includes how well supported the technicians are by the ability they have to complete IDLs without needing to ask a consultant, specialty or GP for more input. We believe that the improvement illustrated below is a direct result of the team being able to work together and support each other by being in a shared space in a way that they could not do before.



Finally, we monitored a control variable which was the percentage of IDLs being marked complete but without requiring any action by Pharmacotherapy. This captures how well practices understand what should be routed to the hub. There was a steep increase in the number being recorded as not requiring action when we moved the full team of technicians into the hub and it is our understanding that whilst new practices did start with the hub at this time and some were routing inappropriate work to the hub the larger part of this increase is likely to have been lack of clarity in the technicians about what constituted an action. Their reviewing the letter and noting that nothing needed done still constitutes an action even if there has been no intervention by the technician into the patients' prescriptions. We have concentrated on working with practice managers and ensuring the team understand the value they add to check letters even when they are not 'doing' something.



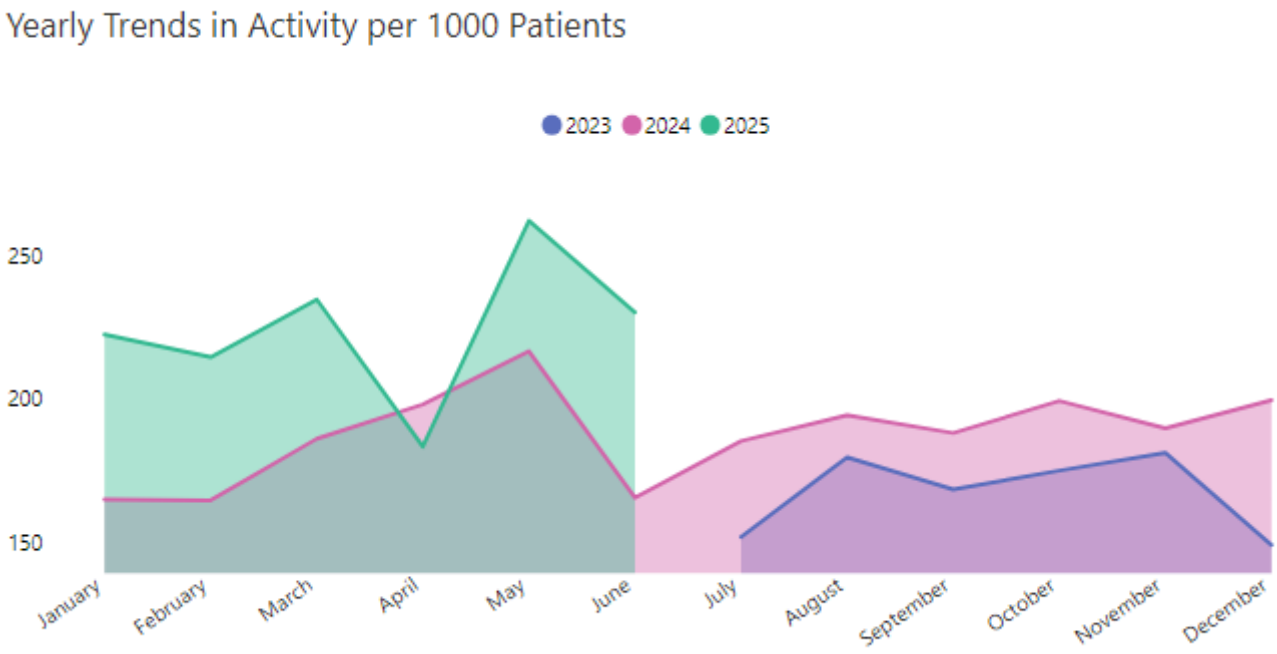
What gaps do we still have to deliver on the 2018 GMS Contract?

Within NHS Borders the attention is focused on delivering the Level 1 tasks only and how we deliver this given the current budget constraints around staffing. This means that delivery of MoU2 is not attainable due to Level 2 and 3 not being delivered by the Pharmacy Team.

Understanding the workload challenges and practice systems has led to the realisation both locally and nationally that we need to do more work to make practices "pharmacotherapy ready" - where the Level 1 tasks can be devolved to the pharmacy team by reducing the volume of demand for these tasks – e.g. moving acute and repeat prescriptions to serials, undertaking deprescribing through polypharmacy reviews and introducing digital prescribing.

Our original modelling of a total resource of 1 WTE pharmacotherapy team member per 5000 patients has been shown over the past 2 years to be inadequate and this finding is supported across Scotland. A national view is awaited regarding an optimum staffing model but this will be difficult to deliver due to current funding and workforce availability. The outcomes from the demonstrator site projects will assist in defining delivery of the contract, but unfilled vacancies may mean that we are delayed in demonstrating this.

It's also clear that the volume of demand that is being routed to the Pharmacotherapy is increasing and it's assumed that this is due to an overall increase in demand from the population rather than practices routing more work to the service. This is demonstrated in the below chart outlining the activity per 1000 patients each month year on year:



Key Risks to Pharmacotherapy Delivery:

- **Service resilience**
  This has been challenging, trying to maintain a service with vacancies is not possible. The definition of Pharmacotherapy previously quoted, includes covering annual leave, sickness and parental leave. The difficulty with this ask is that with low team numbers there is very limited flex in the allocations to move staff without leaving other noticeable gaps in practices. The hub helps with this to cover technician vacancies and absence but Pharmacist cover for practices remains impossible for regulate sessional allocation. Numbers of staff off or vacancies in the hub team have also been considered the reason for drops in the Hub teams performance against their targets in the recent months so the hub has not fixed this issue completely although it does mean the GP practices do not see work handed back.
- **Vacancy Management**
  Within the rural setting of NHS Borders, trained Pharmacy Technicians (not already employed by the Board) are becoming harder to find. Newly qualified staff (particularly pharmacists) are also moving away to the cities for a large part of their career. This is causing movement within teams and sectors rather than new employees joining the NHS. Vacancies are being advertised for considerable periods of time with no candidates applying that meet the essential criteria which is causing delays in service development.
- **Leadership**
  As the teams grow in size, more time is required to lead the changes required within practices and support the less experienced staff. We have introduced a technician led service model to support with leadership, training and service delivery in the team.

The Primary and Community Services (P&CS) Team within NHS Borders Health Board are responsible for delivering safe, efficient and sustainable CTAC services 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.

Since September 2024 the Community Treatment and Care Service has operated phlebotomy clinics in 20 out of 22 practices, with more activities, such as wound care, ear care, catheter care and medication administration being added as the workforce as it has developed.

This table gives an overview of the current service delivery against contract activities.

Practice	Phlebotomy	Chronic or Long term condition monitoring	Ear Care	Wound Care including suture removal	Medicine administration	ECG	Urinalysis
Braeside							
Coldstream							
Duns							
Earlston							
Eildon							
Eyemouth							
Greenlaw							
Jedburgh							
Kelso							
Mairches Gala							
Mairches Hawick							
Merse*							
Neidpath							
Newcastleton							
Roxburgh Street,Gala							
Selkirk							
St Ronan's							
Stow & Lauder							
Teviot							
Tweed							
West Linton							

Table 1. Green indicates service available to practice, amber means plan to deliver in place but not currently available.

*phlebotomy temporarily paused due to Knoll Hospital Building incident.

The CTAC implementation plan was to build on the current 10 treatment room services in a phased approach;

- Phase 1 – all phlebotomy services transfer to health board, this was completed by September 2024
- Phase 2 – an administration hub takes on booking of appointments – this has been delayed from March 2025 due to the different factors including recruitment of call handlers and IT system build. There is now a 'go live' date of 22nd July 2025. Recognising this is a major change for practices and patients alike, this is being implemented in a phased approach over 3 months.

- Phase 3 – all treatments and care delivered in all sites. Clinical teams are focussed on training for all staff to be ready to offer the full range of appointments.

The project is part of the national Primary Care Phased Investment Programme which is testing the effectiveness of the new GMS contract in alleviating GP workload pressure. The successful bid to allow us to take part in the programme has attracted additional funding which has accelerated our ability to deliver services.

The current workforce is as follows:

Job Title(s)	Band	WTE Staff (in post)	WTE Staff (to recruit)
Senior Charge Nurse	7	1	0
Charge Nurse	6	6.58	0
Registered Nurse	5	13.49	1.29
Healthcare Support Worker	3	25.6	4.02
Admin Supervisor	4	1.21	0
Call Handler	2	1.21	0

CTAC Admin Hub

To support the delivery of 6,300 appointments per week within the single service, NHS Borders CTAC has established a dedicated administrative hub. This hub works in close collaboration with existing Health Board reception teams to enhance service delivery and patient experience.

Key benefits of this approach include:

Improved Patient Experience: A single point of contact, including one telephone number, simplifies access and ensures clearer patient pathways.

Operational Efficiency: Centralised booking and administration enable workforce efficiencies and economies of scale for routine and specialist tasks.

Stronger Governance: Streamlined management and supervision structures support consistent oversight and accountability.

Enhanced Service Resilience: The hub model mitigates risks associated with single points of failure and addresses geographical challenges related to business continuity and staff coverage.

Digital Transformation: Opportunities to reduce reliance on paper-based processes and improve information transfer.

Integrated Primary Care: Promotes collaboration and avoids siloed or fragmented ways of working.

Improved Recruitment and Accessibility: A central location with strong transport links (train and bus) makes the service more accessible to a wider pool of potential staff across the Borders and beyond.

Scalability and Flexibility: The hub is designed to adapt to future service demands, whether expanding or contracting as needed.

Supportive Work Environment: Centralised supervision ensures effective support and development for staff.

This initiative represents a forward-thinking step in delivering high-quality, sustainable healthcare services across NHS Borders.

Engagement activity

GPs and Practice Teams:

Throughout the design and development of the Community Treatment and Care (CTAC) programme, we have had extensive engagement with GP practices. GP representatives continue to be active members of the CTAC Programme Board and Executive Team, ensuring clinical input and collaboration remain central to our decision making.

Over the past year, we have also continued to engage directly with GP practices regarding planned changes. This has included one-to-one and group meetings, email updates, and drop-in sessions. We have worked closely with clinical staff and practice managers on specific elements of the programme, for example through a short-life working group that co-designed the long-term condition monitoring pathway.

As we begin the phased rollout, each practice will be offered a tailored package of meetings to support implementation, share information, and identify any practice-specific concerns.

Patients

As the CTAC booking hub provided an alternative method to book CTAC appointments, the team realised they needed to better understand the potential impact of this change on patients. In response, the team initiated a patient engagement plan, including the completion of an Equality and Human Rights Impact Assessment (EQHRIA), to ensure the new system will be inclusive, accessible, and responsive to patient needs.

Before commencing patient engagement activities, the team completed a RAG status list of the protected characteristics in relation to the CTAC booking hub to prioritise involvement in the project.

Group / Protected Characteristic	Relevance	Rationale
Age	High	The Borders has an ageing population (27% aged 65+). Older adults are high users of CTAC services and may face barriers with telephone access, mobility, or digital exclusion.
Disability (physical & learning)	High	Individuals with disabilities are likely to face challenges with communication, understanding, and accessibility in a phone-based system. A priority group for inclusion.
Gender / Sex	Medium	No direct gender-based impact identified, but women are more likely to be carers and healthcare users. Consideration required to ensure equity in access.
Sexual Orientation	Medium	Potential for marginalisation or past healthcare discrimination. Important to ensure service is welcoming and inclusive.
Gender Reassignment	Medium	While small in number, trans individuals may experience additional barriers to accessing healthcare. Ensure inclusive language and respectful interactions.
Race / Ethnicity	Medium	Borders has a small but growing ethnic minority population. Language barriers and cultural differences may impact telephone booking experiences.
Religion or Belief	Low	No direct impact of service design identified related to religion or belief. Still important to maintain respect for cultural needs.
Marriage and Civil Partnership	Low	Unlikely to impact access to or experience of the CTAC booking process.
Pregnancy and Maternity	Low	No disproportionate impact anticipated.
Other Considerations		
Carers (Unpaid & Professional)	High	Carers often manage appointments for others and may have limited flexibility during working hours. Booking hub design must accommodate their needs.
People Living in Poverty (esp. rural)	High	May face digital exclusion, lack of phone credit, or limited connectivity. Rural isolation and deprivation are important equity factors in the Borders.
People with Limited English Proficiency	Medium	Small population, but potential barriers to understanding and booking by phone. Should be addressed to ensure equity and accessibility.

The RAG list supported the team to identify key consultation topics and the relevant groups to involve in early patient engagement. To ensure a wide range of perspectives, the NHS Borders team engaged with patients, unpaid carers, third-sector organisations, and community advocates. Engagement focused on key areas of inclusion, including:

- **Disability**- working with neurodivergent individuals, Ability Borders, and the National Institute for the Deaf
- **Age**- through the Borders Older People's Partnership and Borders Care Voice: Dementia Working Group
- **Gender**- via the Violence Against Women and Girls Partnership
- **Sexuality**- in collaboration with the Scottish Borders LGBTQ+ Forum
- **Race**- engaging with members of the traveller and refugee communities

Impact

Through patient engagement and co-design activities, the team gathered valuable insights from a diverse range of individuals and community groups. In response to patient and stakeholder

feedback, the team introduced several changes to make CTAC services more accessible, inclusive, and patient-centred.

1. **Referral exceptions**

Access to CTAC initially required a referral from a healthcare professional. However, patient feedback highlighted the need for greater flexibility. In response, the team introduced a self-referral pathway for specific cases, such as patients requiring ear syringing prior to private audiology appointments. The aim of this exception is to improve access to ear care and ensure patients are treated in a timely manner. The team is also considering similar referral exceptions for wound care.

2. **Booking support for those who require it**

To support people who find navigating booking systems difficult, the team created a dedicated hotline for GP practice staff to book appointments on their behalf.

3. **Support for neurodiverse and anxious people**

The team has improved support for neurodiverse and anxious patients by updating the NHS Borders website with clearer information about the CTAC booking process and training call handlers to offer call-backs if a patient becomes overwhelmed during the call.

4. **Use of inclusive language**

The team is promoting the use of inclusive language by encouraging staff to avoid gendered terms unless introduced by the patient, helping create a safer and more inclusive experience for all.

Key Learning

- **Co-design is crucial:** Earlier engagement with patients would have identified issues sooner. Patient groups expressed their desire to be consulted earlier in future when more meaningful changes could have been embedded
- **Rurality matters:** Solutions must account for infrastructure gaps and digital exclusion
- **Multiple access routes are needed:** Sole reliance on phone booking creates inequality
- **Clarity in communication is key:** Clear messaging and consistent communications make a difference
- **Patient engagement should be ongoing:** Feedback should be gathered continuously to help shape future improvement to services

Next Steps

The NHS Borders team are in the early stages of testing the centralised CTAC booking hub, which will be refined as the service evolves. As part of the next phase of patient engagement and service improvement, the team will focus on the following priorities:

- Exploration of hybrid booking models including digital options
- Continue to refine patient messaging using user-tested materials

- Improving data collection and analysis for ongoing equity monitoring
- Sharing learning across Health Board quality improvement forums and national networks
- Embedding EQHRIA earlier in future service design to anticipate and address barriers
- The Care Experience Improvement Model (CEIM) will be used to gather further patient feedback

Secondary Care

Finally, we have engaged secondary care colleagues via a dedicated short-life working group to identify potential issues and prepare for their upcoming rollout, scheduled to follow the GP phase.

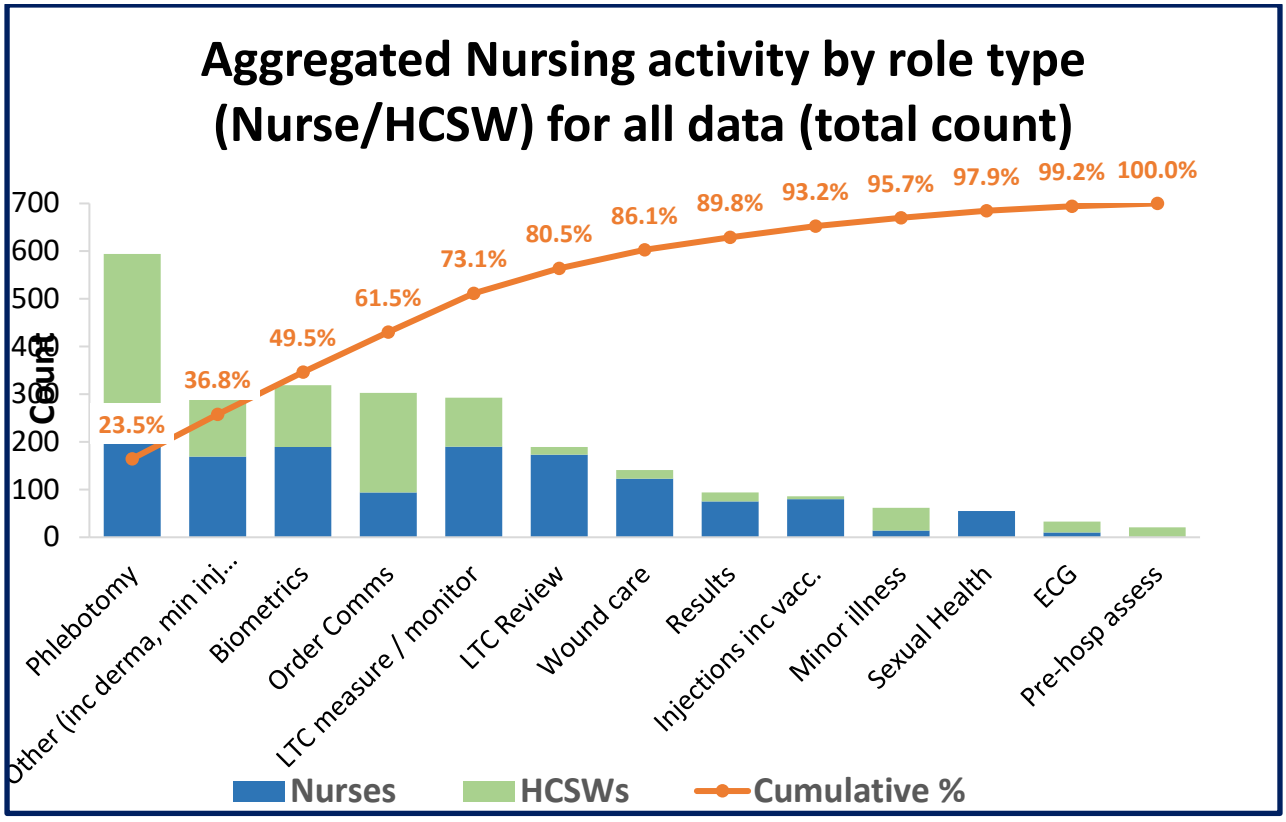
Key Risks

Risk	Details
Finance - long term sustainability	Roughly 50% of our Healthcare Support Worker staffing allocation have been recruited on a fixed term basis due to the fact that this service has not been allocated recurrent funding. This lack of sustainable finance is the key risk for the service, and for NHS Borders as this is a permanent transfer of work out of GP practices into a non-permanently funded service.
Skills and Training	Newly recruited staff require time to achieve the skills and competence required for CTAC activity. This can impact on speed of rollout and type of activity offered per GP practice.
Standardisation of delivery	Each of the 22 practices in the Scottish Borders has differences in processes related to recall of patients with LTC and requests for treatment and care. A standardisation of processes has been developed in partnership with GP practices.
IT infrastructure and changes	Health board and GP services operate on different EMIS patient record systems. In addition, Trakcare is used to request and action blood test results. The lack of a joined up patient record and simple interfaces between systems creates

	clinical risk. In early 2024 all GP practices were meant to be moving to a system called Vision, this has been significantly delayed.
Data assumptions	Data used to create the original CTAC staffing and financial planning model was based on 2019 activity and broad assumptions have been applied rather than a full analysis of demand/capacity across all GP practices. The assumptions will have an impact on the reliability of the model.

Learning from the Week of Care Audit - CTAC

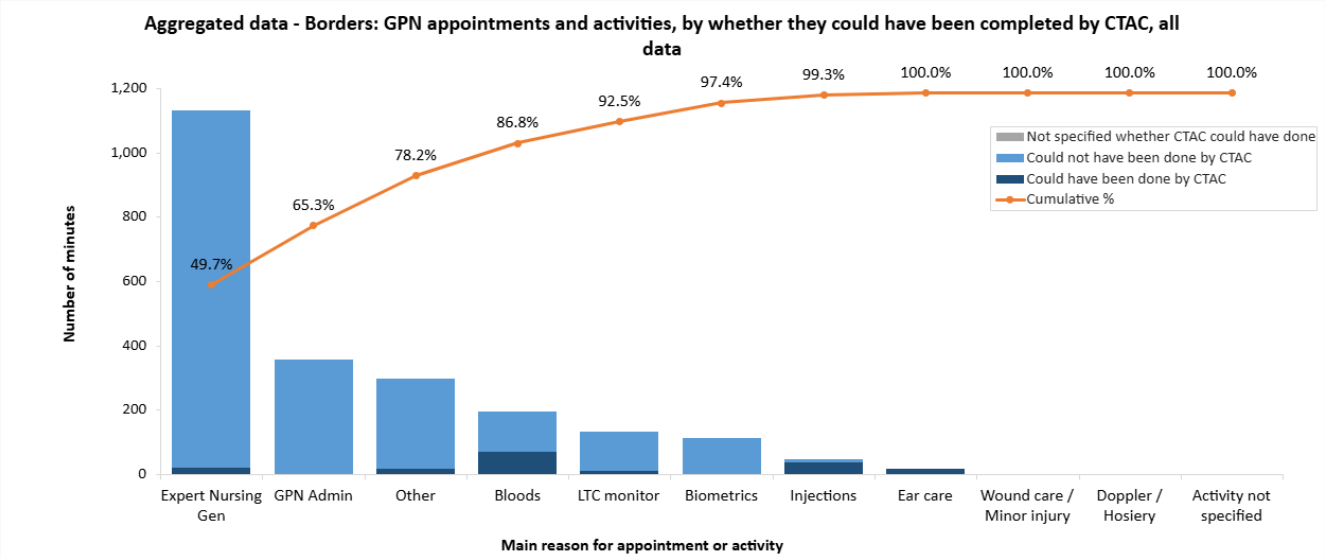
Nursing activity was monitored across Practice Nurses, Treatment room Nurses and Healthcare Support Workers during the Week of Care Audit. This was an attempt to quanitfy demand for activities that fall into CTAC as well as to map out some of the roles that will remain with practice nursing.



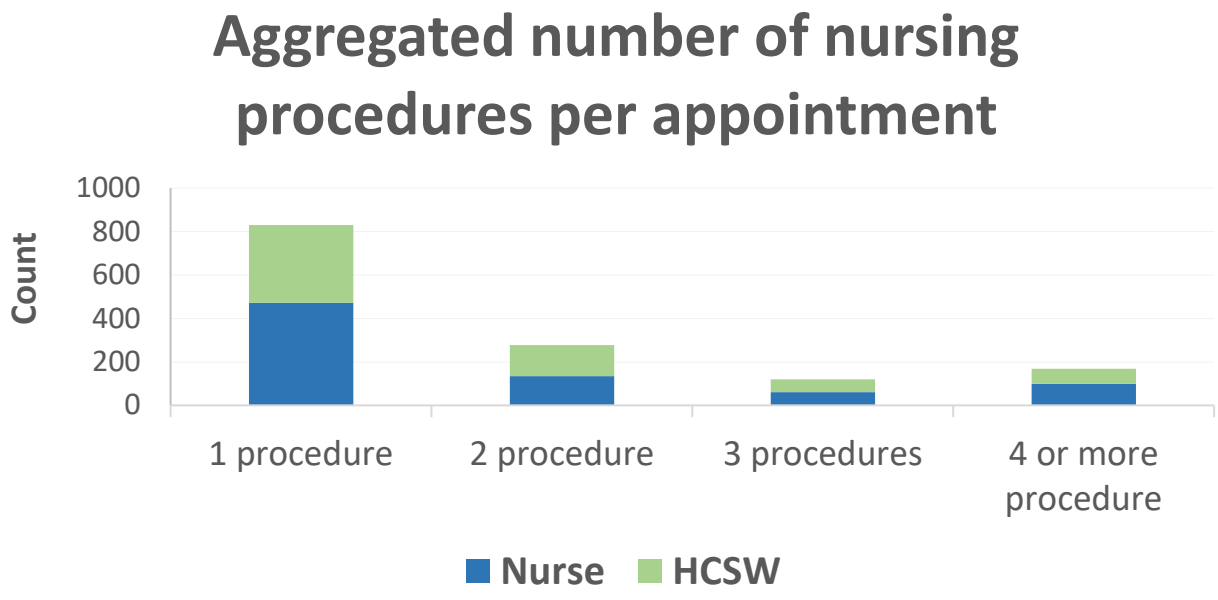
In the above Pareto chart we can see that Phlebotomy and other HCSW tasks are already being undertaken by a proportion of HCSWs. As we complete the implementation of full CTAC we will have

shifted the skill mix across practice treatment rooms from roughly 1/3 Healthcare Support workers versus 2/3 Registered nurses to the reverse proportions.

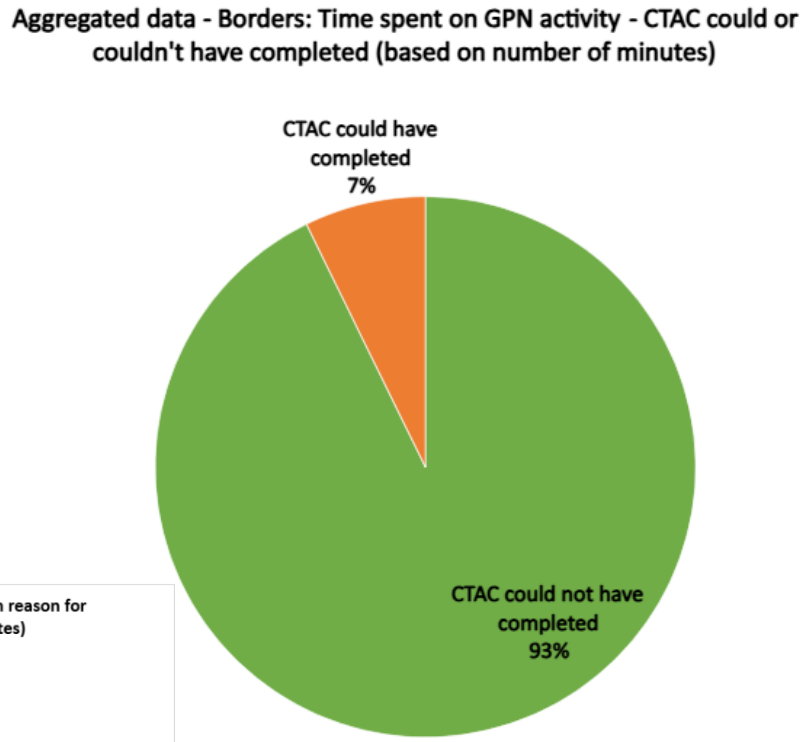
In our March 2025 data collection repeat in 4 practices for GPN activity we can report a significant reduction in the number of bloods being provided by practice nurses with it making up a marginal part of their role and a small proportion of this being seen as suitable for CTAC to have carried out. This is one positive indicator that CTAC is reducing GPN workload.

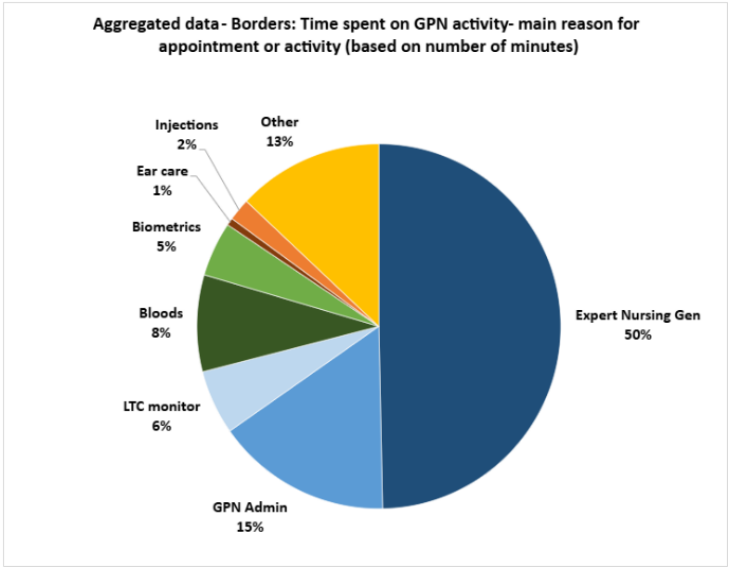


In the graph below we have recorded the number of appointments were multiple treatments were provided within a single appointment. This can often improve patient experience and it is a risk for the implementation of CTAC and the accompanying admin hub that we may see fewer multi-treatment appointments. This also creates more admin demand and is a less efficient use of clinicians time. It is a control measure for the programme that we do not fractuce the patient journey further through the implementation and transfer of these services from practices.



Across the rest of the duration of PCPIP we have planned to run 3 additional week of care audits in 4 practices to follow-up and see how these measures change during implementation of the programme. We have heald 2 of the 3 collections to date: in March and June of 2025. The findings from the March collection are below





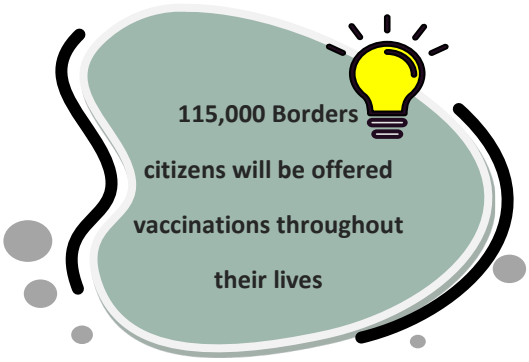
WHAT WE SET OUT TO DELIVER

As per the outcomes of the 2017 GMS contract negotiations, NHS boards and local partners are required to plan, manage and deliver vaccinations rather than the longstanding arrangement of contracting delivery through general practice.

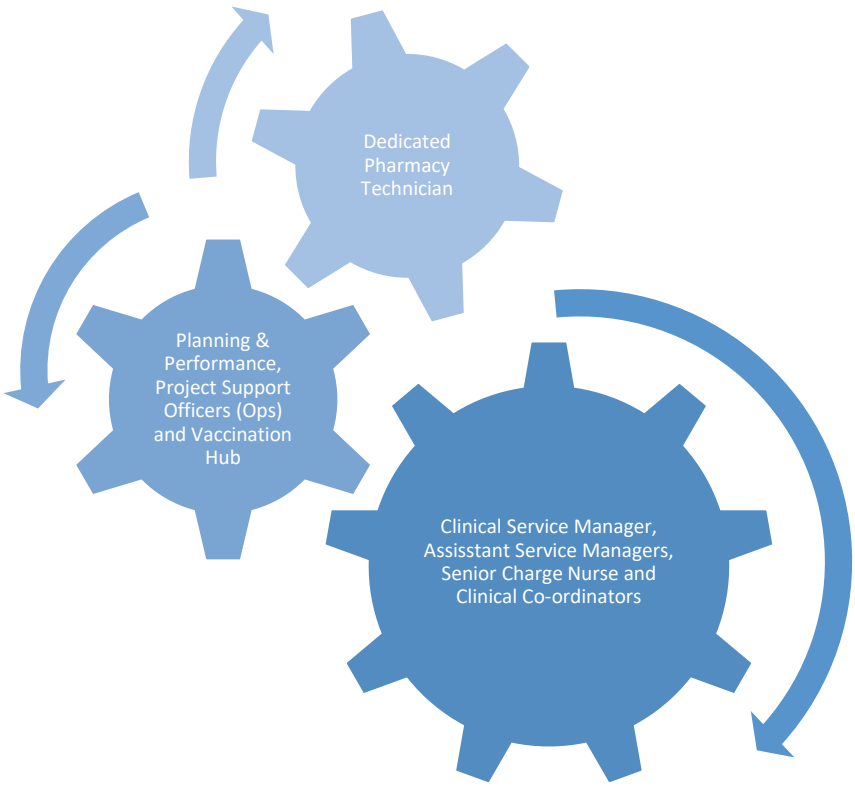
While the UK Joint Committee on Vaccination and Immunisation (JCVI) and Public Health Scotland (PHS) will continue to guide national policy and vaccination programmes, delivery must be managed and implemented by NHS health boards and their local partners to suit their local population, geography and workforce.

Between September 2021 and April 2022, NHS Borders Vaccination Transformation Programme created a dedicated Vaccination Service with responsibility for vaccinations and immunisation, and successfully transitioned all outstanding programmes from GPs to the health board by the required deadline.

NHS Borders Vaccination Service leads the delivery of programmes in partnership with public health, school immunisation, community nursing, occupational health, maternity services, child health, general practice, acute services and the wider Scottish Borders Health and Social Care Partnership.



Vaccination clinics take place on an ongoing basis in health centres, schools, hospitals and community venues across the Borders. Provision is also in place for patients who are housebound or live in residential care.



The service is led by a dedicated Clinical Service Manager, supported by Assistant Service Managers (Planning and Operational) and the following staff:

- Senior charge nurse, Clinical Co-ordinators, vaccinators (nurses) and healthcare support workers.
- Planning and Performance Project Support Manager to assist with planning, uptake monitoring, change and improvement.
- Project Support Officers manage clinic set up, logistics, kit and vaccine transport.
- Vaccination Hub for patient contacts, admin and staffing, including a coordinator, supervisors, admin officers and call handlers.
- A dedicated pharmacy technician to manage vaccine provision.

DELIVERY APPROACH

The Vaccination Transformation Programme delivered patient journeys, operating processes, policies, workforce, communications, resources, systems and reporting from scratch to support a new service.

A dedicated “Vaccination Hub” was developed following its introduction during the 2020 flu programme, evolving to provide a single centre of expertise for:

- Call handling and patient appointment booking line (inbound and outbound)
- Clinic administration (registering patients, arriving patients, liaising with clinical staff)
- Staffing support (recruitment, rostering and training support)
- Dedicated administration and operational support
- Clinical operational support (e.g. clinic kit boxes, printing documentation, ad hoc transport requests)
- Caseload and patient list management (e.g. housebound patients, care homes)
- Records management (devolved management, record amendments, issues and data quality)

Covid-19 and other non-PCIP vaccinations

The Vaccination Programme was integral in the successful delivery of Covid-19 Vaccinations. It is important to note that this vaccine along with other non-PCIP vaccines introduced after the PCIP specification was agreed are funded with a separate additional funding stream.

The Vaccination Transformation Programme capitalised on innovations and new technologies to create a streamlined, resilient, people-centred service introducing:

- A cloud-based telephone system, increasing call capacity, improved patient routing, call queues, options for patient call back, and the capability for call handlers to answer calls remotely.
- Vaccination Management Tool, a national web-based application to support the recording of vaccinations at point of care.
- iPads to support the recording of vaccinations ‘on the move’ and in varied clinic settings.
- National Vaccination Scheduling System to support the appointing of patient en mass by cohort, and a web-based portal allowing patients to book and reschedule appointments online.
- National Clinical Data Store and COVID status app, allowing patients to view their own vaccination status online and automatically pushing data into GP systems.
- Reporting dashboards – sharing concise, visual summaries of uptake, performance and planned appointments.
- Dedicated vaccinations webpage for patients http://www.nhsborders.scot.nhs.uk/vaccinations
- Dedicate vaccinations intranet for NHS staff and partners.

CLINICAL STAFFING BREAKDOWN (July 2025)	Permanent		Fixed Term		As & When	
	In Post	Vacant	In Post	Vacant	In Post	Vacant
Clinical Management	1.4	0.0	0.0	0.0	0.0	0.0
Clinical Co-Ordinator's	1.27	0.0	0.0	0.0	0.0	0.0
VTP (Babies, Pre-School, Travel & Selective) **Adult Vaccinations (Shingles, Pneumo, RSV, Flu & CV-19)**	5.49	0.95	0.0	5.0	0.2 B5 0.03 B3	0.0
School Immunisations	3.72	0.0	0.0	0.0	0.0	0.0
Total:	11.88	0.95	0.0	5.0	0.23	0.0

VACCINATION ACTIVITY & UPTAKE- As of May 2025, the Vaccination Service has given over 760,000 vaccinations, including over 460,000 COVID vaccinations (since December 2020), and 300,000 vaccinations across routine childhood, pneumococcal, shingles, RSV, flu, selective and travel programme.

Programme	Vaccinations given	Uptake range
Routine childhood (baby/pre-school)	39,900	94 – 97%
Pneumococcal	14,400	56 – 80%
Shingles	14,000	57 – 77%
RSV	5,700	52 – 61%
Non-Routine & Travel	5,000	-
Flu	220,000	55 - 93%
COVID	460,000	45 - 82%

Taken from the Renew Annual Report 2023/24 - September 2024

Due to Reporting Schedules being out of Sync the Renew Annual Report for 24/25 will not be available for the SPG and JET stages of the PCIP Annual Report progression through governance. We will update this section to included the 25/26 report in the final version sent to the IJB in October 2025

Introduction and highlights

The Renew service was established in NHS Borders in October 2020, utilising funding from PCIP, Action 15 and psychology services with the aim of offering a "see and treat" model for model for mild to moderate anxiety and depression for those aged 18 and above, using evidence based psychological therapies in primary care.

In the last year we have continued to note high demand for our service, Renew is receiving more referrals for people who have more complex mental health problems, whose needs are not met through low intensity interventions, but not severe enough to warrant secondary care services.

In the past year, we have reviewed our service data, where the areas of demand are and monitored the types of presenting problems referred to the service. Using that data and our understanding of the psychological therapies matrix we have altered some of our service provision.

This has included:

- Reviewing and enhancing the therapeutic intensity of our anxiety and depression courses
- Reviewing the frequency of these courses
- Introducing new skills courses to meet new demand e.g. courses which address problems with emotion regulation, and people who have experienced trauma throughout their lives.
- We have also placed emphasis on ensuring people are matched with the intensity of intervention which best matches their needs at point of referral.

Renew continues to offer a psychological assessment to patients at point of referral. We aim to ensure patients are triaged appropriately within Renew and matched to the evidence-based intervention appropriate to their presentation and goals or referred appropriate to other services in a timely fashion.

This report outlines the performance of Renew against our KPIs for the period of April 2023 to June 2024 in addition to longitudinal service data for comparison purposes. Further, where appropriate we have included comparisons to the Increasing Access to Psychological Therapies (IAPT) Programme, as a comparison for national data.

Key highlights:

- We have noted a change in the type of demand in the service to increased complexity requiring additional 1:1 treatment
- Using service data, we have used quality improvement methodology to understand our referral pathway and plan for changes in order to meet changes in demand, by analysing our waiting lists and using the matrix to plan and provide evidence-based interventions.

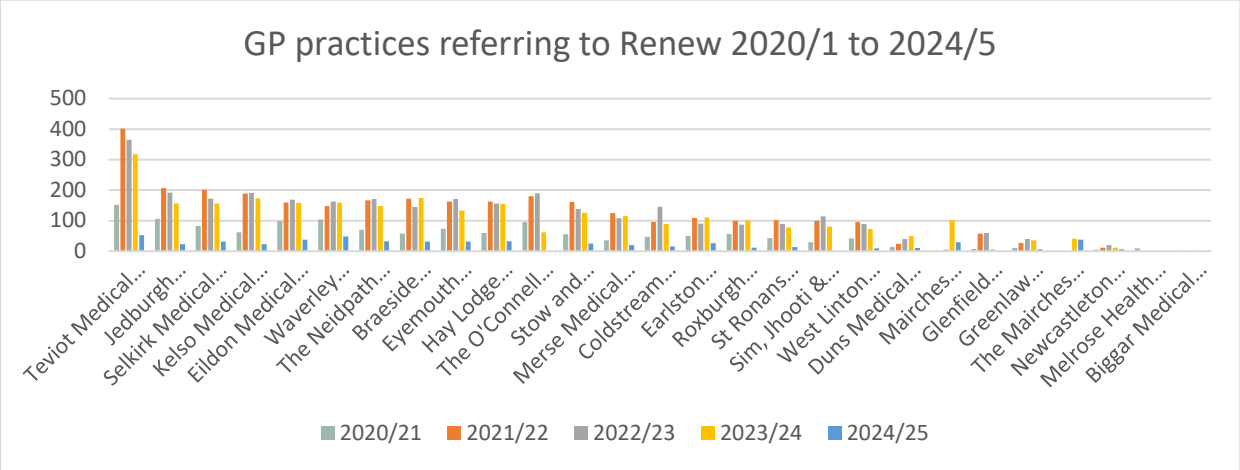
- Our clinical response has been to reallocate our clinical resource in order to provide interventions like Survive and Thrive which meet a clinical need but also allow us to provide treatment to a number of people effectively and efficiently.
- We have updated the content of our skills courses to ensure that they are as therapeutically effective as possible.
- The DBI clinical lead psychologist position, now sits within the Renew structure, ensuring good communication, shared training opportunities and effective transfer for patients between the two services.
- We continue to receive positive feedback from our GP colleagues and patients
- Our data analysis suggests our range of treatments are effective in reducing 'caseness' and bringing about reliable improvement comparable with IAPT data.

Progress as per KPI's

KPI1: Demand for service – Referrals

The service continues to experience high demand. All GP practices across NHS Borders have referred to Renew since the service opened in 2020 and the chart below indicates that this pattern has continued as the service has developed.

Chart 1: GP practices referring to Renew



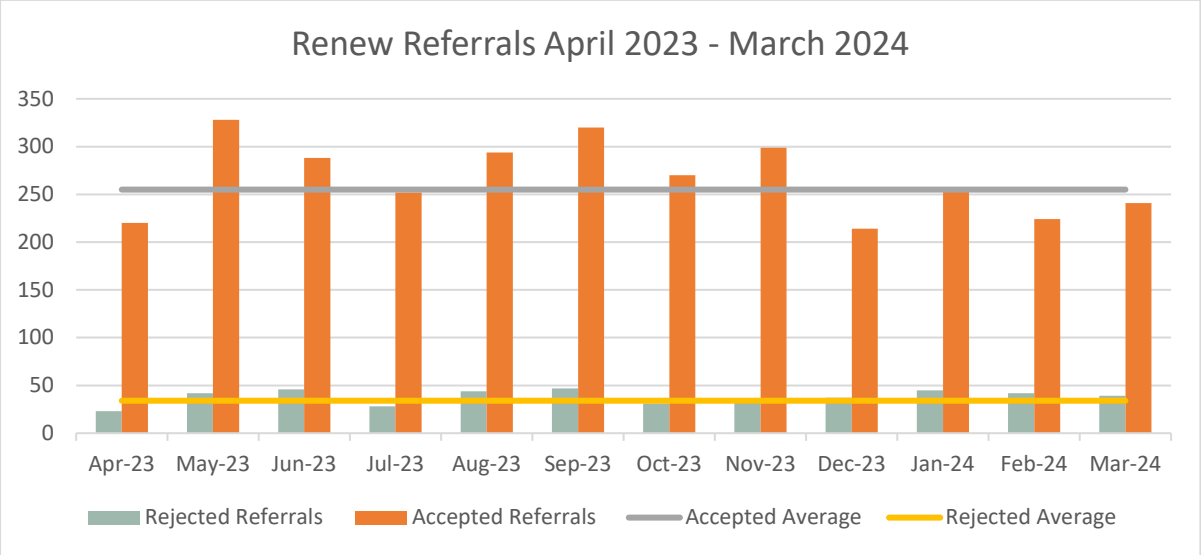
*A number of practices have merged during the reporting periods explaining a reducing in referrals from some practices and an increase in others.

We note some seasonal variation in referrals, with generally lower numbers over the holiday periods. The rate of referral has decreased over the first quarter of this year, but in this we note a declining demand for treatment of mild disorders and an increase in demand for treatment of moderate presentations of anxiety, depression and both single and complex presentations of psychological trauma.

Chart 2 below, highlights the number of referrals accepted and declined each month, with the overall mean for comparison. We aim to have a high threshold for declining referrals and therefore very few of the referrals to Renew each month are declined. We triage and monitor referrals daily,

the main reasons recorded for declining referrals are as follows: significant complexity which would require a multidisciplinary approach, or the treatment approach is located in Secondary Care (eating disorder, EUPD) or the patient presents with significant risk could not be safely supported in primary care.

Chart 2: Referrals to Renew April 23-June 24



We wanted to understand the repeat referrals to the service. When the service was initially launched in 2020/2021 the community was experiencing high levels of anxiety. The service responded to this by offering high volume evidence-based CBT skills courses and whilst the data and patient feedback suggests these are effective at alleviating distress, we noted a number of return referrals to the service, suggestive that patients as the anxiety from the Covid period has reduced there are a number of patients with psychological distress which requires higher intensity interventions.

As we have understood the referral data and amended our treatment approach over the second quarter of 2023/2024, we have seen a reduction in return referrals to the service as demonstrated in Table 1 and Chart 3. We will continue to monitor this going forward.

Table 1: Percentage of New to Return Referrals 2021-2023

Year	2021	2022	2023
Percentage New referrals	88%	83%	86%
Percentage Return referrals	12%	17%	14%

KPI 2: Speed of Access/Service Efficiency to see and treat

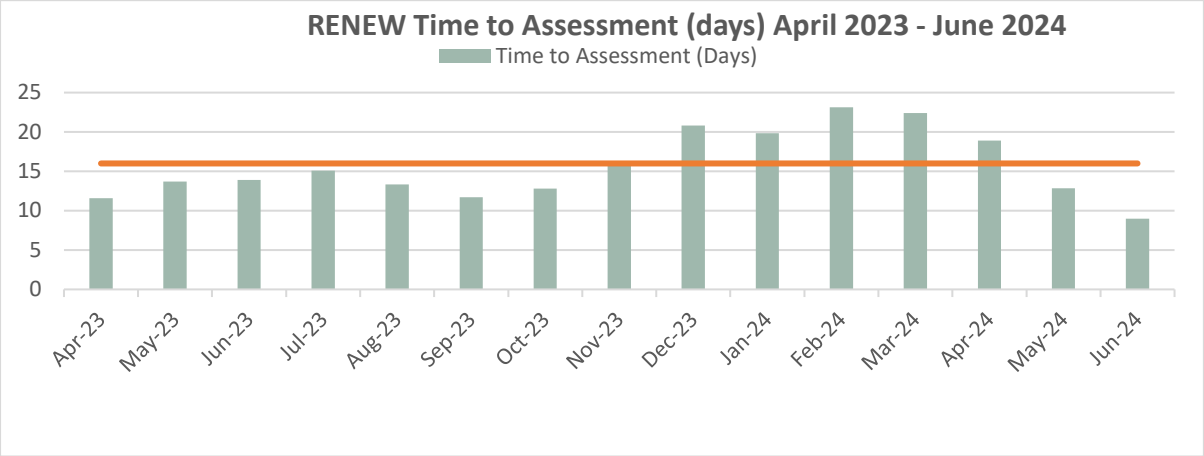
A) Assessment

In the last financial year, average time from referral to assessment was 13 days. There was an increase in the latter part of 23/24 due to increased referrals to the service, seasonal staff sickness and maternity leave. We subsequently amended the distribution of our resource to ensure that

these times were improved. GP's have told us that they value us doing an assessment and giving an opinion on best treatment within a short period of time.

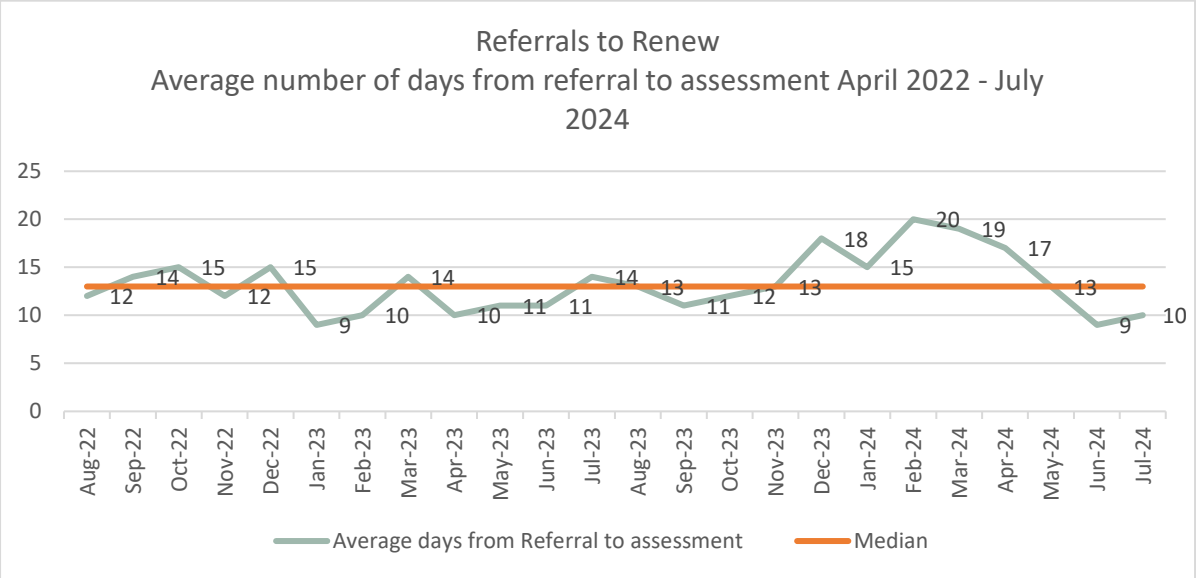
In Renew, we front load clinical expertise to ensure that people receive a psychological assessment and treatment outcome quickly. This may mean a psychological treatment in Renew, but it may also mean being signposted or referred on to an organisation who may more appropriately meet the person's needs e.g. Secondary Care Psychology, Cancer Services, or a third sector organisation who can provide mental health assistance which meets the persons goals. We note that a proportion of the people we assess don't necessarily need psychological therapy but are able to signpost them to the best option possible for them. Although this takes resource, GP's tell us they value assessment appointments with letters sent to GP's giving them recommendations.

Chart 4: Average time to assessment



We know it's important to patients and GPs that people are assessed quickly. Chart 5 below demonstrates that our referral to assessment time has been consistent across the last two years.

Chart 5: Referrals to Renew: Average number of days from referral to assessment April 2022-July 2024



B) Treatment

In the last financial year on average people started treatment within 8.7 weeks of referral. Those who access digital treatments can start immediately, those attending skills courses should wait no longer than 4 weeks till the next available course. The longest waits in the service are for those people who require individual interventions. The change in demand in types of referrals has altered the flow of patients through the system as more people wait for individual interventions. However, the service consistently performed well against the HEAT standard of referral to treatment within 18 weeks.

Chart 6: Renew Time to treatment (days) April 2023 – June 2024

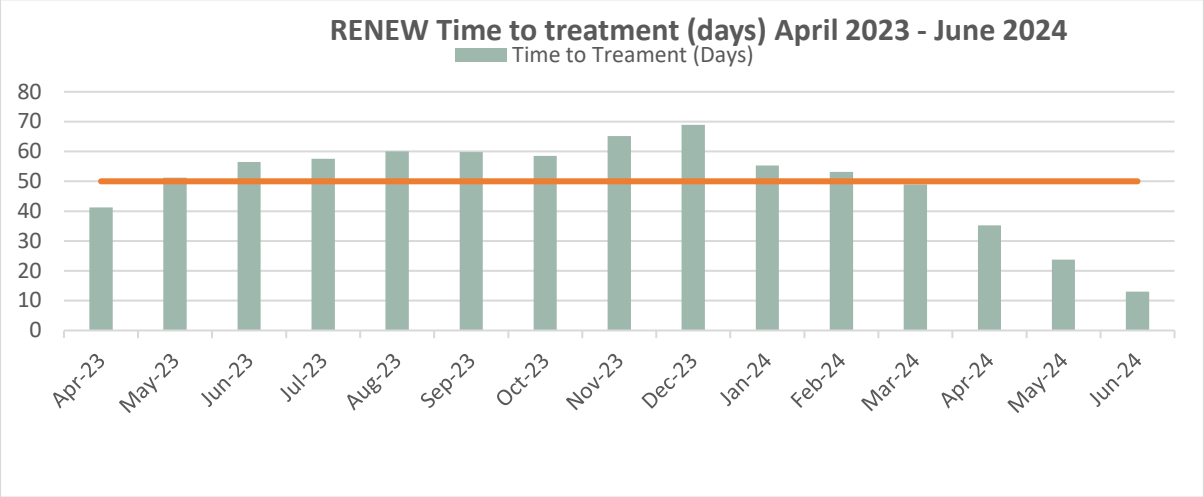
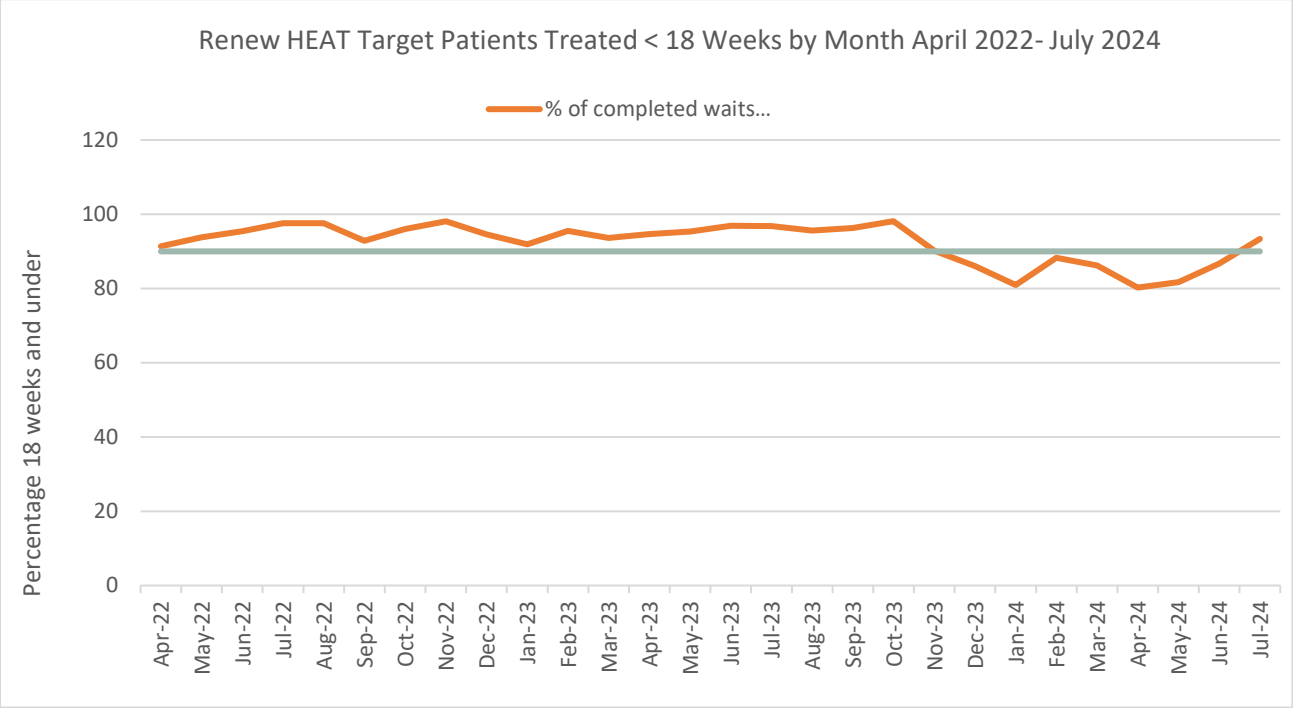


Chart 7: Renew Performance against 18 Weeks Heat Target.



Our performance against the HEAT target fell in November and December 2023 due to increased clinical demands of those waiting for treatment, staff on maternity leave and significant seasonal

illness in our staff. We reviewed the delivery of skills courses, the clinical needs of those waiting on our individual treatment waiting lists and reallocated resource, including the introduction of Survive and Thrive (evidence based group intervention for those who have experienced repeated interpersonal psychological trauma). We were also able to recruit qualified psychologists to enable throughput on our clinical psychologist individual waiting lists. This has significantly improved performance.

C) Treatment interventions offered

We currently offer psychological interventions of varying intensities in Renew to ensure we are able to offer the correct 'dose' of therapy. There are three types of individual intervention offered, EPP (brief intervention), CAAP (8-12 sessions of high intensity CBT), Clinical or Counselling Psychologist (12-16 sessions of highly specialist therapy).

Approximately 30% of the people referred to renew are suitable for treatment in a one of the skills courses; these include Anxiety, Low mood (mild to moderate symptoms of anxiety or low mood/depression), healthy self esteem for those whose psychological difficulties are impacted by their self esteem (moderate difficulties) Emotion Resources is most appropriate for people with moderate difficulties experiencing problems with emotion regulation and the most recent addition to the service is Survive and Thrive, appropriate for people who have moderate difficulties associated with having experienced repeated interpersonal psychological trauma.

The skills courses offered in Renew remain a highly popular and effective treatment option. In 2023/24 we have reviewed and updated the content of the anxiety, low mood and healthy self esteem skills courses to ensure they remain consistent with the evidence base, and they are offering the correct 'dosage' of treatment. We will continue to review the impact of these changes in terms of patient feedback and clinical outcomes.

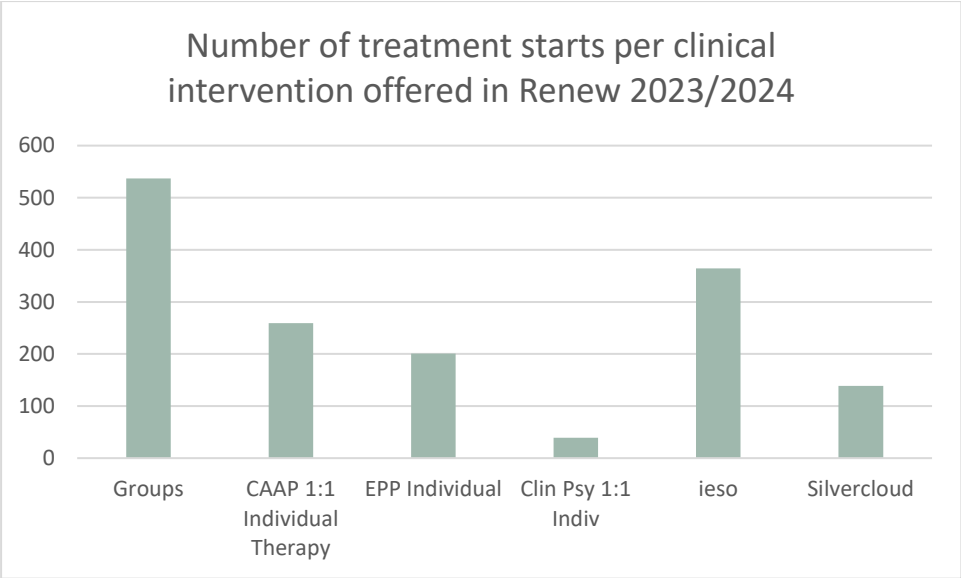
Digital interventions are also offered in the service. Silver Cloud has a range of modules for people experiencing mild to moderate psychological difficulties. These are provided with online support from our Assistant Psychologists. People work through these modules independently in their own time. IESO is a higher intensity digital intervention. This is offered by therapists who are providing a text-based appointment service People accessing the service are offered individual CBT at an appointment time of their choice which provides a flexible alternative for those people who do not wish to take time off work to attend appointments or may require flexibility for childcare.

Treatment options in Renew are outline in more detail in Appendix 1.

D) Demand and Uptake of Interventions:

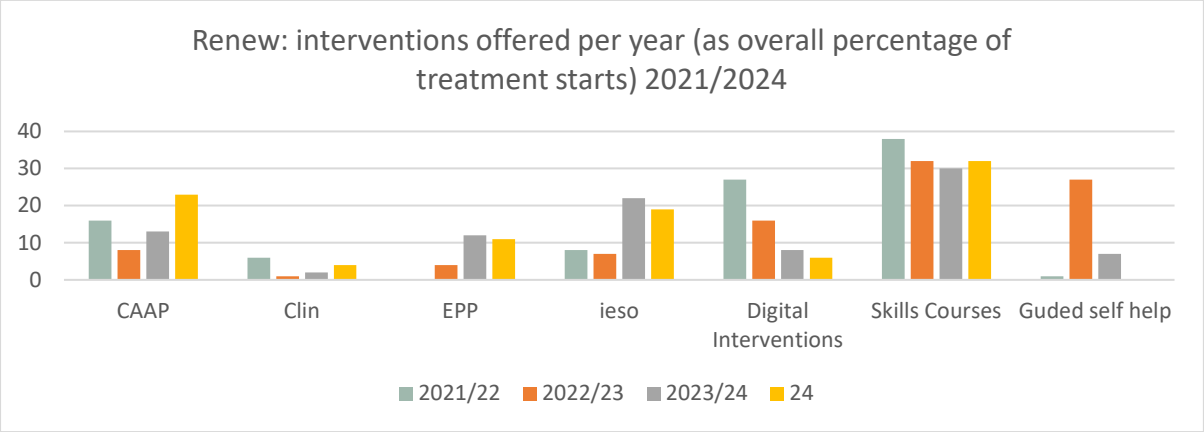
Chart 8 below shows the types of interventions offered in Renew over the reporting period as a percentage of overall treatment starts. The figure demonstrates that approximately 30% of interventions offered in Renew over the past year were 1:1 (Clin Psych, CAAP or EPP), a further 30% of interventions were via our skills courses.

Chart 8: Clinical Interventions delivered in Renew in 2023/24



As discussed earlier in the report, we have noted a change in profile for the demand for different types of interventions over the course of Renew's establishment with a focus on increased demand for interventions for moderate presentations of common mental health problems which often demand a 1:1 intervention. Charts 9 and 10 below indicate the percentage treatment starts for each intervention over the period of 2021 to 2024.

Chart 9: Type of clinical intervention offered per year (as overall percentage of treatment starts) 2021/2024



We note the graph demonstrates increasing demand for individual therapy (Clin/Counselling Psychologist, CAAP or EPP) and the number of these interventions offered within the service continues to increase. We believe this reflects the increasing complexity of presentations referred to Renew, and that people who are being referred to the service have their care appropriately matched to their presenting complaint.

There is an overall decline in demand for digital therapies, particularly Silver Cloud. IESO falls between an individual and a digital intervention, as it is a chat-based therapy provided on a 1:1

basis. We have seen increased demand and uptake of ISEO across the period 2021-2024, largely we believe due to the increased flexibility of appointment times and overall increased demand for individual therapy.

Chart 10 Renew demand for individual and group therapies (percentage of treatment starts) 2020/21 to 2023/24

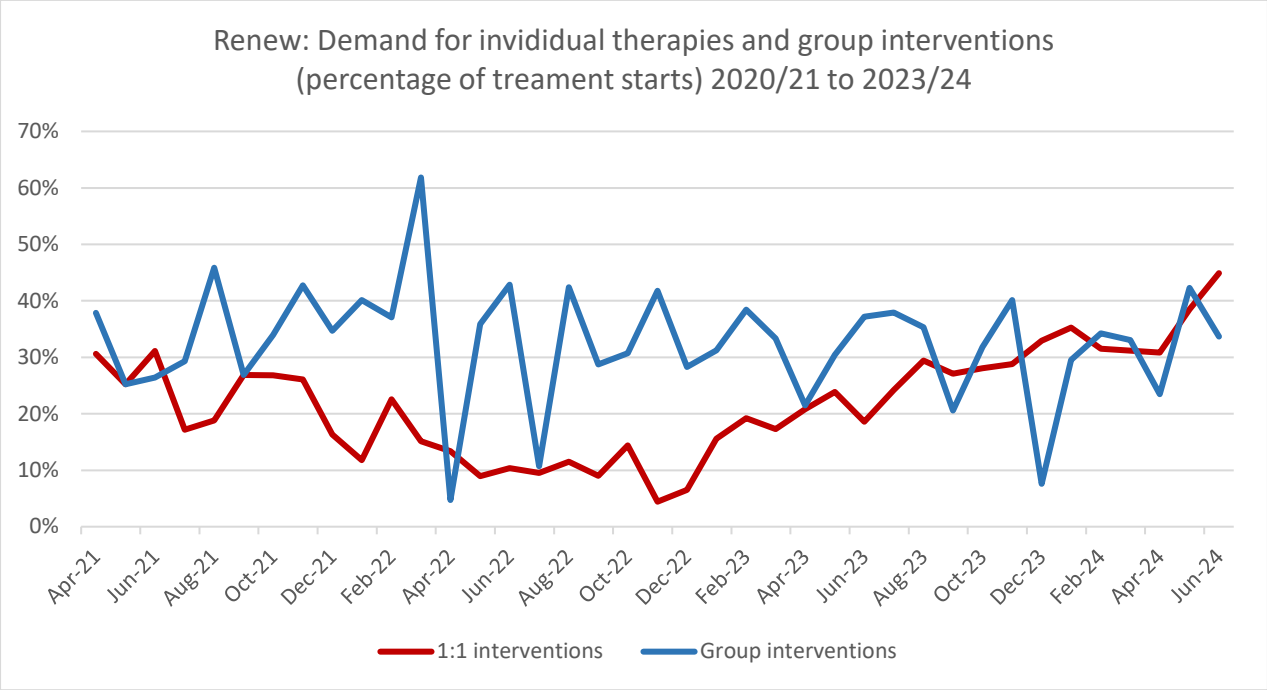
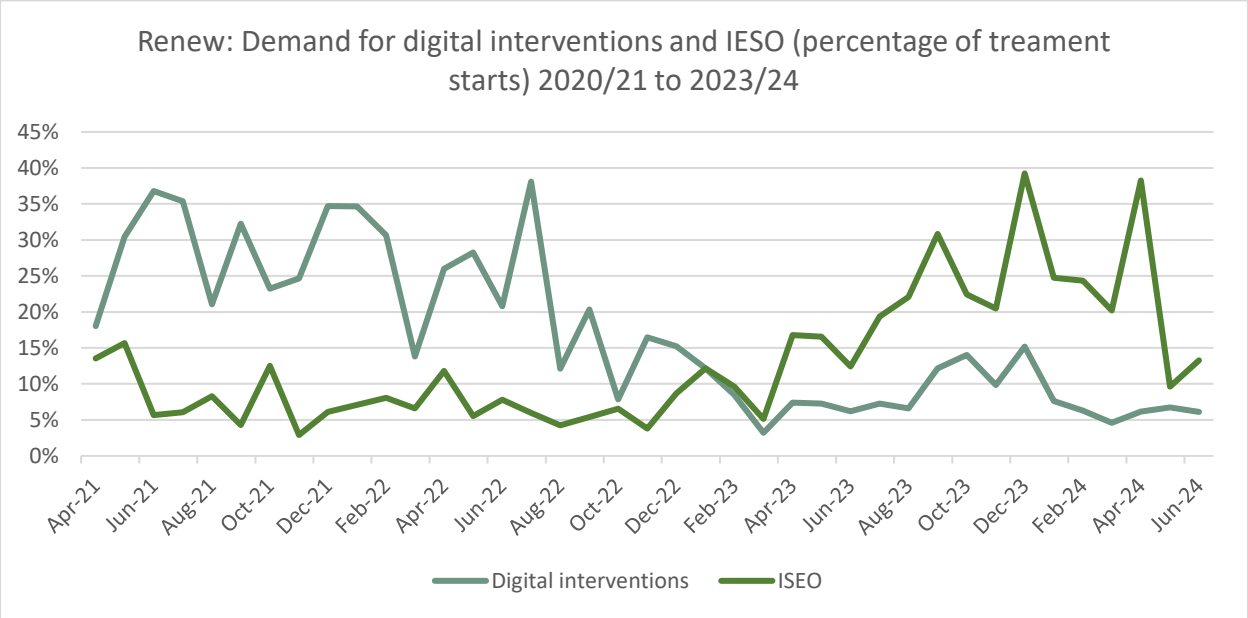


Chart 10 demonstrates the relatively stable demand for CBT skills courses across the last three years. Months where there are drops in numbers are where we tend to run fewer courses or experience changes in referral numbers. We have noted that as we have altered our treatment allocations to these courses overall compliance has also increased. Importantly chart 10 notes the significant increased demand for individual interventions in Renew and the importance of these for the people accessing our service. Typically, people requiring individual interventions experience moderate psychological distress with associated impact on functioning, common presentations include, PTSD (type 1 and 2), OCD, birth trauma, health anxiety, or more complex presentations of depression which require formulation.

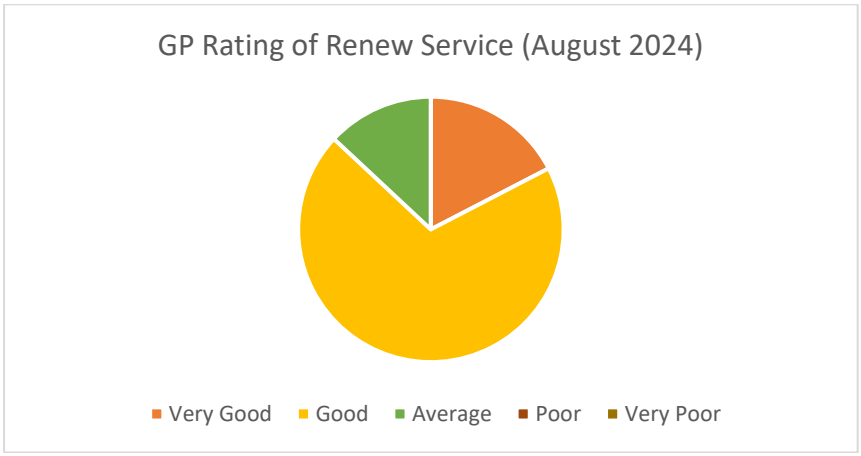
Chart 11 clearly demonstrates the significant decline in demand for self-guided digital interventions like SilverCloud with significant increased demand for 1:1 therapist chat based appointments increasing over the last 18 months. This is also attributable to increased complexity in referrals to Renew and the demand from some patients for flexible appointment times.

Chart 11: Demand for digital interventions in IESO – 2021-2023/24



KPI 3: Service Outcomes – service valued by GP's and patients and treatment effectiveness

1. GP Feedback:
   As our key stakeholders, GP feedback is an important element in understanding out service. In August 2024 we sent out a questionnaire to GP colleagues asking them their views on the service.



   We were delighted to note that 100% of the respondents rated Renew positively, also offering helpful and constructive feedback on the ongoing delivery of the service.

2. <u>Some GP comments (May 2022):</u>
   What does Renew do well?
   - Contacts patients quickly
   - Good initial assessment and signposting

- Many of my patients have fed back what a fantastic experience they have had with Renew and how they have really helped them
- Good service for patients, rapid triage and contact

What could Renew do better?

- Keep GPs updated about how Renew is working – so we can let patients know what to expect
- More face-to-face interventions
- Increase capacity for ongoing psychological treatments
- Signposting referrals on to secondary care or CMHT rather than passing back to GP

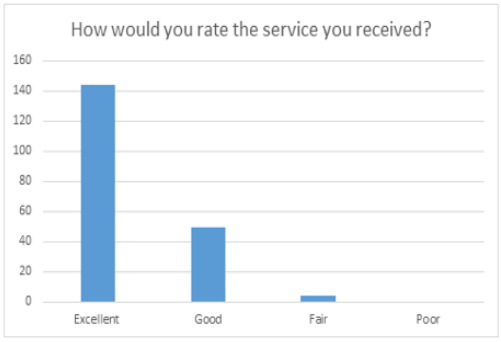
Other comments about Renew?

- Overall, I think Renew is a great service and has benefited a lot of patients
- Mental Health presentations in general practice are no longer heart sink because there is a service like this
- Good service. Has revolutionised mental health care for the Borders GP
- I am aware of the increasing complexity of cases given to Renew as CMHT push back in Borders, and am grateful your service exists

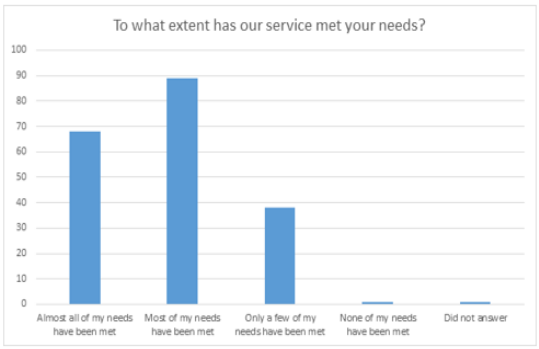
The feedback received from our GP stakeholders was positive and encouraging. Demonstrating that our focus on frontloading our service resource to provide high quality brief psychological assessments in a timely fashion is useful. We value the constructive feedback on what the service could do better and will take that forward in our delivery of the service over the next year.

3. **<u>Service user feedback:</u>**
   Following each intervention, we give patients the opportunity to provide feedback on the service they received. Renew uses the Client Satisfaction Questionnaire (CSQ-8) as a structured form of feedback. The following responses have been received from patients using the service from 2020-2024
   We routinely monitor this data in order to consider our patient experience and the effectiveness of interventions.

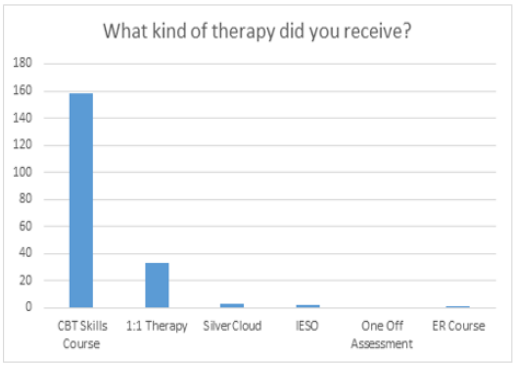
A) How would you rate the service you received?



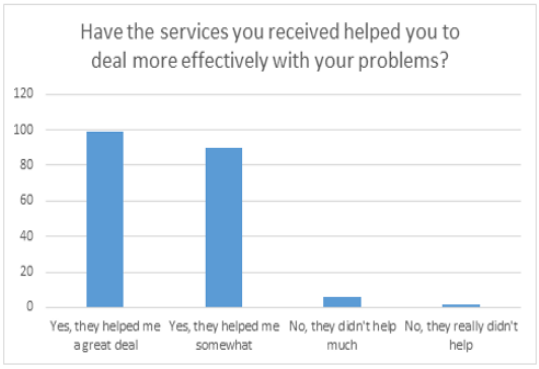
B) To what extent has our service met your needs?



C) If you were to seek help again, would you come back to our service?

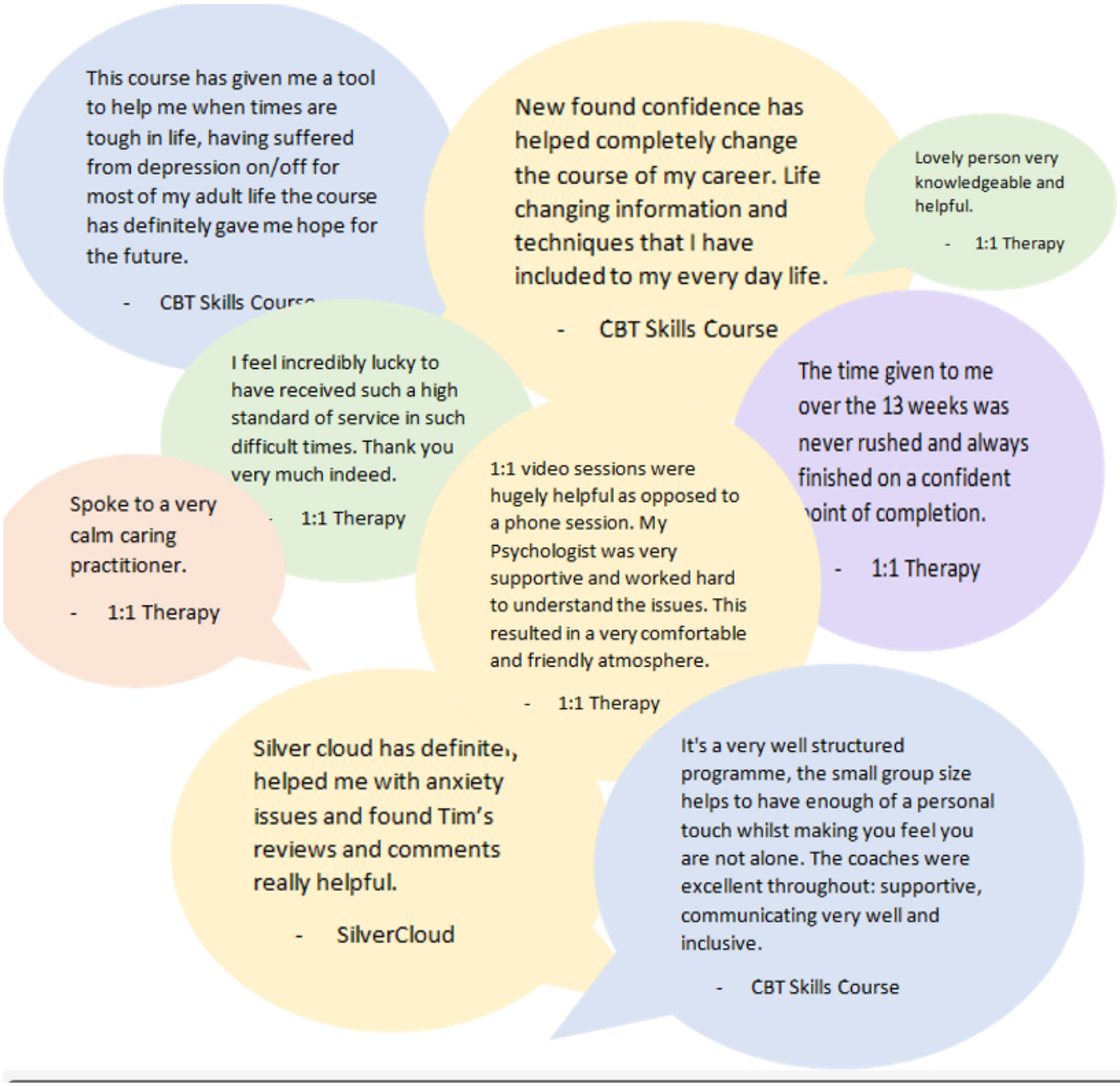


D) Did the service you received help you deal with your problems



Given the volume of patients seen in Renew and the variety of presenting problems treated, we are delighted with the feedback that most patients responding rated their treatment as excellent or good and that people would use our service again. We are further encouraged the significant majority of patients noted that the services they received enabled them to deal more effectively with their problems.

Patient comments



4. Treatment effectiveness

Renew aims to treat low mood/depression and anxiety that presents in a primary care setting. We collect routine clinical measures of depression and anxiety using nationally accepted measures called the PHQ-9 and GAD-7 which are collected pre and post intervention in order to capture this and monitor treatment effectiveness.

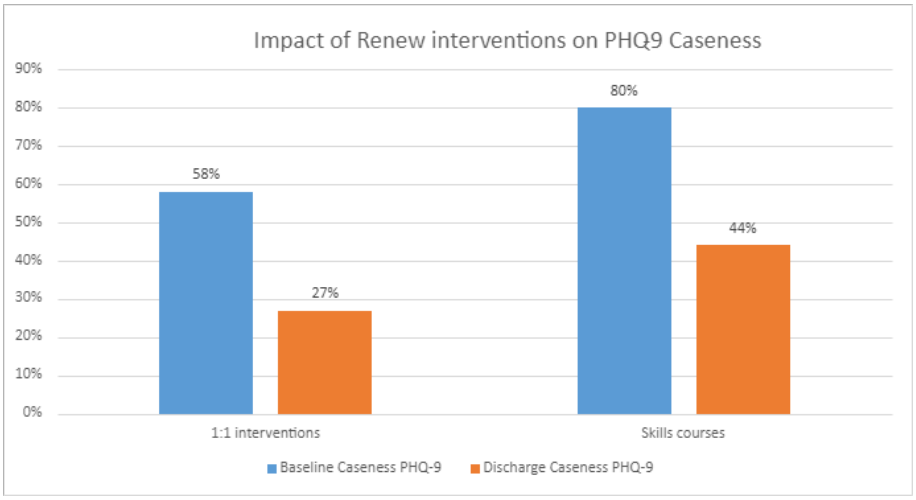
We measure what we call “caseness” using clinical cut offs, which indicate whether a person’s symptoms were significant enough to be considered a clinically significant case. When repeated, this indicator shows the proportion of people who completed a course of treatment who were considered to be a clinical case at the start of treatment (above caseness), and whose symptoms had improved to below the clinical threshold upon completing treatment, giving an overall impression of the clinical effectiveness of an intervention.

The data in Charts X and X demonstrate the percentage of patients achieving “caseness” on each of these measures pre and post intervention.

a) PHQ-9- Low mood and Depression.

The PHQ-9 is a widely accepted measure of low mood and depression which is measured at assessment and discharge. The data in this chart below demonstrates the percentage of patients achieving “caseness” pre and post intervention. Figure 8 below shows an improvement in symptoms and caseness across all interventions offered for low mood and depression.

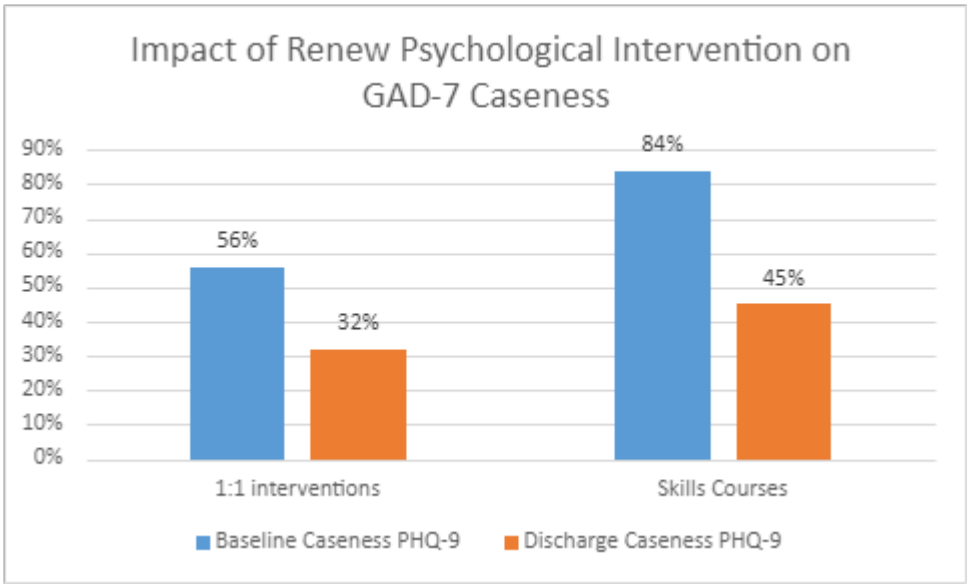
Chart 12: percentage of patients achieving ‘caseness’ pre and post intervention across Renew interventions.



b) GAD-7 – Anxiety

The GAD-7 is a widely accepted measure of anxiety which is measured at assessment and discharge. The data in this chart below demonstrates the percentage of patients achieving “caseness” pre and post intervention. Figure 9 below shows an improvement in symptoms and caseness across all interventions offered for anxiety.

Chart 12 Percentage of patients achieving 'caseness' on GAD-7 across Renew interventions



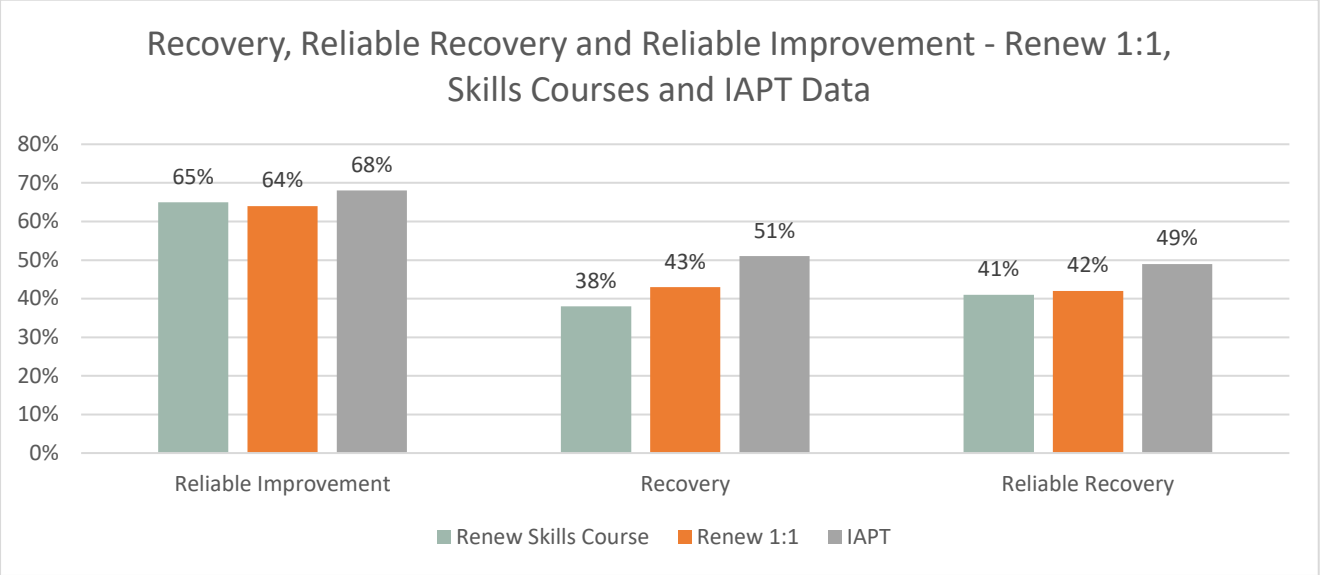
c) Recovery, reliable recovery and reliable improvement by psychological intervention in Renew

Caseness is a different metric to 'reliable recovery' recovery measured by 'casesness' simply means a change in symptoms from above to below the threshold for being considered a clinical case, regardless of the amount of change.

Reliable improvement refers to a statistically reliable improvement, whether people's scores meet clinical threshold or not. Reliable improvement therefore covers people who have recovered, and those whose improvement is significant.

Reliable recovery is achieved when symptoms improve by a significantly large margin pre and post intervention, for people who were considered a clinical case at the start of treatment.

Chart 13 : Recovery, Reliable Recovery, and Reliable Improvement 1:1 and Skills Course Interventions



The data provided above is comparable to IAPT data. In IAPT 68% of people finishing a course of treatment showed reliable improvement vs 64% and 65% in Renew for 1:1 interventions and skills courses respectively.

In reliable recovery, our 1:1 patients are those which present with the most complex difficulties when they attend for treatment. Treatments are delivered according the psychological therapies Matrix (NHS Scotland, 2023). However these individuals often present with co-morbid difficulties. Reliable recovery occurs in 44% of cases undertaken by CAAPs and 39% in cases undertaken by EPPs. EPI are a relatively new intervention in NHS Scotland, and at times people present with multiple difficulties however at a milder level, this may account for the reduced percentage of reliable recovery in that cohort.

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

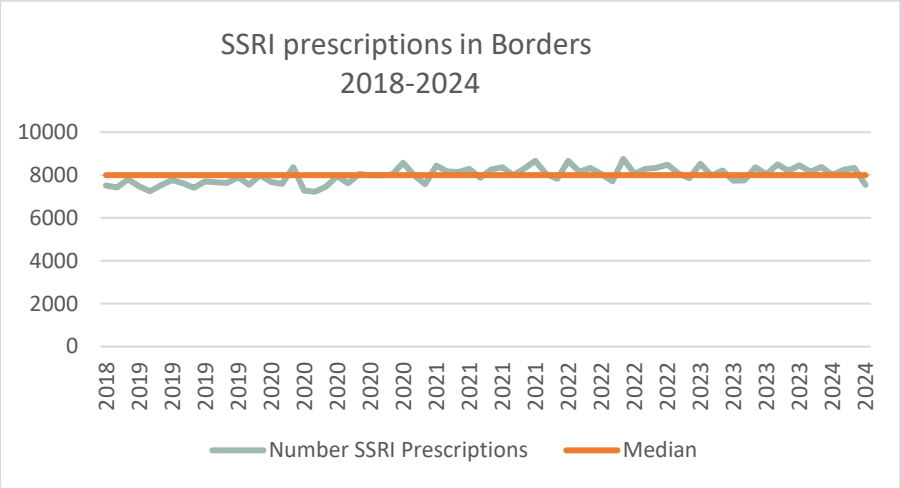
When we did our test of change, an audit on one GP Practice, revealed that for every new GP Mental Health consultation, there were three times as many return appointments. This pointed to the "revolving door" where there was no effective, evidence-based treatment available and was one of the main reasons why we tested out and adopted a "see and treat" model as opposed to usual models of distress management in primary care. 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. 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:

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. 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 have however, been able to review SSRI and anxiolytic prescribing in Borders between 2018 and 2024.

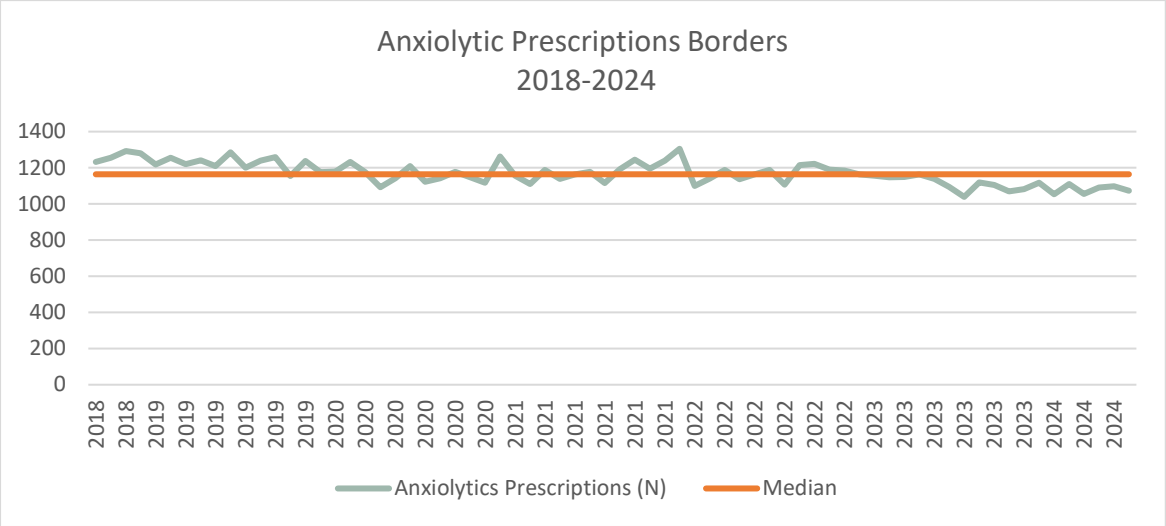
Chart 14 : SSRI prescriptions in Borders 2018-2024



Whilst during the time Renew has been established there has not been a significant impact on SSRI prescribing. National statistics suggest an overall 2% increase in antidepressant prescribing in 2022/23 (NHS England).

We also considered prescribing data around anxiolytics and there does appear to have been a reduction in Anxiolytic prescribing across the Borders area during the period Renew was established. It is interesting data to note, however, we are unable to attribute a causal relationship with the establishment of Renew. Of note, national data suggests that Anxiolytic prescribing decreased by 2% nationally; whilst anxiolytic prescribing in Borders appears to have decreased by 13% overall, this may be reflective of better opportunities to access appropriate psychological therapy in Primary Care as an alternative to prescribing for anxiety related disorders.

Chart 15: Anxiolytic Prescriptions: Borders 2018-2024



c) Impact on Mental Health Services

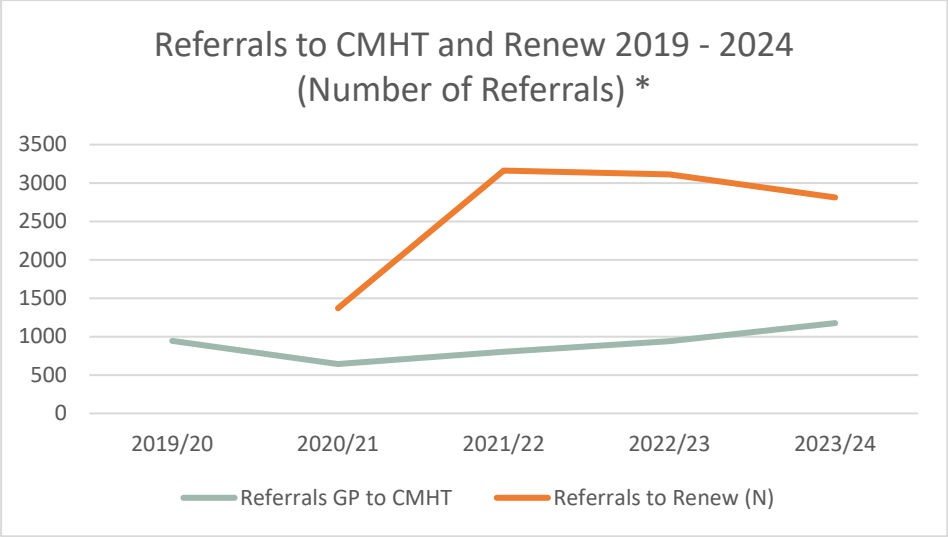
At the time, we considered a balancing measure to be that there was not an increase in referrals to other mental health services, namely the CMHT. To monitor this, we have looked at two pieces of data – total referrals from GP's to CMHT's and referral data between Renew and the CMHT.

Referrals from GP's to CMHT

Data collected between 2019/20 and 2023/24 indicates that there was an initial significant reduction (30%) in referrals to CMHT which occurred around the time Renew was launched. It was noted in earlier reports that whilst it was an interesting trend, the period coincided with the end of the Covid-19 Pandemic which may have impacted overall referral data.

Data for 2020/21 onwards demonstrates a gradual increase in referrals to CMHT, bringing the figure closer to baseline (pre-pandemic) referral numbers. This data is consistent with the recent findings of Gomes (2024) who noted a significant decreased of the number of new referrals to a specific community mental health service with the onset of Covid and a following progressive increase of referrals following on from the end of the pandemic. This is further supported by NHS England data which suggests an increase of 24% to mental health services across NHS funded secondary mental health services between 2019-2020 and 2022-23 (NHS England, 2024). We would therefore conclude that the increased referrals to CMHT is likely a multifaceted issue not directly linked to the introduction of Renew.

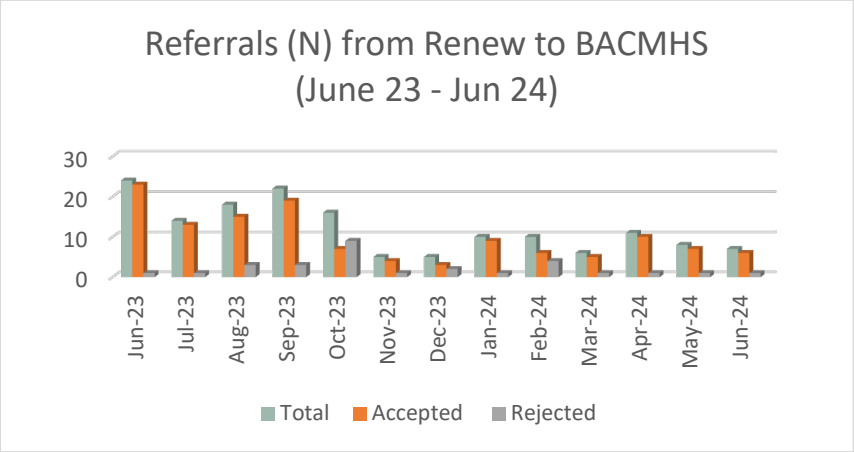
Chart 16: Referrals to CMHT and Renew period 2019 - 2024



*Renew launched in 2020

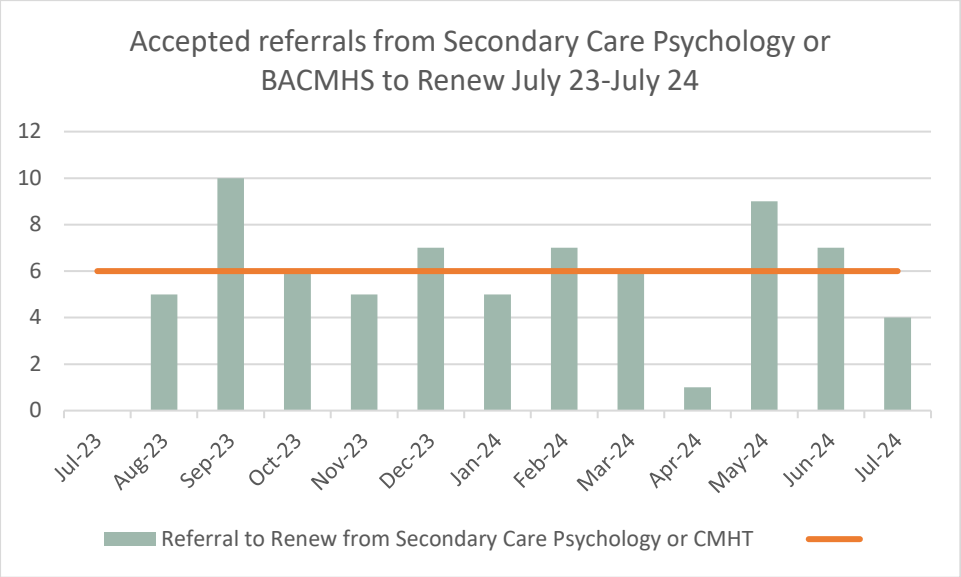
Chart 18 below indicates the referrals made to BACMHT by Renew over the last year, including the total number, those accepted and those declined during that time. There has been a significant overall decline in referrals to BACMHS from Renew over this period as referral criteria has been clarified for BACMHS and referrals to Renew have fallen within our service criteria and fewer have required additional support following referral.

Chart 17: Referrals from Renew to BACMHS (June 23- June 24)



Renew continue to work closely with our colleagues in Secondary Care Psychology and BCAMHS to provide an efficient and patient centred pathway enabling transfer between the services. We meet on a weekly basis to discuss referrals being transferred between the services. The chart below notes the number of accepted referrals transferred from Secondary Care Psychology and BCAMHS to Renew.

Chart 18: Accepted referrals (N) from Secondary Care Psychology or BCAMHS to Renew Jul 23-Jul 24



Key outcomes:

- We will continue to use QI methodology to understand the demand, activity, capacity and queues in our service.
- We will continue to seek and use the feedback of our key stakeholders and patients in their experience of the service
- Using both forms of data, alongside the psychological therapies' matrix, we will continue to adapt and reallocate our clinical resources to ensure we are providing high quality evidence-based interventions to ensure we are meeting the needs of the people referred to the service.
- The evidence suggests that there is an increasing requirement to provide individual interventions as people referred to the service having increasing complexity, including psychological trauma. We will therefore, as far as we are able continue to reallocate our resources to ensure that they are focussed on this demand whilst continuing to provide evidenced based interventions for anxiety and depression for those meeting clinical thresholds.
- Patients and our GP stakeholders value the quick access to assessment within our service, we will therefore continue ensure that people have access to timely assessment and treatment allocation.
- Following on from GP feedback in August 2024, we will deliver regular updates regarding the service with information about the types of interventions provided and what to expect from contact with the service.
- Continue the close working relationship with Secondary Care Psychology and BCAMHS in order to provide and effective and efficient patient pathway between the services.

Treatment interventions offered in Renew

1:1 intervention	Clinical and Counselling Psychologists	Proved interventions at the highest complexity and intensity in Renew. They provide interventions across psychological models and offer 12-16 sessions of psychological therapy. Typical cases for clinical psychologists in Renew involve processing of complex trauma, or presentations of anxiety, OCD or depression which are more complex in presentation and require a higher intensity of intervention
	Clinical associates in applied psychology (CAAPs)	CAAPs in Renew offer 8-12 sessions of cognitive behavioural therapy to patients presenting with mild to moderate anxiety and depression related difficulties. CAAP interventions are offered 1:1 via Near Me or face to face where clinically indicated. CAAPs also provide a central role in the design and delivery of the CBT skills courses.
	Enhanced Psychological Practitioners	Enhanced Psychological Interventions are CBT-informed, high volume approaches suitable for people presenting in primary care settings. They enable staff to help more people, who are seen for a shorter duration and time (generally 6-8 30min sessions). Their interventions are focussed on providing a single strand of CBT for people with milder presentations.
CBT Skills Courses	Anxiety	8 week evidence based CBT skills course. 2 hours per session, delivered remotely by CAAPs and Assistant Psychologists. This course is appropriate for people with mild to moderate symptoms of anxiety
	Low Mood	8 week evidence based CBT skills course. 2 hours per session, delivered remotely by CAAPs and Assistant Psychologists. This course is appropriate for people with mild to moderate symptoms of low mood or depression.
	Healthy Self Esteem	9 week evidence based CBT skills course following low self esteem treatment model. 2 hours per session delivered remotely by CAAPs in the Service. This course is appropriate for people who have mild to moderate difficulties which are largely driven by low self esteem
	Emotion Resources	9 week evidence based CBT skills course following emotion resources treatment model. 2 hours per session delivered remotely by CAAPs in the Service
	Survive and Thrive	10 week course, delivered by two clinical psychologists and a CAAP. Evidence based treatment for symptoms of complex PTSD. 2 hour course delivered remotely by CAAPs in the service
Digital interventions	Silver Cloud Modules	We offer a range of effective evidence based digital therapy offerings for patients accessing Renew. Beating the Blues has now been phased out and replaced by Silvercloud which offers 14 different modules of evidence based computerized CBT (cognitive behavioural therapy). Silvercloud is appropriate and effective for people who have mild to moderate mental health problems
	IESO	IESO is a further digital intervention offered as part of the service. Offered in three tiers from guided self-help to higher intensity interventions for depression and anxiety; patients make a 1:1 appointment and engage with a therapist via text, access is quick, usually within 2 weeks. People referred to this service from NHS Borders experience 67.7% reliable improvement following treatment. This effective treatment can be offered in evenings or weekends which suit people who have work or family commitments find it difficult to access appointments in working hours.

Workforce and footprint:

First Contact, Advanced Practice Physiotherapy services were implemented in the Borders in 2019 with only 2.2 WTE B7 Physiotherapists.

The service has grown to 100% of budget allocation with a staff compliment of 9.2 WTE FCP's in service from February 2022, working at a 1:21 000 population ratio. The service has carried one 0.5 WTE vacancy from August 2024, including a 0.8 WTE maternity leave from August 2024 and a 1WTE long term sick leave with reduced clinics.

The service is funded for 8.7 WTE Clinically and 0.5 WTE Management. FCP services are delivered in 100% of the 22 GP practices in the Borders in with each GP practice having a dedicated FCP in the clinic based on their individual list size.

- Vision:
  - First contact, Advanced Practice Physiotherapy (FCP) in the Borders will provide a trusted and direct triage service, in the GP practice, for patients presenting with musculoskeletal pathologies.
- Mission:
  - To be the Gold standard of FCP in Scotland. To inspire hope and contribute to health and well-being by providing the best first contact MSK care to every patient through integrated clinical practice, education and research.
- Slogan:
  - "Together we are the difference"

Key Focus areas:

1. Multidisciplinary teams:

The team is well integrated in all 22 of the 22 GP practices within the Borders. The FCP work-stream have trialled using a hybrid delivery system in the past and has moved back to deliver services in dedicated working model imbedded in the GP practices. The key priorities of FCP remain to be a service of excellence in being:

- Safe
- Person centred
- Equitable
- Accessible
- Outcome focused

- Effective
- Sustainable
- Affordable
- Value for money

2. Pathways:

The team has been working continuously on developing various pathways across the MDT for better patient care, early access and “right time-right care-right practitioner”.

FCP pathways established is with

- MSK teams
- Orthopaedics
- Community link workers incl. Mental health
- OT/Speech and Language therapist
- Podiatry and orthotics
- Third party vendors e.g. Live Borders

3. Expert Generalist role

FCP continuously work towards our four pillars of practice to enhance our skill, clinical outcomes for patients and our leadership within the developing roles and delivery of care in PCIP and the Physiotherapy profession.

4. Digital innovation

   In April 2024 we embarked on a pilot study implementing PHIO a MSK digital solution into each and every GP practice. The project has now progressed to year 2 with more focus on the primary care triage offering. The digital application is set to triage all presenting MSK pathologies and direct patients to the correct outcomes as per the NHS Borders clinical pathways. Phio with high clinically safe sensitivity settings, also directly refers onto the MSK rehabilitation team or GP practice for additional investigations, were a patient does not meet the criteria for self-management. See more on data and visualisations from PHIO below.

5. Enablers

1. Workforce: 9.7 Clinical WTE delivering FCP services in 22 GP practices to a 1:21 000 ratio. (1 WTE Maternity leave until September 2025)
    i. GP requirement is currently 223.57 hours per week (10731.36pa – 48 weeks)
    ii. 8.7 WTE FCP = 321.9 FCP hours per week
        1. 1(70% clinical time /30% time to work towards our professional four pillars of practice.
        2. N 225.33 clinical hours -10815.84 pa over 48 weeks

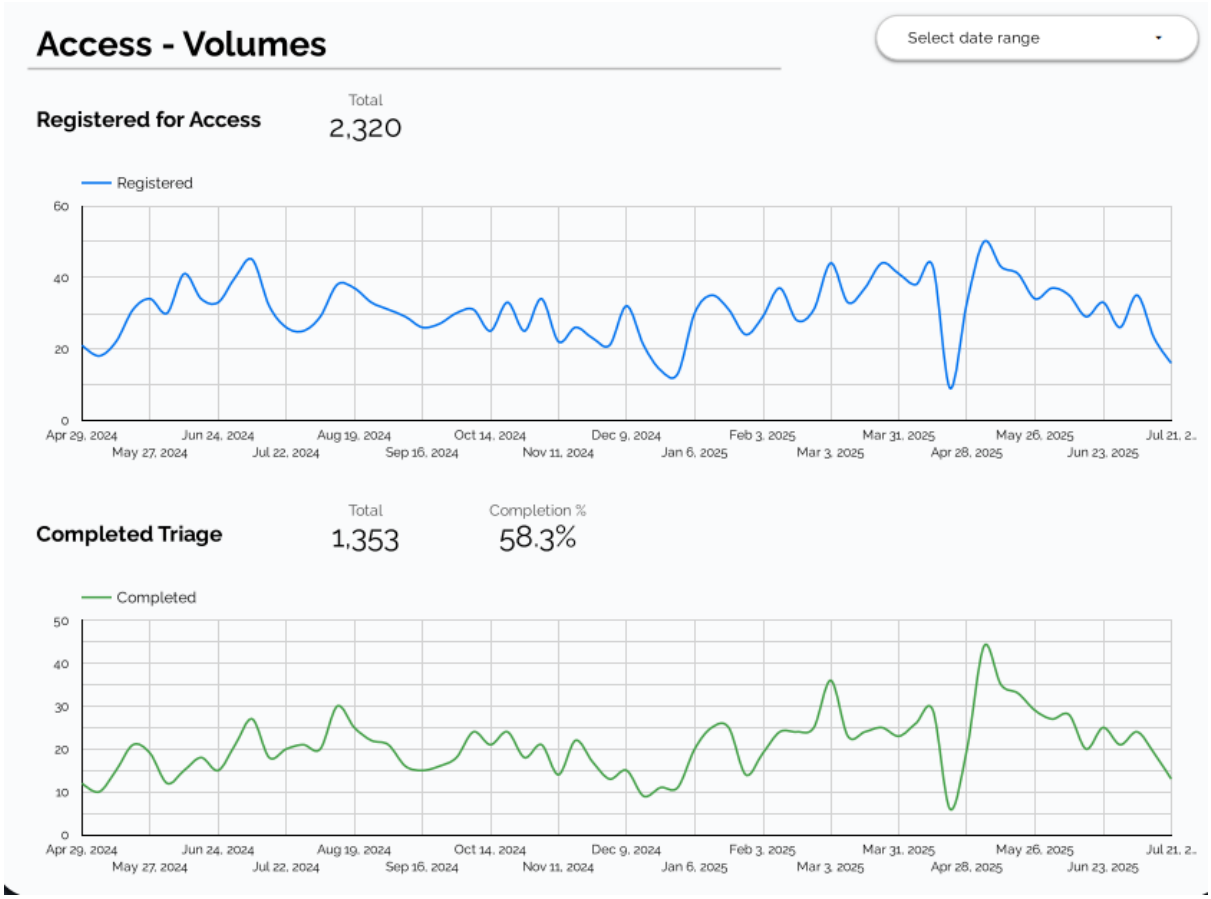
2. Education and training:
    i. 100% of the FCPs are cortisone injection therapy trained.
    ii. 100% FCP staff members are IRMER trained and refer for special investigations including MRI scans
    iii. 5 members of staff received their qualification as independent prescribers for non-medical prescribers with four more members of staff wanting to follow in the next 24 months.
    iv. One member of staff finalising their M.Sc degree with support from the Board.
3. The APP lead represents The Borders at the National APP Primary Care Network.

6. Premises:
    1. In GP practice service delivery model for FCP in Borders are limited to certain days due to accommodation shortages in some practices.
    2. Blended working format between Face-Face / Telephone triage and Near Me consultations, with Face-to-face being the preferred method of service delivery to enable reduction in double appointments being used.

7. Digital:
    1. The change over from the hybrid IT system as reported on in 2023 was welcomed by all and aim to deliver the service direct, cost effective and at the point of the patient asking for an appointment. The imbedding back into the GP practice has raised the team's overall wellbeing and work satisfaction as well as the satisfaction of our patients. A greater cohesive MDT working relationship are being reported with GP /ANP and FCP sharing skills and information daily. The key marker is our DNA rate of appointments are down from 13% average on the hybrid model to below 4% on the direct care deliver model.

PHIO

- Year 2 of digital innovation implementation, Focus on primary care in front of GP practice as a self-triage tool, and refers directly into MSK for ongoing rehabilitation where needed.
- Based on clinical pathways of the NHSB
- 800-1000 consultations per month for the cost of one B5 post
    - (FCP with 8.2 WTE 1350 consultations pm)
- Completed the first 100 audit and high level of confidence with more than 95% falling into predicted outcome category.
- Working with Phio to streamline patient experience and see how we can adjust for a waiting list management tool as well.


Access - Volumes
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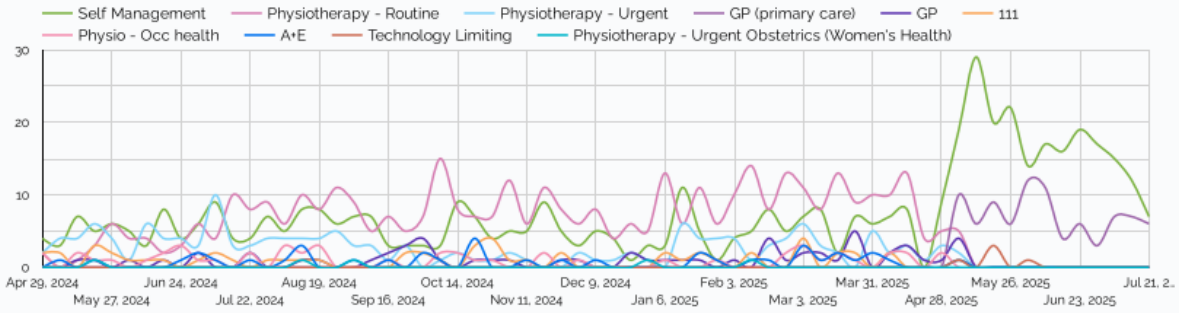
May 27, 2024
Jun 24, 2024
Jul 22, 2024
Aug 19, 2024
Sep 16, 2024
Oct 14, 2024
Nov 11, 2024
Dec 9, 2024
Jan 6, 2025
Feb 3, 2025
Mar 3, 2025
Mar 31, 2025
Apr 28, 2025
May 26, 2025
Jun 23, 2025
Jul 21, 2...

Access - Outcomes

Select date range

Triage Outcome over Time

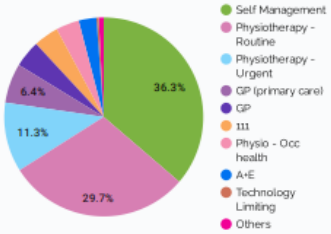


EQL Clinician Review and Agreement

	Triage Outcome	Agreement Rate	Count
1.	Self Management	97.6%	492
2.	GP (primary care)	83.7%	86
3.	GP	50.8%	59
4.	111	32.7%	55
5.	A+E	35.9%	39
6.	Technology Limiting	100.0%	5
7.	Declined Engage	100.0%	3
8.	Urgent	66.7%	3

1 - 8 / 8

Outcome Split



Access - Reviewed Outcomes

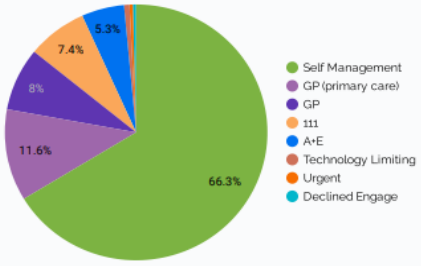
Select date range

EQL Clinician Review and Agreement

	Triage Outcome	Agreement Rate	Count
1.	Self Management	97.6%	492
2.	GP (primary care)	83.7%	86
3.	GP	50.8%	59
4.	111	32.7%	55
5.	A+E	35.9%	39
6.	Technology Limiting	100.0%	5
7.	Urgent	66.7%	3
8.	Declined Engage	100.0%	3

1 - 8 / 8

Outcome Split (Before)

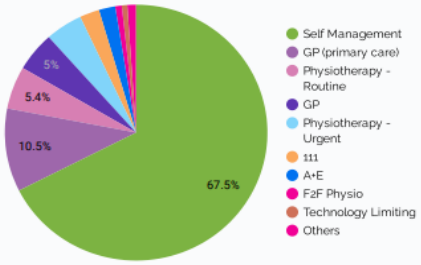


Changed Outcomes

	Triage Outcome	Updated Outcome	Count
1.	GP	Physiotherapy - Routine	15
2.	GP (primary care)	Self Management	14
3.	111	Physiotherapy - Urgent	13
4.	111	Physiotherapy - Routine	12
5.	A+E	Physiotherapy - Routine	11
6.	A+E	Physiotherapy - Urgent	9
7.	GP	Physiotherapy - Urgent	9
8.	Self Management	GP (primary care)	6

1 - 23 / 23

Outcome Split (After)



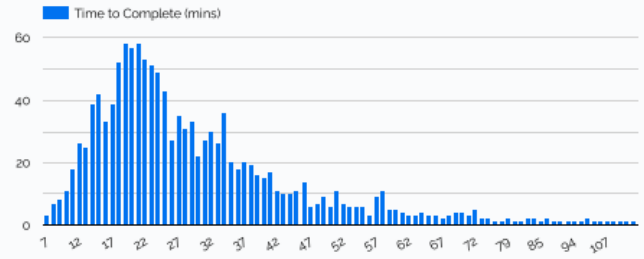
Patient Demographics and Behaviour

Select date range

Time to Complete

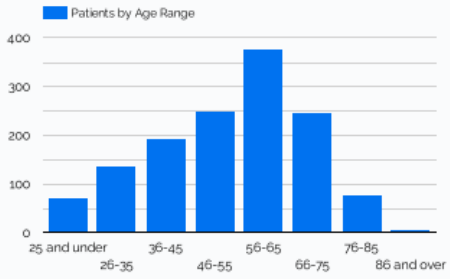
Median 25.0

Average 29.8

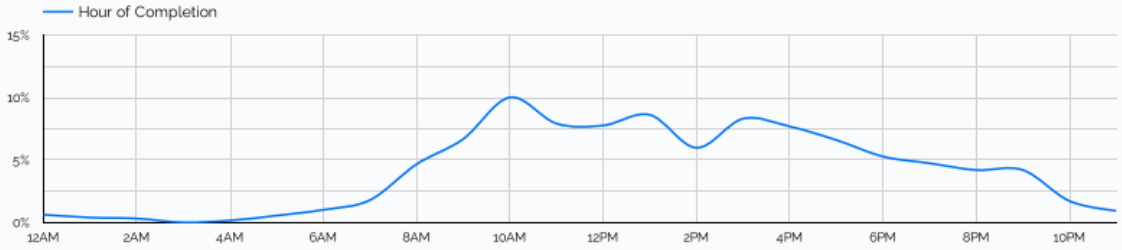


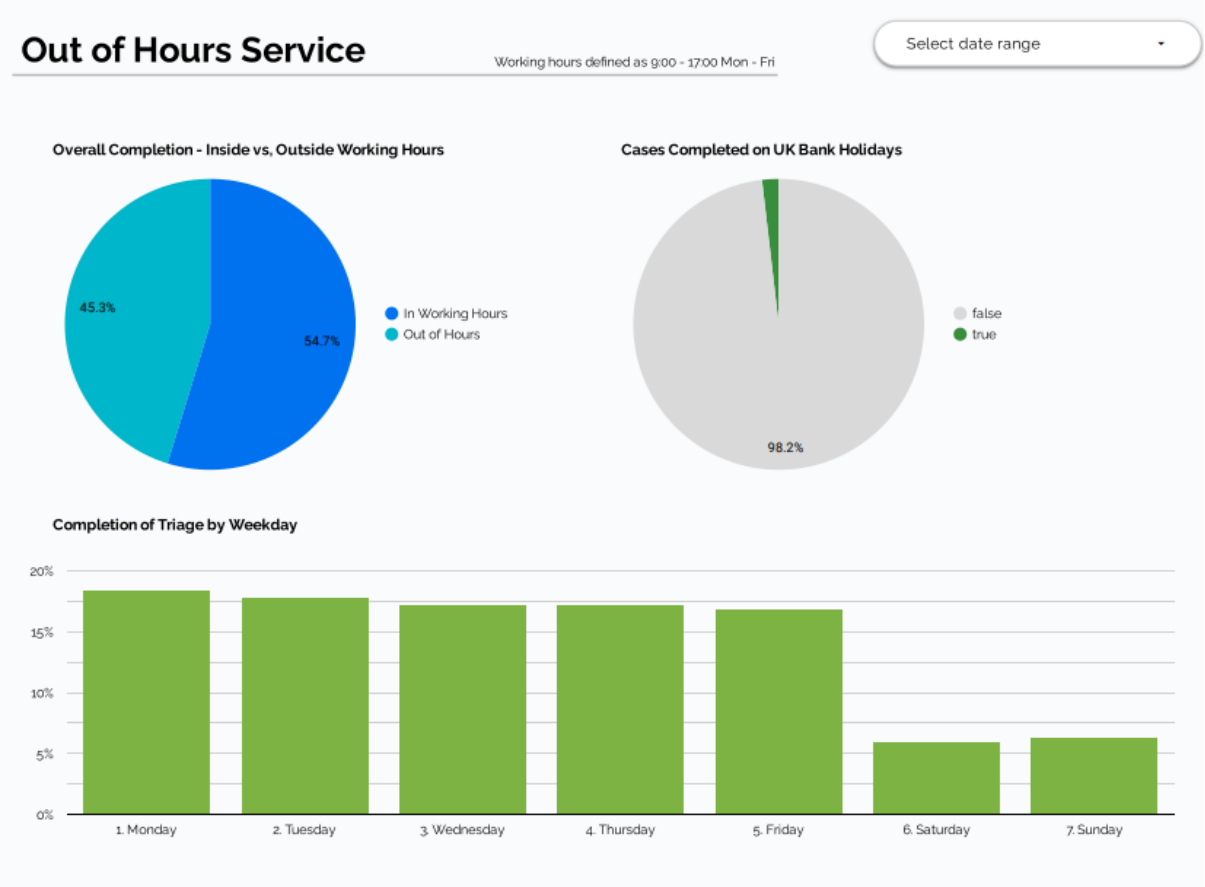
Age

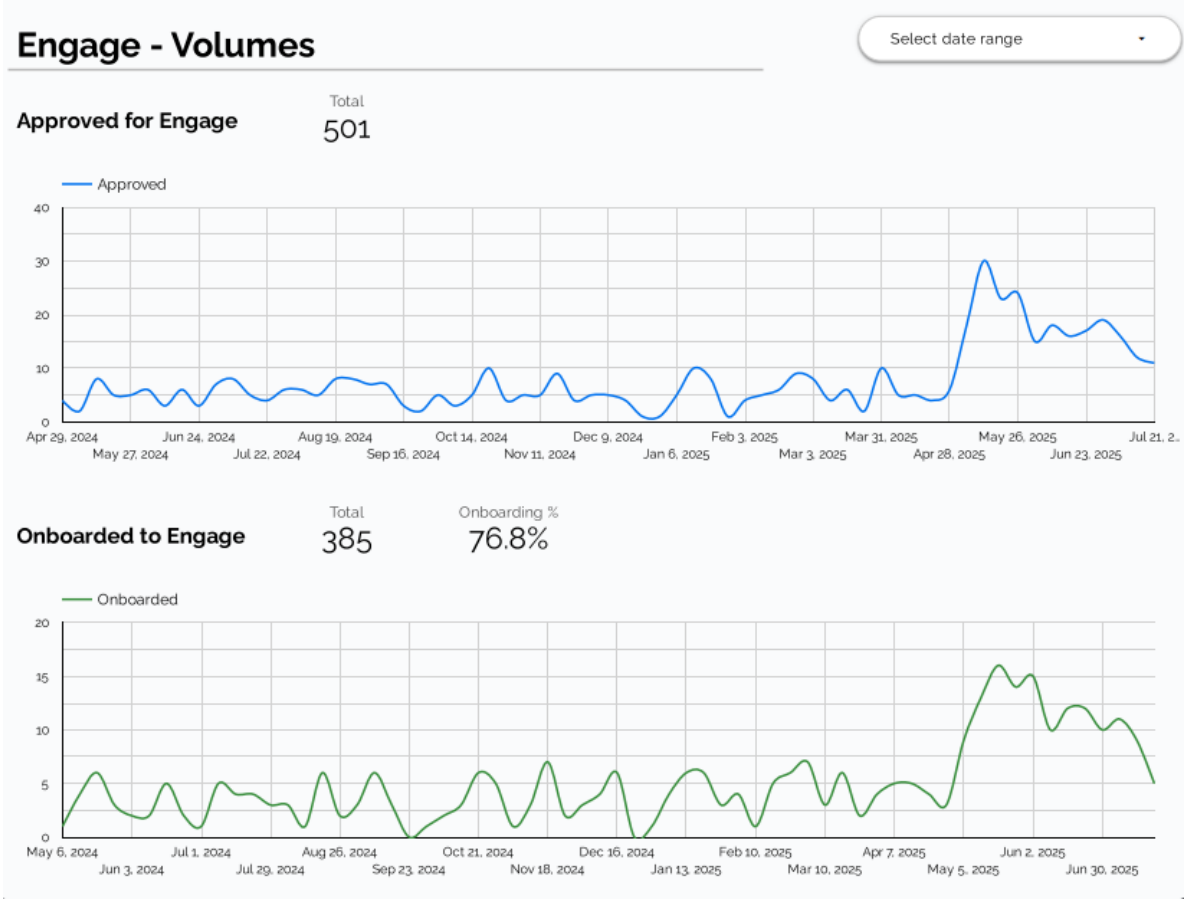
Average 54.0



Time of Day

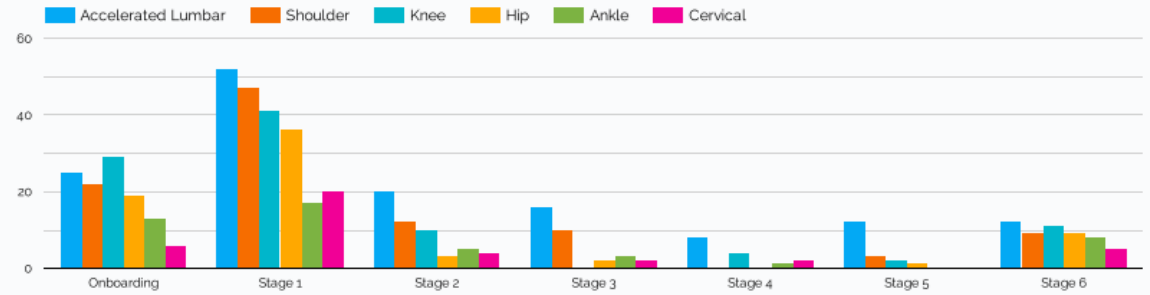



Out of Hours Service
Working hours defined as 9:00 - 17:00 Mon - Fri
Select date range
Overall Completion - Inside vs, Outside Working Hours
45.3%
54.7%
In Working Hours
Out of Hours
Cases Completed on UK Bank Holidays
98.2%
false
true
Completion of Triage by Weekday
20%
15%
10%
5%
0%
1. Monday
2. Tuesday
3. Wednesday
4. Thursday
5. Friday
6. Saturday
7. Sunday

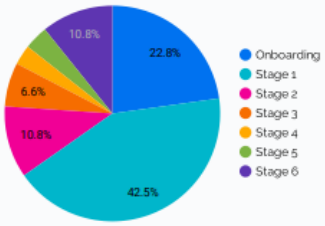

Engage - Volumes
Select date range
Approved for Engage
Total
501
Approved
40
30
20
10
0
Apr 29, 2024
May 27, 2024
Jun 24, 2024
Jul 22, 2024
Aug 19, 2024
Sep 16, 2024
Oct 14, 2024
Nov 11, 2024
Dec 9, 2024
Jan 6, 2025
Feb 3, 2025
Mar 3, 2025
Mar 31, 2025
Apr 28, 2025
May 26, 2025
Jun 23, 2025
Jul 21, 2..
Onboarded to Engage
Total
385
Onboarding %
76.8%
Onboarded
20
15
10
5
0
May 6, 2024
Jun 3, 2024
Jul 1, 2024
Jul 29, 2024
Aug 26, 2024
Sep 23, 2024
Oct 21, 2024
Nov 18, 2024
Dec 16, 2024
Jan 13, 2025
Feb 10, 2025
Mar 10, 2025
Apr 7, 2025
May 5, 2025
Jun 2, 2025
Jun 30, 2025

Engage - Programmes and Stages

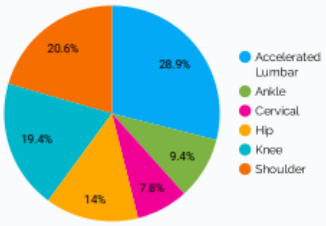
Select date range



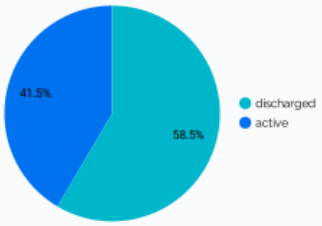
Patients by Current Stage



Patients by Programme



Patients by Current Status



Onboarding and Compliance by Programme

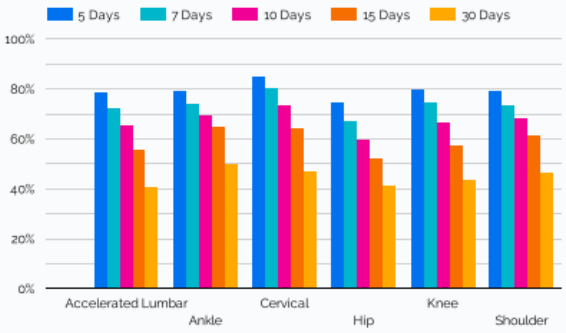
Select date range

Onboarding

	Programme	Onboarding %
1.	Accelerated Lumbar	82.76%
2.	Ankle	72.34%
3.	Cervical	84.62%
4.	Hip	72.86%
5.	Knee	70.1%
6.	Shoulder	76.7%

1 - 6 / 6

Compliance



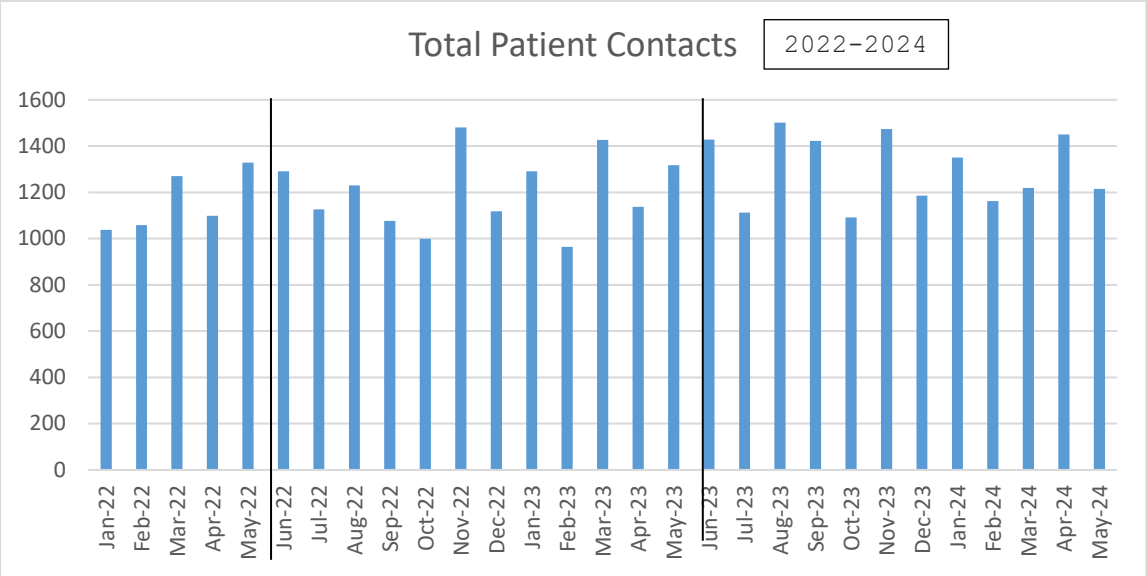
Compliance (cont.)

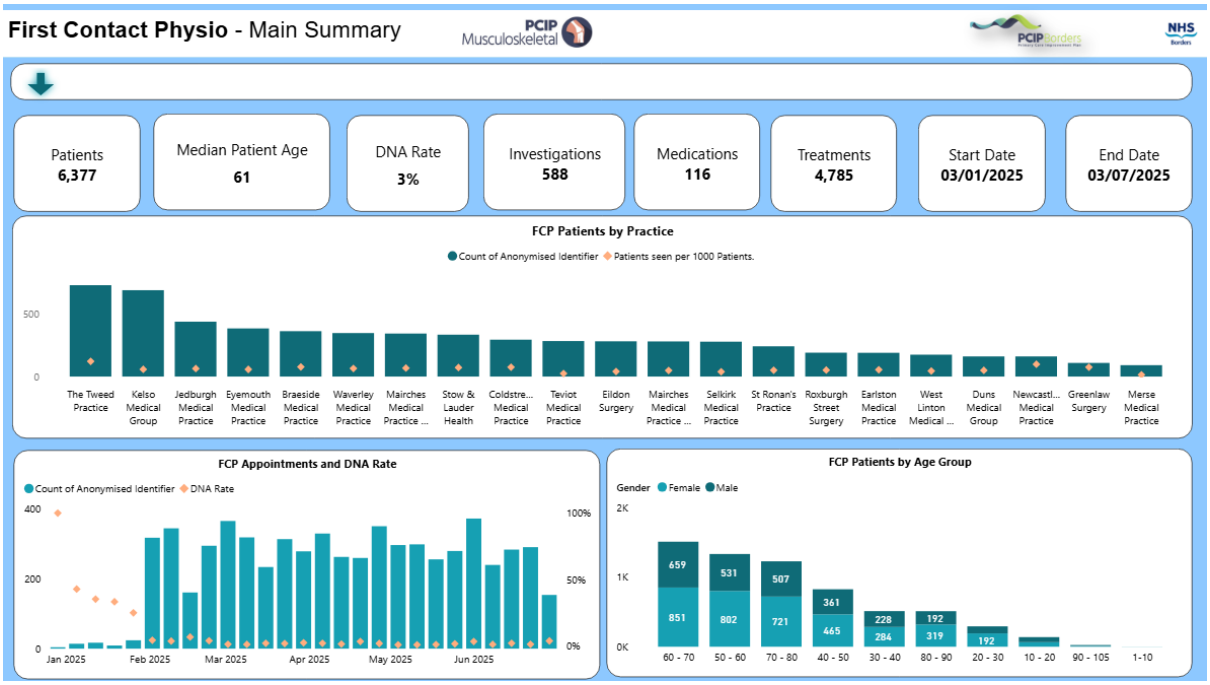
	Programme	First 5 Days	First 7 Days	First 10 Days	First 15 Days	First 30 Days
1.	Accelerated Lumbar	78.81%	72.42%	65.45%	56.24%	40.83%
2.	Ankle	79.29%	73.98%	70%	65.24%	49.88%
3.	Cervical	85.19%	80.42%	73.7%	64.69%	47.41%
4.	Hip	74.63%	67.25%	60%	52.03%	41.38%
5.	Knee	80.35%	75.19%	67.02%	57.31%	43.92%
6.	Shoulder	79.39%	73.81%	68.33%	61.82%	46.72%
	Grand total	**79.25%**	**73.35%**	**66.72%**	**58.54%**	**44.01%**

'Compliance' defined as number of Daily Assessments completed within timeframe.

What did we deliver?

1) Impact on GP workload:





- 1282.33 (2022-2023) compared to 1016.52 (2021-2022) average consultations per month with a 73% average of self-management and no further referral/intervention required.
- 15388 (2022-2023) compared to 13216 (2021-2022)total consultations for the year
- 0.9% patients referred back to GP practice for medication or fit note prescription.

2) X-ray and MRI referrals:
    - 3.7% average referral rate for x-ray views
    - 2.1% average referral rate for MRI views
3) Wider system benefits:

    MSK activity:
    - 6.7% average MSK (Musculoskeletal Physiotherapy department) referral rate (2023-2024)
    - 4.47% MSK referral rate for 2024-date

    Orthopaedic activity:
    - Cortisone injection therapy in primary care setting:
        - Average of 3.7% of FCP activity is administering Cortisone injection therapy
        - 882 CSI injections administered for the year, 46% increase compared to 2023-2024 financial year and ever growing.
    - Orthopaedic referral rate:
        - 6.2% referrals to orthopaedic secondary services.
            - Clinical pathway development was done with focus on the patient journey,
            - Education and in service training to clinically up-skill FCPs on diagnosis and referral patterns.

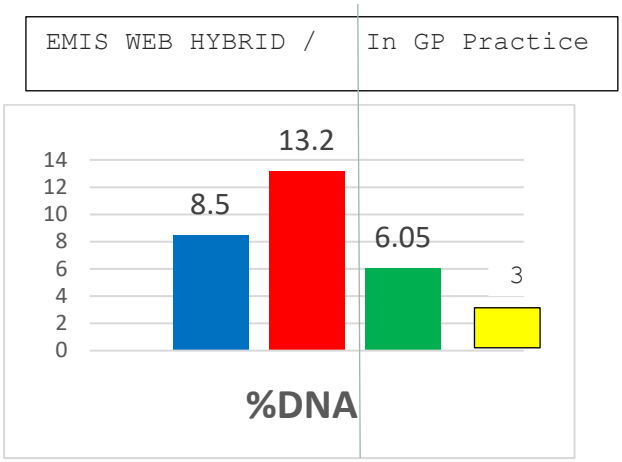
4) IT and technological considerations:
    - Use Emis PCS in the GP practice increasing MDT working to better serve the patients needs.
    - Creation of a platform for automated service audits and activity data.
    - Implement PHIO application to assist in early triage.
    - Improved Quality of care and peer review auditing to support, mentor and educate the FCP team.

Gaps in the delivery of FCP services?

1) HR: To be in line with National service delivery of 1:12 000 population ratio over a 48 week service the Borders are in need of 372.61 additional FCP hours per week.
    - FCPs to increase with 4 WTE to successfully answer to the demand.
2) IT systems:
    a. The current IT provisioning in the Borders does not communicate successfully with IT used in GP practices. To be able to render a virtual model FCPs are using one IT system that is removed from the GP IT system and duplication of clinical notes exist.
    b. Delayed times in reports for investigations due to the different IT systems and FCP need to employ a third system to search for reports.

c. Gap in It reporting evident in below graph.
    i. Positive changes in New to review range after moving hybrid IT system back to being practice based. Lesser consultations used for reviews as more direct Face to face appointments are available.

3) Mitigation of risk:
    a. To reduce DNA and Review rate increasing access, capacity and efficiency we moved the IT system from a hybrid model to be imbedded in the GP practice.



137 DNA slots = 68, 5 hours in 2022-2023 on hybrid system.

83 DNA Slots = 41.5 hours for 2023-2024

3% for 2024-2025

Executive Summary:

- Mean of 985 Face to face consultations per annum = 492.5 Consultation hours away from GP per month.
- 27 hours reduced DNA rate with service imbedded into the GP practice
- 70/30 New to Review ratio compared to 60/40. Being imbedded into the GP practice is a more efficient, convenient and cost effective way to deliver the service while maintaining high standards of patient satisfaction, employee satisfaction and overall better MDT working.

Addition of digital triage systems allows more patients access even in unsociable hours to receive help and care for MSK pathologies.

The initial focus of the Scottish Borders Primary Care Improvement Plan 2018-2021 was the development and establishment of an Advanced Nurse Practitioner model. As there was a shortage of trained ANPs nationally and within the rural Borders demographic, NHS Borders undertook to recruit a cohort of untrained ANPs.

Prior to PCIP roll out there was no workforce supply of trained primary care ANPs and in 2019 a successful pilot of five trainees Advanced Nurse Practitioners (ANP) was carried out across South and West GP Clusters.

The ANP service is highly valued and supports PCIP to meet the urgent care pathway to provide a service to GP practices for `urgent care`, delivering on the day presentations: face to face consultations, telephone consultations and home visits. This releases the GP to take on a more holistic view of patient care and clinical expert role, and improving patient access to care and treatment.

The ANPs are autonomous practitioners and manage the comprehensive clinical care of their patients, including prescribing and onward referral. Independent prescribing is an integral component of advanced practice which allows easier and quicker access to medications for patients and increases patient choice in accessing medication, and there is a growing body of evidence to support the positive impact of independent prescribing by ANPs.

Service User Experience

Patients have embraced the role of advanced practitioners in primary care and they have reported high levels of satisfaction with the care they receive. They have commented on their surprise at the autonomous ability of advanced practitioners to include assessment, diagnosis and treatment. Many patients request to see the ANP again. This allows for continuity of care.

Positive feedback on the referral of patients to secondary care has also been received.

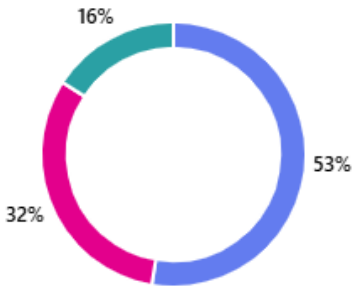
Below is analysis of patient feedback collected and analysed by a member of the team (Kerry McGough ANP) undertaking a project to look at patient's understanding of the role of ANPs in primary care, if their understanding influences how they access services and identifying the factors in patient's choosing to see an ANP rather than a GP.

All Patients over 16 were given a paper questionnaire or a QR code t complete the survey of 10 questions whilst waiting for their appointment. They received 114 responses in total.

A selection of the some of the analysis and findings are bellow:

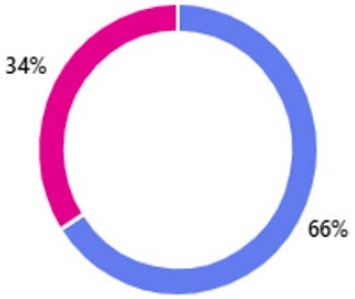
How many times have you visited the surgery in the last year?

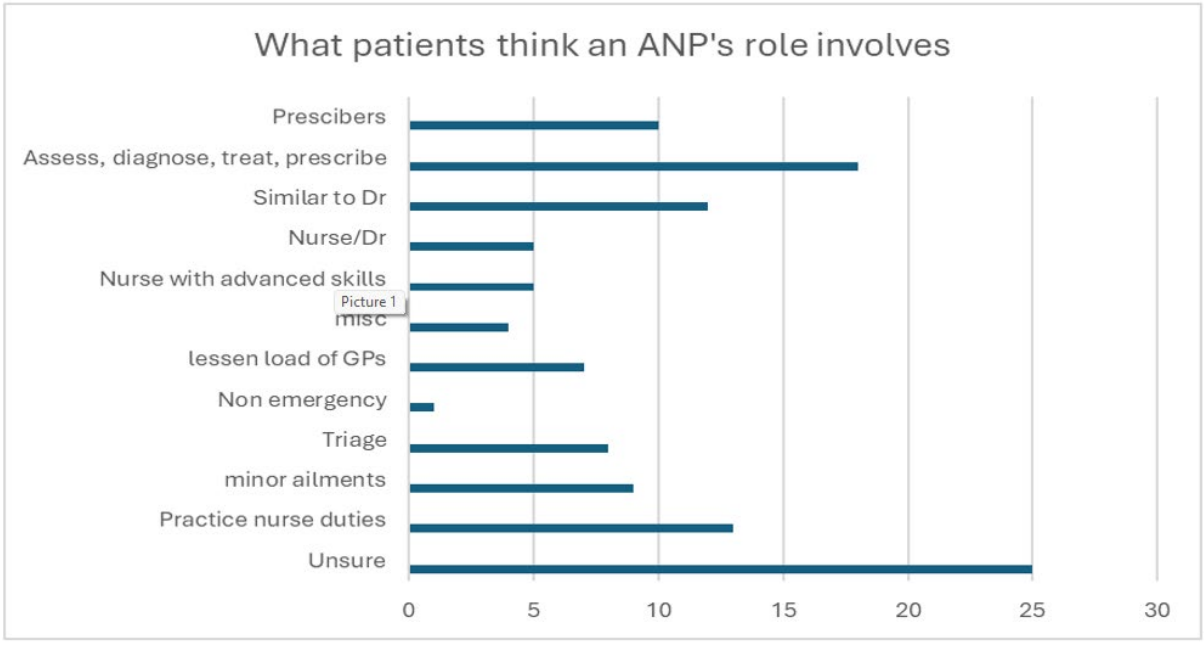
0-5 times	60
5-10 times	36
More than 10 times	18



Have you heard of advanced nurse practitioners (ANPs)?

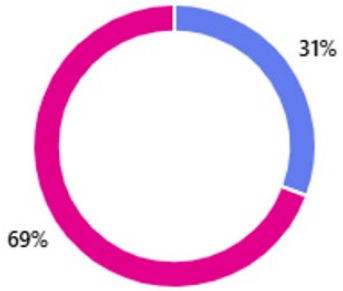
Yes	75
No	39





Have you ever requested to book an appointment with the advanced nurse practitioner?

Yes	35
No	79

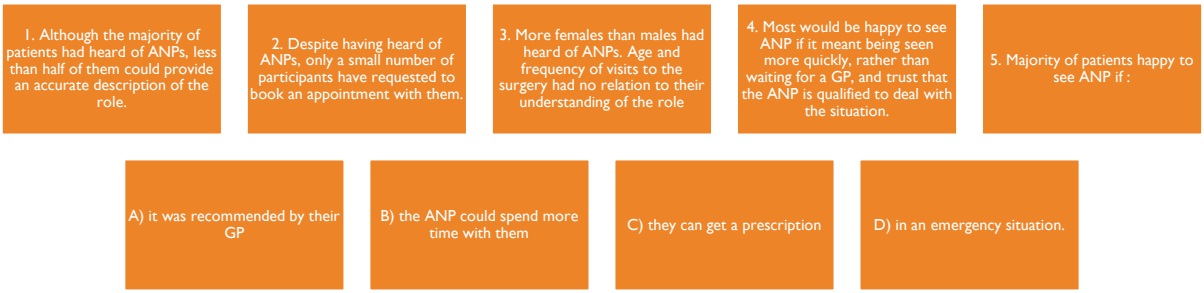


Have you ever requested to book an appointment with the advanced nurse practitioner?

Yes	35
No	79

31%
69%

FIVE KEY RESULTS



RECOMMENDATIONS BASED ON RESULTS:

Receptionists at surgeries could also give a brief description the ANP role when booking appointments.

ANPs themselves could give new patients a brief description of their role upon introduction.

Involvement of GPs in promoting the role, as patients place a high level of trust in their GPs.

Repeat questionnaires in 6-12 months and compare results.

Where are we now?

We are observing a well-led, maturing team of specialist nurses who are experiencing high levels of job satisfaction. They benefit from strong, positive working relationships and receive consistent support through structured clinical supervision.

Through their collaborative efforts, the Clinical Lead and Clinical Service Manager have ensured a stable and consistent urgent care service.

Urgent Care Workstream has significantly matured. A key aspect of this development is the commitment we have made to our trainee Advanced Nurse Practitioners (ANPs) all trainee ANPs have been contracted through a bonding arrangement to remain with NHS Borders for a minimum of two years post-qualification. This agreement has been vital in stabilising our workforce and ensuring consistency in care delivery.

Additional ANPs have been recruited to replace natural movement within the service.

Documentation which elaborates on our current position and future plans have been distributed to practices in the PCIP. These documents are working documents and will be subject to change as the process develops to include:

- Ongoing specific training once qualified to increase knowledge on common presentations seen in primary care.
- Consistent and regular prescribing updates

Challenges and Key Risks:

Recruitment and retention: there is a small pool of qualified nurses, making recruitment highly competitive and tending to take from other area of service to fill gap.

What do we aim to achieve in the coming year?

- Continue development of ANP academy
- Collection of data to further understand the impact that ANPs have in urgent care.
- Collection of patient feedback to continue to shape the service

Performance Reports

Community Treatment and Care (CTAC)

The CTAC Performance Report offers a comprehensive overview of Community Treatment and Care services within NHS Borders. It tracks key performance indicators across areas such as demand, capacity, activity, queue management, staff contribution, and accessibility. This enables clinical and operational teams to monitor trends, identify service gaps, and support informed planning decisions.

To ensure the accuracy and reliability of the data, significant work has been undertaken in collaboration with the IT and Business Intelligence (BI) teams. This effort has focused on improving data quality, which in turn enhances the precision of the performance outputs and reported figures.

By incorporating historical data from treatment rooms, the report also facilitates meaningful comparisons and trend analysis.

Data is extracted from EMIS Web and compiled into reports using Business Objects, including:

- Referrals Report
- Appointments Report
- Unutilised Capacity Report

There are plans to integrate data from GP Order Comms (GPOC) via the TrakCare Order Communication System, which will enhance the report's ability to capture referral and order communication demand.

Two versions of the CTAC performance report are produced:

- A Programme Board version
- A Delivery Group version

Both performance reports are published to the relevant Teams channels, where they are accessible to clinical and operational staff.

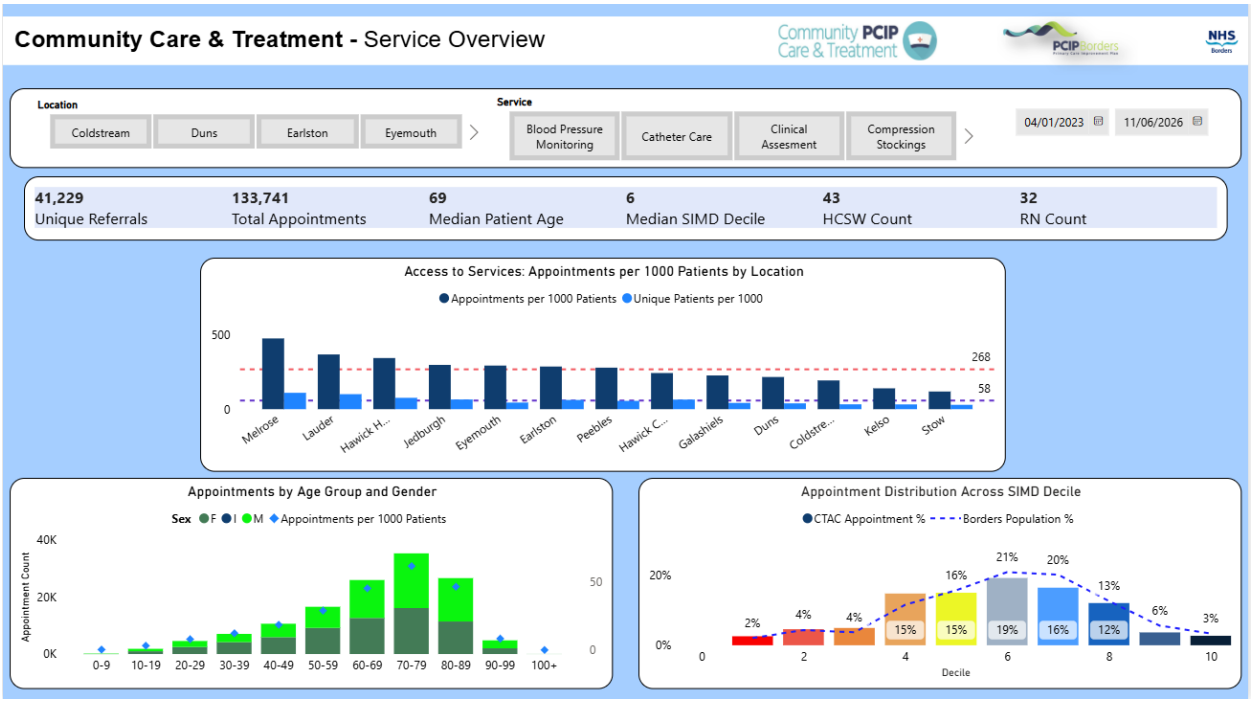


Figure 1. CTAC performance report (service overview)

Pharmacotherapy

The Pharmacotherapy Performance Report provides insights into medication management activities carried out by the pharmacotherapy team. It supports clinical and operational teams in monitoring performance and making evidence-based decisions about the service.

Data is sourced from the Pharmacotherapy Template and compiled using EMIS Web Enterprise Searches and Reports, allowing for data retrieval across all NHS Borders GP practices in accordance with the Data Sharing Agreement.

The report includes a breakdown of activity into two key categories: Prescribing and Pharmacotherapy. This distinction captures both the volume of prescriptions generated and the broader scope of work undertaken by the team, respectively offering a more complete picture of service delivery.

Two versions of the Pharmacotherapy performance report are produced:

- A Programme Board version
- A Delivery Group version

These reports are updated on a 2 weekly basis and are published to the appropriate Teams channels for review by clinical and operational teams.

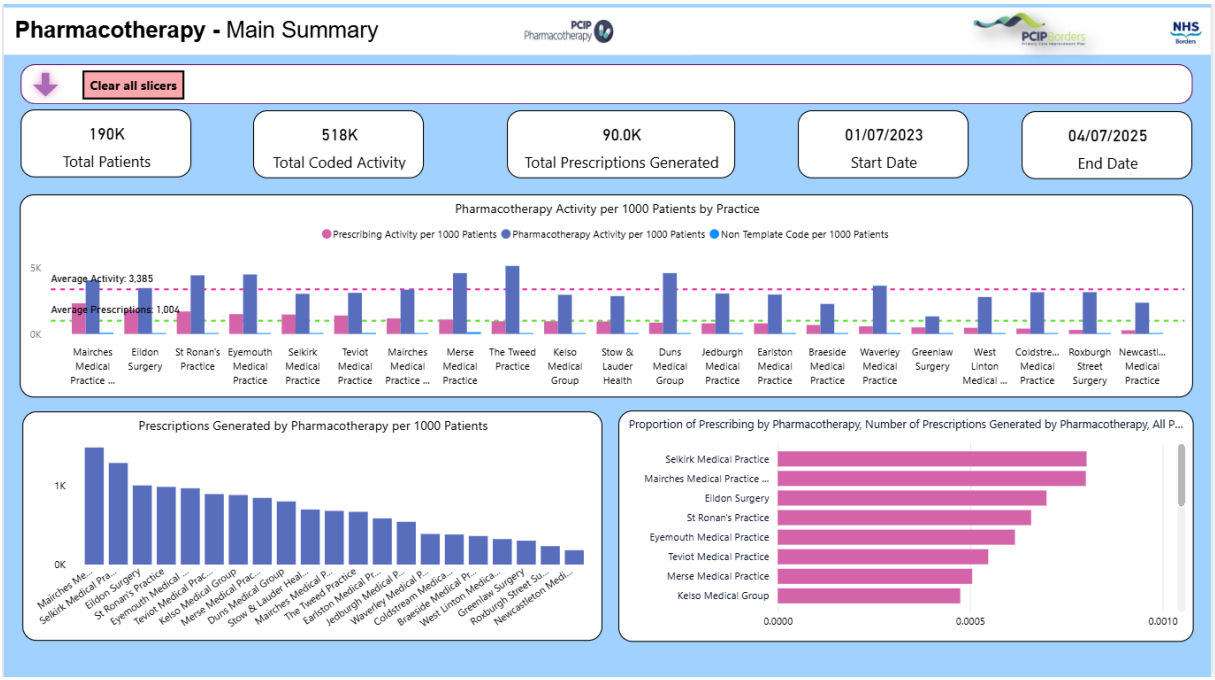


Figure 2. Pharmacotherapy performance report (main summary)

Urgent Care - Advanced Nurse Practitioner (ANP)

The ANP performance report is designed to provide an overview and evolving picture of clinical activity and service delivery. It captures key metrics such as appointment variation, helping to monitor fluctuations in urgent, routine, and follow-up appointments.

The report also includes a breakdown of patient encounter types, procedures carried out, and clinical outcomes. This level of detail helps demonstrate the scope of ANP practice, from initial assessments and prescribing to minor procedures and patient education.

Data is sourced from the ANP Template and compiled using EMIS Web Enterprise Searches and Reports, allowing for data retrieval across all NHS Borders GP practices in accordance with the Data Sharing Agreement.

As the team identified the need for additional data points, the reporting template has undergone recent changes. As a result, this section of the report is still in development, with ongoing refinement to ensure it captures a fuller picture of ANP activity.

Figure 3. Urgent Care - ANP performance report (main summary)

First Contact Physiotherapy (FCP)

The FCP performance report provides an overview of key operational and clinical metrics. It offers insights into appointment variation, highlighting fluctuations in booking patterns and DNA (Did Not Attend) rates.

A detailed clinical activity breakdown is included, showcasing the types and volumes of interventions delivered by the FCPs. This section supports understanding of workload distribution and clinical focus areas. Additionally, the report tracks referrals and outcomes, offering visibility into patient pathways, including onward referrals to secondary care, self-management advice, or discharge outcomes.

Data is sourced from the FCP Template and compiled using EMIS Web Enterprise Searches and Reports, allowing for data retrieval across all NHS Borders GP practices in accordance with the Data Sharing Agreement.

The first version of the performance report is now available, providing a foundational view of service delivery and setting the stage for ongoing quality improvement.

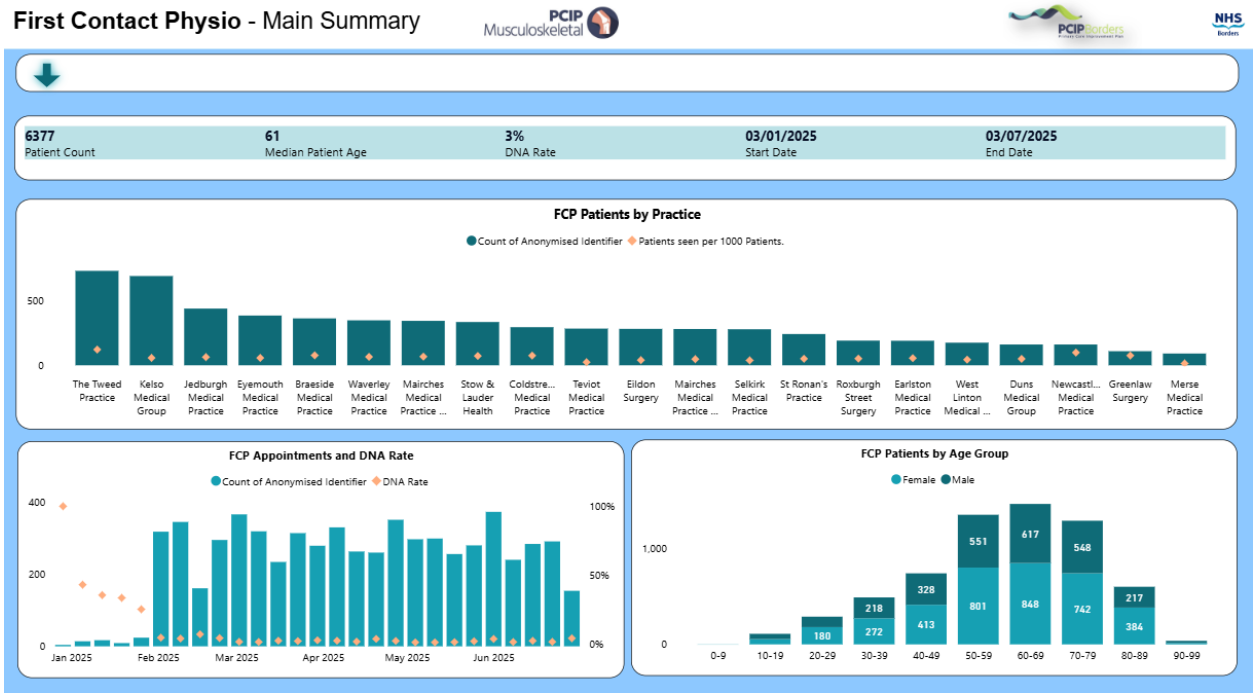


Figure 4. First Contact Physiotherapy (FCP) performance report (main summary)

Renew

As part of ongoing development, the Business Intelligence team are planning to create a Psychology performance report. This performance report will serve as a foundational data source for a future Renew Dashboard.

This approach ensures consistency and efficiency, as Renew includes Psychological Therapy (PT) as a core component of its service delivery. By building on the Psychology Dashboard, we can streamline data integration and avoid duplication of effort.

Once the Psychology performance report is in place, we can work collaboratively to define the specific metrics and insights required for the Renew Dashboard. This will allow us to tailor the Renew Dashboard to the needs of clinical and operational teams, ensuring it is both relevant and actionable

Visual Dashboards Derived from Performance Reports

GP Practice Dashboards

Tailored dashboards have been developed for each Borders GP practice, focusing on key metrics from the pharmacotherapy workstream, including prescriptions generated and patients seen. These dashboards are designed to provide practice-level insights, enabling teams to monitor activity, identify trends, and support local decision-making.

These dashboards are shared quarterly with each practice manager and are accompanied by guidance on how to interpret the data and use it to inform service delivery.

There is a clear roadmap to expand these dashboards to include additional workstreams, such as CTAC, FCP, ANP and Renew. This phased approach ensures that each component is integrated thoughtfully and ensures that the dashboards continue to evolve in line with the needs of the practices and the wider service.

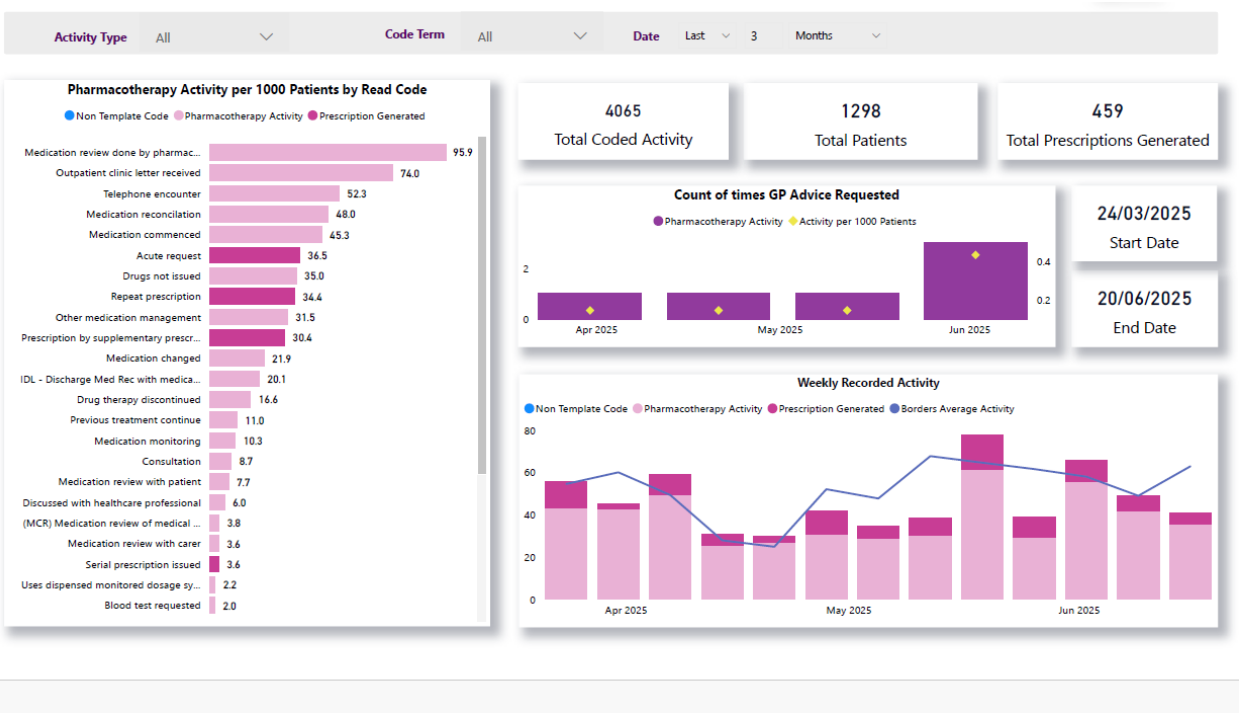


Figure 5. GP Practice dashboard for pharmacotherapy (quarter 2, 2025)

PCIP Dashboard

To support strategic oversight of the Primary Care Improvement Programme (PCIP), a PCIP dashboard has been developed, providing high level performance metrics. This dashboard aims to offer a concise, yet comprehensive view of how the programme is progressing across key workstreams.

At present, the dashboard focuses on the pharmacotherapy workstream, with plans to expand the dashboard to include First Contact Physiotherapy (FCP), Advanced Nurse Practitioners (ANP), Community Treatment and Care (CTAC), and the Renew service. This phased approach ensures that each component is integrated accurately.

Enhancing Report Engagement

As part of ongoing commitment to ensuring data-driven decision making, clinical and operational teams are included during the development and rollout of all performance reports. This collaborative approach ensures that the data is accessible and useful regardless of technical

background. The goal is to empower teams to use the reports proactively to identify areas for improvement, track progress, and celebrate successes.

Continuous quality improvement is promoted by encouraging feedback and input from clinical and operational teams to understand how the reports are being used in practice, identify any challenges they face, and explore opportunities for enhancement. This allows visualisations or metrics to be updated and ensures the performance reports remain relevant and impactful.

All performance reports and dashboards are built using Microsoft Power BI, which serves as the central platform for all performance reporting and data visualization. With the recent implementation of an organisation-wide Power BI license, we now have the capability to enhance how performance reports are shared and consumed.

Rather than distributing static PDF reports, we are planning to schedule interactive dashboards to be sent to Borders GP Practices on a quarterly basis. This will allow users to explore the data in more depth, filter by relevant criteria, and gain more meaningful insights.

Looking ahead to the next quarter, when interactive Power BI dashboards will begin to be distributed to GP practices, collaboration will include a new round of demonstration and support sessions for practice managers and other relevant staff. These will mirror the approach already used with clinical and operational teams, focusing on how to navigate the dashboards, use filters and apply insights.

Premises constraints remain a risk to ongoing PCIP delivery. Pressures on 25 community sites are increasing from more than 50 P&CS, Acute and Mental Health services using health centres and community hospitals. The transfer of PCIP work from GP practices to NHS Borders is further increasing demands, and no single approach has ever been agreed as to whether work should be accommodated in health board rooms or whether GP practices should transfer rooms with work.

NHS Borders Capital Investment Group has committed to a strategic community premises programme to tackle risks associated with capacity, functional suitability and physical condition of premises. Work would deliver recommendations outlined in the Buchan Report (2021) but timelines and resources remain unconfirmed to progress capital works.

Resource constraints within NHS Borders Estates, Capital and IM&T services continue to limit operational and tactical change and improvement works required to implement PCIP workstreams.

Key achievements & priorities

- NHS Borders Capital Investment Group commitment to a community premises improvements programme (timelines and resourcing TBC).
- Full CTAC...
- A single Primary Care admin Hub has been created at Newstead site for both Vaccination and CTAC Services.
- Improved utilisation of health centre rooms, prioritising clinical rooms for patient care. Creation of more shared bookable spaces with standard furniture and equipment.
- Work in progress to introduce room utilisation sensors to health centres to identify capacity, tackle poor room booking behaviours, support with redistribution of space between health board and GP practices and to help prioritisation of capital investment.
- Ongoing investment in clinical and non-clinical equipment, furniture and IT equipment with a cautious approach to spending given financial grip & control measures.
- P&CS premises governance linked into board-wide management groups including capital investment, transport, security, chemical safety, water safety, ventilation safety, period poverty.

Key challenges and risks

- No progress on capital investment programme for community premises. Timelines and resources remain unconfirmed, dependent upon Capital, Estates and IT resources.

- Increasing PCIP demands on existing health board rooms (ANPs, vaccinations, CTAC, pharmacotherapy). Work is transferring from GP practices to the health board but GPs are retaining rooms. No single, agreed approach to PCIP rooms across sites.
- Competition for rooms – more than 50 services across P&CS, Acute and Mental Health make use of 400 rooms across 25 community sites. Clinical prioritisation of services vs available rooms will be required. Risk to patient equity if services withdrawn from certain health centres.
- Financial grip and control measures scrutinising, limiting or denying spend.
- NHS Borders has committed to freezing GP rent until premises improvements have been delivered, throttling potential source of income. GPs paying significantly below market rates for utilities and resources.
- Scottish Government has paused funding of construction projects (new health centres and hospitals) until 2026 at the earliest, advising health boards to make better use of existing resources.

Background

Each quarter, a PCIP budget monitoring report is made to the PCIP Executive. This report outlines:

- Latest known information with regard to expected / actual PCIF allocation;
- Conditions over its use;
- How the recurring PCIF allocation has been directed / allocated across PCIP workstreams by PCIP Executive;
- Expenditure against the workstream budgets created in support of this direction;
- Forecast expenditure by workstream to 31 March;
- How non-recurring slippage / allocation are expected to be utilised during the financial year;
- Proposed revisions to the PCIP and their financial impact; and
- Risks to delivery and overall affordability.

The majority of PCIP activity is funded entirely by Scottish Government Primary Care Improvement Fund allocation, with only a relatively smaller amount of resource coming from NHS Borders baseline and other funding across the Community Treatment and Care Service and Mental Health Renew.

2024/25

Core PCIF

On 05 July 2024, NHS Borders and Scottish Borders Health and Social Care Partnership (the Board / Partnership) received its Annual PCIF funding letter. The national PCIP funding envelope was **£190.80m** in 2024/25. NHS Borders' NRAC proportion is 2.15% of the national resource envelope equating to a PCIF allocation of **£4.109m**, inclusive of an Agenda for Change Pay Uplift of **£0.449m**.

Within the July allocation letter, the Scottish Government stated that reserves carried over into 2024-25 financial year will contribute to your overall 2024-25 allocation and our allocation will be adjusted accordingly to reflect this. In order to minimise adverse impact, no reserves were brought forward in respect of PCIF funding within Scottish Borders.

The minimum funding position for PCIF is guaranteed at £190.8 million annually with additional funding being provided in full to support Agenda for Change uplifts for recruited staff. Following agreement at National Oversight Group, the Scottish Government has agreed to explore the potential for baselining the full PCIF in 2026/27. In the interim, it will establish a sub-group to further work through the issues presented by baselining including options to mitigate the risks that baselining could present, as well as to consider the processes for baselining the VTP element of PCIF prior to 26/27.

PCIP Funding 2024/25

	2024/25 PCIF Allocation £'000
2024/25 NRAC Allocation	**3,660**
2022/23 / 2023/24 Pay Allowance	**449**
Less: SG noted Reserves b/f	0
Less: Baselined Funding	(161)
Tranche 2	0
2023/24 Tranche 1 Allocation	**3,948**

PCIP Expenditure 2024/25

At 31 March 2025, the full £4.109m PCIF allocation was spent in full.

Workstream	PCIP Recurring Investment £'000	Actual Expenditure to 31 March 2025 £'000	Forecast Expenditure to 31 March 2025 £'000	Surplus / Slippage / (Deficit) at 31 March 2025 £'000
VTP	455	487	487	(32)
Pharmacotherapy	951	956	956	(5)
CTAC	121	71	71	50
Urgent Care	1,084	960	960	124
FCP	571	711	711	(140)
Mental Health	724	834	834	(110)
GP Engagement	12	10	10	2
Community Link Workers	150	0	0	150
Central Costs	40	80	80	(40)
Total Expenditure	**4,109**	**4,109**	**4,109**	**(0)**
Funded by:				
2.15% of £170m*	(3,660)			3,660
2022/23 - 2023/24 Pay Allowance	(449)			449
Forecast Expenditure			(4,109)	(4,109)
Total	**(4,109)**		**(4,109)**	**0**

This funds the entirety of the core PCIF programme with the following exceptions:

- CTAC: only a small contribution (programme management) towards the roll out of CTAC;
- Pharmacotherapy: Core funded with expansion funded by PCPIP Pathfinder allocation;
- VTP: A contribution to the wider Vaccination Programme funded by a combination of PCIF, SG Vaccination-specific allocation and core NHS Borders funding.

PCPIP Pathfinder

NHS Boards and Health and Social Care Partnerships were invited by the Scottish Government to submit bids, by the end of October 2023, to host a phased investment programme demonstrator site, in order to demonstrate what a model of full implementation can look like in practice. Demonstrator sites will be supported to achieve full delivery of pharmacotherapy and CTAC services, utilising improvement methodologies to support the approach, over an initial 18 months, while maintaining full delivery of VTP.

The Scottish Borders bid was successful and over the Spring of 2024, discussions commenced with Health Improvement Scotland regarding planning and refinement of workstream models. Following this work, Scottish Government issued formal allocation letters to successful Boards / HSCPs in early May 2024.

PCPIP Allocation 2024/25 – 2025/26:

HSCP	Total £'000	2024/25 £'000	2025/26 £'000
Scottish Borders	4,340	2,870	1,470
Ayrshire and Arran	4,620	3,320	1,300
Edinburgh City	1,890	1,200	690
Shetland	1,040	730	310
Healthcare Improvement Scotland	3,200	1,800	1,400
Total Expenditure	**15,090**	**9,920**	**5,170**

Scottish Borders' allocation amounted to a total of **£4.340m** relating to 18 months' pathfinder pilot over financial years 2024/25 and 2025/26. For 2024/25, the allocation was **£2.870m**.

PCPIP Expenditure 2024/25:

Service	Budget £'000	Q1 Actual £'000	Q2 Actual £'000	Q3 Actual £'000	Q4 Actual £'000	Total Actual £'000	Forecast Under / (Over) £'000
CTAC Admin	442	0	0	0	7	7	435
CTAC Clinical	1,646	69	161	239	273	741	904
Pharmacotherapy	447	0	0	0	6	6	440
Project Support	194	0	0	6	14	19	174
Hub Costs	81	5	15	66	4	89	(8)
Staff IT	60	0	9	15	27	50	10
	2,870	**74**	**184**	**325**	**331**	**914**	**1,956**

Against this allocation of **£2.870m**, expenditure to 31 March 2024 was **£0.914m**. Due to the original uncertainty regarding confirmation of funding allocation, coupled to time taken to recruit, there has been slippage in the profiled expenditure. As a result the overall slippage at the end of 2024/25, when compared to the original PCPIP bid plan has increased from **£0.667m** at Q1 and **£1.344m** at Q2 to **£1.956m** at outturn.

PCPIP 2025/26:

Given the slippage in the programme, it is critical that the Scottish Borders H&SCP maintains regular and frequent communication with both the Scottish Government and Health Improvement Scotland. This will ensure that the programme is not compromised by slippage in the phasing of the expenditure, both in terms of absolute delivery of the Pathfinder programme and in the ability to carry forward any unspent balances to 2025/26 for use next financial year in line with Pathfinder programme requirements.

The Scottish Government has committed to funding the pathfinder pilot in 2025/26. Whilst this will not be to the full level previously allocated, it will ensure that the programme can run not only to 31 September 2025, the original end date, but during the period that follows to 31 March 2026, within which the data collected will be analysed which in turn will inform the future national strategy for PCIP and in particular CTCS and Pharmacotherapy and its associated funding requirements.

A summary of the key provisions relating to the 2025/26 allocation for PCPIP is detailed below:

PRIMARY CARE PHASED INVESTMENT PROGRAMME: ALLOCATION 2025-26

1. I am writing to confirm your 2025/26 financial allocation for the Primary Care Phased Investment Programme (PCPIP).

2. Funding can be used to support programme costs up until March 2026, reprofiling the spend beyond the programme's conclusion in September 2025.

3. This recognises there are risks to the programme of not supporting costs beyond the 18-month period, including potential workforce attrition and stakeholder disengagement. It will enable sites to continue to deliver enhanced multidisciplinary team support and spread the learning from the programme beyond September 2025, while national policy development on the next phase of multidisciplinary team support is ongoing. It will also enable sites to support any requests for additional information or engagement during the report writing phase from October to December 2025.

4. There is no change in the total funding envelope for the programme. Revised allocations are summarised in Table 1 below:

Table 1: PCPIP Allocations by Board/HSCP

	24/25 (£m)	25/26* (£m)	Total programme costs (£m)
Ayrshire and Arran*	1.66	1.40	3.06
Scottish Borders*	1.44	2.12	3.55
Edinburgh City	0.62	1.04	1.66
Shetland	0.48	0.58	1.06
Healthcare Improvement Scotland	0.90	2.03	2.93
Total	5.10	7.16	**12.26**

*25/26 allocation is exclusive of 24/25 T1 funds held in reserve

5. Funding will be provided based on actual spend incurred. Any funding held in reserve from 24/25 should be reinvested in PCPIP. To ensure continued financial oversight, allocations will continue to be processed in two 50% tranches: the first in Quarter 1 of 2025/26 and the second in January 2026, following the submission of Quarter 3 financial returns confirming latest spend and forecast data.

6. The allocations do not include provisions for Agenda for Change (AfC) uplifts on staff costs; these will be provided separately. An uplift of 2% has been applied for non-AfC cost pressures.

Ongoing management of risk

7. While a key aim of the programme is to inform future long term Scottish Government investment, we cannot pre-empt the findings of the programme by taking decisions on recurring funding now, leading to potential equity concerns for other HSCPs. Sites are asked to develop contingency plans to embed the additional workforce recruited through the programme into their core Primary Care Improvement Plan or other services beyond March 2026.

8. Sites should also not undertake any significant expansion in workforce for the programme beyond 1 April 2025. This is because, given data collection for the programme will conclude by end of September 2025, there would be limited ability to integrate significant additional workforce into teams and gather meaningful data on delivery and impact over this time period. Sites should also ensure financial implications associated with recruitment under PCPIP, including, for example, extending fixed term contracts, are considered through local risk management processes and potential benefits are balanced against risks and mitigations.

9. In parallel, we remain committed to working collaboratively with all demonstrator sites and Healthcare Improvement Scotland to mitigate identified risks and maximise the impact of programme funding. Our intention is to undertake a further review on the residual financial risks resulting from the programme in autumn 2025 as part of the 2026/27 budget process and within the wider context of national policy development on the next phase of primary care multidisciplinary teams.

10. To support financial planning and ensure robust data collection, we ask that you update your forecast spend for 25/26 against the revised allocations in the PCIP 8 tracker template available on Objective Connect. Thereafter, we will continue to request quarterly financial updates.

“

The Primary Care Improvement Programme has continued to drive forward significant change in the last year despite the financial uncertainty facing the services implemented

”

- Lizzie Turner
- Integration Joint Board
Chief Financial Officer

Acknowledgements

Delivering PCIP would not be possible without the dedication and commitment of everyone involved in the workstreams highlighted in this report. It is not possible to name every partner and stakeholder who has played their part in this year's work. We would therefore like to thank everyone who has contributed to the Scottish Borders' Primary Care Improvement Plan – including those below and everyone else involved.

Workstream Leads

Workstream	Lead
Vaccination Transformation Programme	Nicola Macdonald – Clinical Service Manager
Community Treatment and Care Services	Kathy Steward – Clinical Nurse Manager
Pharmacotherapy	Cathryn Park – Head of Primary Care Pharmacy
Community Mental Health "Renew"	Dr Caroline Cochrane – Director of Psychological Services
Urgent Care Services	Sharon Dempsey – Lead Advanced Nurse Practitioner
Musculoskeletal Services "First Contact Physio"	Wilna-Mari Van Staden – Clinical Lead Advanced Physiotherapy Practitioner
Premises	Rob Cleat – Primary and Community Services Premises Lead
Communications	Clare Oliver – Communications Manager
Finance	Paul Mcmenamin–Deputy Director of Finance / Finance Business Partner (IJB)

PCIP Executive Committee

GP Executives	Dr Robert Duncan Dr Emily Collin Dr Rachel Mollart Dr Kevin Buchan Dr Kirsty Robinson Dr Robert Manson
NHS Borders	Cathy Wilson – General Manager Dr Tim Young – AMD Philip Grieve - ADoN for P&Cs and Chief Nurse IJB Malcolm Clubb - DoP Paul Williams - ADoAHP
Integration Joint Board	Chris Myers – Chief Officer **(outgoing)** Lizzie Turner – Chief Finance Officer

PCIP Team

Senior Project Manager	Owain Simpson
Information Analyst	Fiona Grant
Project Manager	Alice Maguire

July 2025

Scottish Borders

PCIP Executive Committee

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**2 October 2025**
Title:	**Policy on Prescribing Following Private Consultation**
Responsible Executive/Non-Executive:	**L McCallum, Medical Director**
Report Author(s):	**M Clubb, Director of Pharmacy** **R Devine, Consultant in Public Health Medicine** **K Maclure, Lead Pharmacist Medicines Utilisation**

1 Purpose

This is presented to the Board for:

- Decision - approval

This report relates to a:

- Local policy

This aligns to the following NHS Scotland quality ambition(s):

- Safe
- Person Centred

2 Report summary

2.1 Situation

There has been an expressed need from prescribers in NHS Borders for guidance on prescribing to patients following their interaction with private healthcare providers. This policy gives clear, consistent guidance to follow in such situations.

2.2 Background

The issue of how to approach prescribing requests from patients who have utilised private healthcare has been considered before, and previous papers have been

developed focussed on principles. This paper details clear guidance on an approach to be applied to support prescribers and patients and ensure consistency.

The authors of the paper are sighted on policy approaches in other territorial health boards in Scotland and are clear on the need for guidance for prescribers in NHS Borders. The paper references guidance documents from Human Medicines Regulation government legislation, British Medical Association ethics guidance, and the NHS Circular No 1992 (GEN) 11.

2.3 Assessment

Without this guidance, approaching the issue of private prescription requests could be more challenging for prescribers. This paper includes appendices with (i) a draft letter which could be shared with patients considering using private healthcare and (ii) an easy-to-follow flow chart to explain the process of prescribing at the public / private interface in this context.

As part of the development of this policy we considered if this guidance could materially impact on people in relation to their protected characteristics. A stage 1 scoping assessment was conducted by Public Health and Pharmacy and shared and discussed with Area Drug and Therapeutics Committee members. It was concluded there is no apparent advantage or disadvantage to any group through the introduction of this policy.

As detailed above and below the paper has been developed using key reference sources and has been presented at multiple stakeholder meetings.

2.3.1 Quality/ Patient Care

Potentially improved quality and consistency of care when clear guidance is introduced which is accessible for all prescribers.

2.3.2 Workforce

GPs and prescribers have expressed a need for clear guidance on this topic and this policy has been written to support them.

2.3.3 Financial

No impact on finance from implementing this guidance.

2.3.4 Risk Assessment/Management

Nil for noting.

2.3.5 Equality and Diversity, including health inequalities

An assessment of potential impacts of this proposed policy was undertaken by the paper authors and shared with members of the Borders Area Drug and Therapeutics Committee for comment. That stage 1 scoping report considered:

Who will be affected by this document?

- Any individuals who opt to seek private healthcare rather than NHS provision.
- GPs providing care for patients who have used Private Healthcare.

How will the proposed policy impact on people?

- The guidance states that anyone recommended treatment via a private prescription by a private provider would receive the same level of care from NHS Borders as any other patient presenting with the same healthcare needs through the usual channels.
- If someone wishes to pursue a treatment plan which is outwith usual NHS care, then they would revert back to the private provider.
- This guidance will not materially impact on people in relation to their protected characteristics and there is no potential advantage or disadvantage to any group through the introduction of this policy.

That initial stage 1 HIIA scoping report was completed, shared with ADTC and it was decided no further action was necessary. It is included as appendix 1.

2.3.6 Climate Change

Nil for noting.

2.3.7 Other impacts

Nil for noting.

2.3.8 Communication, involvement, engagement and consultation

The Board has carried out its duties to involve and engage external stakeholders where appropriate. Authors of this report have presented and discussed the contents of this paper and proposed policy with our local GP prescribers through multiple fora:

- GP Sub-committee of the Borders Area Medical Committee, 25 November 2024
- Borders Area Medical Committee, Spring 2025
- Area Drug and Therapeutics Committee, 28 May 2025

2.3.9 Route to the Meeting

This has been previously considered by the following groups as part of its development. The groups have either supported the content, or their feedback has informed the development of the content presented in this report.

- GP Sub-committee of the Borders Area Medical Committee, 25 November 2024
- Borders Area Medical Committee, Spring 2025
- Area Drug and Therapeutics Committee, 28 May 2025

2.4 Recommendation

- **Decision** – Reaching a conclusion after the consideration of options.

The Board will be asked to confirm the level of assurance it has received from this report:

- **Significant Assurance (recommended)**
- Moderate Assurance
- Limited Assurance
- No Assurance

If a single level of assurance cannot be determined Officers are asked to suggest a level based on the following split of assurance:

- **Systems and Processes**
- **Outcomes**

3 List of appendices

The following appendices are included with this report:

- Appendix 1 - Information for patients considering private medical consultations
- Appendix 2 - Summary of request for NHS prescription following private medical services
- Appendix 3 - Stage 1 HIIA Scoping Report

Appendix 1
INFORMATION FOR PATIENTS CONSIDERING PRIVATE MEDICAL CONSULTATIONS

When you consult a private specialist you should be aware of what may happen about medication you may need after the consultation. You may not always be ableto obtain an NHS prescription for medication arising from a private consultation.

Guidance for NHS patients
General principles for NHS patients seeking private healthcare include:

- your NHS care will continue to be free of charge
- you cannot be asked to pay towards your NHS care, except where legislation allows charges, such as travel medicines
- the NHS cannot pay for or subsidise your privately funded care
- your privately funded care must be given separately, at a different time and place from your NHS care

Independent Private Referral:
If you choose to refer yourself to a consultant independently of your GP for additional privately funded care (i.e. outside the NHS), whether in the UK or abroad, you are expected to pay the full cost of any treatment (including medication) you receive in relation to the package of care provided privately (including non-emergency complications).

Private referral through your GP:
After a private referral made by your GP, your private specialist may give you a prescription. You may only need one prescription. The prescription provided by your private specialist will be a private prescription and you must pay for the medication.

If you need continued treatment you may initially be given just one private prescription (which you will need to pay for) and advised to return to your GP to see iffurther NHS prescriptions can be provided.

There is no obligation, however, for your GP to accept the recommendation made to prescribe the treatment recommended by a private specialist. To judge your clinical need for the treatment including the reasons for the proposed medication, your GP must have received a full clinical report from the private specialist.

If your GP does not feel able to accept this responsibility, then the GPs may consider:

- Offering a referral to an NHS consultant to consider whether the recommended medication should be prescribed as part of on-going NHS funded treatment.
- Asking the specialist to remain responsible for the treatment because of its specialist nature, and to provide further prescriptions, for which you will need

to pay.

- Prescribing you an equivalent locally recommended medication, which should deliver a similar / identical benefit.

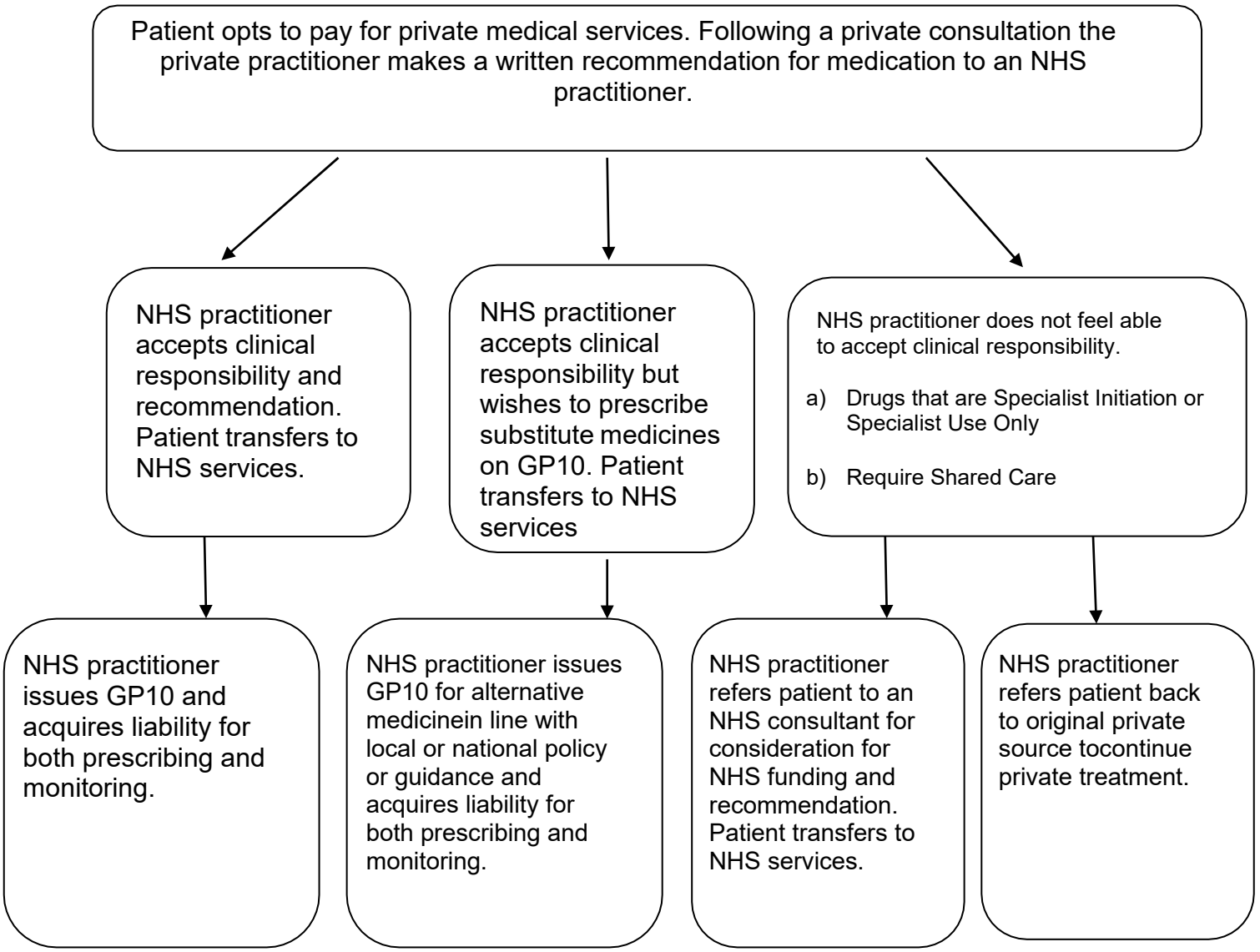
Only if your GP considers there is a clinical need for your medicine, and that an NHS patient would be treated in the same way, would an NHS prescription to continue your treatment be considered.
If the recommendation from your private specialist is for treatment that is not in line with local policies, then your GP may change the medication in line with that used for NHS patients.

How much will a private prescription cost?
The cost of a private prescription is calculated depending on the medicine. There is considerable variation in the cost of medicines so it is wise to discuss the possible cost with your consultant as part of your treatment plan.
Any community pharmacy can supply and dispense your medication on private prescription. Some private hospitals have pharmacy departments that can dispense your private prescription.

The pharmacy will charge you for the full cost of your medication. They will also charge a professional fee for the process of obtaining, dispensing and checking yourmedicine. This may vary from pharmacy to pharmacy so you are entitled to 'shop around' before deciding where you would like your medicine dispensed.

Appendix 2

Summary of request for NHS prescription following private medical services



HIIA Scoping Report

Policy title: Guidance for Prescribers Following Private Consultation
Date: May 2025
Lead: Rebecca Devine / Malcolm Clubb / Keith Maclure

This assessment is the first stage of a Health Inequalities Impact Assessment of the clinical document. This report is not a definitive statement or assessment of impacts but presents possible impacts that may require further consideration. The report also identifies some questions to be addressed to understand the impacts further. The purpose of further work following this scoping stage is to inform recommendations to improve impacts on health and enhance actions to reduce health inequalities, avoid discrimination and take action to improve equality and enhance human rights.

Rationale and aims of document:

1. Who will be affected by this document?

- Any individuals who opt to seek private healthcare rather than NHS provision.
- General Practitioners providing care for patients who have used Private Healthcare.

2. How will the document impact on people?

- ➔ The guidance states that anyone recommended treatment via a private prescription by a private provider would receive the same level of care from NHS Borders as any other patient presenting with the same healthcare needs through the usual channels.
- ➔ If someone wishes to pursue a treatment plan which is outwith usual NHS care, then they would revert back to the private provider.
- ➔ This guidance will not materially impact on people in relation to their protected characteristics and there is no potential advantage or disadvantage to any group through the introduction of this policy.

As part of the process, we have considered whether certain characteristics may influence health seeking behaviour via private or NHS channels more broadly:

Population groups and factors contributing to poorer health	Potential impacts and explanation why	Recommendations to reduce or enhance such impacts
Age: older people; middle years; early years; children and young people	Neutral - age unlikely to be a factor in seeking private healthcare	
Gender: men; women; people undergoing gender reassignment; pregnancy and	Neutral – gender unlikely to be a factor in seeking private healthcare	

maternity; experience of gender-based violence		
Disability: physical impairments; learning disability; sensory impairment; mental health conditions; long term medical conditions	Neutral – Ill health makes you more likely to seek healthcare but not more likely to seek private healthcare which results in a prescription	
Race and ethnicity: minority ethnic people; non English speakers; gypsies/travellers; migrant workers	Neutral – unlikely to be a factor in seeking private healthcare	
Refugees and asylum seekers	Neutral – unlikely to be a factor in seeking private healthcare	
Religion & belief: people with different religions or beliefs, or none	Neutral – unlikely to be a factor in seeking private healthcare	
Sexual orientation: lesbian; gay; bisexual; heterosexual	Neutral – unlikely to be a factor in seeking private healthcare	
Marriage: people who are married, unmarried or in a civil partnership	Neutral – unlikely to be a factor in seeking private healthcare	
Looked after and accommodated children and young people	Neutral – unlikely to be a factor in seeking private healthcare	
Carers: paid / unpaid, family members	Neutral – unlikely to be a factor in seeking private healthcare	
Homelessness: people on the street; staying with friends / family; in hostels, B&Bs	Less likely to choose to spend money on private healthcare and prescriptions therefore less need for this guidance but not negatively impacted by this guidance	
Involvement in the criminal justice system: offenders in prison / on probation, ex offenders	Neutral – unlikely to be a factor in seeking private healthcare	
Addictions and substance misuse	Neutral – unlikely to be a factor in seeking private healthcare	
Staff: full/part time; voluntary; delivering / accessing services	Neutral – unlikely to be a factor in seeking private healthcare	
Low income	Less likely to choose to spend money on private healthcare and prescriptions therefore less need	

	for this guidance but not negatively impacted by this guidance	
Low literacy	Neutral – unlikely to be a factor in seeking private healthcare instead of NHS provision	
Living in deprived areas	Less likely to choose to spend money on private healthcare and prescriptions therefore less need for this guidance but not negatively impacted by this guidance	
Living in remote, rural and island locations	Less likely to have access to private healthcare and prescriptions than those living in urban environments therefore less need for this guidance but not negatively impacted by this guidance	
Discrimination / stigma	n/a	
Any other groups and risk factors relevant to this policy	none	

3. How will the policy impact on the causes of health inequalities

Will the policy impact on:	Potential impacts and any particular groups affected	Recommendations to reduce or enhance such impacts
Income, employment and work	Neutral – unlikely to be a factor in seeking private healthcare	
Availability and accessibility of work, • paid / unpaid employment, wage levels, job security • Tax and benefits structures • Cost / price controls: housing, fuel, energy, food, clothes, alcohol, tobacco • Working conditions	As above	
The physical environment and local opportunities	As above	

• Availability and accessibility of housing, transport, healthy food, leisure activities, green spaces • Air quality and housing / living conditions, exposure to pollutants • Safety of neighbourhoods, exposure to crime • Transmission of infection • Tobacco, alcohol and substance use		
Education and learning • Availability and accessibility to quality education, affordability of further education • Early years development, readiness for school, literacy and numeracy levels, qualifications	As above	
Access to services • Availability of health and social care services, transport, housing, education, cultural and leisure services • **Ability to afford, access and navigate these services** • Quality of services provided and received	Differences in access to private clinics (e.g. less in rural locations) and differences in ability to afford private over NHS provision do exist. For this reason, having clear guidance in place to support both patients and NHS providers to have a consistent approach will make a positive impact to reducing inequality based on ability to navigate healthcare. This guidance will not negatively impact access to services.	
Social, cultural and interpersonal • Social status	Neutral	

• Social norms and attitudes • Tackling discrimination • Community environment • Fostering good relations • Democratic engagement and representation • Resilience and coping mechanisms		

4. Potential impacts on human rights

The group identified the following potential human rights impacts

Articles	Potential impacts and any particular groups affected	Recommendations to reduce or enhance such impacts
The right to life (absolute right)	None	
The right not to be tortured or treated in an inhuman or degrading way (absolute right)	None	
The right to liberty (limited right)	None	
The right to a fair trial (limited right)	None	
The right to respect for private and family life, home and correspondence (qualified right)	None	
The right to freedom of thought, belief and religion (qualified right)	None	
The right to freedom of expression (qualified right)	None	
The right not to be discriminated against	None	
Any other rights relevant to this policy	None	

5. Will there be any cumulative impacts as a result of the relationship between this policy and others?

Nil apparent to the authors of the paper or members of the GP Sub Committee or members of the AMC.

6. What sources of evidence have informed your impact assessment?

Evidence type	Evidence available	Gaps in evidence
Population data eg demographic profile, service uptake		No current routine data collection identifying total numbers of people opting for private healthcare and prescriptions therefore not possible to disaggregate by protected characteristic.
Consultation and involvement findings eg any engagement with service users, local community, particular groups	Nil taken place specifically. However, management information informs us there is an expressed need from prescribers for clear guidance to approach public private prescribing.	
Research eg good practice guidelines, service evaluations, literature reviews	Research exists which suggests systematic differences in utilisation of health care in some higher income countries is related to socio-economic status.[1] Further, there is some evidence that lower socioeconomic groups are more likely to attend GPs and hospitals, and persons in high socioeconomic positions may choose to use private health services including access to specialist physicians.[2] However, this research was conducted in Spain and therefore these	

[1] Socioeconomic inequalities in primary-care and specialist physician visits: a systematic review | International Journal for Equity in Health

[2] Socioeconomic patterns in the use of public and private health services and equity in health care | BMC Health Services Research

	findings cannot be extrapolated to the UK NHS.	
Participant knowledge eg experiences of working with different population groups, experiences of different policies	The authors of the paper are sighted on policy approaches in other territorial health boards in Scotland and are clear for the need for guidance for NHS Borders prescribers.	

7. Summary of key impacts, research questions and evidence sources

The following is a summary of the key areas of impact identified at the workshop, some possible questions to address in order to understand these, and suggested evidence sources to answer these research questions. This is not a definitive or necessarily complete list of research questions and some may turn out on further assessment not to be relevant. The list is put forward as a starter to inform the next stage of the impact assessment, and is likely to be amended by the steering group. The work done to explore these questions should be proportionate to the expected benefits and potential to make changes as a result. Evidence-informed recommendations are central to a robust impact assessment; however, 'evidence' to support the development of recommendations can be thought of more widely than just formal research. Furthermore, a lack of available robust evidence should not lead to the impact assessment process being delayed or stopping altogether. Often there is poor or insufficient evidence about the links between a proposal and health; there may, however, be plausible theoretical grounds to expect an impact.

Area of impact	Research questions	Possible evidence sources

8. Who else needs to be consulted?

The authors agree that members of the Area Drugs and Therapeutics Committee will be sighted on this stage 1 HIIA and given the opportunity to comment.

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**2 October 2025**
Title:	**Resources & Performance Committee Minutes**
Responsible Executive/Non-Executive:	**K Hamilton, Chair**
Report Author:	**I Bishop, Board Secretary**

1 Purpose

This is presented to the Board for:

- Awareness

This report relates to a:

- Government policy/directive

This aligns to the following NHSScotland quality ambition(s):

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

The purpose of this report is to share the approved minutes of the Resources and Performance Committee with the Board.

2.2 Background

The minutes are presented to the Board as per the Resources & Performance Committee Terms of Reference and also in regard to Freedom of Information requirements compliance.

2.3 Assessment

The minutes are presented to the Board as per the Resources & Performance Committee Terms of Reference and also in regard to Freedom of Information requirements compliance.

2.3.1 Quality/ Patient Care

As detailed within the minutes.

2.3.2 Workforce

As detailed within the minutes.

2.3.3 Financial

As detailed within the minutes.

2.3.4 Risk Assessment/Management

As detailed within the minutes.

2.3.5 Equality and Diversity, including health inequalities

An HIIA is not required for this report.

2.3.6 Climate Change

Not applicable.

2.3.7 Other impacts

Not applicable.

2.3.8 Communication, involvement, engagement and consultation

Not applicable.

2.3.9 Route to the Meeting

This has been previously considered by the following group as part of its development. The group has supported the content.

- Resources & Performance Committee 11 September 2025.

2.4 Recommendation

The Board is asked to **note** the minutes which are presented for its:

- **Awareness** – For Members' information only.

3 List of appendices

The following appendices are included with this report:

- Appendix No 1, Resources & Performance Committee minutes 08.05.25

Borders NHS Board

Minutes of a meeting of the **Resources and Performance Committee** held on Thursday 8 May 2025 at 9.00am via MS Teams.

Present:
K Hamilton, Chair
F Sandford, Non Executive
J Ayling, Non Executive
L Livesey, Non Executive
D Parker, Non Executive
J McLaren, Non Executive
P Moore, Chief Executive
A Bone, Director of Finance
S Horan, Director of Nursing, Midwifery & AHPs
S Bhatti, Director of Public Health
J Smyth, Director of Planning and Performance
A Carter, Director of HR, OD & OH&S
L Jones, Director of Quality & Improvement
O Bennett, Interim Director of Acute Services
G Clinkscale, Director of Acute Services
Y Smith, Partnership Chair

In Attendance:
I Bishop, Board Secretary
S Laurie, Senior Communications Officer

1. Apologies and Announcements

1.1 Apologies had been received from L O'Leary, Non Executive and L McCallum, Medical Director.

1.2 The Chair welcomed G Clinkscale, Director of Acute Services to the meeting.

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.

The **RESOURCES AND PERFORMANCE COMMITTEE** noted there were none declared.

3. Minutes of Previous Meeting

3.1 The minutes of the previous meeting of the Resources and Performance Committee held on 6 March 2025 were amended at paragraph 4.1, line 3, replace "appointed" with "assigned" and with that amendment the minutes were approved.

4. Matters Arising

4.1 **Action: 2024-4:** The Committee agreed to leave the matter open on the action tracker.

4.2 **Action 2024-5:** P Moore suggested realigning the action with the Annual Delivery Plan performance requirements and providing a whole performance plan to the next meeting that would major on delayed discharges.

4.3 **Action 2025-1:** J Smyth suggested closing the action given the Committee would be receiving a regular HR management report that contained triangulation of data on cross cutting workforce impacts.

The **RESOURCES AND PERFORMANCE COMMITTEE** agreed to close Action 2025-1.

The **RESOURCES AND PERFORMANCE COMMITTEE** noted the action tracker.

5. Laboratory Services Programme Update

5.1 G Clinkscale provided an update on the current situation in regard to the laboratory services programme of work and the anticipated LIMS go live date of 2 June 2025. He further updated the Committee in regard to the UKAS Accreditation status and the replacement of analysers as the organisation moved to a regional contract managed service contract. A programme board had been established to enable the laboratory services programme of work to be progressed.

5.2 Discussion focused on: level of risk being carried and mitigations in place; requested breakdown of the £404,295 revenue requirement, the majority of which related to senior roles in the laboratory team; managing the financial costs of the whole LIMS project in moving to a national framework; point of care testing is available; critical failures reported directly to the Board in terms of business continuity; and critical failures reported through the Clinical Governance Committee if there is harm to patients.

5.3 A Bone to circulate a detailed breakdown outwith the meeting to enable the Committee to reach a decision.

The **RESOURCES & PERFORMANCE COMMITTEE** supported £404,295 revenue requirement to support the Laboratory Services programme over the next 18-months, and to address concerns highlighted by UKAS and MHRA. The Director of Finance confirmed it was provided for within the financial year plan.

The **RESOURCES & PERFORMANCE COMMITTEE** confirmed that it had received Limited Assurance due to timescales and inter-dependencies of the report.

6. Performance Scorecard

6.1 J Smyth provided an overview of the content of the report and highlighted several elements which included performance against the standard targets for the 2024/25 ADP and some other KPIs reported on nationally. The report set out performance to the end of March 2025 and was in effect the end of year performance report and used as the Quarter 4 submission to the Scottish Government. Moving forward a

more integrated report would be submitted with a wider range of targets from the April data.

The **RESOURCES & PERFORMANCE COMMITTEE** noted performance as at the end of March 2025.

The **RESOURCES & PERFORMANCE COMMITTEE** confirmed that it had received Moderate Assurance from the report.

7. Finance Report

7.1 A Bone provided an overview of the finance report and highlighted that the outturn financial performance for the year to 31 March 2025 was an overspend of £13.3m which included £3.5m of support from the Scottish Government. The Quarter 4 position resulted in a final outturn position below the brokerage limited. The final position would remain as draft until the external auditors had concluded their audit.

7.2 The Chair enquired about the over-recovery of income and A Bone commented that it referred to a longstanding contract with Northumbria.

7.3 P Moore commented that the end of year position was a reflection of the work across the organisation to manage spend and he was keen to reflect on what had been learnt and could be replicated in terms of approach for the 2025/26 financial year. He further recognised that the Board was moving away from the position of being one of the most troubled Health Boards financially in Scotland and emphasised that, that was due to the leadership and work taken forward by A Bone and his team.

7.4 The Chair echoed P Moore's comments and mentioned that it was very positive to see an overspend figure that was less than had been previously anticipated.

7.5 J Ayling commented that it was a tremendous achievement to have all the accounts lodged in time.

7.6 A Bone commented that conversations continued to take place with Scottish Government colleagues in regard to a 5 year financial plan to move towards financial sustainability.

The **RESOURCES & PERFORMANCE COMMITTEE** noted that the Board was reporting a breakeven position at 31st March achieved through additional SG support and the request for Brokerage, as detailed below:

	£m
Forecast Outturn Deficit	(18.00)
Business Unit Improvement	1.20
Actual Outturn Deficit	(16.80)
Supported by Scottish Government:	
Additional RRL (NR support)	3.50
Brokerage (i.e. repayable borrowing)	13.30
Total Support & Brokerage	16.80

The **RESOURCES & PERFORMANCE COMMITTEE** noted that the Board met its requirement to deliver a minimum of 3% recurring savings in 2024/25 (Section 5).

The **RESOURCES & PERFORMANCE COMMITTEE** noted that the overall position remained draft pending external audit of the Board's final accounts for the financial year 2024/25.

The **RESOURCES & PERFORMANCE COMMITTEE** confirmed that it had received Moderate Assurance given the improved position in regard to completion.

8. Whole System Infrastructure Planning

8.1 A Bone provided a presentation and highlighted: the purpose was to update on the status of capital planning and national processes; risk judgements; 48 projects ranked against risk and service prioritisation; paired comparison adjustment; BCP submission; Phase 1; Phase 2; next steps; and development of a property strategy aligned to organisational and clinical strategies.

8.2 The Chair enquired in relation to half of general spend being on remedial works and if there were any workforce implications as a consequence. A Bone responded that there was a small capital team and they were reprioritising their work given the Knoll incident. He was actively trying to bring more resource on board to support the team.

8.3 J Ayling commented that he was pleased to see Scottish Government involvement in the allocation of risk and the determination in how funds were spent. He further enquired about the proceeds of property sales and if proceeds were retained for capital expenditure or claimed by the Scottish Government. A Bone responded that in terms of capital receipts from disposals, technically the guidance referred to capital receipts being reverted to the Minister as the property owner, as the Health Board were the custodians of the property. However, if the Board identified the disposal opportunity it had been custom and practice for those receipts to refer back to the Health Board to secure for capital if the Health Board could demonstrate that it would be spent on a very high priority matter.

8.4 L Jones reiterated the significant risk being carried by the organisation in terms of the healthcare environment and suggested that property and digital were the 2 main risks of the organisation and should be prioritised for any resource that might be available.

8.5 F Sandford suggested off balance sheet contracts would require support before being progressed. She also enquired about the provision of non gender based spaces given the supreme court ruling.

8.6 A Bone confirmed that in regard to off balance sheet contracts, he would be seeking expert advice before taking any action. In terms of non gender based spaces he suggested the matter would be for operational colleagues to manage space without any additional works being required.

8.7 A Carter commented that currently transgender service users and staff were following the Supreme Court ruling and the Equalities and Human Rights Commission had issued some basic advice. Further advice was expected in July

which the Scottish Government were expected to review and issue guidance out to public bodies. He further commented that in terms of the BGH there were changing spaces for Males, Females and Unisex/Non Gender Specific areas within the old Autoclave which contained cubicles with locked doors or curtains.

8.8 P Moore advised that he was in close contact with the other Regional Board Chief Executives in regard to the transgender issue.

The **RESOURCES & PERFORMANCE COMMITTEE** noted the presentation.

The **RESOURCES & PERFORMANCE COMMITTEE** confirmed that it had received Moderate Assurance for systems/processes and Limited Assurance given the level of risk being carried overall.

9. Strategic Risk: Healthcare Environment

9.1 A Bone commented that in reviewing the strategic risk there had been little movement apart from adding in the whole system infrastructure planning. The risk assessment had not changed and the fact that it was not within risk appetite was the key point to draw from it.

The **RESOURCES & PERFORMANCE COMMITTEE** noted the risk.

The **RESOURCES & PERFORMANCE COMMITTEE** confirmed that it had received Moderate Assurance in terms of governance and controls and Limited Assurance in terms of operational risks, with an overall rating of Limited Assurance.

10. Strategic Risk: Climate Change

10.1 A Bone provided an update on the strategic risk and reminded the Committee of the national target for achieving net zero by 2040 for the public sector. The Health Boards action plans in regard to achieving net zero were based on the NHS Scotland climate strategy. In terms of looking at the risk the risk assessment remained the same. The action plans supporting the assessment were high level as the organisation worked through the operational delivery of the immediate strategy and looked to build a long term plan to get to 2040.

The **RESOURCES & PERFORMANCE COMMITTEE** noted the risk.

The **RESOURCES & PERFORMANCE COMMITTEE** confirmed that it had received Limited Assurance from the paper.

11. HR Management Report

11.1 A Carter provided an overview of the HR report supported by a presentation and highlighted that: the paper had been shared with the Staff Governance Committee; WTE staff numbers; staff turnover; sickness absence rates; statutory and mandatory training compliance; health and safety; appraisal data; and referrals to occupational health.

11.2 The Chair enquired where the dashboard could be accessed.

11.3 J McLaren commented on the easy navigation of the dashboard and questioned the number of employee relations cases. A Carter commented that he would discuss with J McLaren outwith the meeting as the numbers for March data were correct.

11.4 J Ayling enquired if data was recorded on why people left the organisation. A Carter confirmed that there was a process for exit interviews whereby line managers or another manager could hold a face to face discussion, equally an anonymous online system was also in place.

The **RESOURCES & PERFORMANCE COMMITTEE** noted the report.

The **RESOURCES & PERFORMANCE COMMITTEE** confirmed that it had received Moderate Assurance from the report.

12. Any Other Business

12.1 P Moore suggested the Deloitte Report be revisited by the Committee.

12.2 J Smyth commented that much of the Deloitte Report linked to the 15 Box Grid and a more detailed update would be brough to the September meeting.

12.3 J Smyth commented that in terms of the Buchan Associates Report, what had been commissioned had been a strategic modelling data tool and the Business Intelligence team were to be trained to use the tool. She suggested bringing forward the output once completed.

The **RESOURCES & PERFORMANCE COMMITTEE** noted the update.

The **RESOURCES & PERFORMANCE COMMITTEE** agreed to receive an update on the Deloitte Report in September.

13. Date and Time of Next Meeting

13.1 The Chair confirmed the next meeting of the Resources & Performance Committee would be held on Thursday, 4 September 2025 at 9.00am via MS Teams.

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**2 October 2025**
Title:	**Audit & Risk Committee Minutes**
Responsible Executive/Non-Executive:	**A Bone, Director of Finance**
Report Author:	**I Bishop, Board Secretary**

1 Purpose

This is presented to the Board for:

- Awareness

This report relates to a:

- Government policy/directive

This aligns to the following NHSScotland quality ambition(s):

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

The purpose of this report is to share the approved minutes of the Audit & Risk Committee with the Board.

2.2 Background

The minutes are presented to the Board as per the Audit & Risk Committee Terms of Reference and also in regard to Freedom of Information requirements compliance.

2.3 Assessment

The minutes are presented to the Board as per the Audit & Risk Committee Terms of Reference and also in regard to Freedom of Information requirements compliance.

2.3.1 Quality/ Patient Care

As detailed within the minutes.

2.3.2 Workforce

As detailed within the minutes.

2.3.3 Financial

As detailed within the minutes.

2.3.4 Risk Assessment/Management

As detailed within the minutes.

2.3.5 Equality and Diversity, including health inequalities

An HIIA is not required for this report.

2.3.6 Other impacts

Not applicable.

2.3.7 Communication, involvement, engagement and consultation

Not applicable.

2.3.8 Route to the Meeting

This has been previously considered by the following group as part of its development. The group has supported the content.

- Audit & Risk Committee 26 June 2025
- Audit & Risk Committee 22 September 2025

2.4 Recommendation

The Board is asked to **note** the minutes which are presented for its:

- **Awareness** – For Members' information only.

3 List of appendices

The following appendices are included with this report:

- Appendix No 1, Audit & Risk Committee minutes 19.06.25
- Appendix No 2, Audit & Risk Committee minutes 26.06.25

Minutes of a Meeting of **Borders NHS Board Audit & Risk Committee** held on Thursday, 19th June 2025 @ 1 p.m. via MS Teams.

Present: J Ayling, Non Executive Director (Chair)
L Livesey, Non Executive Director
L O'Leary, Non Executive Director

In Attendance: A Bone, Director of Finance
J Boyd, Director, Audit Scotland
B Everitt, Personal Assistant to Director of Finance (Minutes)
S Harold, Senior Audit Manager, Audit Scotland
G MacLeod, Risk Advisory Services Manager, BDO
A McCloy, Senior Finance Manager (Item 6.1)

1. **Introduction, Apologies and Welcome**

James Ayling welcomed those present to the meeting.

Apologies were received from D Parker, Non Executive Director and P Moore, Chief Executive.

James confirmed that today's meeting was quorate.

2. **Declaration of Interest**

There were no declarations of interest.

3. **Minutes of Previous Meeting – 26th May 2025**

The minutes were approved as an accurate record.

4. **Matters Arising**

Action Tracker

The Committee noted the action tracker.

Annual Accounts 2024/25
Andrew Bone provided an update where it was noted that the clearance meeting had been held the previous week with Audit Scotland and although no significant issues had arisen from the audit there were still a number of items being finalised, therefore it had been necessary to defer the final annual report and accounts from today's meeting and arrange an extraordinary meeting on the 26th June 2025 prior to the Board meeting.

John Boyd reassured the Committee that there were no significant issues and explained that had they come to today's meeting there would have been a number of areas where work was still ongoing so by deferring a week allowed for this work to be undertaken to allow the Committee to recommend putting forward the accounts to the Board for approval. John confirmed that based on work to date an unqualified opinion was expected.

James Ayling noted that the draft accounts had been reviewed at the informal session held earlier in the month, however these had not yet been seen specifically by the Committee and although no issues were anticipated he was concerned around the timing of these coming forward to allow adequate time for review.

Andrew Bone highlighted the tight timescales involved for completion of the accounts, however advised that he would be looking at the timetable going forward.

Members felt that it would be helpful to have a slot diarised in advance to avoid any late requests for an extraordinary meeting and noted that this was the same situation as the previous year which was not ideal from a governance perspective in allowing sufficient time for review.

Andrew noted the comments raised and would take these into consideration when looking at the timetable going forward.

5. **Internal Audit**

5.1 *Final Internal Audit Plan 2025/26*
Andrew Bone advised that he had discussed timings around some of the audits with Internal Audit and it was noted that the comments made at the last meeting around the timing of the whistleblowing audit had been taken into account and amended within the plan.

The Committee confirmed it had received a significant level of assurance.

The Committee approved the Internal Audit Plan for 2025/26.

6. **Corporate Governance Framework**

6.1 *Review of Corporate Governance Framework 2024/25 - Final*
Anita McCloy spoke to this item and highlighted the changes made since the last version received. Anita went on to take the Committee through these and referred to the comments made at the last meeting on the Staff Governance Committee assurance report and advised that the amended report should now take these into account. Anita advised that she would be providing support to ensure that these followed due process going forward.

Anita advised that all third party audit reports had now been received for major services provided to NHS Borders and that a disclosure had been added, as per discussion at the last meeting, as only limited assurance could be taken from these.

James Ayling noted that within the Audit & Risk Committee assurance report it referred to reviewing the service audits for the national systems provided to NHS Borders, however these had not been seen by the Committee due to timing issues. Anita agreed to circulate these around the Committee for information. James also noted that there were some minor amendments required which he would pick up outwith the meeting.

James felt that going forward assurance reports should also be requested from an Executive Director who leaves the organisation covering the period from 1st April to the date they leave.

James also felt that assurance reports should be signed off by the whole Committee rather than just the Chair of the Committee. Lynne Livesey agreed with this comment, even if this required to be undertaken virtually.

Andrew Bone proposed that as well as providing guidance to Executive Directors around judging materiality and disclosure to be considered within assurance statements, this should also be extended to the Governance Committees for their assurance reports. This was agreed. Anita added that the template could also be amended to capture the sign off process to provide the necessary assurance.

The Committee confirmed it had received a moderate level of assurance.

The Committee noted the final Review of Corporate Governance Framework for 2024/25.

6.2 *Audit & Risk Committee Assurance Report*
This item was discussed and approved under item 6.1.

The Committee confirmed it had received a moderate level of assurance.

The Committee noted the report.

7. Items for Noting

7.1 *Information Governance Committee Minutes: 24th March 2025*
The Committee noted the minutes from the Information Governance Committee meeting held on the 24th March 2025.

James Ayling noted the concerns made regarding lack of attendance which could be monitored through future minutes received by the Committee.

The Committee confirmed it had received a moderate level of assurance.

The Committee noted the minutes.

7.2 *Final Internal Audit Annual Report 2024/25*
The Committee noted the final version of the Internal Audit Annual Report for 2024/25 following discussion at the previous meeting and that the relevant amendments had been made.

The Committee confirmed it had received a moderate level of assurance.

The Committee noted the final Internal Audit Annual Report for 2024/25.

7.3 *Internal Audit Follow-Up Tracker*
The Committee noted the updated Internal Audit follow-up tracker following discussion at the previous meeting. Andrew Bone advised that this was more of a management tool which would be taken over by BDO using their own format.

The Committee confirmed it had received a moderate level of assurance.

The Committee noted the follow-up tracker.

8. **Any Other Competent Business**

None.

9. **Date of Next Meeting**

Thursday, 26th June 2025 @ 8.45 a.m. via MS Teams (Extraordinary Meeting)
Monday, 22nd September 2025 @ 10 a.m. via MS Teams

BE
25.06.25

Minutes of an Extraordinary Meeting of **Borders NHS Board Audit & Risk Committee** held on Thursday, 26th June 2025 @ 8.45 a.m. via MS Teams.

Present: J Ayling, Non Executive Director (Chair)
L Livesey, Non Executive Director
L O'Leary, Non Executive Director

In Attendance: A Bone, Director of Finance
J Boyd, Director, Audit Scotland
B Everitt, Personal Assistant to Director of Finance (Minutes)
S Harold, Senior Audit Manager, Audit Scotland
S Harkness, Senior Finance Manager
L Jones, Director of Quality & Improvement
G MacLeod, Risk Advisory Services Manager, BDO
S Swan, Deputy Director of Finance (Head of Finance)

1. Introduction, Apologies and Welcome

James Ayling welcomed those present to the meeting.

Apologies were received from D Parker, Non Executive Director and P Moore, Chief Executive.

James confirmed that today's meeting was quorate.

2. Declaration of Interest

There were no declarations of interest.

3. External Audit

3.1 *External Audit Annual Report (including ISA 260 Requirement) 2024/25*
James Ayling reminded the Committee that the deadline for submitting the annual accounts to Scottish Government was 30th June 2025. James noted that this was the first opportunity for the Committee to review the annual report from External Audit and this had been discussed by members at the pre-meeting where they agreed it was a very concise and clear report and noted the unqualified opinion so were therefore content to proceed with this morning's meeting.

John Boyd went on to present the annual report which was a conclusion of the audit work undertaken throughout the year and included the independent audit opinion which would be included within the final set of accounts. John highlighted the letter of representations and confirmed that these were all standard and he had no issues to bring to the Committee's attention. John was pleased to report that an unqualified audit opinion was proposed and that the financial statements were free from material misstatement.

It was noted that the report was being presented as draft and would be finalised following signing of the accounts and published on the Audit Scotland website.

John went on to take the Committee through the report and highlighted key areas. John explained the concept of materiality levels and advised that this had been assessed and for this year's audit had been set at 1.5% of gross expenditure.

John highlighted that the Code of Audit Practice required public sector auditors to communicate key audit matters and referred to exhibit 2 which detailed significant findings, namely an amount received from the Clinical Negligence and Other Risks Scheme (CNORIS) which had been netted off against expenditure rather than being disclosed as income and due to the value this was classed as significant. It was noted that this had been updated within the accounts and there was no impact on the outturn position.

The other significant finding was in relation to Health & Social Care integration expenditure where it was noted that at the year-end an additional line for total expenditure and total income with the Integration Joint Board (IJB) is disclosed within the accounts. The expenditure figure had been incorrect in the unaudited accounts due to a timing issue in receiving the information from the IJB and again due to the value was classed as significant.

John also referred to appendix 2 of the report which included a summary of corrected misstatements which management have accepted and acted upon.

John referred to the audit approach for the wider scope and best value which included financial management, financial sustainability, vision, leadership and governance and use of resources to improve outcomes. John highlighted the significant challenges the Board continues to face in delivering financial sustainability.

John also referred to the requirement to develop a financial strategy and highlighted recommendations for this within appendix 1.

John thanked the Director of Finance and wider Finance team for their ongoing support throughout the course of the audit to allow this to be concluded within the statutory deadline.

Andrew Bone noted his thanks to the Finance team involved in the production of the annual report and accounts and to the Audit team.

James Ayling referred to the misstatements and enquired if these had been one-off errors. John confirmed that this was the case and advised that additional testing is undertaken against errors found to provide this assurance.

The Committee confirmed it had received a significant level of assurance on the annual audit report relating to the accounts themselves.

The Committee then confirmed it had received a limited level of assurance on the wider findings reported regarding financial sustainability and financial balance.

The Committee noted the External Audit Annual Report for 2024/25.

4. **Annual Accounts 2024/25**

4.1 *Update Report – Track of Changes for Annual Report and Accounts 2024/25*
Susan Swan spoke to this item which detailed the changes made to the annual report and accounts following the informal session held on 5th June 2025 and advised that they were materially unchanged. It was noted that points of clarity around the narrative within the annual report and presentational changes within the annual accounts had been made. Susan highlighted the 2 adjustments made in relation to the misstatements for CNORIS and the IJB as discussed under the previous item.

It was noted that the accounts remain consolidated with the Endowment Fund Annual Accounts, Patient's Private Funds Annual Accounts and the IJB Annual Accounts. Susan advised that the Endowment Fund Annual Accounts had received a clear audit opinion and had subsequently been approved by Trustees at their meeting on 12th June 2025.

The Committee confirmed it had received a significant level of assurance.

The Committee noted the track of changes for the Annual Report and Accounts 2024/25.

4.2 *Final Annual Report and Accounts 2024/25*
This item was discussed under item 4.1.

The Committee confirmed it had received a significant level of assurance.

The Committee reviewed the Annual Report and Accounts for 2024/25 and recommended that they go forward to Borders NHS Board for approval at their meeting on 26th June 2025.

4.3 *Final Endowment Fund Annual Report and Accounts 2024/25*
This item had been discussed under item 4.1.

The Committee confirmed it had received a significant level of assurance.

The Committee noted the Endowment Fund Annual Report and Accounts for 2024/25.

4.4 *Final Patient's Private Funds Annual Report and Accounts 2024/25*
Susan Swan advised that these accounts had been audited by the External Auditor, Thomson Cooper, and a clear audit opinion had been given.

The Committee confirmed it had received a significant level of assurance.

The Committee reviewed the Patient's Private Funds Annual Report and Accounts for 2024/25 and recommended that they go forward to Borders NHS Board for approval at their meeting on 26th June 2025.

James Ayling, on behalf of the Committee, thanked Susan and the Finance team for all their input in the production of the annual report and accounts.

5. **Items for Noting**

5.1 *Third Party Audit Reports*

Andrew Bone advised that the 3 third party audit reports were being presented to note following discussion at the previous meeting and the limited assurance which could be taken from these due to the modified opinions. It was noted that the 3 reports were for services provided to NHS Borders, namely the finance system provided by NHS Ayrshire & Arran, IT services provided by NSS and practitioner services provided by NSS.

James Ayling asked for clarification in the event of anything arising from these audits as he assumed there would be no recourse for the Board as we did not instruct them. Andrew confirmed that this was correct in regard to the commissioning of the report as these were directed to the provider for each service. Andrew advised that the Directors of Finance network had previously discussed ways to get the necessary assurances and this remained a live issue.

John Boyd went on to provide the Committee with some assurance on this issue where it was noted that due to the significant spend involved their audit included looking at the controls reporting and evaluation of the controls report to place reliance on the work undertaken where this is possible. Should there be any gaps these would be assessed and local controls looked at to provide assurance that controls were in place locally.

The Committee noted the Third Party Audit Reports.

6. **Any Other Competent Business**

None.

7. **Date of Next Meeting**

Monday, 22nd September 2025 @ 10 a.m. via MS Teams

BE
27.06.25

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**2 October 2025**
Title:	**Finance Report – August 2025**
Responsible Executive/Non-Executive:	**A Bone, Director of Finance**
Report Author:	**S Harkness, Senior Finance Manager** **P McMenamin, Finance Business Partner** **M Khan, Finance Business Partner**

1 Purpose

This is presented to the Committee for:

- Awareness

This report relates to a:

- Annual Operational Plan/Remobilisation Plan

This aligns to the following NHSScotland quality ambition(s):

- Effective

2 Report summary

2.1 Situation

The report describes the financial performance of NHS Borders and any issues arising.

2.2 Background

NHS Health Boards operate within the Scottish Government (SG) Financial Performance Framework. This framework lays out the requirements for submission of Financial Performance Reports (FPR) to SG which include comparison of year to date performance against plan with full review of outturn forecast undertaken on a periodic basis (i.e. both monthly and through formal quarterly reviews).

NHS Borders has determined that regular finance reports should be prepared in line with the SG framework (i.e. monthly).

The board has remitted the Resources & Performance committee to "review action (proposed or underway) to ensure that the Board achieves financial balance in line with its statutory requirements".

The board continues to receive regular finance reports for reporting periods where there is no scheduled committee meeting.

2.3 Assessment

2.3.1 Quality/ Patient Care

Any issues related to this topic are provided as background to the financial performance report and it is expected that, where relevant, these issues will be raised through the relevant reporting line.

2.3.2 Workforce

Any issues related to this topic are provided as background to the financial performance report and it is expected that, where relevant, these issues will be raised through the relevant reporting line.

2.3.3 Financial

The report is intended to provide briefing on year to date and anticipated financial performance within the current financial year.

No decisions are required in relation to the report and any implications for the use of resources will be covered through separate paper where required.

2.3.4 Risk Assessment/Management

The paper includes discussion on financial risks where these relate to in year financial performance against plan. Long term financial risk is considered through the board's Financial Planning framework and is not relevant to this report.

2.3.5 Equality and Diversity, including health inequalities

An impact assessment has not been completed because the report is presented for awareness and does not include recommendation for future actions.

2.3.6 Climate Change

There are no impacts in relation to Climate Change within this paper.

2.3.7 Other impacts

There are no other relevant impacts identified in relation to the matters discussed in this paper.

2.3.8 Communication, involvement, engagement and consultation

Not Relevant. This report is presented for monitoring purposes only.

2.3.9 Route to the Meeting

This has been previously considered by the following groups as part of its development. The groups have either supported the content, or their feedback has informed the development of the content presented in this report.

- Senior Finance Team, 16th September 2025
- BET, 29th June 2025

2.4 Recommendation

- **Awareness** – For Members' information only.

The Board will be asked to confirm the level of assurance it has received from this report:

- Significant Assurance
- Moderate Assurance
- Limited Assurance
- No Assurance

If a single level of assurance cannot be determined Officers are asked to suggest a level based on the following split of assurance:

- **Systems and Processes**
- **Outcomes**

3 List of appendices

The following appendices are included with this report:

- Appendix 1 – Finance Report for the period to the end August 2025

FINANCE REPORT FOR THE PERIOD TO THE END OF AUGUST 2025

1 Purpose of Report

1.1 The purpose of the report is to provide committee members with an update in respect of the board's financial performance (revenue) for the period to end of August 2025.

2 Recommendations

2.1 Committee Members are asked to:

2.1.1 **Note** the contents of the report including the following:

YTD Performance	£5.94m overspend
Outturn Forecast at current run rate	£14.25m overspend
Projected Variance against Financial Plan (current run rate)	£1.45m adverse
Actual Savings Delivery (current year effect)	£2.32m (actioned)
Projected gap to FP Forecast	Best Case £11.00m (Forecast Q1) Worst Case £14.25m (trend)

2.1.2 **Note** the assumptions made in relation to Scottish Government allocations and other resources.

3 Key Indicators

3.1 Table 1 summarises the key financial targets and performance indicators for the year-to-date performance to end August 2025.

Table 1 – Key Financial Indicators

	Financial Plan £m	Month 5 £m
Summary		
Year to Date (forecast/actual)	(5.33)	(5.94)
Core Operational	(3.71)	(0.99)
Board Reserves & Flexibility[1]	5.51	2.30
Savings	(14.60)	(7.24)
Average Monthly Run Rate	(1.07)	(1.19)
Outturn Forecast (pro-rata)	(12.80)	(14.25)
Outturn Target (Scottish Government)	(10.00)	(10.00)
Updated Forecast as at Q1	-	(11.00)
Savings		
Full Target	(19.66)	(19.66)
In year target	(12.15)	(12.15)
Forecast Delivery	12.15	12.15
Recurring Schemes		
Implemented	-	2.27
Planned/Mandated	6.44	3.79
In Development / At Risk	2.68	3.05
Non Recurring Schemes		
Implemented	-	0.05
Planned/Mandated	2.19	0.45

[1] Includes £5.5m SG non-recurrent 'sustainability' allocation (share of £250m nationally)

In Development / At Risk	-	1.69
Cost Avoidance Measures		
YTD Achieved		0.20
Forecast at current run rate	0.85	0.48
Slippage / At Risk	-	0.32
Memorandum | Brokerage Position		
Accumulated Brokerage Mar-25	49.33	49.33

4 Summary Financial Performance

4.1 The board's financial performance as at 31st August 2025 is an overspend of £5.94m. This position is summarised in Table 2, below.

Table 2 – Financial Performance for five months to end August 2025

	Opening Annual Budget	Revised Annual Budget	YTD Budget	YTD Actual	YTD Variance	Forecast Outturn as at Q1
	£m	£m	£m	£m	£m	£m
Revenue Income	350.15	391.14	162.18	162.49	0.31	0.04
Revenue Expenditure	350.15	391.14	147.57	153.81	(6.24)	(11.04)
Surplus/(Deficit)	-	-	(14.61)	(8.68)	(5.94)	(11.00)

4.2 Core Operational Performance

4.2.1 The core operational performance excluding savings is £0.99m overspent. This position has been adjusted to £1.31m (underspent) in anticipation of additional resources not yet implemented within operational budgets.

4.2.2 The overall impact of these adjustments is a £3.03m improvement included within the position reported above. These adjustments are summarised as follows.

4.2.3 Adjustment is made to the position to anticipate release of reserves held in respect of non-pay growth, where budget setting has not yet been completed. This work is ongoing. The level of funding assumed to be released is £3.03m.

4.2.4 A breakdown of the boards income and expenditure has been included in Appendix 1. This represents the information reported to Scottish Government via the Financial Performance Returns each month and shows the boards income and expenditure against a number of key headings. This data is presented by Business Units in Section 5 of this report.

4.2.5 A number of Key trend areas have been included in Appendix 2, which again represent data reported to Scottish Government. These key trends show the monthly spend against some of the highest cost areas including Agency spend to show the trend over the last 17 months.

4.3 Savings Delivery

4.3.1 As noted in Table 1 (key financial indicators), the overall financial performance at Month 5 is £5.94m overspent, of which £7.24m represents unmet savings. Excluding savings, the operational position (including unallocated resources) is underspent by £1.3m (net, including cost pressures).

4.3.2 The financial plan assumes delivery of £9.11m recurring savings during 2025/26 which would result in a residual balance of unmet savings to be carried forward of £10.60m.

4.3.3 If savings were delivered on a pro-rata basis (i.e. equally over the twelve months) then this would be expected to result in a shortfall of £4.42m after five months. The year to date position of £7.24m unmet savings highlights the extent to which savings are either not identified, or are phased to deliver in later periods.

4.4 As set out in the Q1 review, there are mitigations in place to offset non-delivery of savings in 2025/26; nonetheless the continued slippage against plan presents a significant risk to the underlying deficit and opening financial position at March 2026.

4.5 As at M05, the recurring savings delivered to date have a current year effect of £2.27m. This is lower than the savings delivered at this point during 2024/25 and focus on delivering recurring savings needs to remain constant to ensure the Board meets its Financial Plan targets. This situation is discussed further in Section 6.

5 Financial Performance – Budget Heading Analysis

5.1 Income

5.1.1 Table 3 presents analysis of the board's income position at end August 2025.

Table 3 – Income by Category, year to date August 2025/26

	Opening Annual Budget £m	Revised Annual Budget £m	YTD Budget £m	YTD Actual £m	YTD Variance £m	Forecast Outturn as at Q1 £m
Income Analysis						
Revenue Resource Limit	329.25	360.35	150.15	150.15	-	-
Family Health Services	10.24	19.03	7.93	7.93	0.00	-
External Healthcare Purchasers	4.55	4.65	1.92	1.98	0.06	(0.15)
Other Income	6.11	7.12	2.19	2.44	0.25	0.19
Total Income	**350.15**	**391.14**	**162.18**	**162.49**	**0.31**	**0.04**

5.1.2 There is an over recovery on other income which is linked to income received in relation to Resident Doctors and is linked to timing of income.

5.1.3 Currently income generated from non-Border residents is marginally over recovered. This position is largely based on estimated activity due to the six week delay in coding of activity therefore this position should be treated with a degree of caution and will monitored robustly once actual activity data is available.

5.2 Operational performance by business unit

5.2.1 Table 4 describes the financial performance by business unit at August 2025.

Table 4 – Operational performance by business unit, August 2025

	Opening Annual Budget £m	Revised Annual Budget £m	YTD Budget £m	YTD Actual £m	YTD Variance £m	Forecast Outturn as at Q1 £m
Operational Budgets - Business Units						
Acute Services	84.73	94.29	39.43	40.00	(0.57)	(2.09)
Acute Services - Savings Target	(4.08)	(3.54)	(1.49)	-	(1.49)	(3.54)
TOTAL Acute Services	**80.65**	**90.75**	**37.94**	**40.00**	**(2.06)**	**(5.63)**
Set Aside Budgets	34.52	35.72	14.95	17.29	(2.33)	(3.70)
Set Aside Savings	(3.83)	(3.60)	(1.50)	-	(1.50)	(3.75)
TOTAL Set Aside budgets	**30.69**	**32.12**	**13.45**	**17.29**	**(3.84)**	**(7.45)**
IJB Delegated Functions	121.69	166.40	66.41	65.72	0.68	2.08
IJB – Savings	(5.00)	(4.14)	(1.72)	-	(1.72)	(4.72)
TOTAL IJB Delegated	**116.69**	**162.26**	**64.68**	**65.72**	**(1.04)**	**(2.64)**
Corporate Directorates	23.41	26.56	10.95	10.36	0.58	1.63
Corporate Directorates Savings	(1.73)	(1.69)	(0.70)	-	(0.70)	(1.70)
TOTAL Corporate Services	**21.68**	**24.87**	**10.24**	**10.36**	**(0.12)**	**(0.07)**
Estates & Facilities	24.75	26.21	10.79	10.55	0.24	0.18
Estates & Facilities Savings	(2.10)	(1.98)	(0.83)	-	(0.83)	(1.98)
TOTAL Estates & Facilities	**22.65**	**24.23**	**9.96**	**10.55**	**(0.59)**	**(1.81)**
External Healthcare Providers	36.61	39.07	16.28	16.91	(0.63)	(0.10)
External Healthcare Savings	(2.75)	(2.39)	(0.99)	-	(0.99)	(2.33)
TOTAL External Healthcare	**33.86**	**36.68**	**15.28**	**16.91**	**(1.63)**	**(2.43)**
Board Wide						
Depreciation	5.87	5.87	2.44	2.44	(0.00)	-
Year-end Adjustments	1.28	(8.72)	(9.47)	(9.47)	(0.00)	(0.15)
Planned expenditure yet to be allocated	32.00	18.32	3.05	-	3.05	10.25
Central Unallocated Savings Target	-	4.77	(0.02)	-	(0.02)	(0.05)
Board Flexibility	-	-	-	-	-	2.90
Board Risks		-	-	-	-	(3.97)
Total Expenditure	**350.15**	**391.14**	**147.57**	**153.81**	**(6.24)**	**(11.04)**

5.2.2 **Acute[2] Overall**.

The position is £5.90m overspent with £2.90m relating to operational overspend and £3.00m relates to non-delivery of the remaining element of the three-year saving targets of £10.3m.

Savings Summary: The £10.3m recurring three-year target set in 24/25 has been reduced to £7.5m due to the savings achievement made by the Acute Board in 2024/25. It is expected that the Acute Board will achieve the remaining balance by the end of 26/27.The Acute Board has a savings plan for £2m and are currently working on the feasibility of all savings commitments, with £1m identified to be realised by the end of Q2 2025.The proportion of saving anticipated in 25/26 is a minimum of 3% or £3.1m recurring cash releasing savings. At month 5 there has been retraction of full year recurring saving of £0.8m.

[2] Budget reporting is categorised as 'Acute Services' covering health board retained functions including planned care and women & children's services, and 'Set Aside' representing unscheduled care functions under strategic direction of the Scottish Borders IJB.

Operations Summary: Operational pressures across Acute continue, with exceptional reliance on medical locum to cover non-recruitment and vulnerable service issues which continue to grow. Nursing bank/agency to cover core activity as well as high cost out of hours services are still prevalent. There are substantial unfunded surge beds within both urgent and planned care (totally 22 surge beds) which are driving material overspend. However, it should be noted there are operational workstreams focusing on front-door patient flow to mitigate delayed discharge pressures and consequential reliance on long-term surge beds using an integrated approach which are due to be implemented over winter. Additionally, overspend within drugs, supplies and instruments which can be driven by non-op factors add to cost pressures.

5.2.3 **Acute Services (excluding Set Aside)** is reporting a YTD overspend of £2.06m, of which £0.57m relates to operations and £1.49m related to savings.

Operational Summary: Operational pressures continue within Acute Services, specifically vulnerable services in Paediatrics, Obstetrics and Gynaecology and General Medicine which continue to see growing medical staffing issues including non-recruitment, retirement and absence. Reliance on medical locum and nursing agency/bank to cover core activity as well as out of hours services are still prevalent. Cost pressures with supplies and instruments have been noted in 5.2.2, compounded with inflationary overspend experienced in previous years which remain unfunded. There is increased expenditure on diabetic supplies previously funding via Scottish Government. The drugs budget has been increased and therefore the level of overspend related to drugs is a new pressure and work is being carried out with pharmacy to review and understand this overspend.

Contributing factors include ongoing clinical demand, staffing constraints, and the use of external reporting support in radiology. The Board has now received confirmation of waiting times funding, which will be reflected in budgets in due course.

5.2.4 **Set Aside.** The set aside budget is overall, £3.84m overspent, at the end of August 25. This overspend is broken down into £2.33m operational overspend and £1.50m related to savings. The unmet savings reported in the position relate to five twelfths of the saving required to be achieved during 25/26 and 26/27. The Acute Board has plans in place to achieve the majority of the minimum requirement for 25/26 of 3% recurring and this overspend will begin to decrease as plans are completed.

5.2.5 Overspend continues across unscheduled care, primarily driven by the sustained operation of additional surge beds and pressures in medical staffing, including the use of agency cover for sickness absence. While the drugs budget has been funded to match prior year expenditure, specific areas—such as dermatology—remain under review due to emerging cost pressures. These factors are contributing to the overall financial position. As noted in 5.2.2, there are workstreams going live focusing on patient flow, delayed discharged and an integrated approach to quality assessment of patients.

5.2.6 **IJB Delegated.** Excluding non-delivery of savings, the HSCP functions delegated to the IJB are reporting a net underspend on core budgets of £0.680m. Within Mental Health (net £0.380m underspend excluding savings), medical agency use (locums) continues to be a pressure (£0.317m at M05), offset by savings of £0.186m in the MH Drugs budget. Nursing and Psychology pay budgets are reporting a net underspend of £0.427m net, including and partly offset by additional bank / agency costs.

5.2.7 The largest area of financial pressure again relates to Learning Disability out-of-area placements (£0.810m) at the end of the first quarter offset by pay vacancies of £0.050m.

5.2.8 Primary Care Prescribing is reporting a underspend position of (£0.340) at M05. Whilst a higher than average trend in the volume of items dispensed (7.5% c/f 2023/24) continues, average cost per item continues to fall which is partly offsetting the impact of this. The net residual pressure has been mitigated by the release of additional Financial Plan investment of £1.48m during M03 profiled over the financial year, slightly more than the current overall trend of expenditure increase. The position will continue to be monitored on a monthly basis.

5.2.9 Within Primary and Community Services there is a net underspend at M05 of £0.710m. Savings from vacancies across Dental £0.309m and Allied Health Professional Services £0.216m contribute significantly to the position. These are further supplemented by other pay underspends associated with vacancies in Community Hospitals £0.200m, Community Nursing £0.163m and Sexual Health £0.026m. These underspends are partially offset by an overspend in Home First (£0.040m) and Vaccination and Immunisation (£0.175m).

5.2.10 **Corporate Directorates** are reporting a net under spend of £0.58m on core budgets. The underspend observed in previous months continues, primarily across departments such as Workforce, Pharmacy, Planning and Performance, and Finance. These areas are either undergoing workforce reviews or have completed them but are still experiencing underspends due to challenges in recruiting to the agreed staffing models. As a result, the savings being realised are non-recurring in nature.

5.2.11 **Estates & Facilities** are reporting an operational underspend of £0.24m. The underspend in Estates relates to vacancies. The underspend in Estates & Facilities is primarily due to staffing vacancies. Within Estates, workload pressures remain, and recruitment to key posts is necessary to address these. As vacancies are filled, the underspend is expected to reduce and should therefore be considered non-recurring. In Facilities, staffing levels are aligned to nationally agreed cleaning standards, and any sustained underspend would only be recurring if the Board were to revise its commitment to those standards.

This underspend is offset by overspends in supplies within facilities, specifically Patient Transport which continues to face cost pressures due to an increasing number of patients requiring travel to Edinburgh for cancer treatment. This issue was highlighted during 2024/25 and remains ongoing. A proposal is currently progressing through governance to seek additional funding from the cancer endowment fund to support these transport costs.

5.2.12 **External Healthcare Providers** Excluding savings there is an over-spend of £0.63m. Data is not usually available until six weeks after the end of the current month. Therefore, much of the external healthcare position is based on estimated data and therefore the main element of the overspend continue to be related to our contact with NHS Lothian but is based on 24/25 trends.

6 Savings Delivery

6.1 The savings targets set within the Financial Plan for 2024/25 are £9.12m recurring (3%) and £3.04m non-recurring (1%).

6.2 The FIP Board has agreed that targets set at individual business unit level should continue to be monitored against the three year target set in 2024/25. This means that there is a difference between the target set within the financial plan and the operational targets included within individual business unit budgets.

6.3 This issue is addressed by creation of an unallocated 'organisation wide' target which is expected to be managed through identification of workstream schemes not included within business unit plans. This approach has been viewed as preferable to minimise disruption to local plans and to ensure that there is consistency of approach across the three year period to March 2027.

6.4 Given the scale of risk inherent in this assumption, provision was made at £3.04m (1%) within the plan; in effect, this reduces the forecast delivery in year to 3% overall (£9.12m). This forecast remains above the level of savings identified within the plan.

6.5 It should be noted that Scottish Government has set an expectation that all NHS Boards deliver a minimum of 3% recurring and that the position outlined above is consistent with this approach. The additional non-recurrent target set out above is in line with the three year local target (10%) set in 2024/25 and is required in order to achieve the trajectory set out over the medium term financial plan.

6.6 Actual Savings Delivery

6.6.1 Table 5 below shows actual level of savings achieved to date, including amounts expected to be delivered to March 2026 in respect of schemes implemented in August 2025.

Table 5 – Current year savings achieved as at August 2025

	Savings Target (inc. NR) £m	**Recurring Savings Achieved £m**	**Non Recurring Savings Achieved £m**	**Total Achieved £m**	**Unmet Savings (current year) £m**
Acute Services	(2.50)	0.08	0.00	0.08	(2.43)
Set Aside	(1.67)	0.68	0.00	0.68	(0.99)
IJB Directed Services	(2.26)	0.84	0.00	0.84	(1.42)
Prescribing	(1.02)	0.15	0.00	0.15	(0.87)
Corporate Directorates	(1.07)	0.04	0.03	0.07	(1.01)
Estates & Facilities	(0.90)	0.11	0.00	0.11	(0.79)
External Healthcare Providers	(1.68)	0.37	0.03	0.39	(1.29)
Central Unallocated Target	(1.05)	0.00	0.00	0.00	(1.05)
Total	**(12.16)**	**2.27**	**0.05**	**2.32**	**(9.84)**

6.6.2 Against the 2025/26 target, £2.32m has been delivered to date. This reflects actual adjustments reported through the finance systems and impacting on service budgets and does not include any cost avoidance measures which do not result in budget retraction.

6.6.3 The balance of savings to be delivered in 2025/26 is £9.84m, with a minimum of £6.8m required to be delivered in order to meet the financial plan target (ref. para 6.4, above).

6.6.4 The balance of savings to be delivered in 2025/26 is £9.84m, with a minimum of £6.8m required to be delivered in order to meet the financial plan target (ref. para 6.4, above).

6.6.5 Section 6.8 sets out the value of schemes identified not yet enacted within the financial position. This indicates a forecast savings delivery of £6.06m (recurring) in 2025/26, which remains below the minimum level of savings delivery required in the plan (£6.8m, per para 6.63 above).

6.6.6 The level of unmet savings remaining against the three year target (10%) is £16.82m. This position will continue to be reported as a measure of progress towards delivery of the medium term plan. Continued slippage on recurring savings delivery presents a significant risk to the path to financial balance over the medium and long term.

6.7 Agency Use

6.7.1 Table 7 below reports the change in agency use against the same period for the previous year and projects forward to outturn position based on current trend.

Table 7 – Agency use by Staff Group

	Apr-Aug			Ave Monthly (FYE)		
	2024/25 £k	2025/26 £k	Movement (increase/ -decrease) £k	2024/25 £k	2025/26 £k	Movement (increase/ -decrease) £k
Medical	915	1732	817	151	346	196
Nursing	83	176	93	40	35	-5
Other	225	92	-133	130	18	-112
	1224	**2001**	**777**	**321**	**400**	**80**

6.7.2 Comparison with average month values for the prior (full) year give a clearer indication of trend at this stage; this indicates an increase in agency usage in both Medical and Nursing workforce between April and August of this year compared to 2024/25.

6.7.3 This increase in agency within Medical and Nursing over the first five months of this year is attributed to a requirement to sustain vulnerable services within key specialist posts (predominantly medical) and general workforce pressures arising from sickness absence and other factors.

6.7.4 Agency use is monitored against the projected £0.85m cost reduction identified within the Financial Plan as cost avoidance measure. At this stage it is considered that this target will not be met in 2025/26 with the main reason for this being the continuation of vacancies against specialty medical posts.

6.7.5 Appendix 2 provides further information on trends in key costs, including agency staffing within context of overall pay expenditure.

6.8 Progress towards Implementation

6.8.1 The Project Management Office (PMO) maintains a register of all schemes which are included within agreed plans. Schemes in development do not appear within this register until such time as they are developed to Gateway 1.

6.8.2 Targets have been set for progress against each gateway and this is reported monthly to the Financial Improvement Programme (FIP) Board. This includes escalation of individual business units to more frequent steering group meetings and implementation of local vacancy control measures where necessary.

6.8.3 Schemes which are expected to be cost avoidance (i.e. do not impact on budget but result in a reduction to overall expenditure) are not presently reported through the mandate process.

6.8.4 Table 8 summarises the recurrent plans currently identified by business units for 2025/26. This is set against the 3% recurring target.

Table 8 – Recurring Plans 2025/26 by Business Unit

	Number of Schemes	3% Target £m	FYE £m	PYE £m
Acute	36	(3.13)	3.62	2.61
Commissioning	4	(1.26)	0.56	0.46
Corporate	13	(0.79)	0.33	0.26
Estates	7	(0.30)	0.35	0.35
Facilities	19	(0.38)	0.27	0.26
IJB - MH/LD	15	(0.61)	1.02	0.86
IJB - PACS	13	(1.08)	0.37	0.33
Organisation Wide	1	(0.80)	0.15	0.08
Primary Care Prescribing	37	(0.77)	1.17	0.85
	145	(9.12)	7.83	6.06

6.8.5 Table 9 describes the same information as Table 7 in terms of the progress towards implementation through the Gateway mandate process. Schemes which are reported as 'Gateway 3 Blue' are fully implemented.

Table 9 – Recurring Plans 2025/26: Progress by Gateway

	FYE £m	PYE £m	Total Schemes
At planning stage	-	-	-
Gateway 1	3.93	2.96	82
Gateway 2	0.81	0.60	17
Gateway 3	0.25	0.23	7
Gateway 3 - Blue	2.85	2.27	39
Total Schemes	**7.83**	**6.06**	**145**

6.8.6 Approximately 50% of schemes remain at Gateway 1 and this falls below the level of progress expected at M05 set out in milestone targets. This position is actively being discussed by the Financial Improvement Programme Board and recovery actions are being considered to improve progress in 2025/26. An update on this work will be provided to the Resources & Performance Committee following the Q2 review.

7 Scottish Government Oversight

7.1 As previously advised, Scottish Government has indicated that brokerage will not be available in 2025/26 and therefore any deficit reported at end of the financial year will be reported in the Board's Annual Accounts.

7.2 The Board's medium term financial plan has been approved by Scottish Government conditional on the basis that the Board develops a five year financial plan which demonstrates a path to financial balance of that period; savings delivery is at a minimum of 3% of RRL; and that actions are identified to deliver an improved in year financial performance at a target deficit of no greater than £10m in 2025/26.

7.3 Following Q1 review feedback from SG colleagues was positive in relation to in year progress however the need to increase delivery against the 3% recurring savings target and to present a long term (five year) path to financial balance was reiterated.

7.4 A financial recovery plan is expected to be presented to SG at end September setting out the path to financial balance. As at date of preparation of this report, this plan remains in development.

7.5 Brokerage accumulated to date is £49.33m. The current financial framework requires that repayment is made after achievement of a balanced financial position. No change to this arrangement has been indicated at present.

7.6 The Health Board remains at Stage 3 of the Scottish Government's Support and Intervention Framework. This situation has recently been reviewed and updated guidance issued which confirms that the key driver for the Board's escalation remains its financial sustainability.

8 Key Risks

8.1 In line with the issues noted above, financial sustainability remains a *very high* risk on the board's strategic risk register (Risk 547). This risk has been updated to reflect the Board's medium term financial plan and financial recovery plan for the period 2025/26 to 2027/28. In line with the enhanced monitoring arrangements in place with Scottish Government, this risk is now being reviewed quarterly with the next review due in October 2025.

8.2 Where identified, risks are currently reported on an individual basis through the InPhase system.

Appendices

- Appendix 1 – Income and Expenditure Analysis as reported to Scottish Government via FPR

- Appendix 2 – Key Expenditure Trends

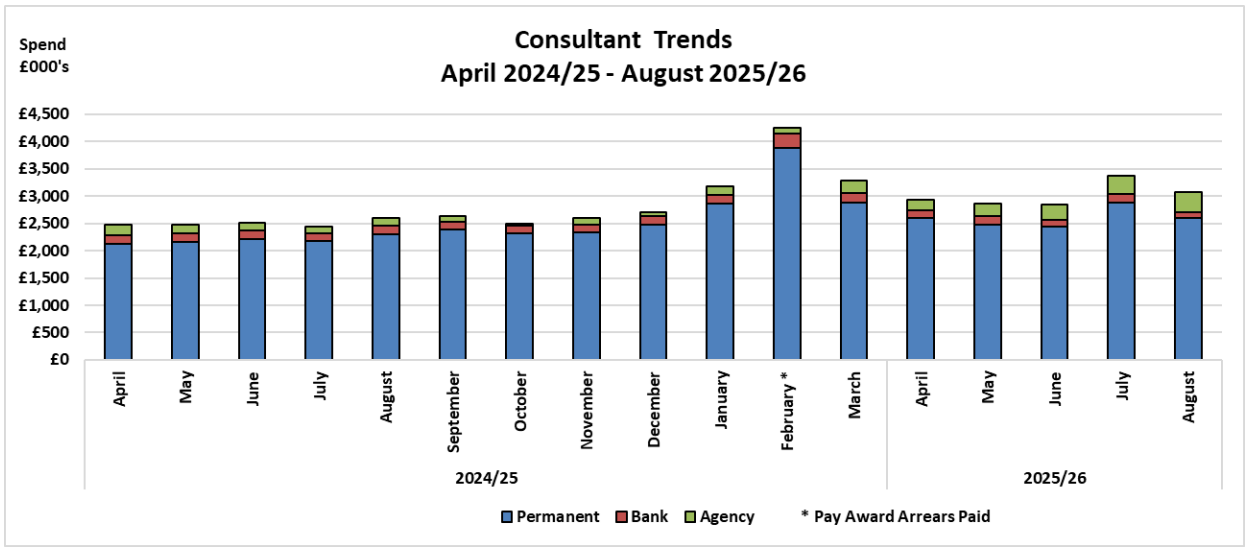
Author(s)

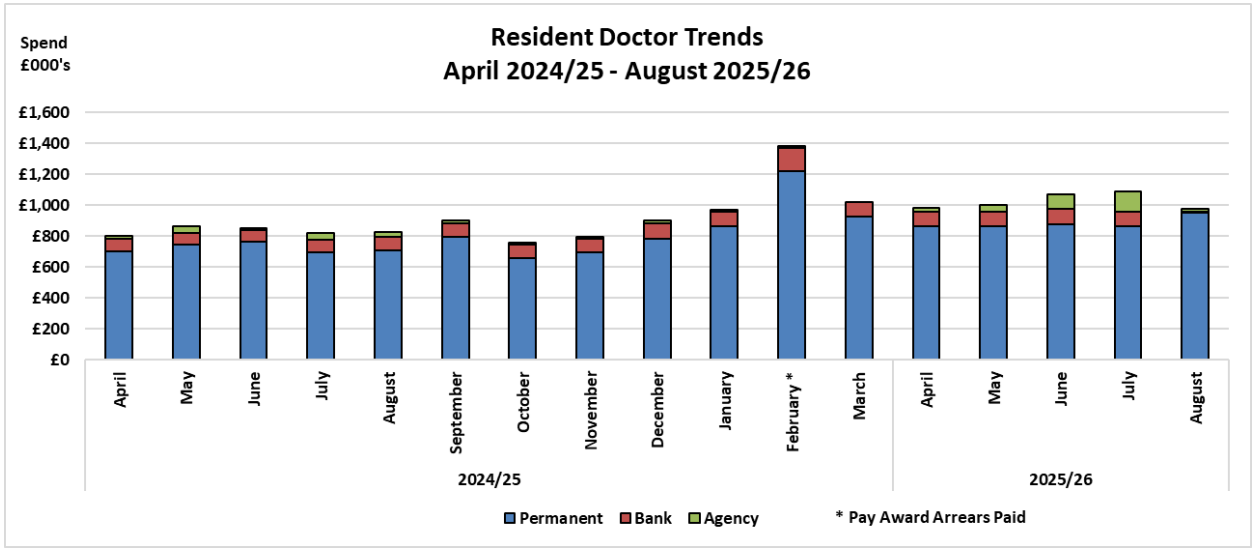
Samantha Harkness Senior Finance Manager Sam.harkness@nhs.scot	Paul McMenamin Finance Business Partner (IJB Services) Paul.mcmenamin2@nhs.scot	Maryam Khan Finance Business Partner (Acute Services) Maryam.khan2@nhs.scot

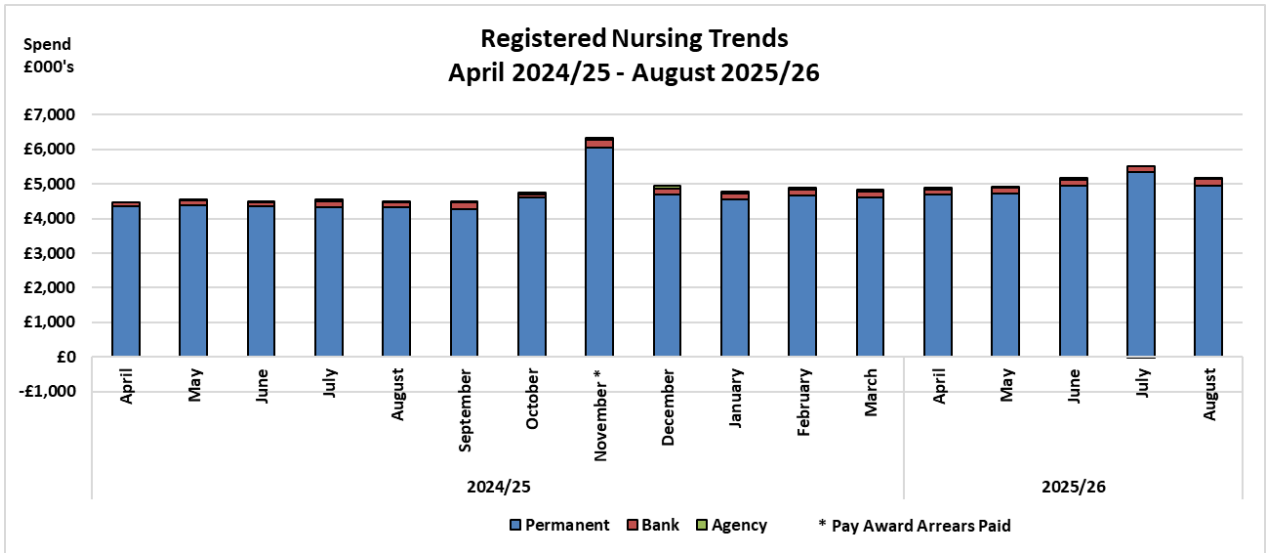
Appendix 1 – Income and Expenditure Analysis as reported to Scottish Government via FPR

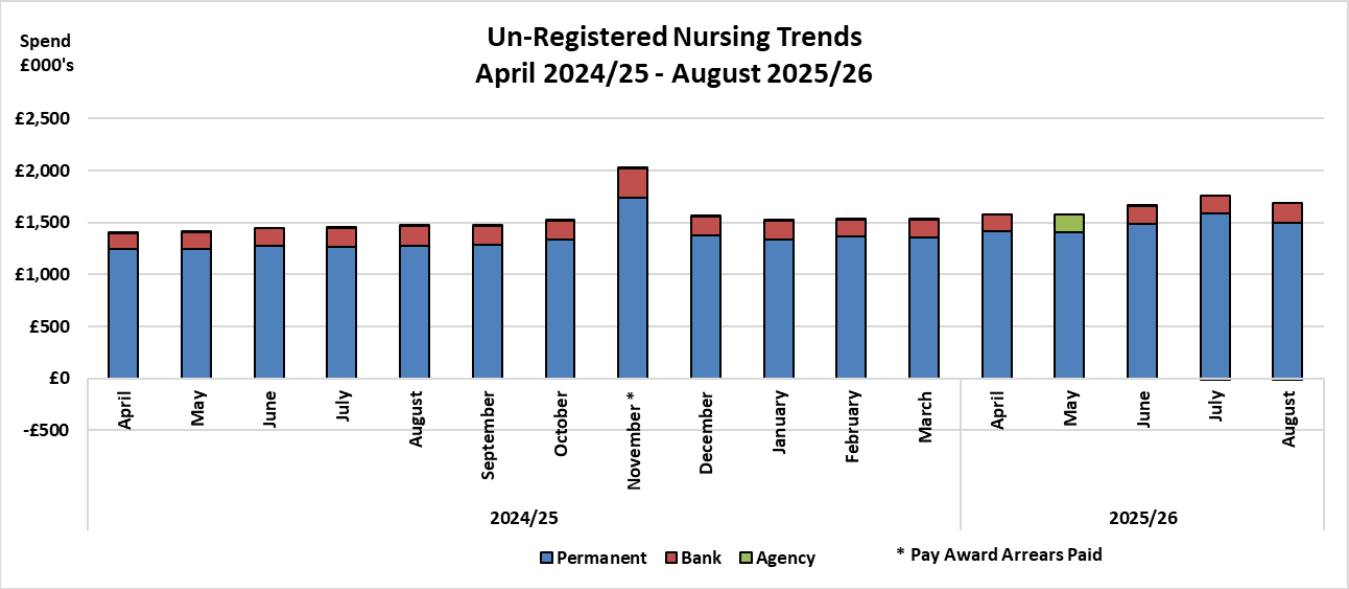
	Opening Annual Budget £m	Revised Annual Budget £m	YTD Budget £m	YTD Actual £m	YTD Variance £m
Pay					
Medical & Dental	42.78	45.34	18.96	19.57	(0.61)
Nursing & Midwifery	72.78	81.08	33.95	33.90	0.06
Other	69.66	81.56	34.21	31.75	2.47
Sub-total	**185.22**	**207.98**	**87.13**	**85.22**	**1.91**
Non Pay					
Independent Primary Care Services					
General Medical Services	22.94	24.61	10.24	10.29	(0.05)
Pharmaceutical Services	4.02	7.08	2.95	2.95	0.00
General Dental Services	5.75	9.68	4.03	4.03	(0.00)
General Ophthalmic Services	1.63	2.27	0.94	0.95	(0.00)
Sub-total	**34.35**	**43.64**	**18.17**	**18.22**	**(0.05)**
Drugs and medical supplies					
Prescribed drugs Primary Care	25.72	26.83	11.11	11.23	(0.12)
Prescribed drugs Secondary Care	14.10	16.43	6.89	7.52	(0.63)
Medical Supplies	7.31	7.54	3.16	4.08	(0.92)
Sub-total	**47.13**	**50.79**	**21.15**	**22.82**	**(1.67)**
Other health care expenditure					
Goods and services from other NHSScotland bodies	34.27	36.10	15.10	15.88	(0.78)
Goods and services from other providers	5.45	5.96	2.48	3.29	(0.81)
Goods and services from voluntary organisations	0.17	0.18	0.07	0.07	0.00
Resource Transfer	2.81	2.77	1.15	1.15	0.00
Loss on disposal of assets	0.00	0.00	0.00	0.00	0.00
Other operating expenses	44.60	44.38	2.77	7.46	(4.69)
External Auditor - statutory audit fee & other services	0.00	0.00	0.00	0.12	(0.12)
Sub-total	**87.30**	**89.39**	**21.59**	**27.98**	**(6.39)**
Income Analysis					
Income from other NHS Scotland bodies	(6.39)	(7.43)	(2.85)	(3.11)	0.25
Income from NHS non-Scottish bodies	(2.73)	(2.79)	(1.14)	(1.16)	0.02
Income from private patients	(0.06)	(0.06)	(0.03)	0.00	(0.03)
Patient charges for primary care	(11.41)	(19.03)	(7.93)	(7.93)	0.00
Non NHS					
Overseas patients (non-reciprocal)	0.00	0.00	0.00	0.00	0.00
Other	(4.17)	(8.01)	(3.00)	(3.02)	0.02
Total Income	**(24.76)**	**(37.31)**	**(14.95)**	**(15.22)**	**0.27**
Net Total Expenditure	**329.25**	**354.48**	**133.09**	**139.03**	**(5.94)**

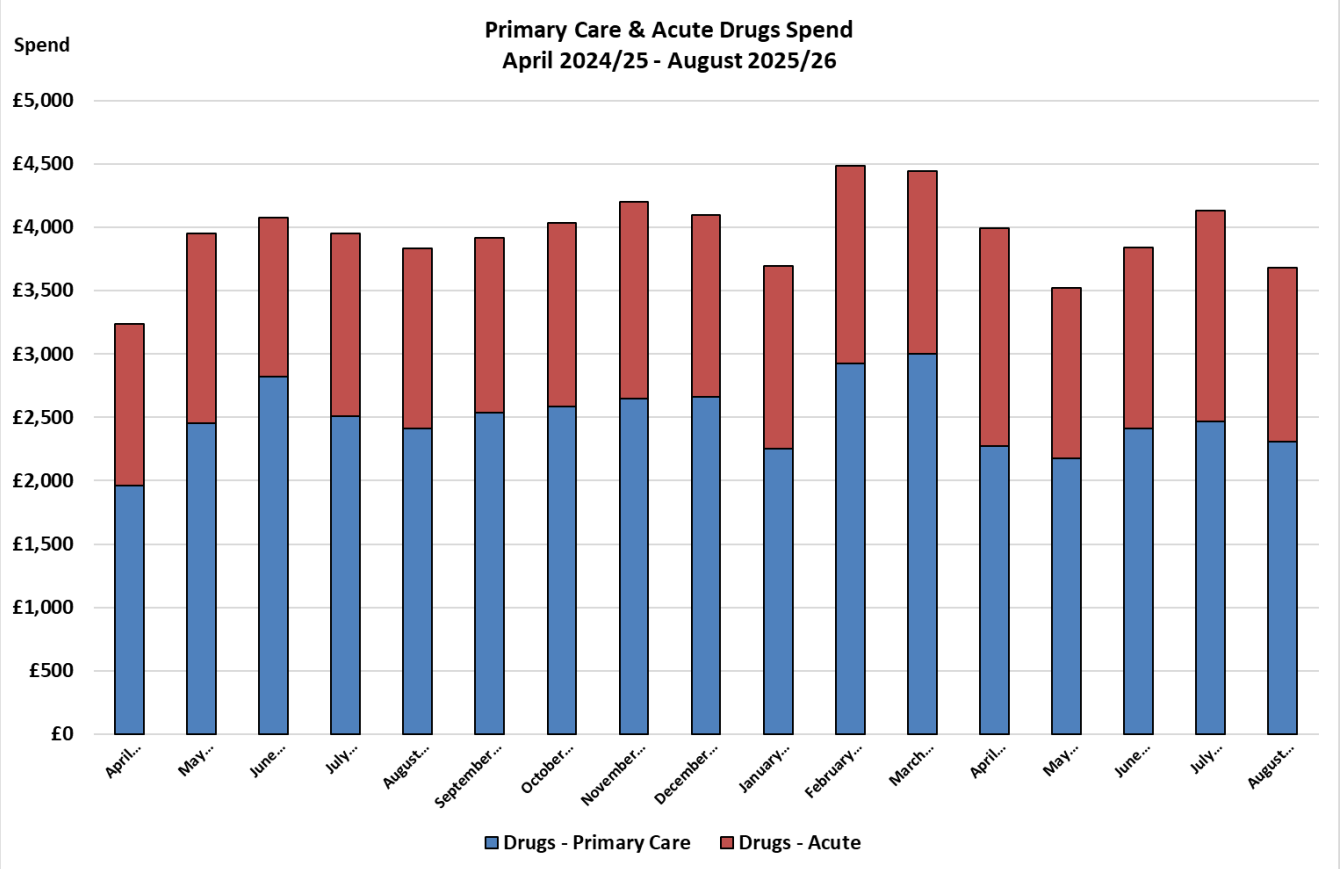
Appendix 2 - Key Cost Charts

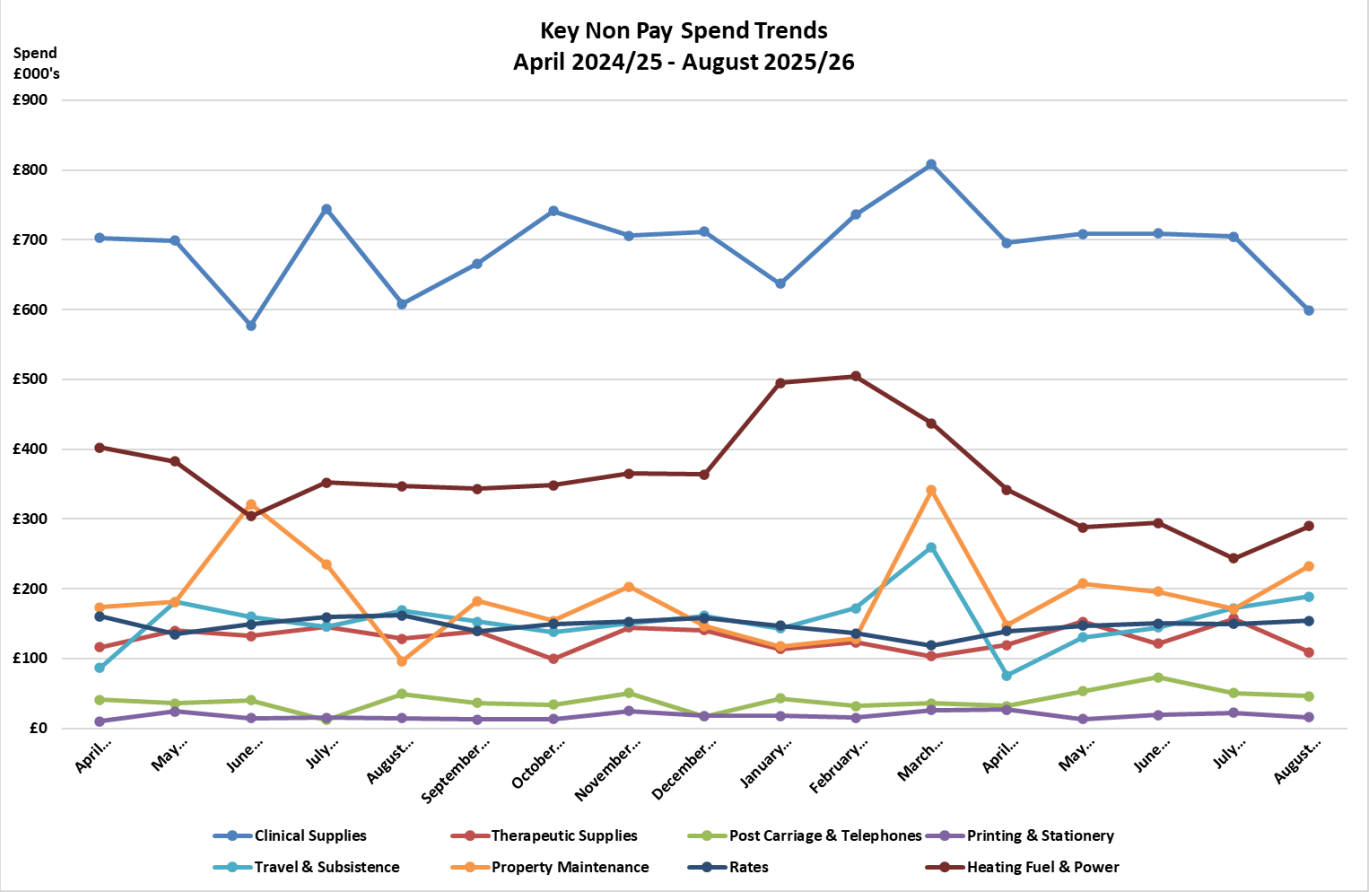







Un-Registered Nursing Trends
April 2024/25 - August 2025/26
Spend
£000's
£2,500
£2,000
£1,500
£1,000
£500
£0
-£500
April
May
June
July
August
September
October
November *
December
January
February
March
April
May
June
July
August
2024/25
2025/26
Permanent
Bank
Agency
* Pay Award Arrears Paid


Primary Care & Acute Drugs Spend
April 2024/25 - August 2025/26
Spend
£5,000
£4,500
£4,000
£3,500
£3,000
£2,500
£2,000
£1,500
£1,000
£500
£0
April...
May...
June...
July...
August...
September...
October...
November...
December...
January...
February...
March...
April...
May...
June...
July...
August...
Drugs - Primary Care
Drugs - Acute


Key Non Pay Spend Trends
April 2024/25 - August 2025/26
Spend
£000's
£900
£800
£700
£600
£500
£400
£300
£200
£100
£0
April...
May...
June...
July...
August...
September...
October...
November...
December...
January...
February...
March...
April...
May...
June...
July...
August...
Clinical Supplies
Therapeutic Supplies
Post Carriage & Telephones
Printing & Stationery
Travel & Subsistence
Property Maintenance
Rates
Heating Fuel & Power

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**2 October 2025**
Title:	**Clinical Governance Committee Minutes**
Responsible Executive/Non-Executive:	**L Jones, Director of Quality & Improvement**
Report Author:	**I Bishop, Board Secretary**

1 Purpose

This is presented to the Board for:

- Awareness

This report relates to a:

- Government policy/directive

This aligns to the following NHSScotland quality ambition(s):

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

The purpose of this report is to share the approved minutes of the Clinical Governance Committee with the Board.

2.2 Background

The minutes are presented to the Board as per the Clinical Governance Committee Terms of Reference and also in regard to Freedom of Information requirements compliance.

2.3 Assessment

The minutes are presented to the Board as per the Clinical Governance Committee Terms of Reference and also in regard to Freedom of Information requirements compliance.

2.3.1 Quality/ Patient Care

As detailed within the minutes.

2.3.2 Workforce

As detailed within the minutes.

2.3.3 Financial

As detailed within the minutes.

2.3.4 Risk Assessment/Management

As detailed within the minutes.

2.3.5 Equality and Diversity, including health inequalities

An HIIA is not required for this report.

2.3.6 Climate Change

Not applicable.

2.3.7 Other impacts

Not applicable.

2.3.8 Communication, involvement, engagement and consultation

Not applicable.

2.3.9 Route to the Meeting

This has been previously considered by the following group as part of its development. The group has supported the content.

- Clinical Governance Committee 10 September 2025

2.4 Recommendation

The Board is asked to **note** the minutes which are presented for its:

- **Awareness** – For Members' information only.

3 List of appendices

The following appendices are included with this report:

- Appendix No 1, Clinical Governance Committee minutes 23.07.25

Borders NHS Board
Clinical Governance Committee
Approved Minute

Minute of meeting of the **Borders NHS Board's Clinical Governance Committee** held on **Wednesday 23 July 2025** at 10am via Microsoft Teams

Present
Fiona Sandford, Non-Executive Director (Chair)
Lynne Livesey, Non-Executive Director

In Attendance
Diane Laing, Clinical Governance & Quality (Minute)
Rose Roberts, Director of Quality & Improvement (shadowing secretariat)
Laura Jones, Director of Quality & Improvement
Peter Moore, Chief Executive
Sohail Bhatti, Director of Public Health
Malcolm Clubb, Director of Pharmacy
Sarah Horan, Director of Nursing Midwifery and Allied Health Professionals
Philip Grieve, Associate Director of Nursing, Chief Nurse Primary & Community Services
Paul Williams, Associate Director of Nursing, Allied Health Professionals
Peter Lerpiniere, Associate Director of Nursing, Mental Health & Learning Disabilities
Sam Whiting, Infection Control Manager
Amanda Cotton, Associate Medical Director, Mental Health Services (virtual attendance)
Julie Campbell, Lead Nurse for Patient Safety and Care Assurance

K Hamilton, NHS Borders Chair attended for part of the meeting.

1 Apologies and Announcements

1.1 The Committee have opted to trial using co-pilot, AI Service to generate brief executive summaries of meeting papers. These summaries will accompany the papers to help members quickly grasp key points. Additionally, the Board Secretary is exploring an AI tool to assist with minute-taking. Concerns were raised about inputting sensitive information into AI systems, the Secretariat will consult Information Governance however the Organisation has approved the use of this system. If successful, the trial will help to inform future organisational guidance on AI use.

1.2 The Chair noted that Elaine Dickson had changed roles and would no longer be attending Clinical Governance Committee, she acknowledged Elaine's input and on behalf of the Committee wished her well in her new role.

1.3 Apologies were received from
Caroline Cochrane, Head of Psychological Services
Oliver Bennett, Interim Director of Acute Services
Lynn McCallum, Medical Director
Olive Herlihy, Associate Medical Director, Acute Services & Clinical Governance

1.4 Absent
Jonathan Manning, Associate Medical Director, Acute Services
Imogen Hayward, Associate Medical Director, Acute Services

Lettie Pringle, Risk Manager
Kirsteen Guthrie, Associate Director of Midwifery & GM for Women & Children's Services

The Chair confirmed the meeting was quorate.

1.5 The Chair welcomed:
Gareth Clinkscale, Director of Acute Services (in attendance to support Mental Health paper)

Martin McCormack, Clinical Director of NHS Borders Public Dental Services and Morag Muir, Consultant in Dental Public Health (Item 5.6)

2 Declarations of Interest

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

2.2 The **CLINICAL GOVERNANCE COMMITTEE** noted there were none declared.

3 Minute of Previous Meeting

3.1 The Clinical Governance Committee approved the minute of the previous meeting held on Wednesday 14 May 2025 following correction to amendments made to item 5.1.5 and a spelling error was corrected

3.2 Sohail Bhatti raised concerns about the inclusion of marital status indicators in meeting minutes. Although members had previously been asked to confirm their preferred forms of address, Sohail noted using marital status could pose a risk to the organisation. The Secretariat assured Sohail that, following discussions with the Board Secretary, a new approach had been agreed and would be implemented from 1st July 2025.

4 Matters Arising/Action Tracker

4.1 Matters Arising from the previous meeting were noted and action Tracker was updated accordingly

5 Effectiveness/Annual Assurance

5.1 Clinical Board update LD Services

5.1.1 Peter Lerpiniere provided a brief overview of the content of the report. He reported the first client has successfully moved back from out of area and after initial period of destabilisation they are now settling well. The team is happy with the way Lothian are managing work associated with further developments to secure beds in Lothian.

5.1.2 Further property purchases are progressing via an agency, with contracts being prepared by Scottish Borders Council. Peter emphasised the importance of careful planning due to the client base.

5.1.3 Gareth Clinkscale informed the Committee about ongoing funding negotiations with SBC. The Integrated Joint Board (IJB) has indicated the need for joint funding for

these clients. Currently, SBC is not supporting community discharges until a joint agreement is established. Gareth will continue to provide updates. Peter assured the Committee that client suitability will be monitored continuously, confirming ongoing oversight. He also noted that arrangements for individuals awaiting placement will continue to be monitored as before.

5.1.4 Peter asked that the committee note Lisa Blackwood was honoured with a Scottish Learning Disability Nursing Network award for her innovative practice following recent mortality reviews. The Committee commended her, Jasmine Woolley and the team for their outstanding work.

5.1.5 ACTION: include updates regarding the outcomes of discussions with SBC concerning funding for the Coming Home project in future reporting as appropriate.

5.1.6 The **CLINICAL GOVERNANCE COMMITTEE** noted contents of the report and confirmed **Moderate Assurance**

5.2 Clinical Board update Acute Services – taken out of sequence

5.2.1 Philip Grieve provided the Committee with an update on acute services. He highlighted that the Emergency Department (ED) continues to face significant demand, which is compromising patient safety and standards due to high levels of delayed discharges. Stroke care remains a high-risk area, and there are concerns about undetected cancers among patients on the colonoscopy waitlist.

5.2.2 The 62-day cancer waiting time performance has declined, largely due to issues in the prostate cancer pathway, with NHS Borders reporting the lowest performance among mainland health boards in Q1. Efforts are underway to collaborate with Lothian to improve this pathway.

5.2.3 Pharmacy may be interested in exploring how they can assist with prescribing Systemic Anti-Cancer Therapy (SACT) for prostate cancer. Enzalutamide and Abiraterone are oral treatments currently prescribed in Lothian, with appropriate training, this regime could potentially be used here. This initiative could also support capacity building in Lothian.

5.2.4 Delayed discharges are averaging around 60, impacting acute operations and patient safety. Efforts to manage this include escalation processes and cross-system collaboration. Challenges include limited social care capacity and the need for increased investment in residential and home care services.

5.2.5 Peter Moore discussed the need for an effective escalation process and continuous learning in the acute team, emphasizing risks in the ED's waiting area. The Chair stressed the importance of keeping the Committee informed without adding excessive paperwork. Peter announced the creation of a new urgent care board with four work streams and noted an upcoming summit with the council to discuss increasing social care and care home capacity.

5.2.5 Positive developments include the successful implementation of a new system in labs, recognition of the Special Care Baby Unit (SCBU) team as Scottish Neonatal Nurse Group Team of the Year, and the extension of the Supervisory Senior Charge Nurse pilot. Improvements were noted in training compliance, appraisal completion, sickness absence rates, and pressure damage reduction.

5.2.6 The Committee raised concerns about missed audits, such as the mattress audit last conducted in 2018. Suggestions included maintaining a centralised audit tracking system to ensure timely completion of required audits. Sarah Horan and Laura Jones will work how these audits can be reported to the Committee.

5.2.7 ACTION: Sarah and Laura will work on how data relating to audits be presented to the Committee.

5.2.8 The **CLINICAL GOVERNANCE COMMITTEE** noted contents of the report and confirmed **Limited Assurance** due to ongoing risks and challenges in acute care, despite notable improvements and initiatives.

5.3 Clinical Board update PCS Services

5.3.1 Paul Williams talked to the report noting the implementation of a care assurance approach in Primary and Community Services, placing responsibility on clinical teams to ensure safe staffing, supervision, and regulatory compliance. He noted graphics illustrating this approach were in the report.

5.3.2 Delayed discharges remain a significant risk, particularly following the closure of the Knoll. There are currently 29 delayed discharges across three community hospitals, impacting patient care and rehabilitation.

5.3.3 Key risks for AHP and Speech Therapy include limited inpatient rehabilitation capacity and prolonged waiting times for children and young people's speech and language therapy, currently between 90 and 100 weeks. These delays pose significant long-term developmental risks. The Committee requested regular updates on speech and language waiting times due to serious concerns about developmental delays for these children.

5.3.3 Positive developments include increased capacity in the virtual ward due to Home First pathway changes, and a successful music therapy pilot in DME, which has positively impacted patients, families, and staff.

5.3.4 The **CLINICAL GOVERNANCE COMMITTEE** noted contents of the report and confirmed **Limited Assurance** due to ongoing challenges, particularly in speech and language therapy.

5.4 Clinical Board update MH Services – taken out of sequence

5.4.1 Peter Lerpiniere noted the Fatal Accident Inquiry (FAI) report which highlights the significant organisational effort involved in responding to the FAI. Sheriff Patterson made a key recommendation regarding controlling entry and exit to Huntlyburn Ward. The Mental Welfare Commission confirmed NHS Borders' interpretation of guidance was appropriate, though the team is reviewing procedures, including introducing a 10-second delay on the green button exit system and revising standard operating procedures.

5.4.2 Due to connection issues Peter was unable to continue with his report, Laura Jones stepped in to give further update. On reconnection Peter offered to answer any questions regarding remainder of Mental Health update paper offline.

5.4.3 Laura Jones clarified that the FAI did not find defects in care or system failures. The Sheriff's recommendation was based on observations beyond the FAI's scope. NHS Borders already uses the system referenced in the recommendation. A formal Section 12 response is due mid-August. The Committee acknowledged the enormity of the circumstances that lead to an FAI for both the Family and Staff involved.

5.4.4 Lynne Livesey emphasised the importance of thoroughly documenting all work and responses related to the recommendation. This ensures that if a decision is made not to act on the recommendation, there is clear evidence of the rationale behind it, should any issues arise in the future. Sohail Bhatti stressed the need to be mindful of staff morale following external scrutiny.

5.4.5 Gareth Clinkscale reassure Lynne, there was a documented discussion on this matter at the Senior Leadership Team for Mental Health. Peter has also written to the Mental Welfare Commission to confirm the details of that discussion and their advice. Additionally, a clinical governance trail is in place. The senior team is actively engaged and providing substantial support. This is a high-functioning team that has received considerable praise from national bodies, which sometimes adds to the challenge. However, the senior team is fully committed and supportive.

5.4.6 The **CLINICAL GOVERNANCE COMMITTEE** noted contents of the report and confirmed Limited **Assurance.**

5.5 Pharmacy Annual Report

5.5.1 Malcolm Clubb provided a brief overview of the content of the report, he noted the implementation of pharmacotherapy hub and IDLS has enabled the collection of a new dataset, providing visibility into turnaround times and activity levels. This marks a significant step forward in assurance and operational insight.

5.5.2 The absence of a Hospital Electronic Prescribing and Medicines Administration (HEPMA) system is a major limitation. Hindering the ability to monitor antimicrobial use, control drug accountability, and ensure effective stewardship. The lack of data impacts the ability to provide assurance on safe and appropriate medicine use.

5.5.3 Concerns were raised in relation to high opioid usage, particularly for non-cancer pain, and the need for improved stewardship. Similarly, antimicrobial stewardship is limited by the lack of real-time data, making it difficult to ensure appropriate use and compliance with national targets.

5.5.4 The report acknowledged environmental impact of pharmaceuticals, particularly inhalers. Efforts are underway to transition to more sustainable options and align with climate responsibilities.

5.5.5 Malcolm enquired if the Committee could consider more regular reporting rather than one annual report, he proposed three separate reports: a primary care report, an acute report, and a medicines governance report. This approach would make reports more manageable and provide more frequent and focused discussions and opportunities for review and feedback.

5.5.6 ACTION Discuss adding regular reporting relating to Pharmacy into the Committee workplan.

5.5.7 The **CLINICAL GOVERNANCE COMMITTEE** noted contents of the report and confirmed **Moderate Assurance**. Whilst the pharmacy team is actively identifying and addressing governance gaps, the absence of HEPMA and unresolved risks around controlled drugs warrant a cautious level of assurance.

5.6 Dental Services Annual Report

5.6.1 Martin McCormack noted the paediatric dental service in NHS Borders continued to face significant challenges with long waiting times. The current longest wait is 817 days, and the average wait time has increased from 92 to 447 days. These delays are particularly concerning for vulnerable children who require general anaesthetic (GA) for dental procedures.

5.6.2 Martin and Morag Muir, Joint Directors of Dentistry, are taking actions to address the issue. Discussions with acute and paediatric colleagues are underway to increase surgical capacity and resume day-case operations via the Day Procedure Unit (DPU). New funding streams have been identified to support these initiatives, and there is optimism that improvements will be seen from September onward.

5.6.3 The Committee recognise that extended waiting times can negatively affect children's school attendance, long-term health, and overall well-being. Vulnerable children are disproportionately impacted, especially those on the GA waiting list who tend to have higher dental needs.

5.6.4 On a positive note the Child Smile Programme has been widely praised for its preventive impact, benefiting all school children in the Borders. There has been a significant reduction in tooth decay among Primary 7 children. The Oral Health Improvement Team is recognised for its proactive and effective work. Dentists are also contributing to broader public health goals such as smoking cessation and nutritional advice.

5.6.5 The Committee will continue to monitor the situation via the PACS updates to the Committee. There is a shared commitment to improving the situation and ensuring timely access to paediatric dental services.

5.6.6 The **CLINICAL GOVERNANCE COMMITTEE** noted contents of the report and confirmed they were **significantly assured** by the prevention efforts but a **Limited Assurance** remains due to the current waiting times for paediatric dental services.

6 Patient Safety

6.1 Infection Control Report

6.1.1 Sam Whiting informed the Committee that for the first time, death data related to infections had been included in the report. The data is crude and dependent on death certificate entries. Most deaths were associated with E. coli. Further analysis is underway to align this data with existing surveillance.

6.1.2 A statistically significant increase in C. difficile trends was observed in Q1 (9 cases), prompting an action plan. Q2 data (4 cases) indicates improvement. All cases are reviewed, with no evidence found to suggest cross-transmission.

6.1.3 Overall hand hygiene compliance was 66%, up from 64%. Doctors improved from 54% to 65%. Medical wards (4, 5, 6) achieved over 80% compliance. However, compliance remains low in surgical teams and among nursing staff.

6.1.4 Discussion raised on the potential impact of cleaning staff absence on cleanliness standards. Clinical areas are prioritised during staff shortages to maintain hygiene standards.

6.1.5 Infographics are being introduced to wards to visualise performance and encourage improvement. Leadership visibility and QI efforts will be enhanced across sites.

6.1.6 The **CLINICAL GOVERNANCE COMMITTEE** noted contents of the report and confirmed **Moderate Assurance**

6.2 Strategic Risks - Acute Services

6.2.1 Oliver Bennett was unable to attend to present his report, Laura Jones provided a brief overview for the Committee who discussed the strategic risk associated with the vulnerability of acute services, particularly those with small staff groups or reliance on regional pathways. These include specialties such as neurology, cardiology, and paediatrics. The discussion acknowledged the need for a long-term viable model for these services, which is being addressed through the clinical strategy work.

6.2.2 Specific actions have been taken in neurology and cardiology, including recent business cases to address staffing and demand. These cases have been reviewed by the Borders Delivery Group. Additional concerns were noted in diagnostic services such as endoscopy and the urology pathway.

6.2.3 The developing clinical strategy is expected to incorporate a comprehensive review of vulnerable specialties. This will include an assessment of long-term service models and sustainability. A more extensive paper on vulnerable services is anticipated as part of this strategy.

6.2.4 The Chair noted the Committee would be able to confirm better assurance once the clinical strategy work is completed and implemented.

6.2.5 The Committee were invited to address any questions relating to the report directly to Oliver.

6.2.6 The **CLINICAL GOVERNANCE COMMITTEE** noted contents of the report and confirmed **Limited Assurance**

6.3 Clinical Risk Oversight Report

6.3.1 The Clinical Governance Committee received an overview of all high and very high risks from the operational and strategic risk registers related to clinical care and patient safety. Management of risk is overseen by the Audit Committee and is intended to ensure non-executive members have adequate oversight of key risks.

6.3.2 Laura Jones explained that while the Audit and Risk Committee oversees risk management, topic-specific committees, including the Clinical Governance Committee, are responsible for monitoring risks relevant to their domains. Many of

the high and very high risks are already extensively reported in Clinical Board reports.

6.3.3 Committee members were invited to highlight any areas where they felt additional insight or assurance was needed. The discussion identified specific concerns regarding the fragility of services in SCBU, paediatrics, and neurology all noted as vulnerable services.

6.3.4 Sarah Horan noted the risk register is effectively identifying and holding risks, particularly in vulnerable services like neurology. There is a concern about the availability of specialist nurses for specific neurological conditions. The Committee requested more information on the clinical impact of these risks, especially in paediatrics and maternity. A detailed paper on this topic, which was delayed, will be tabled soon to provide further insights.

6.3.5 It was acknowledged that while the risk register is functioning appropriately by capturing these vulnerabilities, the volume and severity of risks currently carried by the organisation necessitate a cautious approach.

6.3.6 The **CLINICAL GOVERNANCE COMMITTEE** noted contents of the report and confirmed **Limited Assurance** due to the significant risks the organisation are carrying.

6.4 Adverse Event update

6.4.1 Julie Campbell presented a detailed analysis of adverse events over the past six months, highlighting special cause variation in four clinical areas. The analysis confirmed that appropriate levels of review and follow-up are being conducted, providing assurance in the adverse event management process.

6.4.2 Outcome grading for Significant Adverse Events Reviews (SAERs) was discussed, with grades ranging from 1 to 4. Grades 3 and 4 indicate a confirmed organisational duty of candour and the possibility that different care could have led to better outcomes. Task and finish groups are in place for all such events.

6.4.3 Laura Jones noted that increased adverse events in certain acute areas correlate with the use of surge beds. Additional beds in areas like MAU, Ward 9, and ED have contributed to increased activity and potential harm, highlighting the systemic impact of surge capacity.

6.4.4 Sarah Horan emphasised the risks associated with boarding patients outside their standard care areas, noting deficiencies in nursing and medical oversight. She also raised concerns about delays in finding reviewers for adverse events, which can extend learning timelines significantly.

6.4.5 The Committee discussed the extended timeframes, sometimes up to three years, required to complete reviews, especially when external reviews are needed. This delay hampers timely learning and improvement.

6.4.6 The Committee acknowledged the robustness of the adverse event processes. They supported the proposal to bring summaries of SAERs with outcome grades 3 or 4 to future meetings for oversight and learning dissemination.

6.4.7 Sohail Bhatti raised a query regarding the inclusion of Community Hospital Reinforced Autoclaved Aerated Concrete (RAAC) issue, noting it may have triggered a cascade of other issues. Laura Jones noted clarified that while RAAC is listed on the risk register and have caused service disruption and poor patient experience, they have not resulted in direct patient harm. Therefore, they are not reflected in the adverse event report or SAERs. The impact is noted on the Clinical Risk Register in terms of service and business continuity. Sarah Horan added that, conversely, that the RAAC issue may have reduced patient harm to inpatients by ensuring they were rapidly moved to the appropriate care setting.

6.4.8 The **CLINICAL GOVERNANCE COMMITTEE** noted contents of the report and confirmed **Significant Assurance**

7 Items for Noting

7.1 Public Health annual report

7.1.1 The **CLINICAL GOVERNANCE COMMITTEE** noted the Public Health Annual report.

8 Any other Business

8.1.1 The Chair brought some very concerning feedback from resident doctors working in General Surgery. This feedback raised red flags with NES and the Deanery, especially in the free text sections which suggested bullying and harassing behaviour in the department. This is being investigated, meanwhile, a clear improvement plan is being drawn up where a request for the necessary support from the Deanery, Royal College of Surgeons (RCS) and General Medical Council (GMC) to help in dealing with this situation. It is likely that NHS Borders will be referred to the GMC.

8.1.2 The safety of staff is the highest priority here so NHS Borders will do their utmost to follow any recommendations but the Committee should be aware of the extremely serious consequences if they rule that NHS Borders can no longer have trainee doctors in that department.

8.1.3 This issue has only very recently come to light, and the Chair wanted to cite the committee on it. A fuller report will be brought to the Committee as soon as more evidence has been gathered.

8.1.4 The Committee discussed potential impact on the organisation and workforce, acknowledging the strain on resources. Karen Hamilton suggested the upcoming non-executive session could be a suitable forum to share this issue with the non-executive group.

9 Date and Time of next meeting

The chair confirmed that the next meeting of the Borders NHS Board's Clinical Governance Committee is on **Wednesday 10 September 2025** at **10am** via Teams Call.

The meeting concluded at 11:57

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**2 October 2025**
Title:	**Quality & Clinical Governance Report - October 2025**
Responsible Executive	**L Jones - Director of Quality and Improvement**
Report Author (s):	**J Campbell - Lead Nurse for Patient Safety and Care Assurance** **S Hogg - Patient Experience Coordinator** **J Wilson - Quality Improvement Facilitator Effectiveness** **S Cowe - Senior Project Officer - Covid 19 Inquiries**

1 Purpose

This is presented to the Board for:

- Awareness

This report relates to a:

- Government policy/directive
- Legal requirement
- Local policy

This aligns to the following NHS Scotland quality ambition(s):

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

2.1.1 This exception report covers key aspects of clinical effectiveness, patient safety and person-centred care within NHS Borders.

2.1.2 The Board is asked to note the report and detailed oversight on each area delivered through the Board Clinical Governance Committee (CGC).

2.2 Background

2.2.1 NHS Borders, along with other Boards in Scotland, continue to face pressures on services as they work towards reducing waiting times in planned care services and delays across the unscheduled care system. Demand for services remains intense and is exacerbated in areas by workforce and financial challenges, across the health and social care system.

2.3 Assessment

2.3.1 Clinical Effectiveness

The Board CGC met on 10 September 2025 and discussed papers from all four clinical boards and corporate clinical support services.

2.3.2 The CGC considered a paper from Mental Health and Psychological Services. It was raised to the committee that progress continues within the Child and Adolescent Mental Health Service (CAMHS) to meet their national waiting times target, with a deep dive scheduled to take place in November 2025. The Associate Director of Mental Health and Learning Disabilities briefed the committee on work he is leading to look at themes and trends in suicides particularly in the under 25 age group. The CGC were keen to see the outputs of the work in the context of the suicide prevention work already underway. It was escalated to the committee that there are ongoing shortages of medical staff in psychiatry across the country and this continues to effect local services. This is a national issue acknowledged by Scottish Government and Royal College of Psychiatrists. There is active work underway to attract long-term staff including. The committee heard about recommendations for change within the Adult Mental Health Services Review, including increased psychology input within inpatient wards. The mental health team are working with estates on some Environmental and Safety concerns which may require additional capital and estates resource. The committee were pleased to hear about positive feedback from the Mental Welfare Commission regarding the psychology support at Lindean. It was noted by the committee that the psychology staff have provided valuable support to inpatient teams and were considered a stabilising and supportive force. The committee acknowledged and supported the strong desire, emerging from the clinical strategy engagement, to expand psychological services into areas such as cancer care, stroke services and forensic psychology but recognised the constraints placed on this due to resources. The committee also acknowledged the distinction between psychology as a profession and psychological therapies delivered by various professional groups, with governance frameworks being developed to ensure clarity and appropriate oversight. The Committee took **limited assurance** with particular concern around medical staff noted for the Mental Health Report and **moderate assurance** from Psychological Services.

2.3.3 The CGC received a report from Learning Disabilities Services. The committee noted the work led by the team to introduce a mortality review process. The committee acknowledged the reviews and their aim to learn from early deaths and improve care quality, with themes emerging that align with findings from England's LeDeR project. The committee were pleased to acknowledge that the initiative won a national award at the Learning Disability Nurses forum, and that the Scottish Government has shown interest in scaling this work across other boards, with NHS Borders potentially supporting process development. The committee supported the advocacy for a Scotland-wide strategy to standardise mortality reviews and learning disability care. The

committee also noted that the NHS Borders team have received a national commendation for their innovative approach to annual health checks despite financial constraints. The Committee took **moderate assurance** from the report recognising the ongoing work under the coming home project to ensure appropriate placements of patients within the Scottish Borders and the challenges of delivering this fully.

2.3.4 The committee considered a paper from Primary and Community Services. The team are managing risks relating to short term reduction of community hospital beds for remedial works for Reinforced Autoclaved Aerated Concrete (RAAC). The committee were advised that the Care Home Support Team which was originally funded during the pandemic is now operating with reduced recurring funding. The committee also noted that there has been an increase in sickness absence in some teams and there is work underway to understand this through the work on staff staffing. The committee were advised that there has been in increase in reported pressure damage in the community. This is under review by the Tissue Viability Group to identify causes and improve consistency in reporting. The committee were pleased to note that the School Nursing Service has piloted summer clinics which has improved early intervention and reduced waiting times. The committee also acknowledged the potential for year-round School Nursing service expansion. The committee were informed that there is planning underway for service delivery in response to NHS Board approval for a Glucagon-Like Peptide-1 (GLP-1) Weight Management Workstream. The committee were keen to see progress on a broader obesity strategy which considered long-term health impacts. The committee were pleased to note that community services are actively supporting the BGH's frailty unit and integrated discharge team, recognising positive collaboration across services to prepare for winter. The Committee took **limited assurance** from the report noting positive initiatives are underway but resource constraints and systematic pressures limit consistent service delivery.

2.3.5 The CGC received a report on Acute Services. The committee were concerned to note that there continue to be delays in the Emergency Department (ED) due to the level of delays across the health and social care system but recognised the ongoing work to improve unscheduled flow. The committee noted the recent reduction in reportable delays but were unclear if this was the normal seasonal variation we observe each year so were keen to keep this under review. The committee were advised of service vulnerabilities within acute medicine, cardiology, maternity, paediatrics and urology. The committee acknowledged that medical locums are being used to provide valuable support to these areas, where available, but this does not provide an appropriate long-term solution to sustainable service delivery. The committee noted that obstetrics and paediatrics are particularly vulnerable due to consultant vacancies or sickness presenting pressures particularly to the out of hours rotas having a knock-on effect to in hours working and activity. The CGC were keen to consider vulnerable services within the clinical strategy including what steps can be taken with national and regional partners to build resilience in order to sustain safe local services. The committee received updates on action plans for Significant Adverse Events (SAERs) within the Maternity Service noting that quality improvement audits are underway to improve safety and staff confidence with regards to Cardiotocography (CTG) monitoring and Maternity Early Warning Scores (MEWS). The committee also noted the launch of a staff wellbeing initiative within the service with an effort to further enhance staff support and maintain a proactive safety culture. The committee were updated on the Safe Delivery of Care unannounced inspection and the action plan submitted in response to this. The committee were pleased to note the reduction in elective waiting times across inpatient/day case pathways and outpatients. The committee also noted the positive improvements in cancer waiting times performance. The Prostate Pathway was

highlighted to the committee as an area of concern due to reliance on pathways to other Boards, but the committee acknowledged improvements made to the pathway which have increased from 20% to nearly 50% but were keen to see an ongoing focus in this area. The Committee took **split assurance** from the report, taking **moderate assurance** from the improvement efforts, governance actions and proactive quality initiatives whilst maintaining **limited assurance** from performance within the services, workforce instability and ongoing service vulnerabilities.

2.3.6 The CGC considered the Public Protection Annual Assurance report. The committee were advised of current workforce pressures due to imminent retirements in a specialised nursing team and challenging recruitment because of the advanced practice requirements. It was highlighted to the committee that there has been an increasing complexity in adult and child protection cases which has been exacerbated by socioeconomic pressures and post-pandemic effects. The committee acknowledged that the multiple non-integrated patient management systems used within the Borders Health and Social Care Partnership hinder effective safeguarding, with manual cross-referencing required to link adult and child records, posing a significant risk in child protection scenarios. The committee noted the request for these concerns to continue to be escalated to a national level, as the current fragmentation affects multiple services. It was also escalated to the committee that vulnerable adults face increased harm from delayed discharges, boarding out of specialty and extended waits in the ED. The committee were pleased to note that there has been strong collaboration with the Patient Safety team to embed learning from reviews and that there has been improved integration of governance and clinical safety processes between teams to share intelligence. The committee extended congratulations to the team for the work they do and agreed to support the recommendation for a board development session on Public Protection to be delivered to raise awareness and understanding. The Committee took **moderate assurance** from the report.

2.3.7 The CGC received the Research Governance Annual Assurance report. The committee were pleased to note that research activity is returning to pre-pandemic levels, with the same number of active studies and increased recruitment. The committee also acknowledged an expansion of innovation work with 5-6 active initiatives currently being taken through the Innovation Programme. The committee were advised of significant reductions of funding within the function with a £50,000 cut from the Chief Scientist Office and £20,000 cut from the Regional Cancer allocation. These reductions have strategic implications but will be addressed in future board-level discussions as part of the Research Strategy. It was raised to the committee that the laboratory accreditation issues have not affected current studies thanks to effective mitigations but may impact new study approvals, so resolution is a priority. The committee recognised that the programme is largely driven by a small number of individuals but that there is a strategic aim to increase clinical staff involvement in research, this will be reflected in the Nursing, Midwifery and Allied Health Professions enabling strategy. The committee took **significant assurance** from the report.

2.3.8 The CGC considered the Medical Education Annual Report and update on General Surgery Training. The committee were pleased to note that there has been strong feedback from undergraduate students, especially within orthopaedics and primary care. They were also pleased to acknowledge that NHS Borders is now actively involved in the ScotCom programme from the University of St Andrews which offers an apprenticeship-style General Practitioner (GP) training model. The committee were advised that there is ongoing collaboration with NHS Education for Scotland (NES), with the Medical Director of NES being supportive of remote and rural boards. It was

highlighted to the committee that there were continuing challenges to find Supporting Professional Activity (SPA) time for clinical supervision in consultant job plans but that efforts were continuing. It was noted by the committee that there has been a triggered Deanery quality visit within the General Surgery Department due to feedback from Foundation Year 1s (FY1s) relating to training quality and behaviours. As part of this process the findings are escalated through the Deanery to the General Medical Council (GMC) for enhanced measures and monitoring to ensure the issues are rectified. The committee were advised that this means that the service is now working to a smart objectives' improvement plan, with increased scrutiny on delivery against this plan from both the GMC and the Deanery. The committee acknowledged that this puts the organisation at risk of losing training accreditation for resident doctor posts within the service which would severely impact service delivery. Weekly meetings with FY1s have been implemented along with broader Multi-Disciplinary Team (MDT) engagement to address concerns. The committee acknowledged the seriousness of the situation and were assured of the actions being taken to address this. The Committee took a **split assurance** approach to the report, taking **significant assurance** for Medical Education overall acknowledging the strong governance, positive feedback and strategic engagement with NES and universities; but took **limited assurance** from the General Surgery feedback acknowledging the improvement needed to address the concerns raised and the steps in place for enhanced monitoring.

2.3.9 The CGC received the Infection Control report. The committee were pleased to note a small improvement in hand hygiene audit figures but acknowledged there needs to be continual focus in this area. The committee were advised that some areas that had been marked as amber for their spot checks but had since been re-checked and are now green with improvement work being carried out in other areas. The committee acknowledged that due to the further responsibilities for nursing executives regarding care homes, this has led to an increased workload for the Infection Control Team who have been visiting care homes and delivering training and support. The committee also were advised that a task and finish group is being implemented to look at catheter documentation processes and whether anything can be changed to improve catheter care, and infection risks. The committee took **moderate assurance** from the report.

2.3.10 The CGC considered the Environmental Risk update which detailed the status of actions resulting from two commissioned internal audits on Ventilation and Healthcare Associated Infection (HAI) Scribe. The committee were pleased to note that annual verifications of the critical ventilation systems have now been completed; a contractor has been brought on board and the process is now embedded into the maintenance schedule; and future verifications are now automatically flagged with the next cycle starting imminently. This now marks the completion of ventilation multi-year action plan, improving assurance and compliance. The committee acknowledged that there are three outstanding actions with regards to HAI Scribe which are scheduled for conclusion by the end of quarter three 2025/26. The committee were advised that national guidance is being followed and local policies and Standard Operating Procedures (SOPs) are in development to conclude the final actions. The committee took **moderate assurance** from the report.

2.3.11 The CGC received the Duty of Candour (DoC) Annual update. The committee noted that there have been 141 significant adverse events within the reporting period, with 36 events meeting the Duty of Candour criteria which indicates that different care could have led to a different outcome. The committee were advised that the Review Outcome Grading system has been adopted from the National Adverse Event Management Framework. The committee were appraised of the work to make some revisions to the

local Adverse Event Management Policy in response to amendments to the National Adverse Events Framework and Duty of Candour guidance. This is an area of workload which continues to grow year on year as external scrutiny requirements increase. The committee acknowledged the testing of new approaches to sharing learning summaries with patients and families, with active participation in learning forums to embed improvement. The committee were pleased to note that there has been notable progress and compliance with the DoC process for pressure injury care and falls reviews. Documentation of discussions with patients and family members has shown incremental improvement year-on-year since the introduction of DoC reflecting the level of frontline clinician engagement and emphasis on this within the safety culture work. The committee took **significant assurance** from the report.

2.3.12 The CGC considered the Claims Annual report which provided insight into the 13 new claims from this year, and existing claims from previous years. It was noted by the committee that no consistent trends have emerged over time. The committee were pleased to acknowledge benchmarking efforts within the report recognising the limited national data available. Further data is being pursued to improve visibility for non-executives. The committee were advised that 88% of new claims had been previously identified through SAERs and/or complaints processes. This reflects a growing trend across boards where formal claims precede the proactive review of harm and care experience which is shared openly with patients and families. The committee highlighted the importance or tracking claim values alongside cost-saving measures to prevent the risk of false economies. The committee took **moderate assurance** from the report.

2.3.13 Patient Safety and Care Assurance

2.3.14 Falls

Figure 1 shows normal variation in NHS Borders' fall rate per 1000 Occupied Bed Days (OBDs) across adult inpatient areas. The NHS Borders falls rate sits above the average for NHS Scotland, which is not case mix adjusted for age and case mix:

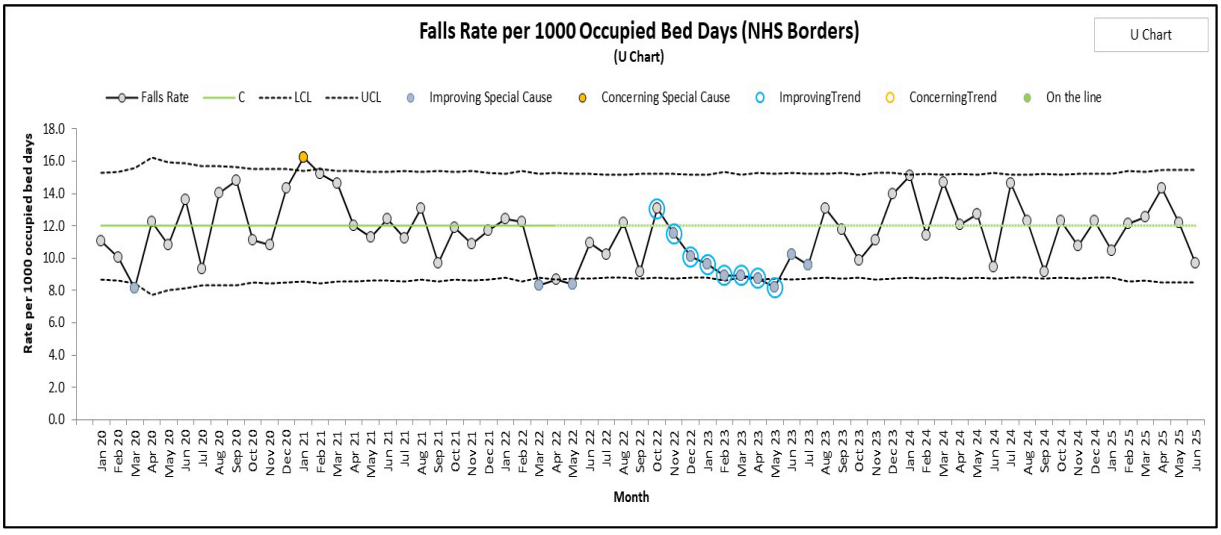


Figure 1: Falls rate per 1000 OBD – NHS Borders

2.3.15 Figure 2 shows normal variation with falls with harm per 1000 OBDs in NHS Borders:

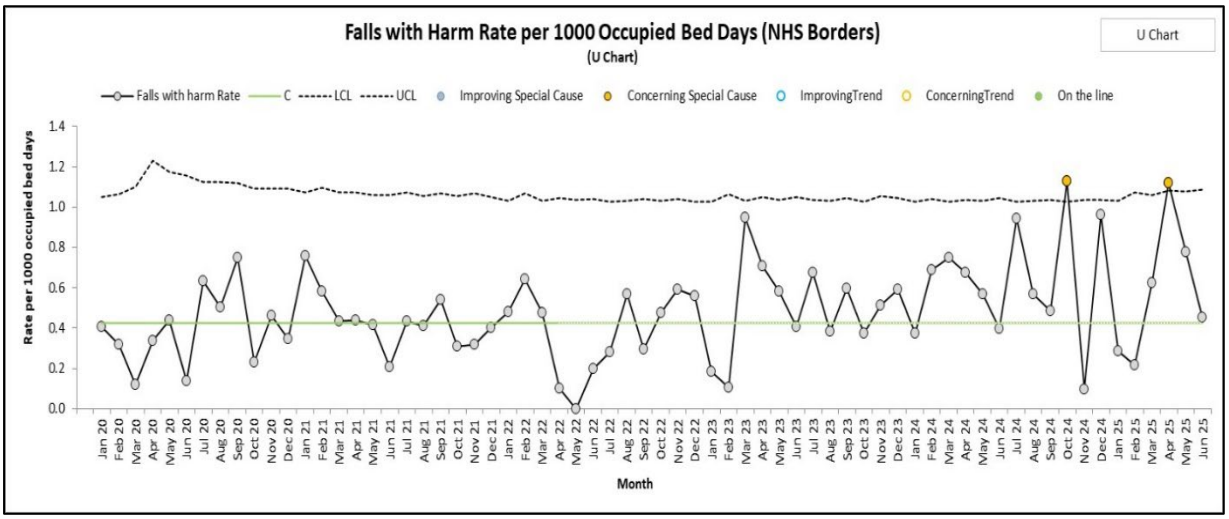


Figure 2: Falls with harm per 1000 OBD – NHS Borders

2.3.16 All reported falls resulting in harm have had a Category 1 Level 2 Fall Review completed to confirm the grading of harm and to identify opportunities for learning and improvement. A revised Fall Review Tool has recently been introduced to address limitations identified in the previous version, including vulnerability to interruption during completion. The updated tool aims to support more consistent and thorough post-fall reviews, enhancing opportunities for learning and improvement.

2.3.17 Pressure Damage

Figure 3 shows the rate per 1000 OBDs of developed pressure ulcers Grade 2 and above rate across NHS Borders showing normal variation:

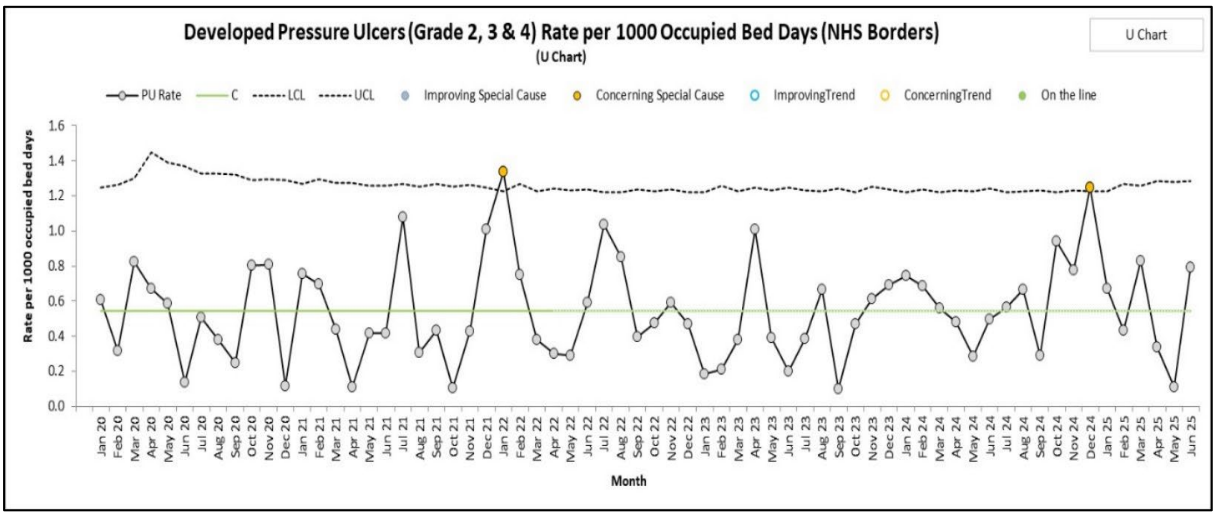


Figure 3: Developed pressure ulcers per 1000OBD – NHS Borders

2.3.18 Reusable heel off-loading equipment has been delivered to the acute wards where a need had been identified. This initiative not only addresses a critical equipment gap but also supports cost savings, reduces reliance on single use items, and contributes to improved waste management and a lower carbon footprint.

2.3.19 Deteriorating Patient

Figure 4 shows the Cardiac Arrest (CA) rate for the Borders General Hospital (BGH) showing normal variation:

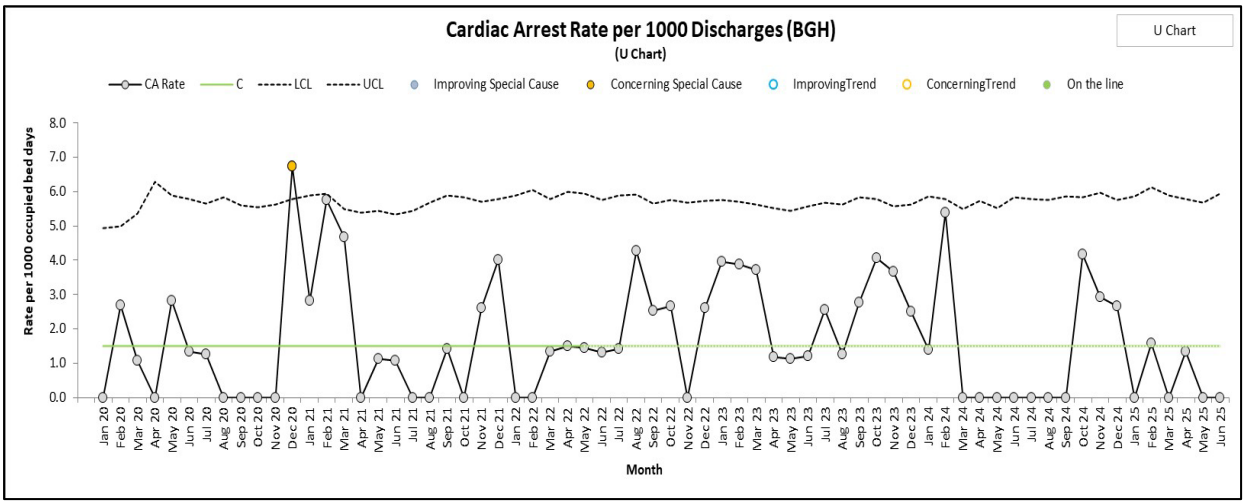


Figure 4: Cardiac Arrest rate per 1000 discharges – BGH

2.3.20 A full review of NHS Borders National Early Waring Scoring System 2 (NEWS2) used in the recognition and response to the deteriorating patients in adult areas has taken place. A wide group of clinicians were involved in the review examining learning and staff feedback to enhance local systems and processes. The revised NEWS2 chart will be rolled out in Quarter 4 of 2025/26 with a supporting education programme.

2.3.21 Care Assurance

The Lead Nurse for Patient Safety and Care Assurance, in collaboration with the Associate Director of Nursing for Acute meets monthly with Clinical Nurse Managers (CNM) to discuss how the Excellence in Care (EiC) Quality of Care (QoC) Guidance is being implemented. Following the QoC review in Ward 7 on 6 May 2025 the Senior Charge Nurse (SCN) and CNM are working on their learning and improvement action plan. The action plan is being developed to assist in future CAV's to provide assurance that patients in receipt of care receive a high standard of care.

2.3.22 Work is underway to develop a refreshed approach to measurement and monitoring of safety within the ED including a continual audit programme focusing on measures important to the delivery of care in this area. Once designed in collaboration with the SCN and clinical team training will be arranged by the Patient Safety Team.

2.3.23 Care Planning

Figures 5 and 6 display improving special cause in the completion of Person Centred Care Planning (PCCP) and What Matters to You (WMTY) discussions within Acute Adult Inpatient areas. This improvement has been commended at the recent Acute Governance Group and shared with SCN's:

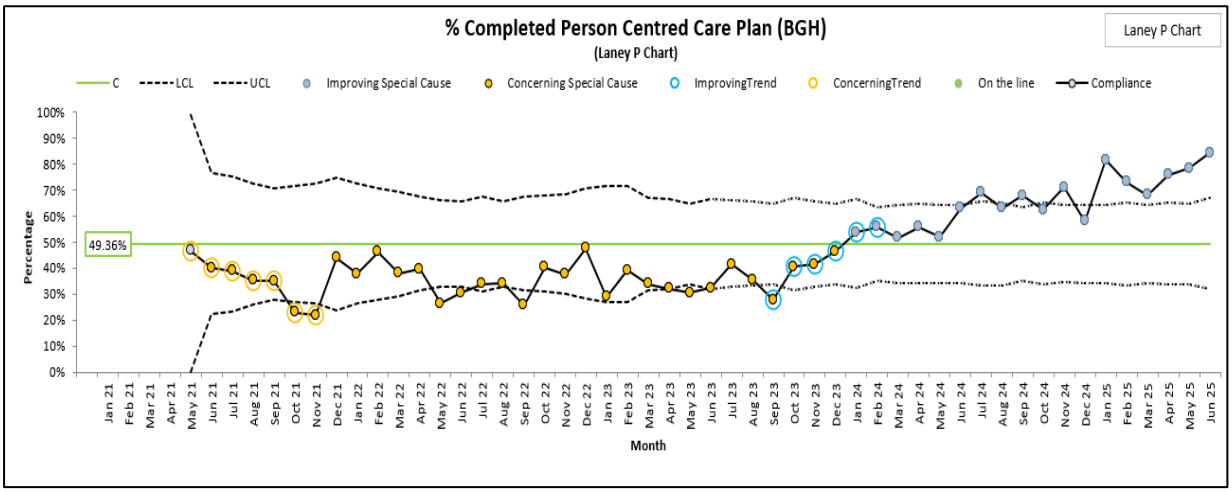


Figure 5: Percentage of Completed Person Centred Care Plan – BGH

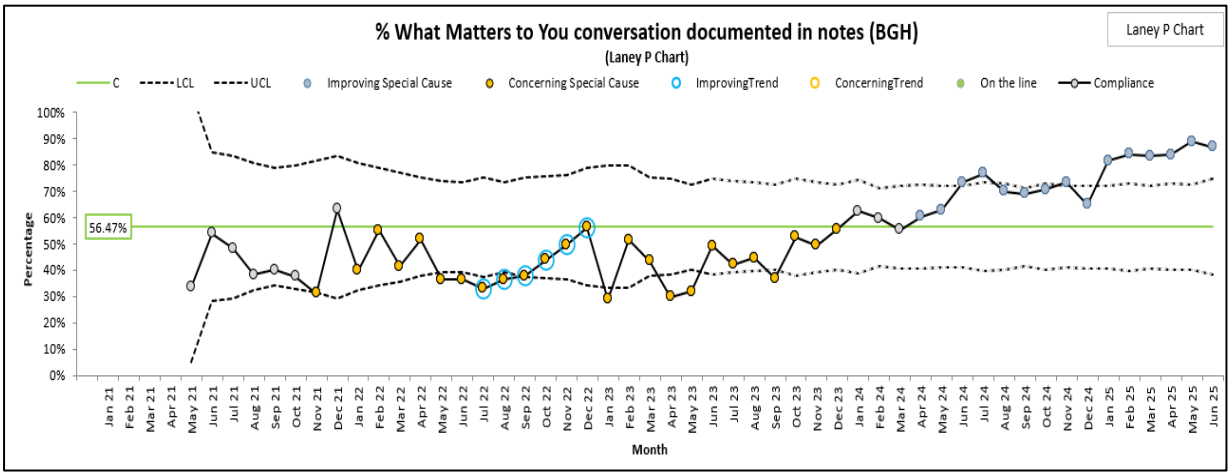


Figure 6: Percentage of Completed What Matters to You Conversations – BGH

2.3.24 Patient Experience

Care Opinion

For the period 1 April 2024 to 31 July 2025 230 new stories were posted about NHS Borders on Care Opinion. Figures 7 and 8 below show the number of stories told in that period and their criticality. As of 27 August 2025, 230 stories had been viewed 39,339 times:

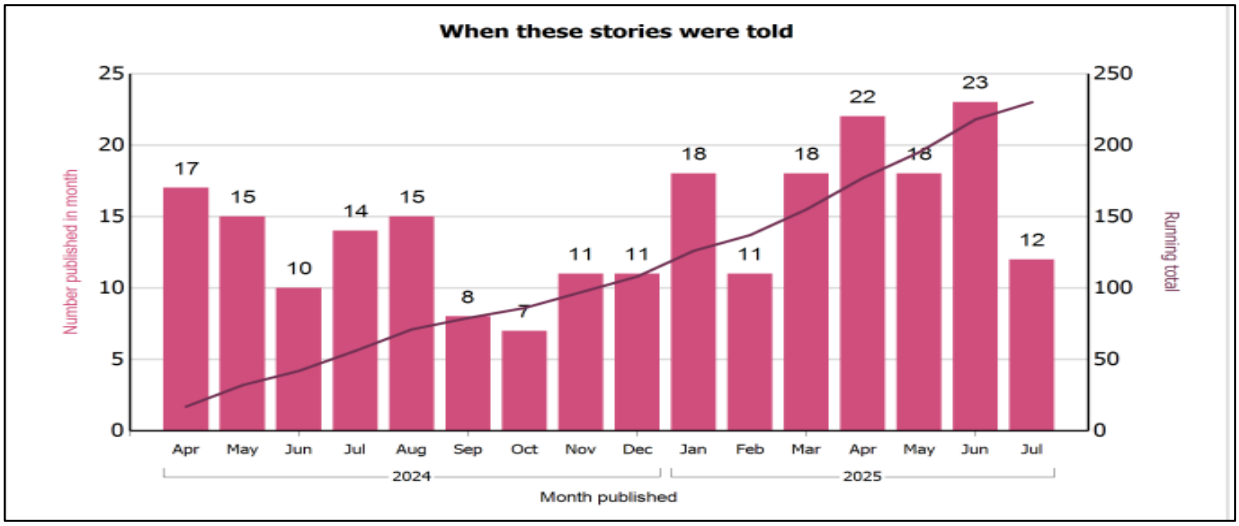


Figure 7

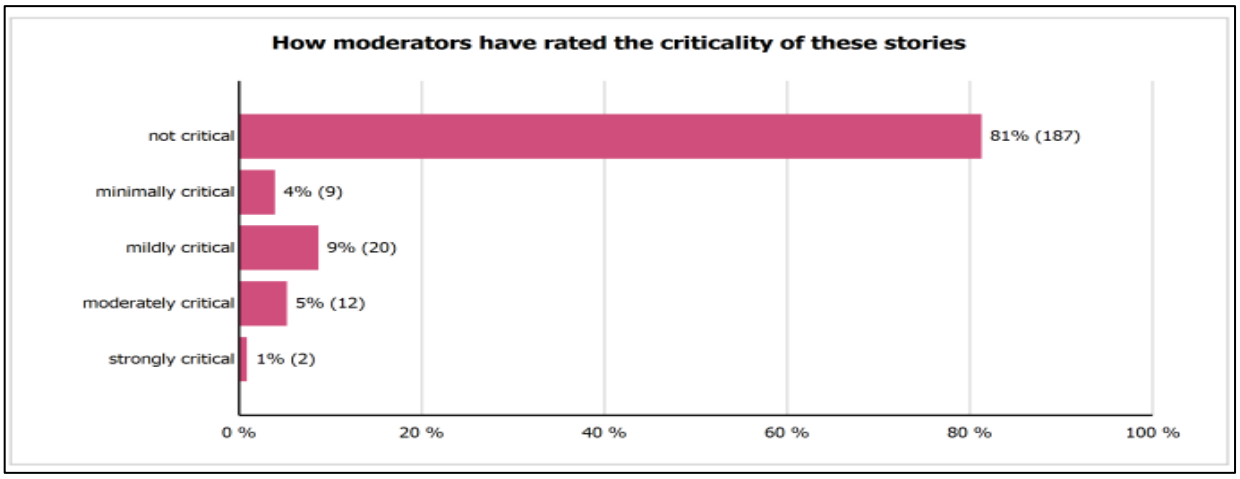
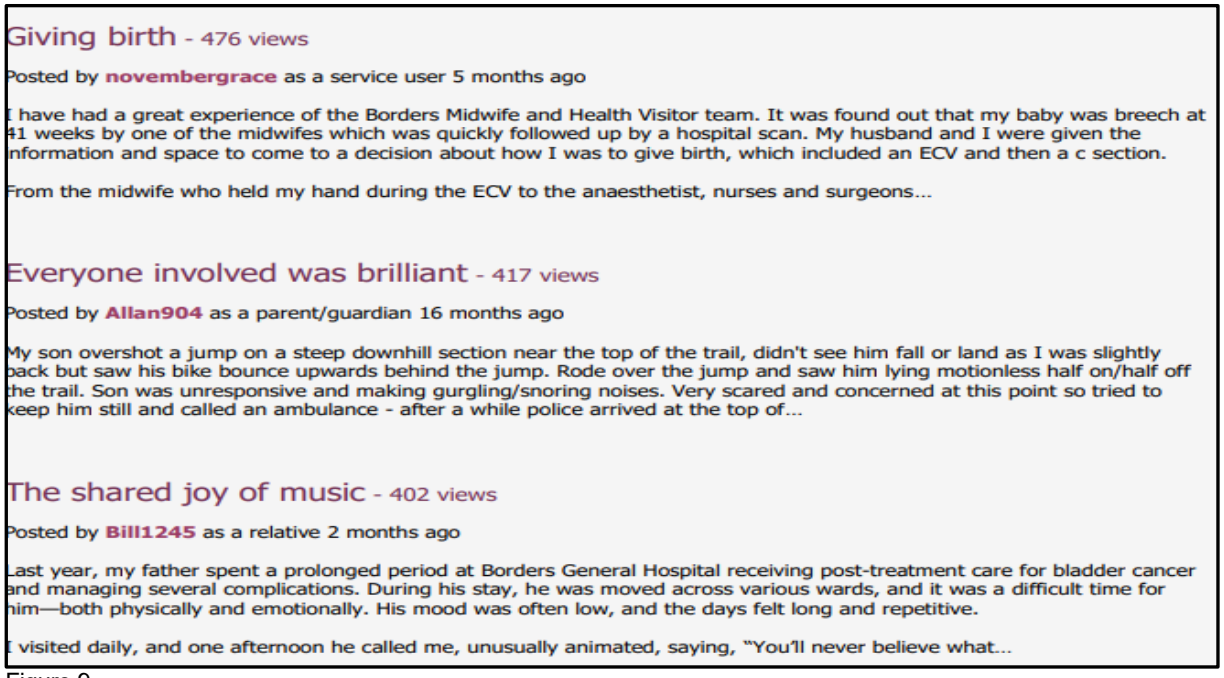


Figure 8

2.3.25 Figure 9 displays the 3 most popular stories, out of all the stories included in this report:



Giving birth - 476 views

Posted by novembergrace as a service user 5 months ago

I have had a great experience of the Borders Midwife and Health Visitor team. It was found out that my baby was breech at 41 weeks by one of the midwifes which was quickly followed up by a hospital scan. My husband and I were given the information and space to come to a decision about how I was to give birth, which included an ECV and then a c section.

From the midwife who held my hand during the ECV to the anaesthetist, nurses and surgeons...

Everyone involved was brilliant - 417 views

Posted by Allan904 as a parent/guardian 16 months ago

My son overshot a jump on a steep downhill section near the top of the trail, didn't see him fall or land as I was slightly back but saw his bike bounce upwards behind the jump. Rode over the jump and saw him lying motionless half on/half off the trail. Son was unresponsive and making gurgling/snoring noises. Very scared and concerned at this point so tried to keep him still and called an ambulance - after a while police arrived at the top of...

The shared joy of music - 402 views

Posted by Bill1245 as a relative 2 months ago

Last year, my father spent a prolonged period at Borders General Hospital receiving post-treatment care for bladder cancer and managing several complications. During his stay, he was moved across various wards, and it was a difficult time for him—both physically and emotionally. His mood was often low, and the days felt long and repetitive.

I visited daily, and one afternoon he called me, unusually animated, saying, "You'll never believe what...

Figure 9

2.3.26 The word cloud displayed in Figure 10 summarises 'What Was Good' as detailed in Care Opinion posts for this period:

Figure 10

2.3.27 Feedback which was given most frequently by service users to convey positive experiences in their care is displayed in the largest font in the word visualisation including:

Staff, Care, Friendly, Support, Professional, Midwives, Communication, Kindness, Above & Beyond

2.3.28 The word cloud displayed in Figure 11 summarises 'What Could Be Improved' as detailed in Care Opinion posts for this period:

Figure 11

2.3.29 Feedback which was given most frequently by service users to convey negative experiences in their care is displayed in the largest font in the word visualisation including:

Communication, Information, Facilities, Discharge Process, More Funding, Waiting Time, Breast Feeding Support

2.3.30 Complaints

Figure 12 shows the number of formal complaints received by month from July 2017 to July 2025:

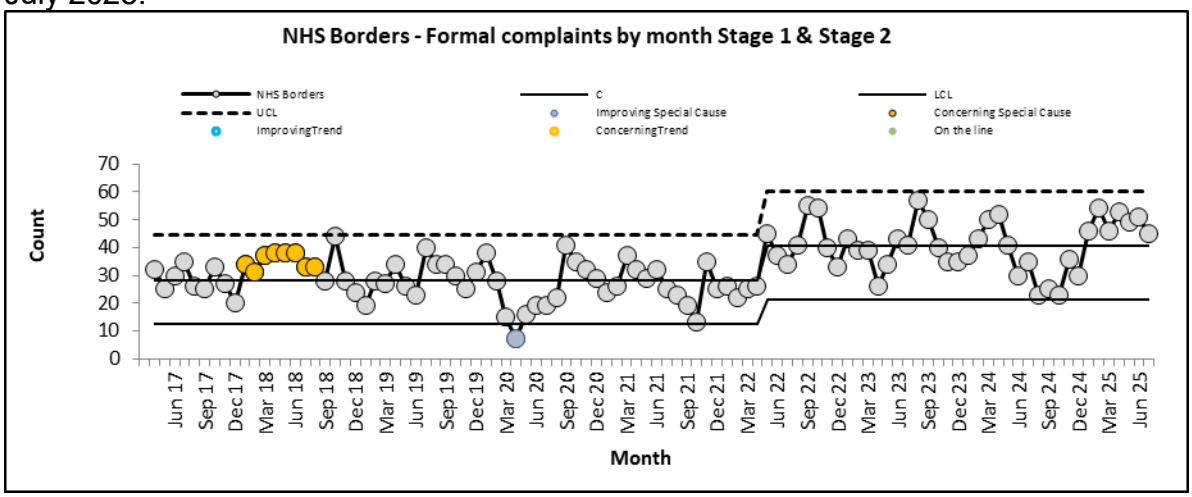


Figure 12

2.3.31 Challenges to respond to complaints within the legislated 20 working days continue and this is reflective in the high volume of new complaints, early resolution and informal enquiries the Patient Experience Team (PET) receive each month.

2.3.32 The additional scrutiny provided by the involvement of the Scottish Public Services Ombudsman (SPSO) is welcomed by NHS Borders as this gives a further opportunity to improve both patient care and our complaint handling. Figure 13 shows complaint referrals to the SPSO to July 2025:

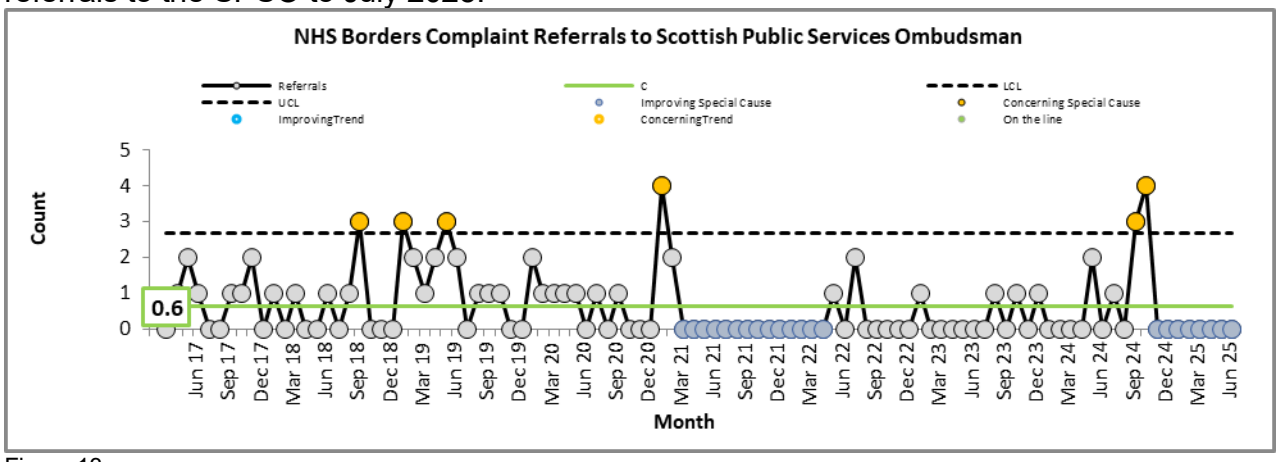


Figure 13

2.3.33 Hospital Mortality

NHS Borders Hospital Standardised Mortality Ratio (HSMR) for the 25th data release under the new methodology is 1.13. This figure covers the period April 2024 to March 2025 and is based on 683 observed deaths divided by 516 predicted deaths. The funnel plot in Figure 14 shows NHS Borders HSMR remains within normal limits based on the single HSMR figure for this period therefore is not a trigger for further investigation:

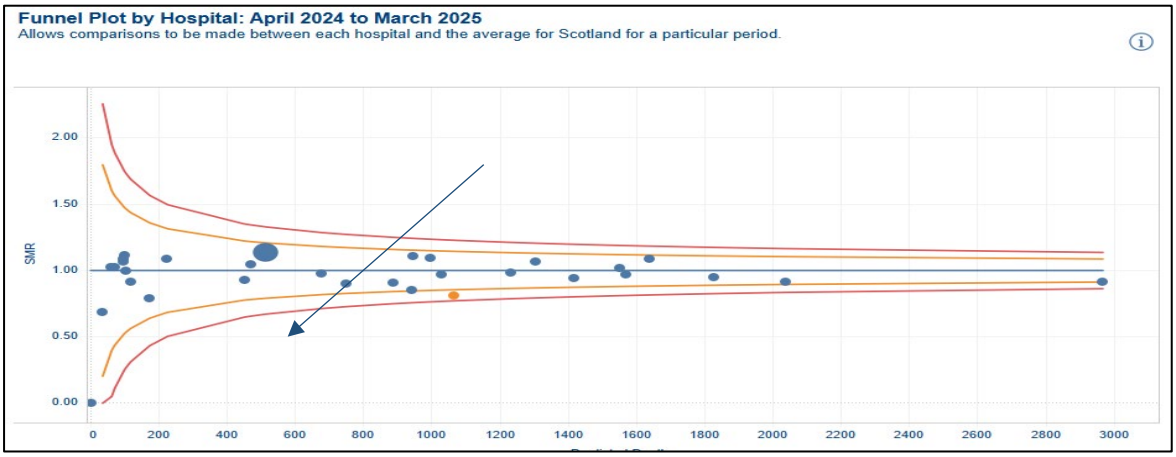


Figure 14 *Contains deaths in the Margaret Kerr Palliative Care Unit

2.3.34 NHS Borders crude mortality rate for quarter January 2025 to March 2025 was 4.1% and is presented in figure 15 below:

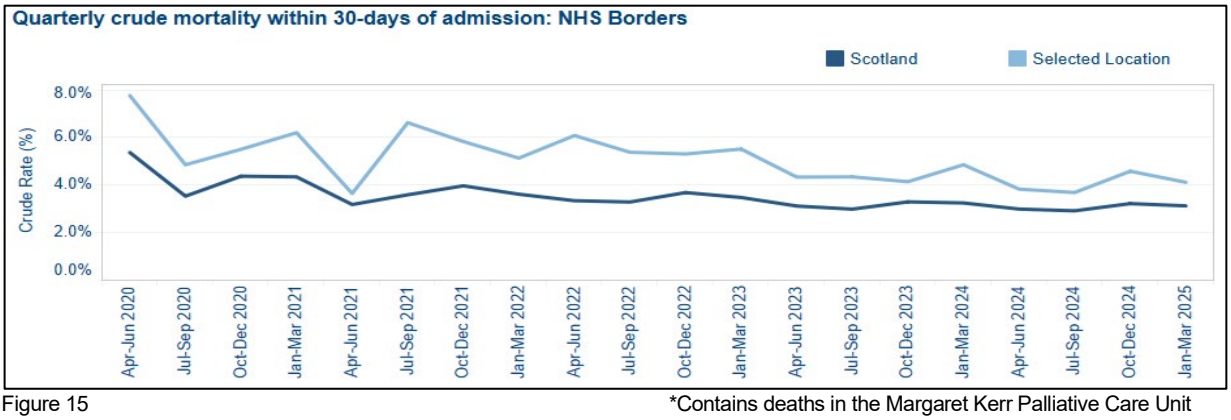


Figure 15 *Contains deaths in the Margaret Kerr Palliative Care Unit

2.3.35 No adjustments are made to crude mortality for local demographics. It is calculated by dividing the number of deaths within 30 days of admission to the BGH by the total number of admissions over the same period. This is then multiplied by 100 to give a percentage crude mortality rate.

2.3.36 Deaths occurring in COVID waves continue to contribute to the periods of elevated crude mortality.

2.3.37 Figure 16 details the COVID 19 deaths which have occurred since the start of the COVID 19 pandemic in March 2020 up to 3 August 2025:

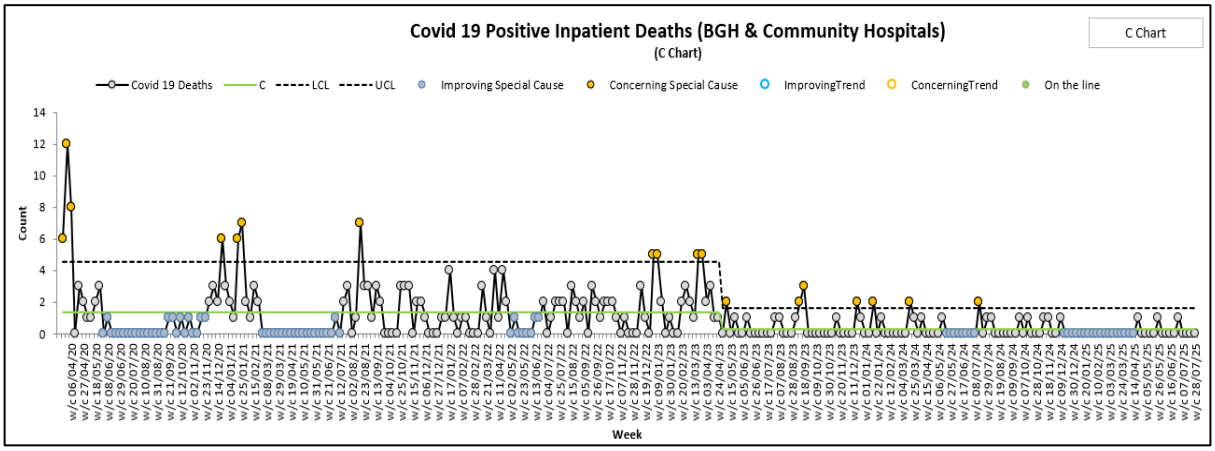


Figure 16 - *From 07/05/2023 patients are counted as Covid positive for 10 days after a positive test. Prior to this, patients were counted as covid positive for 28 days after a positive test.

2.3.38 COVID Inquiries Update

NHS Borders continues to participate in the Scottish Covid-19 Inquiry along with all other Boards in NHS Scotland.

2.3.39 Let's Be Heard, the Scottish Inquiry's public participation project, published a case study highlighting more than 2,000 young voices who shared insights about their experiences during the pandemic and the lessons they think should be learned.

During September 2025, the Scottish Inquiry will hold hearings on:

- lockdowns and other non-pharmaceutical measures, such as social distancing and travel restrictions; and
- different approaches other countries took to limit, or attempt to limit, the spread of COVID-19.

Hearings will be broadcast on the Scottish Covid-19 Inquiry's YouTube channel: https://www.youtube.com/@covidinquirysco.

2.3.40 NHS Borders also participates in the UK Covid-19 Inquiry along with all other Boards in NHS Scotland. The public hearings for Module 6 Care Sector were completed on 31 July 2025. The UK Inquiry will next hold public hearings for Module 8 Children and Young People from 29 September 2025 to 23 October 2025. Hearings will be live streamed on the UK Inquiry's website (UK Covid-19 Inquiry) and also through the Uk Inquiry's You Tube channel using the following link our YouTube channel (opens in new tab). All live streams are available to watch later.

2.3.41 Quality/ Patient Care

Services continue to recover and respond to significant demand with heightened workforce pressure across health and social care. This has required adjustment to core services and non-urgent and routine care. The ongoing unscheduled demand and delays in flow across the system remain an area of concern with concerted efforts underway to reduce risk in this area.

2.3.42 Workforce

Service and activities are being provided within agreed resources and staffing parameters, with additional resources being deployed to support the recovery of waiting times and urgent and unscheduled flow across health and social care. Key workforce pressures have required the use of bank, agency and locum staff groups and further exploration of extended roles for the multi-disciplinary team. Mutual aid has also been explored for a few critical specialties where workforce constraints are beyond those manageable locally. There has been some progress locally in reducing gaps in the registered nursing workforce and positive levels of international recruitment. There continues to be an outstanding response from staff in their effort to sustain and rebuild local services. Whilst many services have recovered there are still a number of services which continue to feel the strain of workforce challenges and this needs to remain an area of constant focus for the Board.

2.3.43 Financial

Service and activities are being provided within agreed resources and staffing parameters, with additional resources being deployed to support the recovery of waiting times and urgent and unscheduled flow across health and social care. As outlined in the report the requirement to step down services to prioritise urgent and emergency care has introduced waiting times within a range of services which will require a prolonged recovery plan. This pressure is likely to be compounding by the growing financial pressure across NHS Scotland.

2.3.44 Risk Assessment/Management

Each clinical board is monitoring clinical risk associated with elective waiting times and pressure on urgent and unscheduled care services across acute, mental health and primary and community services. The NHS Borders risk profile has increased as a result of the extreme pressures across Health and Social Care services.

2.3.45 Equality and Diversity, including health inequalities

An equality impact assessment has not been undertaken for the purposes of this awareness report.

2.3.46 Climate Change

No additional points to note.

2.3.47 Other impacts

No additional points to note.

2.3.48 Communication, involvement, engagement and consultation

This paper is for awareness and assurance purposes and has not followed any consultation or engagement process.

2.3.49 Route to the Meeting

The content of this paper is reported to Clinical Board Clinical Governance Groups and Board Clinical Governance Committee.

2.4 Recommendation

The Board is asked to **note** the report.

The Board will be asked to confirm the level of assurance it has received from this Report, the proposed overall level of assurance based on Board CGC consideration of the topics detailed in this paper is:

- **Moderate** for systems and processes in place
- **Limited** for outcomes being achieved

3 Glossary

BGH	Borders General Hospital
CA	Cardiac Arrest
CAMHS	Child and Adolescent Mental Health Service
CAV	Care Assurance Visits
CGC	Clinical Governance Committee
CGQ	Clinical Governance and Quality
CNM	Clinical Nurse Manager
CTG	Cardiotocography
DoC	Duty of Candour
ED	Emergency Department
EiC	Excellence in Care
FY1	Foundation Year 1
GLP-1	Glucagon-Like Peptide-1
GMC	General Medical Council
GP	General Practitioner
HAI	Healthcare Associated Infection
HSMR	Hospital Standardised Mortality Ratio
MEWS	Maternity Early Warning Scores
MDT	Multi-Disciplinary Team
NEWS2	National Early Warning Score 2
NES	NHS Education Scotland
OBDs	Occupied Bed Days
PCCP	Person Centred Care Planning
PET	Patient Experience Team
QoC	Quality of Care
RAAC	Reinforced Autoclaved Aerated Concrete
SAER	Significant Adverse Event Review
SCN	Senior Charge Nurse
SOP	Standard Operating Procedure
SPA	Supporting Professional Activity
SPSO	Scottish Public Services Ombudsman
WMTY	What Matters to You

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**2 October 2025**
Title:	**Infection Prevention & Control Report – September 2025**
Responsible Executive/Non-Executive:	**S Horan, Director of Nursing, Midwifery & AHPs**
Report Author:	**S Whiting, Infection Control Manager**

1 Purpose

This is presented to the Board for:

- Discussion

This report relates to a:

- Government policy/directive

This aligns to the following NHSScotland quality ambition(s):

- Safe

2 Report summary

2.1 Situation

This report provides an overview for NHS Borders Board of infection prevention and control with particular reference to the incidence of Healthcare Associated Infections (HAI) against Scottish Government targets.

2.2 Background

The Scottish Government requires reports on infection surveillance and monitoring of key topic areas impacting on the prevention and control of infection to be discussed as part of bi -monthly Board meetings and published on NHS Board websites.

2.3 Assessment

Contents

1.0 Headlines

- **Surgical Site Infection (SSI) Surveillance**: Up-to-date data is currently unavailable. A new Arthroplasty SSI Group has been established to review suspected cases and improve future reporting accuracy. Suspected cases from 2024 are currently being reviewed by this Group.

- **Healthcare Improvement Scotland (HIS)**: HIS conducted an inspection of Borders General Hospital on 5–6 August 2025. This was a follow-up inspection on progress since a previous inspection in November 2022. NHS Borders is actively engaging with inspectors and awaiting publication of the final inspection report.

- **Infection Surveillance Trends**:
  CDI: NHS Borders is on track to meet the 2025/26 HAI standard.
  ECB & SAB: NHS Borders is currently **not** on trajectory to meet the new 2025/26 standards. Urinary catheters remain a key risk factor.

- **Hand Hygiene Compliance**: Overall compliance in August was 71%, with medical staff at 67% and nursing staff at 73%. Audits will be repeated in October.

- **Care Home Support**: New support, escalation and audit processes have been implemented. A care home has received targeted support following a Care Inspectorate request.

2.0 Outcome Measures - Infection Surveillance

2.1 *Clostridioides difficile* infection (CDI) - Key Messages

- There has not been any statistically significant change in the number of healthcare associated CDI cases since the last report (**Figure 1**)
- NHS Borders is on trajectory to meet the new Scottish Government HAI CDI standard for 2025/26 (**Figure 2**)
- Measures to reduce the risk of CDI:
  - Antimicrobial stewardship - reduce and control use of antibiotics that are more strongly associated with causing CDI (oversight provided by the Antimicrobial Management Team)
  - Good Hand Hygiene practice **(Section 3.1)**
  - Good standard of environmental and equipment cleaning **(Section 3.2** and **Section 3.3)**
- Background information and explanation is provided in **Appendix A and B**

2.2 CDI National Context (ARHAI Scotland data)

- ARHAI Scotland has not published new data since the previous report

2.3 CDI Local Context

Figure 1

NHS Borders, days between healthcare associated CDI cases (G Chart). May 2023 - Aug 2025

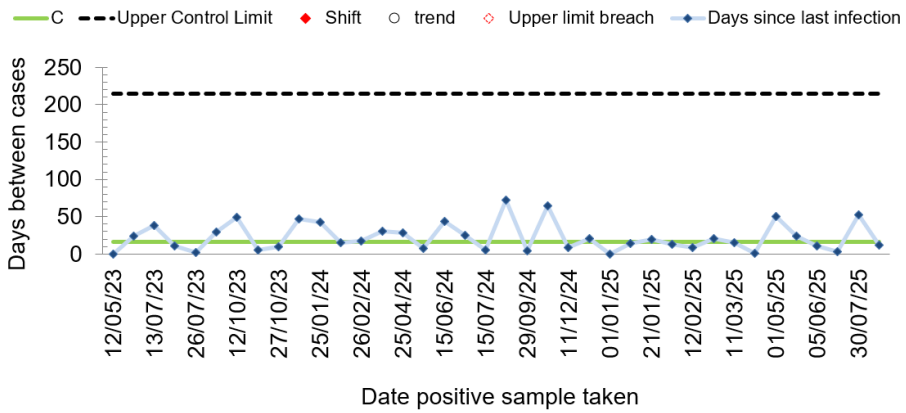
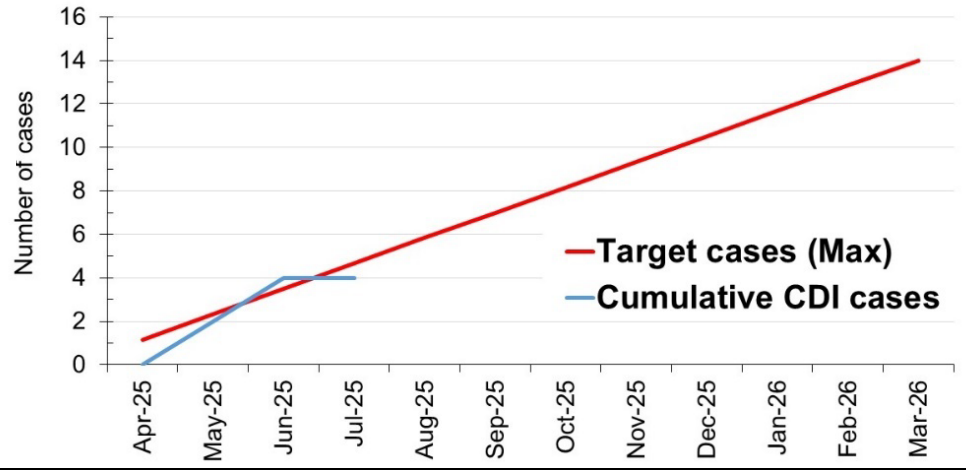


Figure 2

NHS Borders cumulative healthcare associated CDI cases Vs Scottish Government target trajectory (April 2025 - March 2026)



2.4 *Escherichia coli* bacteraemia (ECB) - Key Messages

- There has not been any statistically significant change in the number of Healthcare Associated ECB cases since the last report (**Figure 3**)
- NHS Borders is not on trajectory to meet the new HAI ECB standard for 2025/26 (**Figure 4**)
- Urinary catheters are the primary cause of ECB infections (**Figure 5**)
- Measures to reduce the risk of ECB:
  - Avoid using urinary catheters when possible, maintain urinary catheters in accordance with NHS Borders Policy, remove urinary catheters at the earliest opportunity (**Section 5.1**)
- Background information and explanation is provided in **Appendix A and B**

2.5 ECB National Context (ARHAI Scotland data)

- ARHAI Scotland has not published new data since the previous report

2.6 ECB Local Context

Figure 3

NHS Borders healthcare associated ECB cases per month (C Chart). March 2022 - June 2025

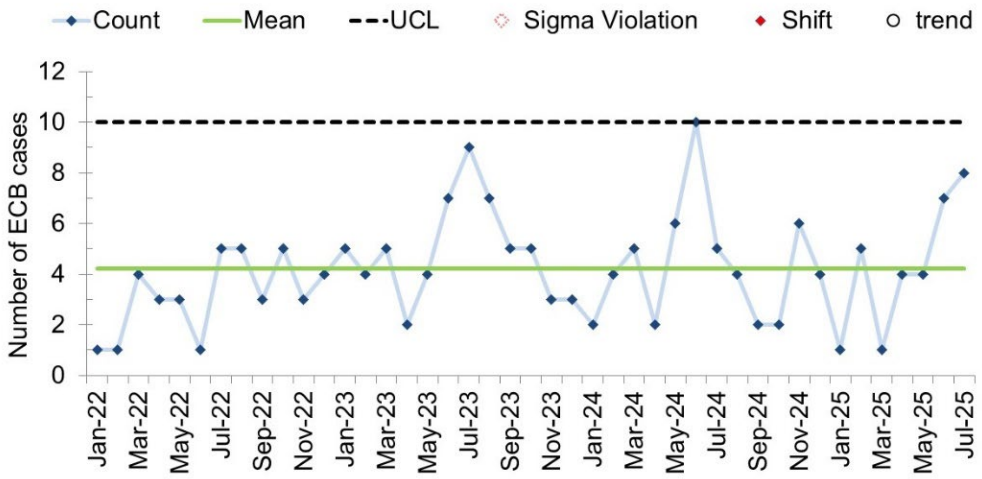


Figure 4

NHS Borders cumulative healthcare associated ECB cases Vs Scottish Government target trajectory (April 2025 - March 2026)

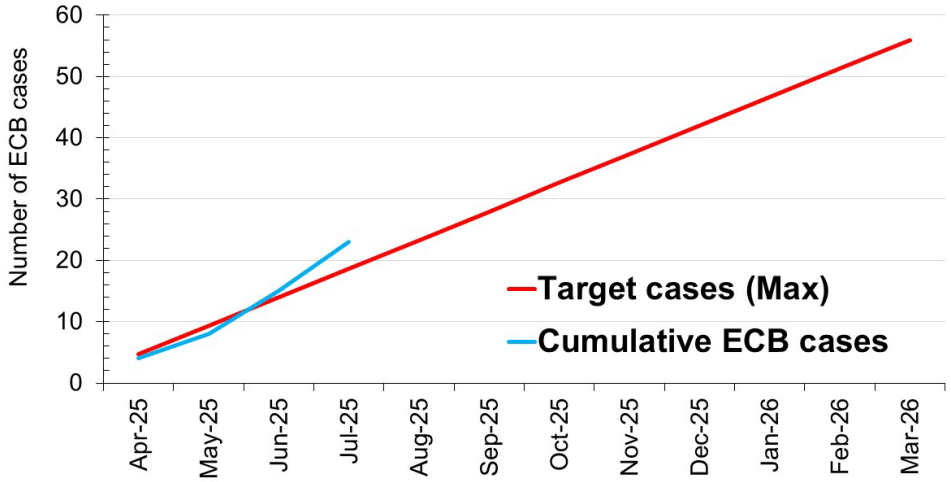
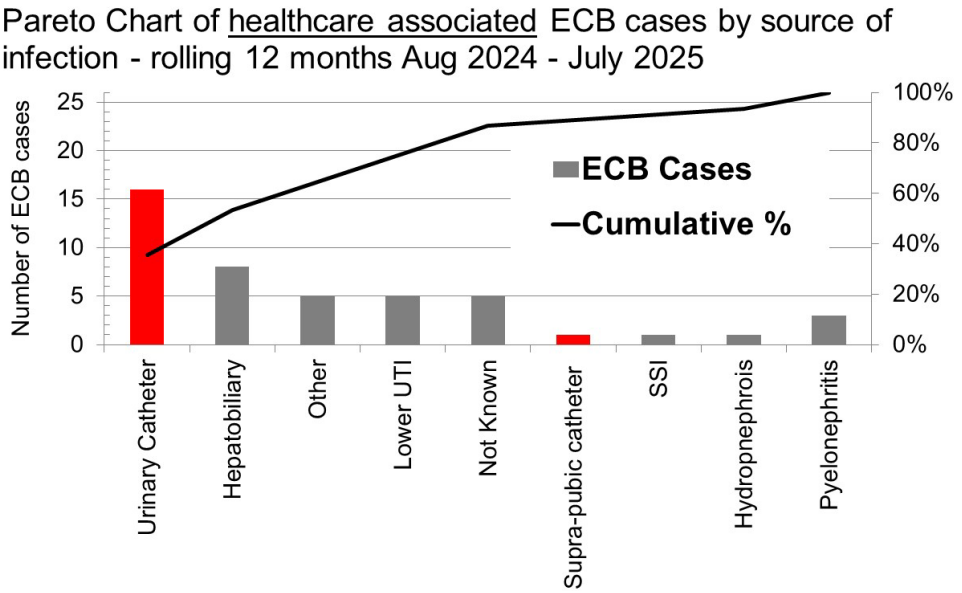


Figure 5



2.7 *Staphylococcus aureus* Bacteraemia (SAB) - Key Messages

- There has not been any statistically significant change in the number of Healthcare Associated SAB cases since the last report (**Figure 6**)
- NHS Borders is not on target to achieve the new HAI SAB standard in 2025/26 (**Figure 7**)
- The main known recent causes of healthcare associated SAB cases were urinary catheters and diabetic foot ulcers (**Figure 8**)
- A clinical review of cases relating to diabetic feet found no evidence of cross infection and no additional interventions to current efforts to optimise diabetes care seemed appropriate.
- Measures to reduce the risk of SAB:
  - Avoid using urinary catheters when possible, maintain urinary catheters in accordance with NHS Borders Policy, remove urinary catheters at the earliest opportunity (**Section 5.1**)

- Adult inpatients (excluding Mental Health and Maternity) should be screened for Methicillin-resistant *Staphylococcus aureus* (MRSA) (**Section 3.5**)

- Background information and explanation is provided in **Appendix A and B**

2.8 SAB National Context (ARHAI Scotland data)

- ARHAI Scotland has not published new data since the previous report

2.9 SAB Local Context

Figure 6

NHS Borders, days between healthcare associated SAB cases (G Chart). January 2023 - July 2025

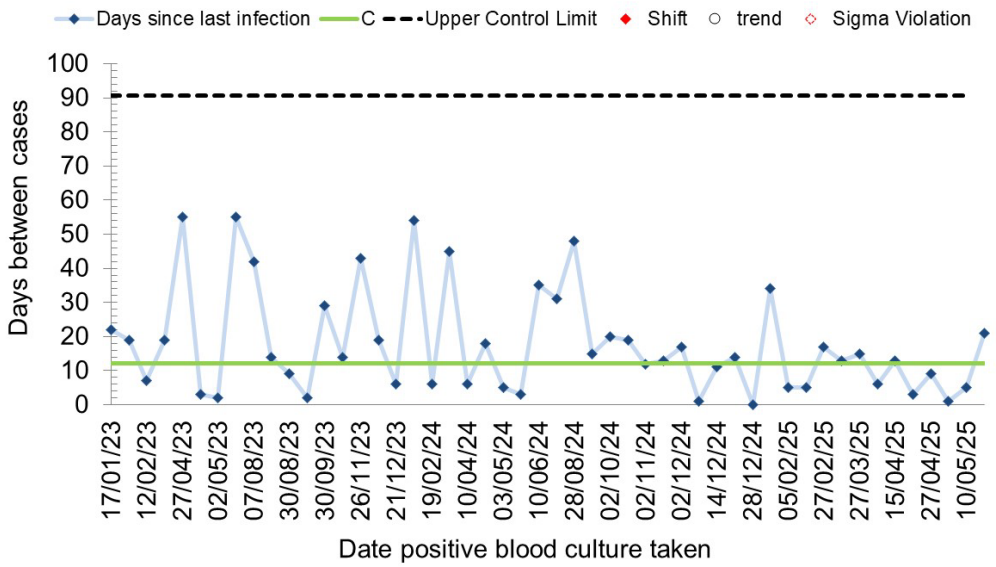


Figure 7

NHS Borders cumulative healthcare associated SAB cases Vs Scottish Government target trajectory (April 2025 - March 2026)

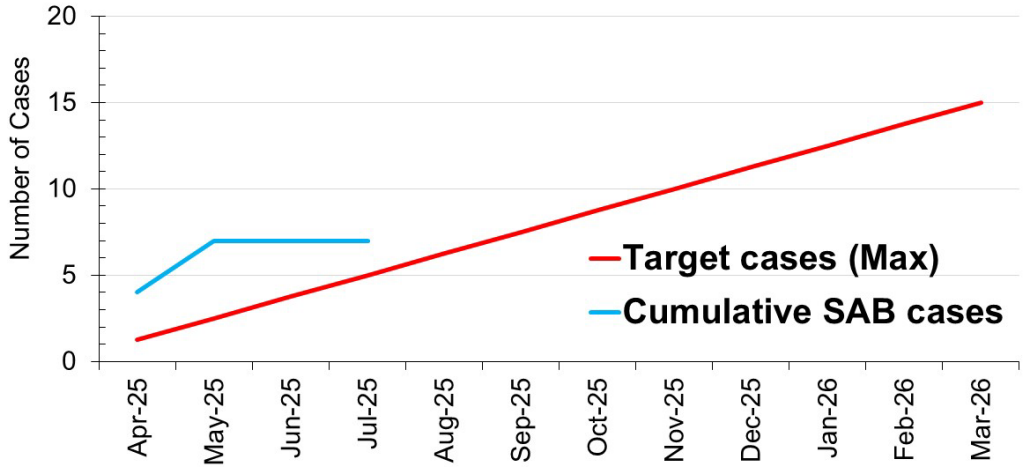
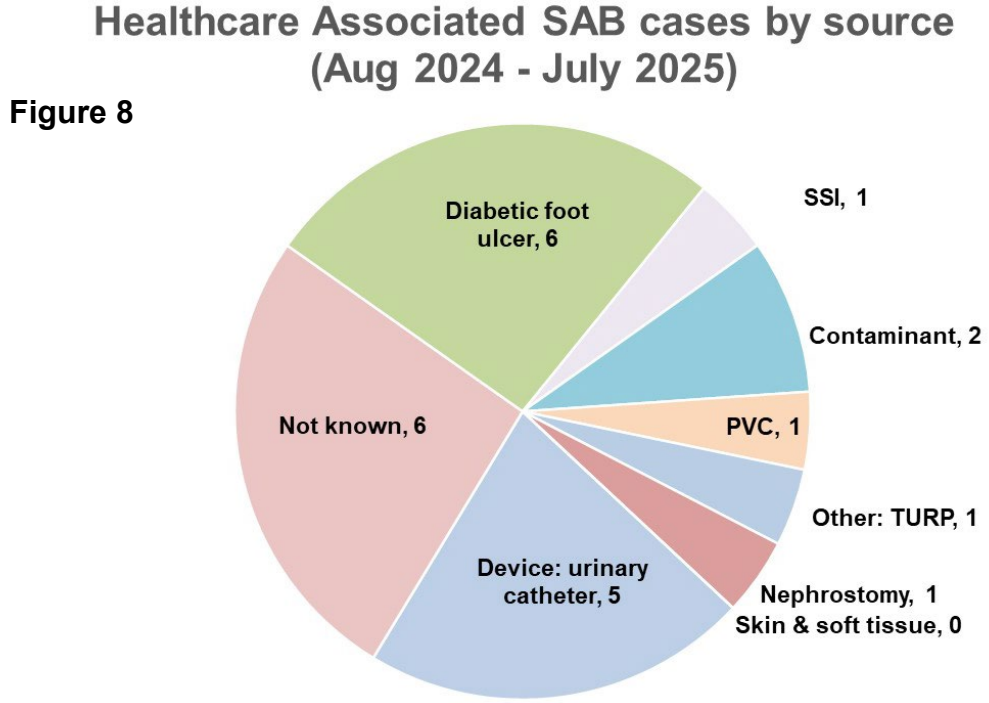


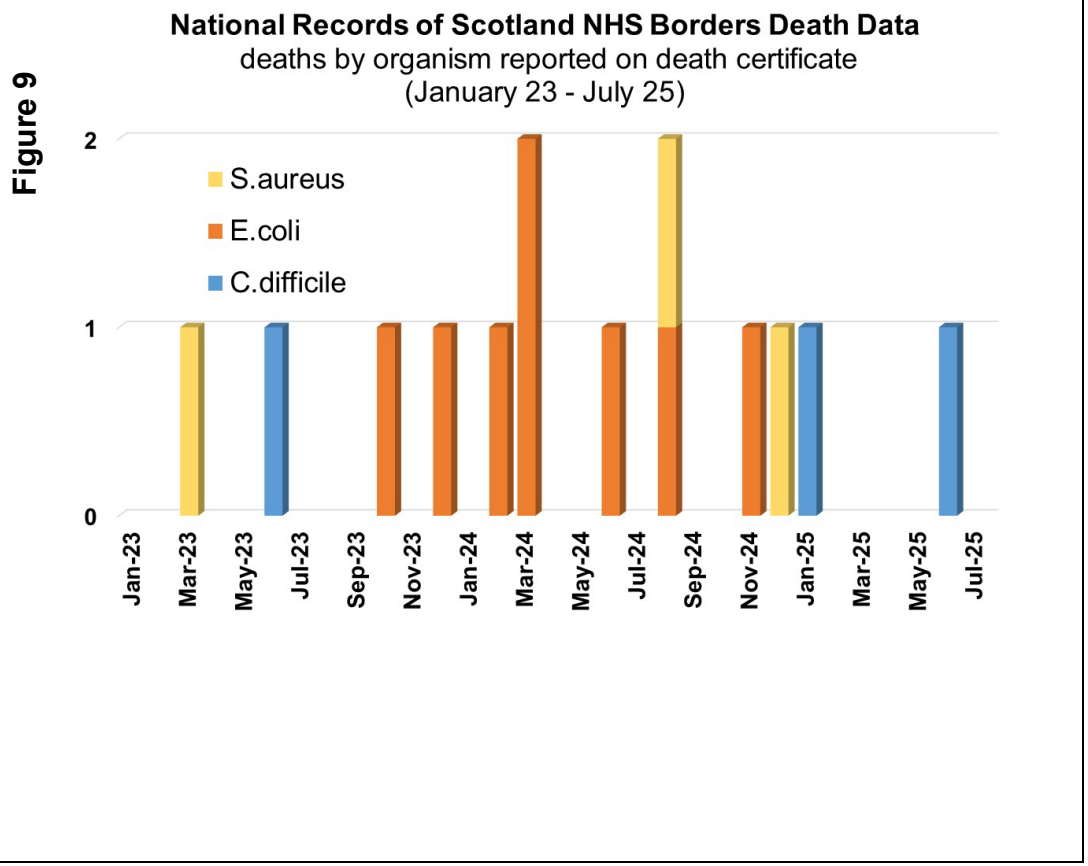
Figure 8


Healthcare Associated SAB cases by source
(Aug 2024 - July 2025)
Diabetic foot ulcer, 6
SSI, 1
Contaminant, 2
PVC, 1
Other: TURP, 1
Nephrostomy, 1
Skin & soft tissue, 0
Device: urinary catheter, 5
Not known, 6

2.10 National Records of Scotland Death Data

- National Records of Scotland (NRS) produce weekly death data reports which are reviewed and collated monthly
- The Scottish Government requires regular reporting of NRS death data for C. difficile and MRSA to the Infection Control Manager (SGHD/CMO 2011/13)
- **Figure 9** shows the number of deaths per month where *C.difficile, E.coli* or *S. aureus* (including MRSA) was noted on the death certificate and the person's primary place of residence at time of death was within the Scottish Borders.
- This data should be interpreted with caution due to variation in recording and coding death certificates, and the absence of acquisition data (community associated Vs healthcare associated).

Figure 9



3.0 Process Measures

3.1 Hand Hygiene – Key Messages

- In August 2025, overall hand hygiene compliance was 71% (**Figure 10**)
- Nursing compliance was 73% (**Figure 11**), Medical compliance was 67% (**Figure 12**)
- Hand hygiene audits will be repeated in October 2025

Figure 10

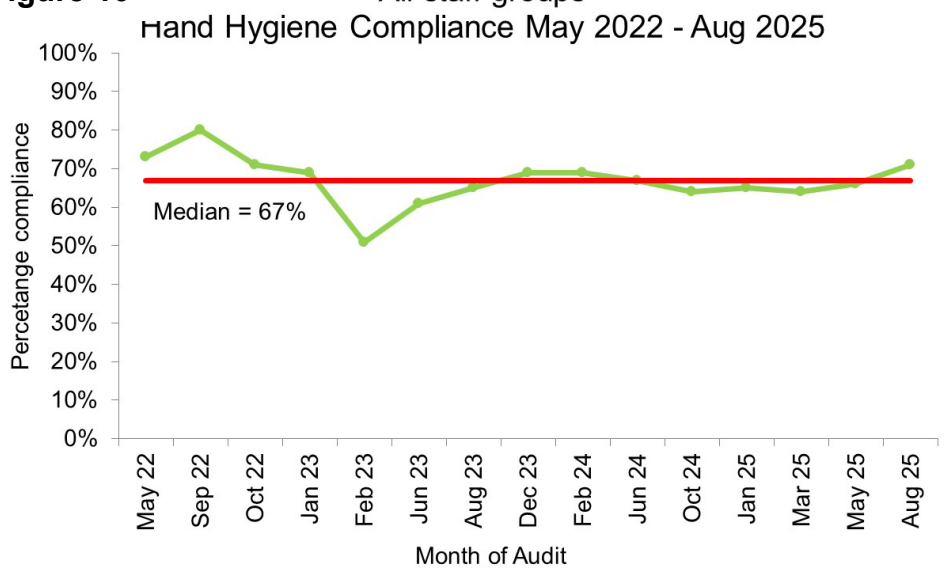


Figure 11

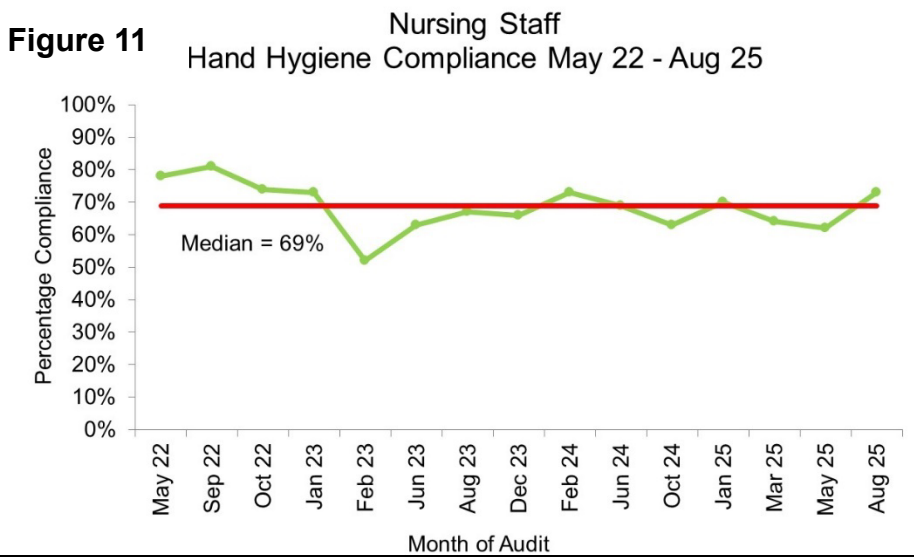
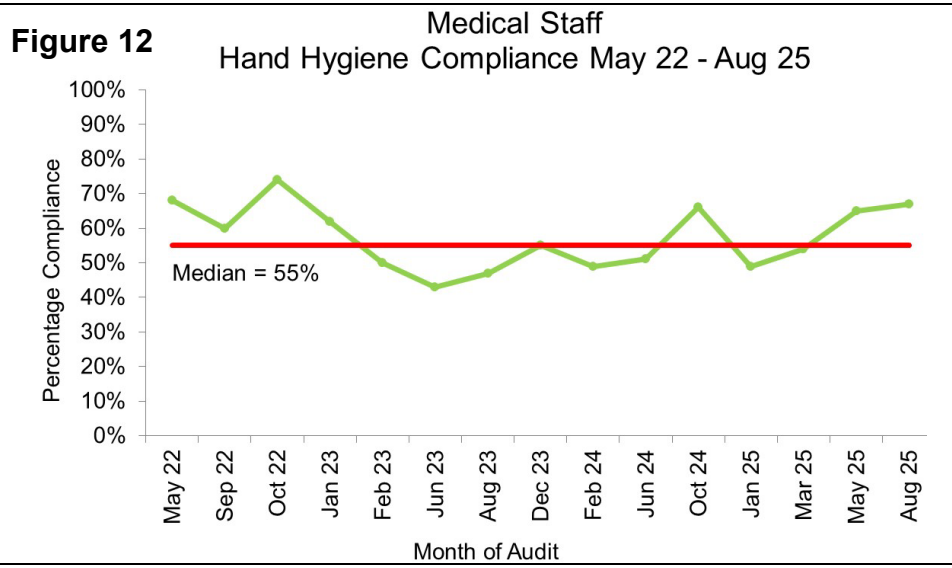


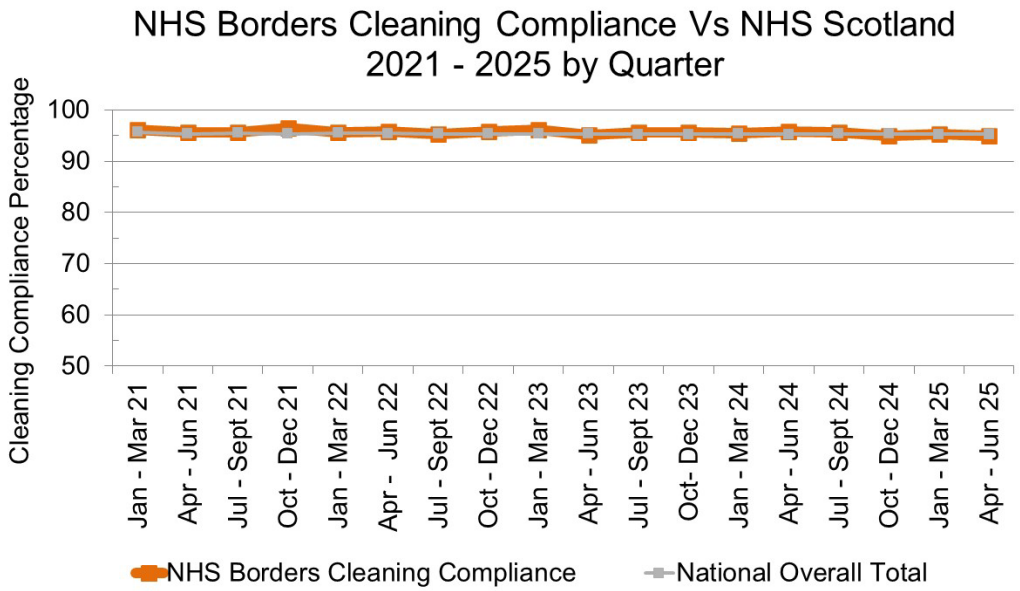
Figure 12



3.2 Cleaning Standards – Key Messages

- Cleanliness is monitored in accordance with national standards
- There is a national target to maintain overall compliance with standards above 90%
- Any area that does not reach this standard should have the issues rectified and the area re-audited within 21 days
- NHS Borders compliance is comparable with NHS Scotland (**Figure 13**)

Figure 13



3.3 Audit – Key Messages

- The management actions in response to the 2024 infection control internal audit report are on target to be completed on time (**Figure 14**)
- In June and July 2025, 5 full infection control audits were completed with all areas achieving a 'green' status
- In June and July 2025, 13 spot checks were completed resulting in 8 areas achieving an 'Amber' status with the remaining achieving a 'green' status with a score of 90% or higher
- Recurring themes from the audits and spot checks:

Recurring themes of good practice

- Staff observed were bare below elbow
- Management of patients with precautions in place
- Correct PPE use
- Correct cleaning processes observed
- Waste managed correctly

Recurring themes of poor practice

- Temporary sharps bin closures not in place
- Use and knowledge of cleaning solution
- Single patient use items in communal areas
- Dirty equipment
- Areas cluttered

- Senior Charge Nurses are provided with verbal and written feedback to share with their teams
- General Services management are copied into feedback to address environmental cleaning issues
- The Senior Charge Nurse Forum has established a Short Life Working Group to standardise cleaning documentation across Borders General Hospital. The output from this work will be shared across NHS Borders.
- Themes from spot checks and audits are used to inform the content of staff education delivered by the Infection Prevention and Control Team
- The timescale to revisit an area is determined by the RAG ('red', 'amber', 'green') status

Figure 14

2024 Internal Audit - Infection Prevention &Control Action

Progress as at 01/07/2025

		Status
1	**Develop and implement standardised cleaning documentation for patient equipment in inpatient areas.** Responsible Officer: Clinical Nurse Managers Executive Lead: Director of Nursing, Midwifery and AHPs Due Date: 31/12/2025	In progress (01/07/25)
2	**Review IPCT audit tool to include assessment of compliance with completion of cleaning records.** Responsible Officer: Infection Control Manager Executive Lead: Director of Nursing, Midwifery and AHPs Due Date: 31/03/2025	Complete
3	**Include IPC audit programme in annual Infection Control Workplan.** Responsible Officer: Infection Control Manager Executive Lead: Director of Nursing, Midwifery and AHPs Due Date: 31/03/2025	Complete
4	**Implement daily IPC review across inpatient wards using the Rapid Assessment Tool Review.** Responsible Officer: Clinical Nurse Managers Executive Lead: Director of Nursing, Midwifery and AHPs Due Date: 31/03/2025	Complete
5	**Clinical Nurse Managers to routinely review completion of Rapid Assessment Tool and improvement activity to address issues.** Responsible Officer: Clinical Nurse Managers Executive Lead: Director of Nursing, Midwifery and AHPs Due Date: 31/05/2025	Complete
6	**Update Hospital Safety Brief script to include Facilities issues.** Responsible Officer: Quality Improvement Facilitator Executive Lead: Interim Director of Acute Services Due Date: 31/12/2024	Complete
7	**Senior Charge Nurses to formalise communication with staff about audit outcomes and improvement activity.** Responsible Officer: Clinical Nurse Managers Executive Lead: Director of Nursing, Midwifery and AHPs Due Date: 31/05/2025	Complete
8	**Infection Control Manager to attend the Senior Charge Nurse Forum to discuss promotion of improvement activity.** Responsible Officer: Infection Control Manager Executive Lead: Director of Nursing, Midwifery and AHPs Due Date: 31/05/2025	Complete
9	**Promote completion of the NES hand hygiene module with Medical staff.** Responsible Officer: Associate Medical Directors Executive Lead: Medical Director Due Date: 31/03/2025	Complete
10	**Raise importance of Hand Hygiene at Clinical Director meeting including review of audit results.** Responsible Officer: Associate Medical Directors Executive Lead: Medical Director Due Date: 31/03/2025	Complete
11	**Infection Control Manager to meet with individual Clinical Directors with areas of poor compliance.** Responsible Officer: Associate Medical Directors Executive Lead: Medical Director Due Date: 31/03/2025	Complete
12	**Include learning, themes and trends from outbreaks, incidents, spot checks and audits in reports to the Clinical Governance Committee and Board.** Responsible Officer: Infection Control Manager Executive Lead: Director of Nursing, Midwifery and AHPs Due Date: 31/03/2025	Complete

3.4 Care Home visits

The Infection Prevention and Control Team (IPCT) provide support and advice to adult care homes in the Scottish Borders. Each care home is visited by the Team at least once every year. An escalation and follow-up process for supportive visits to Care Homes was approved by the Infection Control Committee in August 2025 has been implemented.

A care home audit tool has also been developed to ensure consistency in approach and to support an objective assessment; 'Red', 'Amber' or 'Green' (RAG) status to inform further support and action. Since this tool was implemented, 4 care homes have been visited with 2 care homes achieving a 'green' status, 1 was 'amber' and 1 was 'red'.

Following each visit, the completed audit tool is shared with the care home, NHS Borders Care Home Support Team, SBC Community Care Reviewing Team (CCRT) and the Care Inspectorate. The care home with the 'amber' status will be revisited by the IPCT within 6 months.

The care home with the 'red' status was prioritised for a supportive visit at the request of the Care Inspectorate. The IPCT are collaborating with other agencies and the care home to support improvement including delivery of infection prevention and control education to care home staff. The IPCT will revisit this care home within 6 weeks.

3.5 HAI Risk – Inpatient Admission Screening

- MRSA screening of adult inpatients (excluding Maternity and Mental Health services) is mandatory in Scotland (DL 2019 23)
- Carbapenemase-producing enterobacteriaceae (CPE) inpatient screening is mandatory in Scotland (DL 2019 23)
- MRSA admission screening compliance is monitored on a monthly basis and displayed in run charts for each of the four main admitting wards within BGH (**Figures 15 to 18**).
- Monthly compliance reports are fed back to the Senior Charge Nurse and Clinical Nurse Manager for the relevant wards
- Monthly CPE screening compliance data is now being collected and will be included in future reports

3.6 HAI Inpatient HAI Risk Screening National Context (ARHAI Scotland data)

- ARHAI Scotland has not published new data since the previous report

3.7 Inpatient MRSA Screening Local Context

Figure 15 Ward 5 % of Patients Screened for MRSA

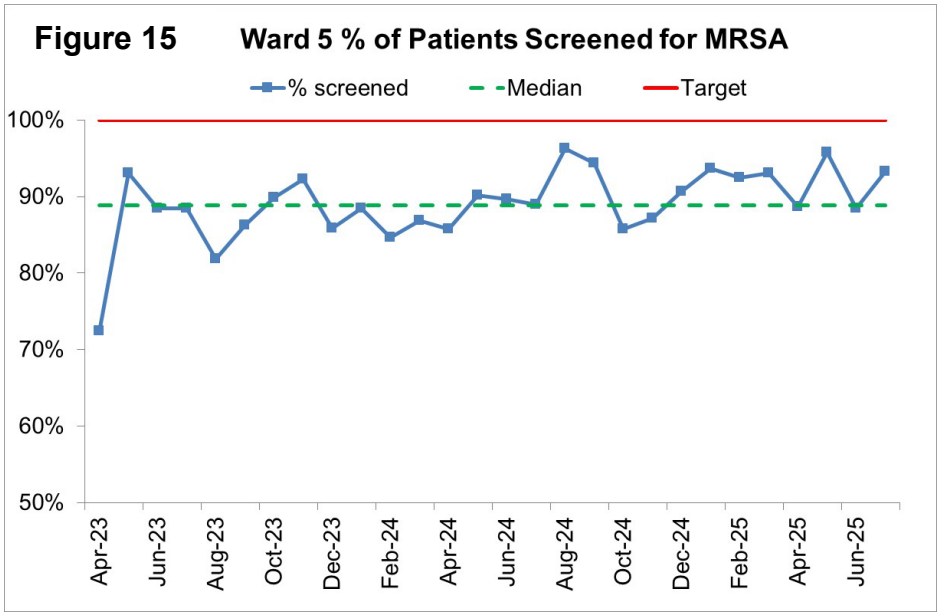


Figure 16 MAU % of Patients Screened for MRSA

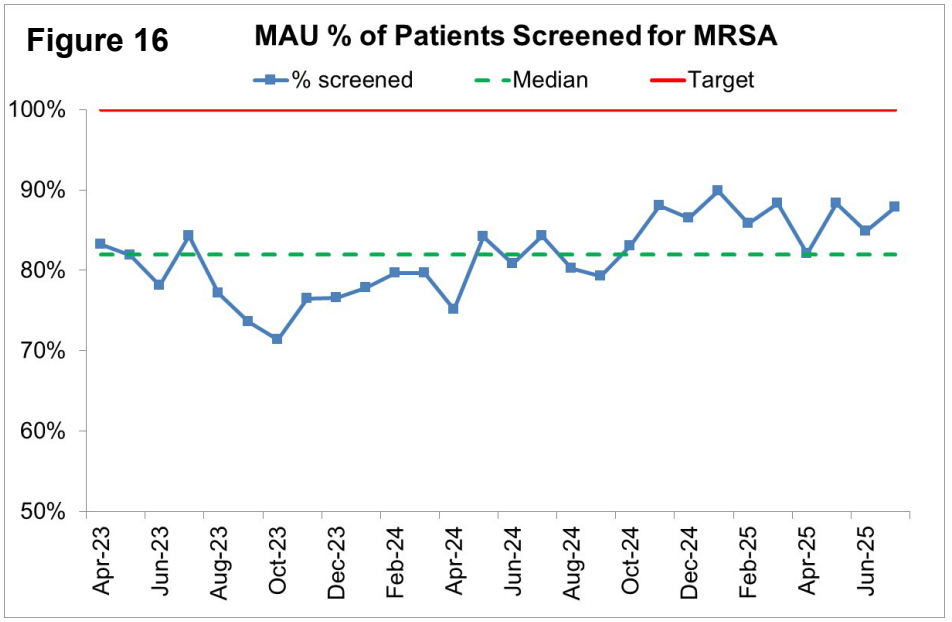


Figure 17 Ward 7 % of Patients Screened for MRSA

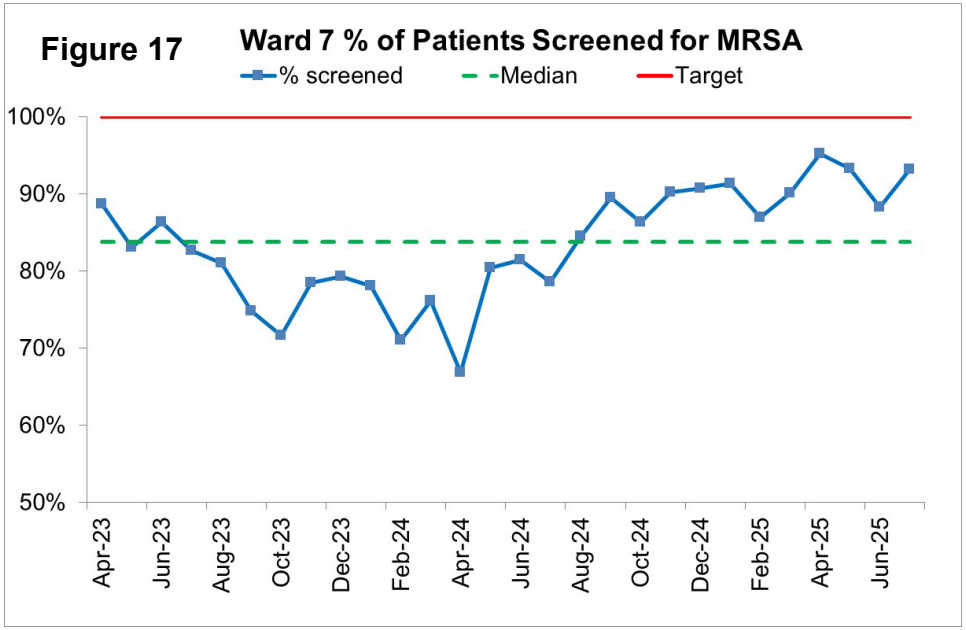
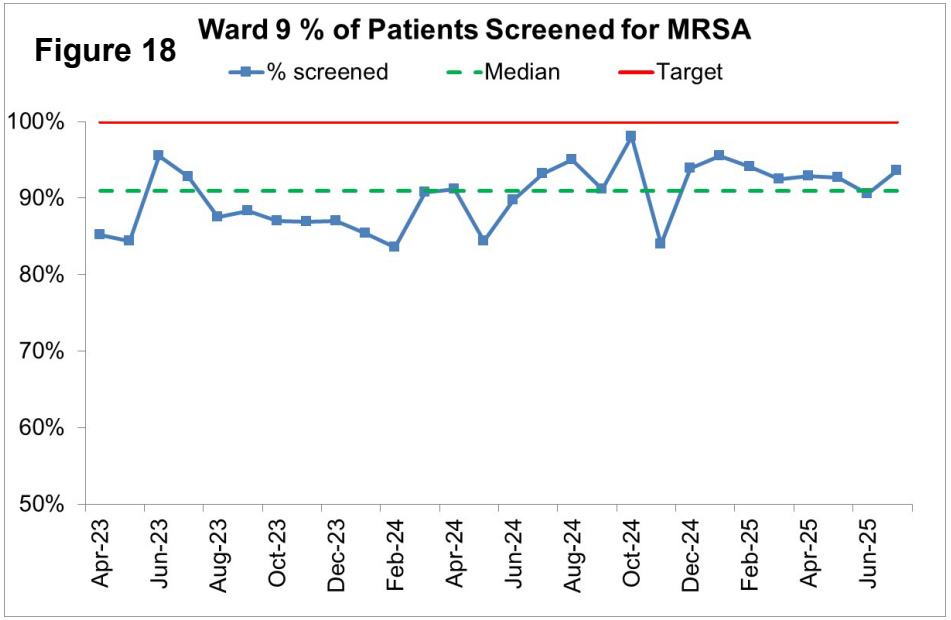


Figure 18 Ward 9 % of Patients Screened for MRSA



3.8 Mandatory Training

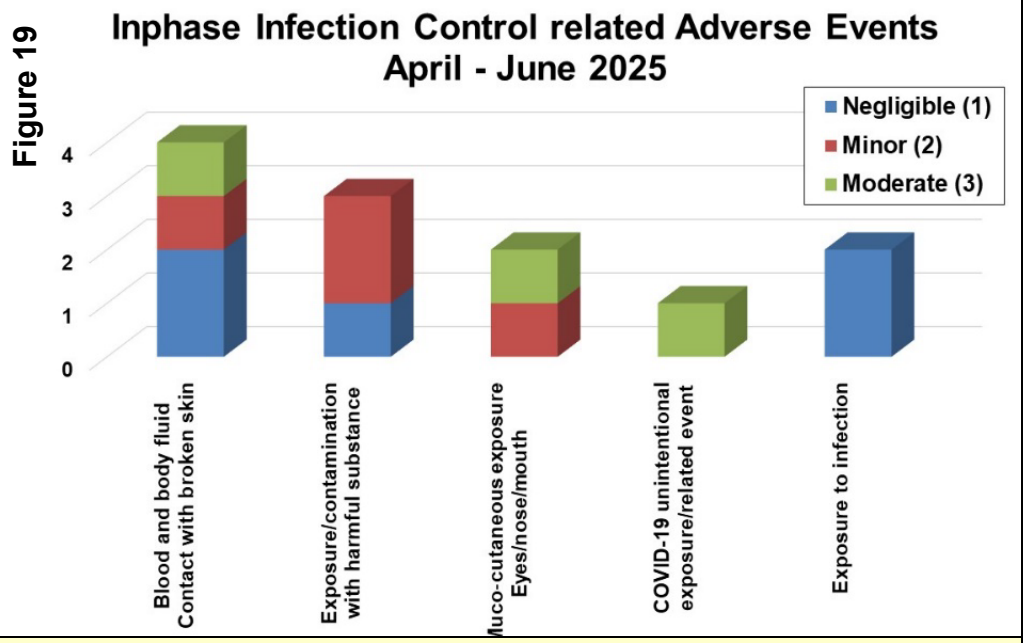
- On 1st July 2025, NHS Borders overall staff training compliance was:
  - Infection Control – Core Mandatory E-Learning Module (all substantive staff) **89%**
  - NHS NES Hand Hygiene – Role Mandatory E-Learning Module (all relevant substantive staff) **24%**
- Please ensure you and your staff comply with the Statutory and Mandatory Training Policy

4.0 Outbreaks and Incidents

4.1 Adverse Events

- The Infection Prevention and Control Team reviews all infection control incidents reported via InPhase and provide topic specialist advice when appropriate
- **Figure 19** shows Infection Control events during the period April – June 2025
- During this period, topic specialist advice was provided in response to one adverse event involving potential infection exposure associated with two patient transfers. On review, the IPCT were content that the patient transfers were appropriate, and an infection exposure incident had not occurred.

Figure 19



4.2 Outbreaks – Key Messages

- Since the last update, there have been 3 closed outbreaks in NHS Borders as at 22/08/25 (**Figure 20**) with the following learning/actions identified:
  - IPCN delivered targeted training to ward staff on hand hygiene and correct PPE use to reinforce control measures
  - Staff were reminded to maintain adequate PPE supplies, especially during ward closures. As part of outbreak management, IPCT will inform Stores of any closures to ensure stock level in affected wards reflect increased usage of key items such as PPE.

Figure 20 – Infection Prevention & Control Daily Outbreak Summary

Daily Outbreak Summary 2025/2026

Location			29/07/25					05/08/25		12/08/25		14/08/25	15/08/25		19/08/25
Ward 4	**Overview**	Organism											Covid-19		
		PAG/IMT held? (Y/N)											N	N	N
	Ward Status	Number of bays closed											1	1	1
		Ward Closed to Admissions											N	N	N
	Patient Information	Number of new laboratory **CONFIRMED** cases											1	0	0
		Number of patients deaths											0	0	0
	Staff Information	New **STAFF** suspected											0	0	0
	Blocked Beds	Number of **EMPTY** blocked beds (does not include single rooms)											0	0	1
	HIIAT Assessment* **Min = Minor** **Mod = Moderate** **Maj = Major**	Severity of illness											Min	Min	Min
		Impact on services											Min	Min	Min
		Risk of transmission											Mod	Mod	Mod
		Public Anxiety											Min	Min	Min
Ward 9	**Overview**	Organism	Covid-19							Covid-19					
		PAG/IMT held? (Y/N)	N	Y	N	Y	N	N		N	N	N			
	Ward Status	Number of bays closed	2	2	2	2	2	1		1	1	0			
		Ward Closed to Admissions (Y/N)	N	N	N	N	N	N		N	N	N			
	Patient Information	Number of new laboratory **CONFIRMED** cases	3	2	1	0	2	0		1	1	0			
		Number of patients deaths	0	0	0	0	0	0		0	0	0			
	Staff Information	New **STAFF** suspected	0	0	0	1	1	0		0	0	0			
	Blocked Beds	Number of **EMPTY** blocked beds (does not include single rooms)	2	2	2	4	6	3		0	0	0			
	HIIAT Assessment* Min = Minor Mod = Moderate Maj = Major	Severity of illness	Min	Min	Min	Min	Min	Min		Min	Min	Min			
		Impact on services	Min	Min	Mod	Mod	Mod	Min		Min	Min	Min			
		Risk of transmission	Min	Min	Mod	Mod	Mod	Mod		Min	Mod	Min			
		Public Anxiety	Min	Min	Min	Min	Min	Min		Min	Min	Min			

*It is a national requirement (DL 2019 23) to use the Healthcare Infection Incident Assessment Tool (HIIAT) to assess every healthcare infection incident

5.0 Quality Improvement

5.1 Prevention of Catheter Associated Urinary Tract Infection (CAUTI)

- The Prevention of CAUTI Group continues to oversee actions to reduce the risk of CAUTI. Recent adverse events identified poor documentation and communication at points of transition of care. To address this, the Prevention of CAUTI Group is establishing a Task and Finish Group with the following specific remit:
  - Develop urinary catheter documentation which will replace use of the Catheter Passport by staff
  - Recommend / develop a patient information leaflet
  - Review the Catheter Policy

6.0 Horizon Scanning

- There are no Infection Prevention and Control alerts since the last report

7.0 National Guidance/Learning

7.1 Policy/guidance updates

- There has been no new guidance or policy updates since the last report.

7.2 Healthcare Improvement Scotland (HIS) Report Findings for noting

Ninewells Hospital – safe delivery of care inspection May 2025 – Healthcare Improvement Scotland

Cleland hospital – mental health safe delivery of care inspection: April 2025 – Healthcare Improvement Scotland

2.3.1 Quality/ Patient Care

Infection prevention and control is central to patient safety.

2.3.2 Workforce

This assessment has not identified any workforce implications.

2.3.3 Financial

This assessment has not identified any specific financial implications.

2.3.4 Risk Assessment/Management

All risks are highlighted within the paper.

2.3.5 Equality and Diversity, including health inequalities

This is an update paper so a full impact assessment is not required.

2.3.6 Climate Change

None identified.

2.3.7 Other impacts

None identified.

2.3.8 Communication, involvement, engagement and consultation

This is a regular update as required by SGHD and has not been subject to any prior consultation or engagement. Much of the data was included in the monthly infection control report presented to divisional clinical governance groups and the Infection Control Committee.

2.3.9 Route to the Meeting

This report has not been submitted to any prior groups or committees but much of the content has been presented to the Clinical Governance Committee.

2.4 Recommendation

Board members are asked to:

- **Discussion** – Examine and consider the implications of a matter.

The Board will be asked to confirm the level of assurance it has received from this report:

- **Moderate Assurance (Recommended)**

3 List of appendices

- Appendix A, Background and Explanation
- Appendix B, Graphs and Data Explanation

Appendix A

Organisms and Infections

1.1 *Escherichia coli* bacteraemia (ECB)

Escherichia coli (*E. coli*) is a bacterium that forms part of the normal gut flora that helps human digestion. Although most types of *E. coli* live harmlessly in your gut, some types can make you unwell.
When it gets into your blood stream, *E. coli* can cause a bacteraemia. Further information is available here:
https://www.gov.uk/government/collections/escherichia-coli-e-coli-guidance-data-and-analysis

NHS Borders participate in the HPS mandatory surveillance programme for ECB. This surveillance supports local and national improvement strategies to reduce these infections and improve the outcomes for those affected. Further information on the surveillance programme can be found here:
https://www.hps.scot.nhs.uk/a-to-z-of-topics/escherichia-coli-bacteraemia-surveillance/

1.2 *Staphylococcus aureus* Bacteraemia (SAB)

Staphylococcus aureus is an organism which is responsible for a large number of healthcare associated infections, although it can also cause infections in people who have not had any recent contact with the healthcare system. The most common form of this is Meticillin Sensitive *Staphylococcus Aureus* (MSSA), but the more well-known is MRSA (Meticillin Resistant *Staphylococcus Aureus*), which is a specific type of the organism which is resistant to certain antibiotics and is therefore more difficult to treat. More information on these organisms can be found at:

Staphylococcus aureus : https://www.nhs.uk/conditions/staphylococcal-infections/

MRSA: https://www.nhs.uk/conditions/mrsa/

NHS Boards carry out surveillance of *Staphylococcus aureus* blood stream infections, known as bacteraemia. These are a serious form of infection and there is a national target to reduce them. The number of patients with MSSA and MRSA bacteraemia for the Board can be found at the end of section 1 and for each hospital in section 2. Information on the national surveillance programme for *Staphylococcus aureus* bacteraemia can be found at:
https://www.hps.scot.nhs.uk/publications/?topic=HAI%20Quarterly%20Epidemiological%20Data

1.3 *Clostridioides difficile* infection (CDI)

Clostridioides difficile is an organism which is responsible for a large number of healthcare associated infections, although it can also cause infections in people who have not had any recent contact with the healthcare system. More information can be found at: http://www.nhs.uk/conditions/Clostridium-difficile/Pages/Introduction.aspx

NHS Boards carry out surveillance of *Clostridioides difficile* infections (CDI), and there is a national target to reduce these. The number of patients with CDI for the Board can be found at the end of section 1 and for each hospital in section 2. Information on the national surveillance programme for *Clostridioides difficile* infections can be found at: https://www.hps.scot.nhs.uk/a-to-z-of-topics/clostridioides-difficile-infection/#data

1.4 Carbapenemase-producing enterobacteriaceae (CPE)

Enterobacteriaceae are a family of bacteria which are part of the normal range of bacteria found in the gut of all humans and animals. However, these organisms are also some of the most common causes of opportunistic urinary tract infections, intra-abdominal infections and bloodstream infections. They include species such as E. coli, Klebsiella sp., Proteus sp. and Enterobacter sp.

Carbapenems are a valuable family of very broad-spectrum antibiotics which are normally reserved for serious infections caused by drug-resistant bacteria (including Enterobacteriaceae). They include meropenem, ertapenem, imipenem and doripenem.

Carbapenemase-producing Enterobacteriaceae (CPE) are a type of Enterobacteriaceae that are resistant to carbapenem antibiotics. These bacteria carry a gene for a carbapenemase enzyme that breaks down carbapenem antibiotics. There are different types of carbapenemases. Infections caused by CPE are associated with high rates of morbidity and mortality and can have severe clinical consequences.

Treatment of these infections is increasingly difficult as these organisms are often resistant to many and sometimes all available antibiotics.

1.5 Enterobacter cloacae complex

The Enterobacter cloacae complex is a group of closely related bacteria that are commonly found in the environment and can cause infections, particularly in healthcare settings. These bacteria are opportunistic pathogens, meaning they can cause illness when the body's defences are weakened. There are growing concerns about antibiotic resistance with these bacteria making infections harder to treat.

Appendix B

Graphs and Data

This report routinely includes Statistical Process Control (SPC) charts to analyse data. All systems including healthcare operate with a level of variation. The graphs generally display an Upper Control Limits (UCL) and / or Lower Control Limits (LCL). When the plotted line is within these limits, it is an indication that a system is stable. The graphs help us by highlighting where the amount of variation is exceptional and outside the normal predicted limits which is indicative that something in the system has changed.

2.1 Funnel plots

A funnel plot chart is designed to distinguish natural variation from statistically significant outliers. The funnel narrows on the right of the graph as the larger health Boards will have less fluctuation in their rates due to greater Total Occupied Bed Days (TOBDs). Any plot that is within the blue funnel is not a statistical outlier.

2.2 C Charts

A control chart that monitors the total number of nonconformities (defects) per unit or subgroup. For example, used to analyse the number of infections per month within NHS Borders.

2.3 G Charts

A control chart used to monitor the frequency of rare events over time. For example, the number of days between infections when there are low numbers of cases each month.

Traditional charts which show the number of cases per month can make it more difficult to spot either improvement or deterioration. These charts highlight any statistically significant events which are not part of the natural variation within our health system.

It is important to remember that as these graphs plot the number of days between infections, we are trying to achieve performance above the green average line.

2.4 U Charts

A control chart used to monitor the average number of nonconformities per unit, or defects per unit, when sample sizes can vary. For example, used to analyse infection rates across all Boards in Scotland.

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**2 October 2025**
Title:	**Whistleblowing Quarter 1 Report**
Responsible Executive/Non-Executive:	**L Livesey, Whistleblowing Champion** **A Carter, Executive Lead Whistleblowing**
Report Author:	**I Bishop, Board Secretary**

1 Purpose

This is presented to the Board for:

- Awareness

This report relates to a:

- Government policy/directive
- Legal requirement

This aligns to the following NHSScotland quality ambition(s):

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

To provide the Board with the Quarter 1 report on Whistleblowing.

2.2 Background

The National Whistleblowing Standards (the Standards) set out how all NHS service providers in Scotland must handle concerns that have been raised with them about risks to patient safety and effective service delivery. They apply to all services provided by or on behalf of NHS Scotland and must be accessible to all those working in those services, whether they are directly employed by the NHS or a contracted organisation. The Standards specify high level principles plus a detailed process for investigating concerns which all NHS organisations in Scotland must follow.

Health Boards have particular responsibilities regarding the implementation of the Standards:

- Ensuring that their own whistleblowing procedures and governance arrangements are fully compliant with the Standards.
- Ensuring there are systems in place for primary care providers in their area to report performance data on handling concerns.
- Working with higher education institutions and voluntary organisations to ensure that anyone working to deliver NHS Scotland services (including students, trainees and volunteers) has access to the Standards and knows how to use them to raise concerns.

2.3 Assessment

The Standards require all NHS Boards to report quarterly and annually on a set of key performance indicators (KPIs) and detailed information on three key statements:

- Learning, changes or improvements to services or procedures as a result of consideration of whistleblowing concerns.
- The experience of all those involved in the whistleblowing procedure.
- Staff perceptions, awareness, and training.

2.3.1 Quality/ Patient Care

Patient Safety/Clinical Impact implications will be addressed in the management of any findings/actions/decisions resulting from any whistleblowing concerns raised.

2.3.2 Workforce

Staffing implications will be addressed in the management of any findings/actions/decisions resulting from any whistleblowing concerns raised.

2.3.3 Financial

Resource implications will be addressed in the management of any findings/actions/decisions resulting from any whistleblowing concerns raised.

2.3.4 Risk Assessment/Management

Risk assessment will be addressed in the management of any findings/actions/decisions resulting from any whistleblowing concerns raised.

2.3.5 Equality and Diversity, including health inequalities

An impact assessment has not been completed.

2.3.6 Climate Change

Not Applicable.

2.3.7 Other impacts

Not Applicable.

2.3.8 Communication, involvement, engagement and consultation

Not Applicable.

2.3.9 Route to the Meeting

This has been formulated directly for the Board.

2.4 Recommendation

- **Awareness** – For Members' information only.

The Board is asked to note the Whistleblowing Quarter 1 report.

The Board will be asked to confirm the level of assurance it has received from this report:

- Significant Assurance
- **Moderate Assurance (recommended)**
- Limited Assurance
- No Assurance

If a single level of assurance cannot be determined Officers are asked to suggest a level based on the following split of assurance:

- **Systems and Processes**
- **Outcomes**

3 List of appendices

The following appendices are included with this report:

- Appendix No1: Whistleblowing Quarter 1 Report

Whistleblowing Performance Report

Quarter 1

1 April 2025 to 30 June 2025

Author: Iris Bishop, Board Secretary/INWO Liaison Officer

Contents Whistleblowing Concerns – Quarter 1

1. CONTEXT

The National Whistleblowing Standards (the Standards) set out how all NHS service providers in Scotland must handle concerns that have been raised with them about risks to patient safety and effective service delivery. They apply to all services provided by or on behalf of NHS Scotland and must be accessible to all those working in those services, whether they are directly employed by the NHS or a contracted organisation. The Standards specify high level principles plus a detailed process for investigating concerns which all NHS organisations in Scotland must follow.

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To comply with the whistleblowing principles for the NHS as defined by the Standards, an effective procedure for raising whistleblowing concerns needs to be:

> *'open, focused on improvement, objective, impartial and fair, accessible, supportive to people who raise a concern and all people involved in the procedure, simple and timely, thorough, proportionate and consistent.'*

A staged process has been developed by the INWO. There are two stages of the process which are for NHS Borders to deliver, and the INWO can act as a final, independent review stage, if required.

> • **Stage 1: Early resolution** – for simple and straightforward concerns that involve little or no investigation and can be handled by providing an explanation or taking limited action – 5 working days.
>
> • **Stage 2: Investigation** – for concerns which tend to be serious or complex and need a detailed examination before the organisation can provide a response – 20 working days.

The Standards require all NHS Boards to report quarterly and annually on a set of key performance indicators (KPIs) and detailed information on three key statements:

- Learning, changes or improvements to services or procedures as a result of consideration of whistleblowing concerns.
- The experience of all those involved in the whistleblowing procedure.
- Staff perceptions, awareness, and training.

2. AREAS COVERED BY THE REPORT

Since the go-live of the Standards in April 2021, processes have been put in place to gather whistleblowing information raised across all NHS services to which the Standards apply. Within NHS Borders in the Health and Social Care Partnership (HSCP) any concerns raised about the delivery of a health service by the HSCP are reported and recorded using the same reporting mechanism which is in place for those staff employed by NHS Borders.

The General Manager for Primary & Community Services has responsibility for concerns raised within and about primary care service provision.

3. IMPLEMENTATION AND RAISING AWARENESS

Work had taken place to raise awareness of the Standards and during this reporting year as part of our improvement plan we are looking to revisit the local processes in place and revise/refresh in light of any learning.

In addition, our plans include the actions outlined below:

- Continue to promote the Standards and how to raise concerns safely within the organisation across the year and specifically utilising Speak Up Week.
- In conjunction with our HR Department train more staff in the process of investigations for both whistleblowing investigations and other investigations.
- Continuous improvement of our processes based on learning and experience.
- Formulate meaningful training plans through our confidential contacts network.
- For each complaint that is upheld or partially upheld formulate an action plan to be put in place to address any shortcomings or apply any identified learning.

4. QUARTER 1 PERFORMANCE INFORMATION APRIL 2025 – JUNE 2025

Under the terms of the Standards, the quarterly performance report must contain information on the following indicators:

Indicator 1 - Total number of concerns, and concerns by Stage

For the Quarter 1 period we have received zero concerns at Stage 1 and zero concerns at Stage 2.

Indicator 2 - Concerns closed at Stage 1 and Stage 2 as a percentage of all concerns closed

For the Quarter 1 period we have zero concerns closed at Stage 1 and zero concerns closed at Stage 2.

Indicator 3 - Concerns upheld, partially upheld and not upheld as a percentage of all concerns closed in full at each stage

For the Quarter 1 period we have zero concerns upheld, partially upheld or not upheld.

Indicator 4 - The average time in working days for a full response

For the Quarter 1 period we continue to have 1 concern at Stage 2 that is held in abeyance until all HR processes have been concluded.

Indicator 5 - Number and percentage of concerns closed in full within set timescales

For the Quarter 1 period we continue to have 1 concern at Stage 2 that is held in abeyance until all HR processes have been concluded.

5. CONCERNS WHERE AN EXTENSION WAS AUTHORISED

For the Quarter 1 period we continue to have 1 concern at Stage 2 that is held in abeyance until all HR processes have been concluded.

6. PRIMARY CARE CONTRACTORS

Primary care contractors (GP practices, dental practices, optometry practices and community pharmacies) are also covered by the Standards.

In total 0 returns were received for the Quarter 1 period for Stage 1 or Stage 2 concerns from:-

22 GP Practices
19 Dental Practices
15 Optometry Practices
29 Community Pharmacies

7. ANONYMOUS CONCERNS

Concerns cannot be raised anonymously under the Standards, nor can they be considered by the INWO. However good practice is to follow the whistleblowing principals and investigate the concern in line with the Standards, as far as practicable.

The definition of an anonymous concern is ‘a concern which has been shared with the organisation in such a way that nobody knows who provided the information’.

There were zero anonymous concerns received during the Quarter 1 period.

8. LEARNING, CHANGES OR IMPROVEMENTS TO SERVICES OR PROCEDURES

System-wide learning, changes or improvements to services can be limited by the need to maintain confidentiality of individual whistleblowers. For each complaint that is upheld or partially upheld a documented action plan will be formulated to address any shortcomings or apply any identified learning.

9. EXPERIENCE OF INDIVIDUALS RAISING CONCERNS

All those who raise concerns are given the opportunity to feedback on their experience of using the Whistleblowing procedure in order that we can learn and make any improvements in our processes as appropriate.

10. STAFF TRAINING

A staff guide has been produced. Investigation training is run by the HR Department for those who may be involved in taking or investigating any matter including whistleblowing concerns. We continue to monitor the uptake of training and promote the TURAS learning modules.

11. INWO INVESTIGATION

We were notified on 16 June 2025 that INWO would be undertaking an investigation in regard to a matter concerning confidentiality. All information requested by INWO was submitted.

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**2 October 2025**
Title:	**Whistleblowing Quarter 2 Report**
Responsible Executive/Non-Executive:	**L Livesey, Whistleblowing Champion** **A Carter, Executive Lead Whistleblowing**
Report Author:	**I Bishop, Board Secretary**

1 Purpose

This is presented to the Board for:

- Awareness

This report relates to a:

- Government policy/directive
- Legal requirement

This aligns to the following NHSScotland quality ambition(s):

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

To provide the Board with the Quarter 1 report on Whistleblowing.

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The National Whistleblowing Standards (the Standards) set out how all NHS service providers in Scotland must handle concerns that have been raised with them about risks to patient safety and effective service delivery. They apply to all services provided by or on behalf of NHS Scotland and must be accessible to all those working in those services, whether they are directly employed by the NHS or a contracted organisation. The Standards specify high level principles plus a detailed process for investigating concerns which all NHS organisations in Scotland must follow.

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- Ensuring that their own whistleblowing procedures and governance arrangements are fully compliant with the Standards.
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- Working with higher education institutions and voluntary organisations to ensure that anyone working to deliver NHS Scotland services (including students, trainees and volunteers) has access to the Standards and knows how to use them to raise concerns.

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The Standards require all NHS Boards to report quarterly and annually on a set of key performance indicators (KPIs) and detailed information on three key statements:

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- The experience of all those involved in the whistleblowing procedure.
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Staffing implications will be addressed in the management of any findings/actions/decisions resulting from any whistleblowing concerns raised.

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2.3.4 Risk Assessment/Management

Risk assessment will be addressed in the management of any findings/actions/decisions resulting from any whistleblowing concerns raised.

2.3.5 Equality and Diversity, including health inequalities

An impact assessment has not been completed.

2.3.6 Climate Change

Not Applicable.

2.3.7 Other impacts

Not Applicable.

2.3.8 Communication, involvement, engagement and consultation

Not Applicable.

2.3.9 Route to the Meeting

This has been formulated directly for the Board.

2.4 Recommendation

- **Awareness** – For Members' information only.

The Board is asked to note the Whistleblowing Quarter 2 report.

The Board will be asked to confirm the level of assurance it has received from this report:

- Significant Assurance
- **Moderate Assurance (recommended)**
- Limited Assurance
- No Assurance

If a single level of assurance cannot be determined Officers are asked to suggest a level based on the following split of assurance:

- **Systems and Processes**
- **Outcomes**

3 List of appendices

The following appendices are included with this report:

- Appendix No1: Whistleblowing Quarter 2 Report

Whistleblowing Performance Report

Quarter 2

1 July 2025 to 30 September 2025

Author: Iris Bishop, Board Secretary/INWO Liaison Officer

Contents Whistleblowing Concerns – Quarter 2

1. CONTEXT

The National Whistleblowing Standards (the Standards) set out how all NHS service providers in Scotland must handle concerns that have been raised with them about risks to patient safety and effective service delivery. They apply to all services provided by or on behalf of NHS Scotland and must be accessible to all those working in those services, whether they are directly employed by the NHS or a contracted organisation. The Standards specify high level principles plus a detailed process for investigating concerns which all NHS organisations in Scotland must follow.

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> *'open, focused on improvement, objective, impartial and fair, accessible, supportive to people who raise a concern and all people involved in the procedure, simple and timely, thorough, proportionate and consistent.'*

A staged process has been developed by the INWO. There are two stages of the process which are for NHS Borders to deliver, and the INWO can act as a final, independent review stage, if required.

> • **Stage 1: Early resolution** – for simple and straightforward concerns that involve little or no investigation and can be handled by providing an explanation or taking limited action – 5 working days.
>
> • **Stage 2: Investigation** – for concerns which tend to be serious or complex and need a detailed examination before the organisation can provide a response – 20 working days.

The Standards require all NHS Boards to report quarterly and annually on a set of key performance indicators (KPIs) and detailed information on three key statements:

- Learning, changes or improvements to services or procedures as a result of consideration of whistleblowing concerns.
- The experience of all those involved in the whistleblowing procedure.
- Staff perceptions, awareness, and training.

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Since the go-live of the Standards in April 2021, processes have been put in place to gather whistleblowing information raised across all NHS services to which the Standards apply. Within NHS Borders in the Health and Social Care Partnership (HSCP) any concerns raised about the delivery of a health service by the HSCP are reported and recorded using the same reporting mechanism which is in place for those staff employed by NHS Borders.

The General Manager for Primary & Community Services has responsibility for concerns raised within and about primary care service provision.

3. IMPLEMENTATION AND RAISING AWARENESS

Work had taken place to raise awareness of the Standards and during this reporting year as part of our improvement plan we are looking to revisit the local processes in place and revise/refresh in light of any learning.

In addition, our plans include the actions outlined below:

- Continue to promote the Standards and how to raise concerns safely within the organisation across the year and specifically utilising Speak Up Week.
- In conjunction with our HR Department train more staff in the process of investigations for both whistleblowing investigations and other investigations.
- Continuous improvement of our processes based on learning and experience.
- Formulate meaningful training plans through our confidential contacts network.
- For each complaint that is upheld or partially upheld formulate an action plan to be put in place to address any shortcomings or apply any identified learning.

4. QUARTER 2 PERFORMANCE INFORMATION JULY 2025 – SEPTEMBER 2025

Under the terms of the Standards, the quarterly performance report must contain information on the following indicators:

Indicator 1 - Total number of concerns, and concerns by Stage

For the Quarter 2 period we have received 1 concerns at Stage 1 and zero concerns at Stage 2.

Indicator 2 - Concerns closed at Stage 1 and Stage 2 as a percentage of all concerns closed

For the Quarter 2 period we have 1 concern closed at Stage 1 and zero concerns closed at Stage 2.

Indicator 3 - Concerns upheld, partially upheld and not upheld as a percentage of all concerns closed in full at each stage

For the Quarter 2 period there was 1 concern upheld, partially upheld or not upheld.

Indicator 4 - The average time in working days for a full response

For the Quarter 2 period the concern raised at Stage 1 was concluded in 2 days.

For the Quarter 2 period we continue to have 1 concern at Stage 2 that is held in abeyance until all HR processes have been concluded.

Indicator 5 - Number and percentage of concerns closed in full within set timescales

For the Quarter 2 period the concern raised at Stage 1 was concluded within the 5 days timescale prescribed.

For the Quarter 2 period we continue to have 1 concern at Stage 2 that is held in abeyance until all HR processes have been concluded.

5. CONCERNS WHERE AN EXTENSION WAS AUTHORISED

For the Quarter 2 period we continue to have 1 concern at Stage 2 that is held in abeyance until all HR processes have been concluded.

6. PRIMARY CARE CONTRACTORS

Primary care contractors (GP practices, dental practices, optometry practices and community pharmacies) are also covered by the Standards.

In total 0 returns were received for the Quarter 2 period for Stage 1 or Stage 2 concerns from:-

22 GP Practices
19 Dental Practices
15 Optometry Practices
29 Community Pharmacies

7. ANONYMOUS CONCERNS

Concerns cannot be raised anonymously under the Standards, nor can they be considered by the INWO. However good practice is to follow the whistleblowing principals and investigate the concern in line with the Standards, as far as practicable.

The definition of an anonymous concern is ‘a concern which has been shared with the organisation in such a way that nobody knows who provided the information’.

There were zero anonymous concerns received during the Quarter 2 period.

8. LEARNING, CHANGES OR IMPROVEMENTS TO SERVICES OR PROCEDURES

System-wide learning, changes or improvements to services can be limited by the need to maintain confidentiality of individual whistleblowers. The future aim is that for each complaint that is upheld or partially upheld a documented action plan will be formulated to address any shortcomings or apply any identified learning.

9. EXPERIENCE OF INDIVIDUALS RAISING CONCERNS

All those who raise concerns are given the opportunity to feedback on their experience of using the Whistleblowing procedure in order that we can learn and make any improvements in our processes as appropriate.

10. STAFF TRAINING

A staff guide had been produced and an updated flow chart has also been produced. Investigation training is run by the HR Department for those who may be involved in taking or investigating any matter including whistleblowing concerns. We continue to monitor the uptake of training and promote the TURAS learning modules.

During this reporting period the Director of HR, OD & OH&S has also formulated a presentation “Whistleblowing – What do I need to know and do” (Appendix 1) and presented it to staff in a range of departments across NHS Borders to raise awareness.

The intranet and internet whistleblowing pages have also been updated during this period.

WHISTLEBLOWING

What do I need to know … and do?

ANDY CARTER, DIRECTOR OF HR

Whistleblowing is the act of an employee, student, contractor or volunteer reporting perceived wrong-doing within an organization, particularly when it is in the **public interest**

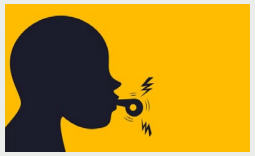
It involves disclosing information about perceived illegal/criminal activities (fraud, theft), breaches of legal obligations/codes of conduct, or other harmful practices, potentially affecting the health, safety, and/or well-being of others

We should always try to resolve any queries/concerns in a *business as usual* way first

Stage 1
EARLY RESOLUTION
Straightforward issues to look into and explain findings (5 days)

Stage 2
INVESTIGATION
More complex matters requiring more time/energy (20 days)

INWO
(backstop)



Doctor and husband jailed after selling PPE stolen from NHS during

Covid pandemic

Examples of people blowing the whistle, or when perhaps they should have .. but were maybe afraid or unsure

Independent National Whistleblowing Officer (INWO)

the aim of the role is to make sure everyone delivering NHS services in Scotland is able to speak out to raise concerns, ultimately contributing to ensuring that the NHS in Scotland is as well run as possible

The INWO Standards

- Part of **S**cottish **P**ublic **S**ervices **O**mbudsman office, established 2021
- Whistleblowing procedures must be open, **focussed on improvement**, **impartial, supportive**, simple, timely, thorough & consistent
- People must be able to raise concerns, confident that they can do so in a protected & anonymous way, that will not cause them personal detriment

For NHS organisations | INWO

NHS Borders Obligations

Have a Whistleblowing **Champion** – Lynne Livesey (Non-Executive) and **Confidential Contacts** (Iris Bishop co-ordinates).

Main source of NHSB information :

www.nhsborders.scot.nhs.uk/corporate-information/whistleblowing/

Procedure to be followed (2 main stages) :

NHSB-Raising-Whistleblowing-Concerns-Guide-for-Staff-2024-.pdf

Flowchart :
https://www.nhsborders.scot.nhs.uk/media/1120757/Whistleblowing-Flowchart-Sep25-.pdf

How can you help?

For ALL staff – general awareness raising

https://www.youtube.com/watch?v=peapzvBr8vU

For Line Management – complete training modules

https://learn.nes.nhs.scot/40284/national-whistleblowing-standards-training

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**2 October 2025**
Title:	**NHS Borders Integrated Performance Report (IPR) - August 2025**
Responsible Executive/Non-Executive:	**J Smyth, Director of Planning & Performance**
Report Authors:	**C Graham, P&P Officer** **C Lyall, Senior P&P Manager** **M Mallin, BI Developer**

1 Purpose

This is presented to the Board for:

- Awareness

This report relates to a:

- Annual Operational Plan / Remobilisation Plan

This aligns to the following NHSScotland quality ambition(s):

- Safe
- Effective

2 Report summary

2.1 Situation

A new Integrated Performance Report (IPR) has been developed using Power BI, with measures and performance monitoring focussed on a Quality Improvement approach. The IPR reflects our Organisational Strategy commitments, the Annual Delivery Plan (ADP) targets and other local Key Performance Indicatiors (KPIs). Whilst this version of the IPR does not include all measures which we have identified for inclusion, it is the first iteration and will be continually developed over the coming months to include these as performance standards are agreed and dashboards created locally.

2.2 Background

A performance report is presented to each Board meeting so that performance against the key standards (national targets and locally agreed standards) can be scrutinised,

and corrective action can be reviewed. The IPR will enhance the data presented to the Board and as outlined above will over time, include more measures. **Appendix 2** outlines the additional measures that will be developed over the coming months and added to the IPR.

The IPR aims to:

- Unify reporting across clinical, operational, and financial domains using a Quality Improvement approach
- Improve transparency and trust through accessible reporting, with one single source
- Enhance decision-making through timely, accurate, and actionable data
- Support continuous improvement by identifying trends and benchmarking performance
- Focus on the measures that require actions to improve

The tables below gives an overview of the key symbols displayed in the IPR, clearly illustrating what the data is telling us.

Figure 1: Variation and Assurance Key

Variation			Assurance		
					
Common cause – no significant change	Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values	Special cause of improving nature or lower pressure due to (H)igher or (L)ower values	Variation indicates inconsistently hitting passing and falling short of the target	Variation indicates consistently (P)assing the target	Variation indicates consistently (F)alling short of the target

Figure 2: Astronomical Points – Sigma Violation

Astronomical Points – Sigma Violation

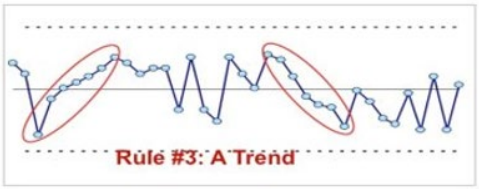
These are points outside the Control Limits, either improving or deteriorating performance depending on colour:

Improving Astronomical Point

Deteriorating Astronomical Point

Shifts

This where there are 6 or more data points in a row above or below the average:

Imp. Shift — Improving Shift Det. Shift — Deteriorating Shift	Eight or more consecutive points above or below the centerline 
Trend This is where there are 6 or more points heading upwards or downwards:	
Imp. Trend — Improving Trend Det. Trend — Deteriorating Trend	Six consecutive points increasing (trend up) or decreasing (trend down) 

2.3 Assessment

At the beginning of 2025, a benchmarking exercise was conducted to compare our Board's scorecard reporting with that of several other NHS organisations, both north and south of the Border, including Northumbria, Highland, Fife, Dumfries & Galloway and Lanarkshire. Members of the Planning & Performance team collaborated with Executive Directors to identify proposed performance indicators and metrics relevant to their respective areas of responsibility, which they intend to include in future reporting. It should be noted that discussions regarding Women & Children's Services (W&CS) and Primary & Community Services (P&CS) metrics are ongoing, and the current list of indicators remains provisional.

The new IPR was presented as a first iteration on 11 September 2025 and will continue to be reported on a monthly basis to both the Resource & Performance Committee (R&PC) and NHS Borders Board, for discussion and assurance. The IPR will be continually developed over the coming months to ensure all required measures are included, enabling the Board to have a robust reporting system in 2026/27 for all commitments.

Lead Directors will be accountable for reviewing and formally approving the sections of the report relevant to their portfolios prior to submission.

The introduction of Integrated Performance Reporting will enhance the Board's capacity to deliver high-quality, person-centred care by providing a more cohesive and transparent view of performance across services. Aligned with national policy and local strategic priorities, this approach strengthens governance by enabling Board members to more effectively interpret and connect key performance indicators, identify trends, and assess service impact. It also facilitates more informed scrutiny and challenge, empowering the Board to hold the Board Executive Team (BET) to account for operational delivery and continuous improvement.

2.3.1 Quality/ Patient Care

The ADP milestones and trajectories, Annual Operational Plan measures and Local Delivery Plan standards are key monitoring tools of Scottish Government in ensuring Patient Safety, Quality and Effectiveness.

2.3.2 Workforce

Directors are asked to support the implementation and monitoring of measures within their service areas.

2.3.3 Financial

Directors are asked to support financial management and monitoring of finance and resources within their service areas.

2.3.4 Risk Assessment/Management

There are several measures that are not being achieved and have not been achieved recently. For these measures service leads continue to take corrective action or outline risks and issues to get them back on trajectory. Continuous monitoring of performance is a key element in identifying risks affecting Health Service delivery to the people of the Borders.

2.3.5 Equality and Diversity, including health inequalities

Services will carry out Equality & Human Rights Impact Assessment's (EHRIA) as part of delivering 2025/26 ADP key deliverables.

2.3.6 Climate Change

None Highlighted

2.3.7 Other impacts

None Highlighted

2.3.8 Communication, involvement, engagement and consultation

This is an internal performance report and as such no consultation with external stakeholders has been undertaken.

2.3.8 Route to the Meeting

The IPR has been developed by the Business Intelligence Team with any associated narrative being provided by the relevant service area and collated by the Planning & Performance Team.

2.4 Recommendation

The Board is asked to note the report.

The Board will be asked to confirm the level of assurance it has received from this report.

- Significant Assurance
- Moderate Assurance
- Limited Assurance
- No Assurance

If a single level of assurance cannot be determined Officers are asked to suggest a level based on the following split of assurance:

- **Systems and Processes**
- **Outcomes**

3 List of appendices

The following appendices are included with this report:

- **Appendix 1:** NHS Borders Integrated Performance Report August 2025
- **Appendix 2:** Development of Additional Measures

NHS Borders

Integrated Performance Dashboard

August 2025

Last Refresh Date: 25/09/2025

Integrated Performance Dashboard - Information

The Integrated Performance Report contains a page per performance measure where Statistical Process Control charts are used to show whether each measure is under control, or whether there are variations in the data that show performance requires exploring. The charts also show targets for achievement, and this is another consideration when viewing the data (red lines). Is the target being achieved or performance improving towards target or deteriorating. Table 1 below shows the rules that are highlighted in the charts to highlight whether further investigation is required or not.

Confidence Levels – Upper Control Limit (UCL) & Lower Confidence Limit (LCL)

The Confidence Limits are shown in the charts with a dotted line either side of the green mean line. The wider the Upper Confidence Limit and Lower Confidence Limit the more varied the data is, the closer the Limits are together the more stable it is.

Variation			Assurance		
					
Common cause – no significant change	Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values	Special cause of improving nature or lower pressure due to (H)igher or (L)ower values	Variation indicates inconsistently hitting passing and falling short of the target	Variation indicates consistently (P)assing the target	Variation indicates consistently (F)alling short of the target

Table 1 - Special Cause Variations

Astronomical Points – Sigma Violation

These are points outside the Control Limits, either improving or deteriorating performance depending on colour:

Imp. Ast. Point - Improving Astronomical Point

Det. Ast. Point - Deteriorating Astronomical Point

Shifts

This where there are 6 or more data points in a row above or below the average:

Imp. Shift - Improving Shift

Det. Shift - Deteriorating Shift

Trend

This is where there are 6 or more points heading upwards or downwards:

Imp. Trend - Improving Trend

Det. Trend - Deteriorating Trend

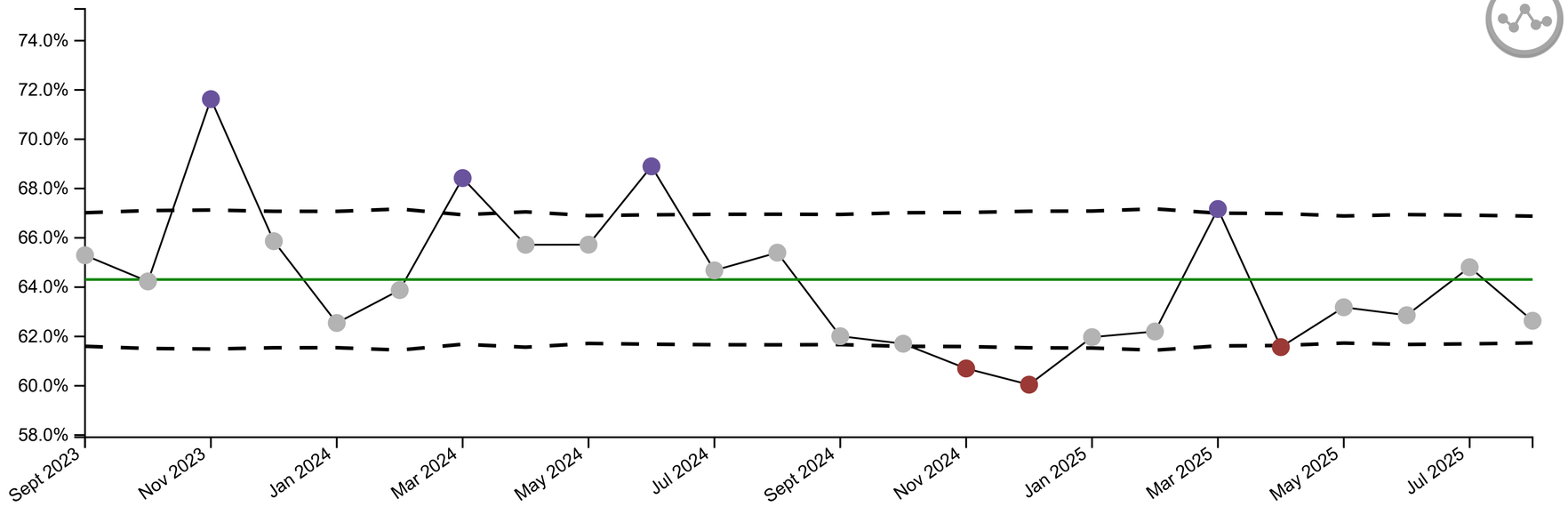
Measure Name	Measure Description	Latest Position	Assurance Status	Variation Status
Emergency Access Standard	Percentage of patients seen within 4 hours of attendance	62.6%		
8 Hour Breaches	Percentage of patients who waited greater than 8 hours	14.6%		
12 Hour Breaches	Percentage of patients who waited greater than 12 hours	9.8%		
Length of Stay	Average Length of stay. Non-elective only. Excludes paediatric and obstetirc specialties and ITU wards	10.0		
Bed Occupancy	Number of acute occupied beds at end of month	93.07%		
Delayed Discharges	Number of delayed discharges at end of month	46		L
Ambulance Handover Time	Average ambulance handover time in minutes per month	33.23	F	
AAU Admissions	Number of patients admitted to AAU	347		H
Outpatient Waiting List	Number of outpatients waiting over 52 weeks	1176		L
Inpatient Waiting List	Number of inpatients waiting over 52 weeks	329		L
Theatre Utilisation	Theatre utilisation per month. Elective only, excludes theatre 5	73.7%		
Diagnostics Over 6 Weeks	Number of patients waiting over 6 weeks	661		H
Cancer 62 Days	Percentage of patients treated within 62 days of referral	72.4%	F	
Cancer 31 Days	Percentage of patients treated within 31 days of referral	95.1%	P	L
Cancer Backlog	Number of patients waiting over 62 days for treatment	14		L
CAMHS RTT	Percentage of patients received treatment within 18 weeks of referral	100.0%	?	H
Psychological Therapy	Percentage of patients received treatment within 18 weeks of referral	81.4%	?	
BAS 3 Week Target	Percentage of Patients treated within 3 weeks of referral	98.0%	P	
Workforce Absence	% of hours lost for all departments per month	5.34%	F	L

Integrated Performance Dashboard - Urgent & Unscheduled Care

NHS Borders

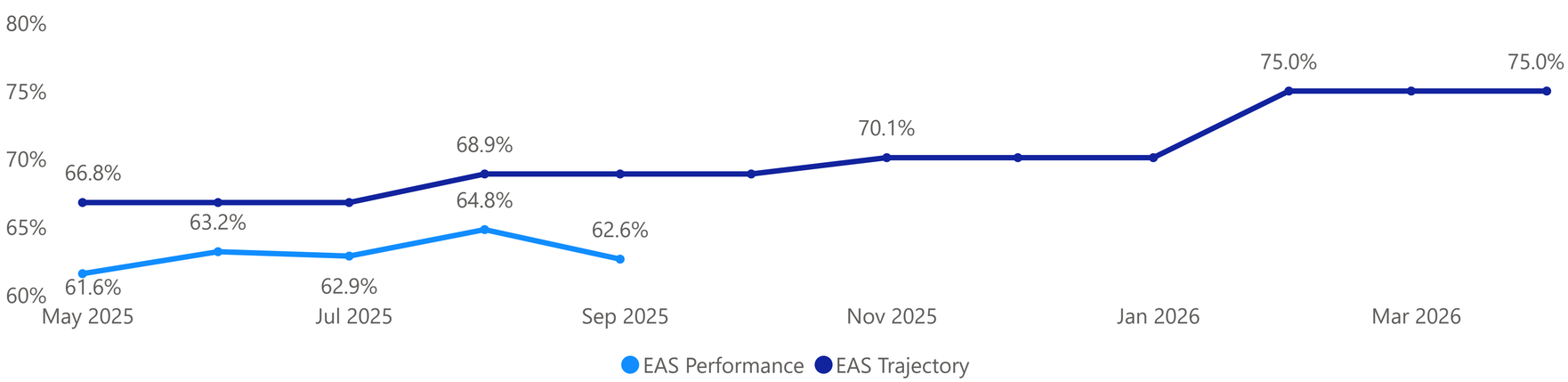
Emergency Access Standard

p-Chart: % of Patients seen within 4 hours of attendance



Mean Line | 99% Limits | Imp. Trend | Det. Trend | Imp. Ast. Point | Det. Ast. Point | Imp. Shift | Det. Shift

Performance against Trajectory



Month

August 2025

The data shows normal variation however performance remains off trajectory. Performance for August was 62.6%. Trajectory is 68% and therefore -5.4% variance. Plans to support the improvement of flow are being managed through the UUC, and include AAU and the Frailty Unit.

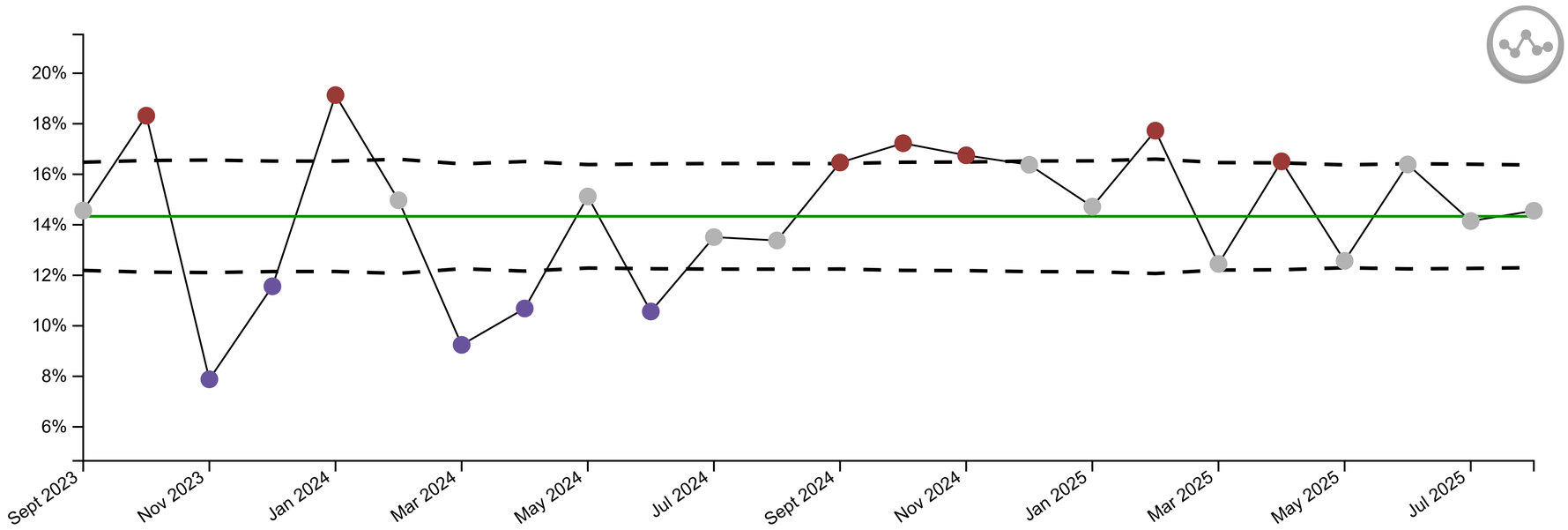
MonthEndDate	Attendances	Breaches	EAS
31/08/2025	3126	1958	62.6%
31/07/2025	3032	1965	64.8%
30/06/2025	2978	1872	62.9%
31/05/2025	3110	1965	63.2%
30/04/2025	2883	1775	61.6%
31/03/2025	2851	1915	67.2%
28/02/2025	2516	1565	62.2%
31/01/2025	2677	1659	62.0%

Integrated Performance Dashboard - Urgent & Unscheduled Care

NHS Borders

8 Hour Delays

u-Chart: Number of patients who waited more than 8 hours



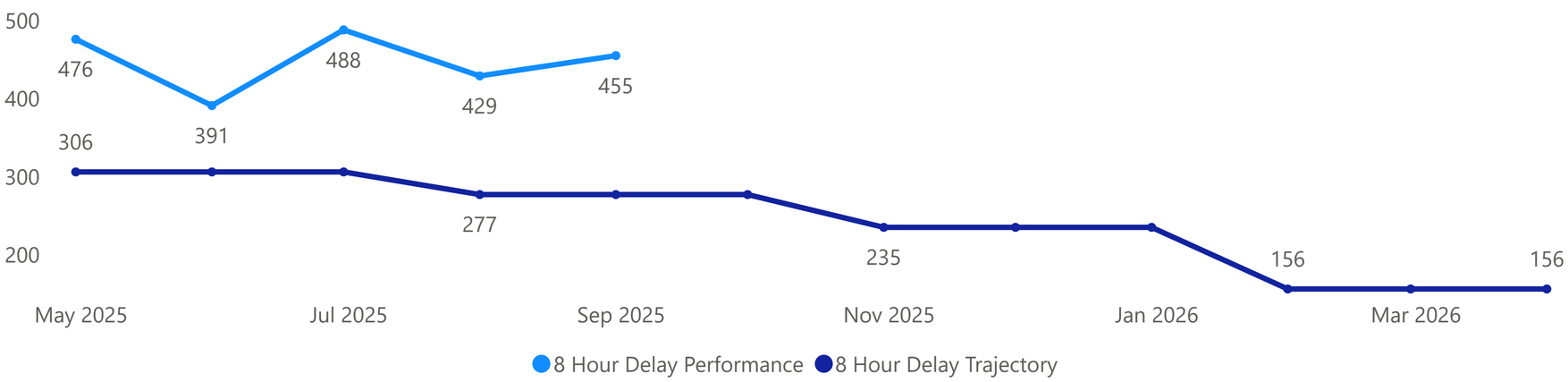
Mean Line | 99% Limits | Imp. Trend | Det. Trend | Imp. Ast. Point | Det. Ast. Point | Imp. Shift | Det. Shift

Month

August 2025

The data shows normal variation however performance is significantly off trajectory. On average 8hr delays for August were 93 against a trajectory of 19. Plans to support the improvement of flow are being managed through the UUC, and include the reset of the MAU when the Frailty Unit opens.

Performance against Trajectory



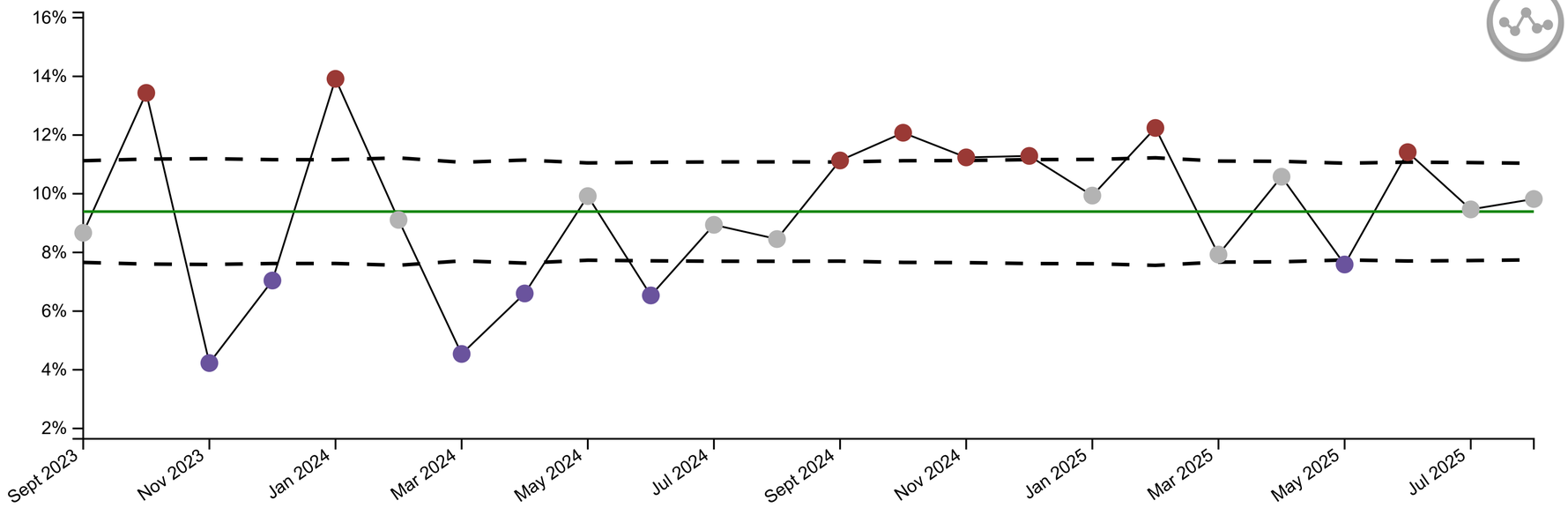
MonthEndDate	Attendances	8 Hour Delays
31/08/2025	3126	455
31/07/2025	3032	429
30/06/2025	2978	488
31/05/2025	3110	391
30/04/2025	2883	476
31/03/2025	2851	355
28/02/2025	2516	446
31/01/2025	2677	394

Integrated Performance Dashboard - Urgent & Unscheduled Care

NHS Borders

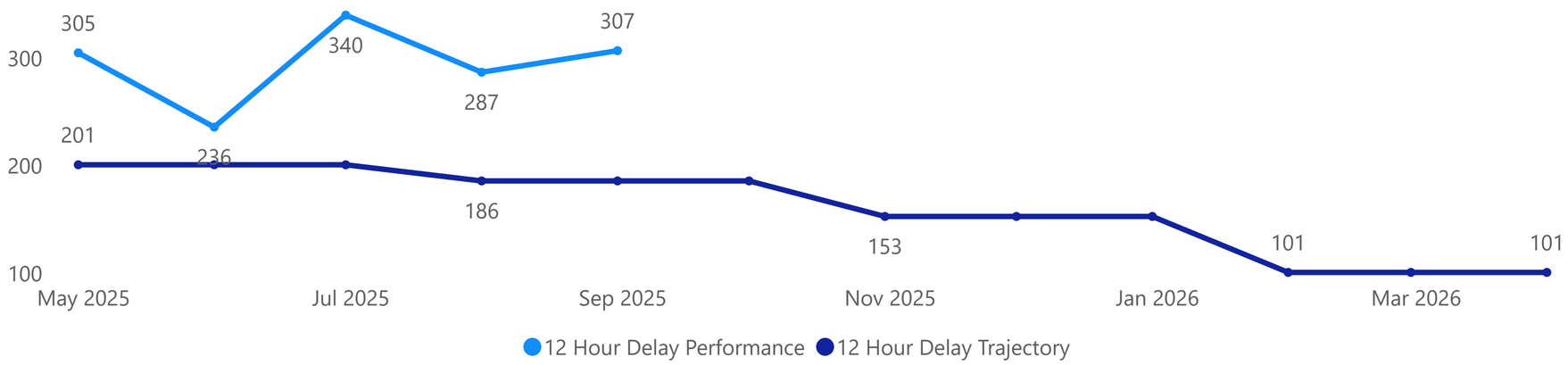
12 Hour Delays

u-Chart: Number of patients waited more than 12 hours



Mean Line | 99% Limits | Imp. Trend | Det. Trend | Imp. Ast. Point | Det. Ast. Point | Imp. Shift | Det. Shift

Performance against Trajectory



Month

August 2025

The data shows normal variation however performance is significantly off trajectory. The trajectory for 12hr delays is 14. BGH is significantly off trajectory and averaged >70 for the month of August. Plans to support the improvement of flow are being supported by the CfSD and reported through the UUC.

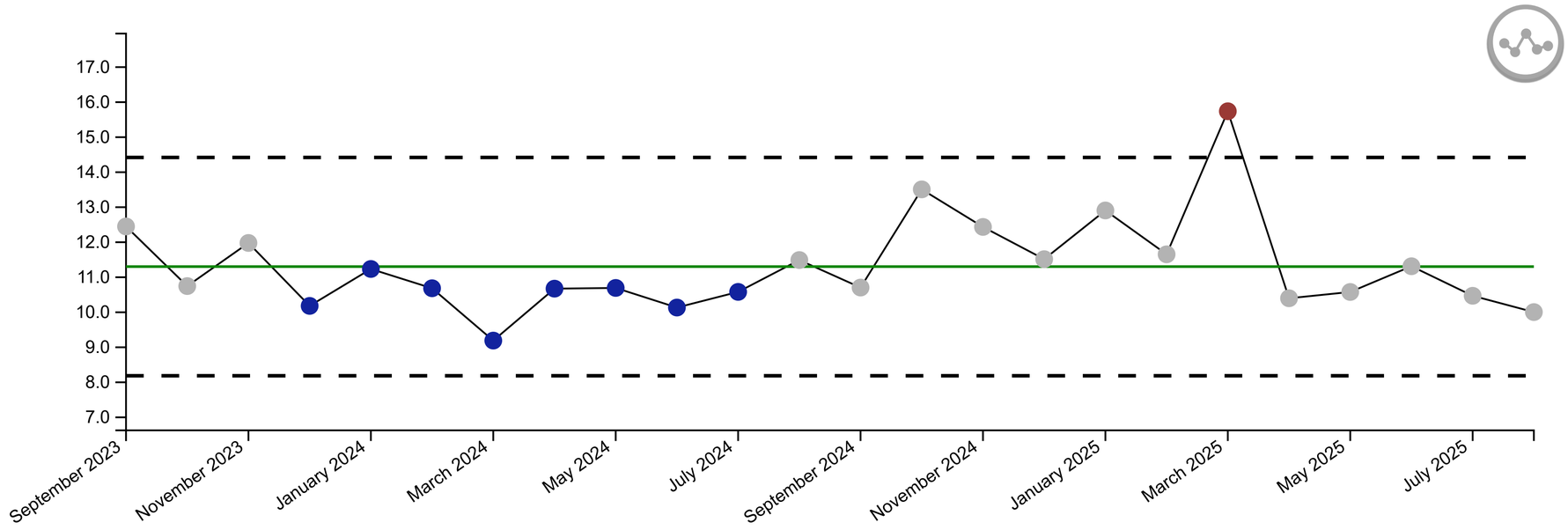
MonthEndDate	Attendances	12 Hour Delays
31/08/2025	3126	307
31/07/2025	3032	287
30/06/2025	2978	340
31/05/2025	3110	236
30/04/2025	2883	305
31/03/2025	2851	226
28/02/2025	2516	308
31/01/2025	2677	266

Integrated Performance Dashboard - Urgent & Unscheduled Care

NHS Borders

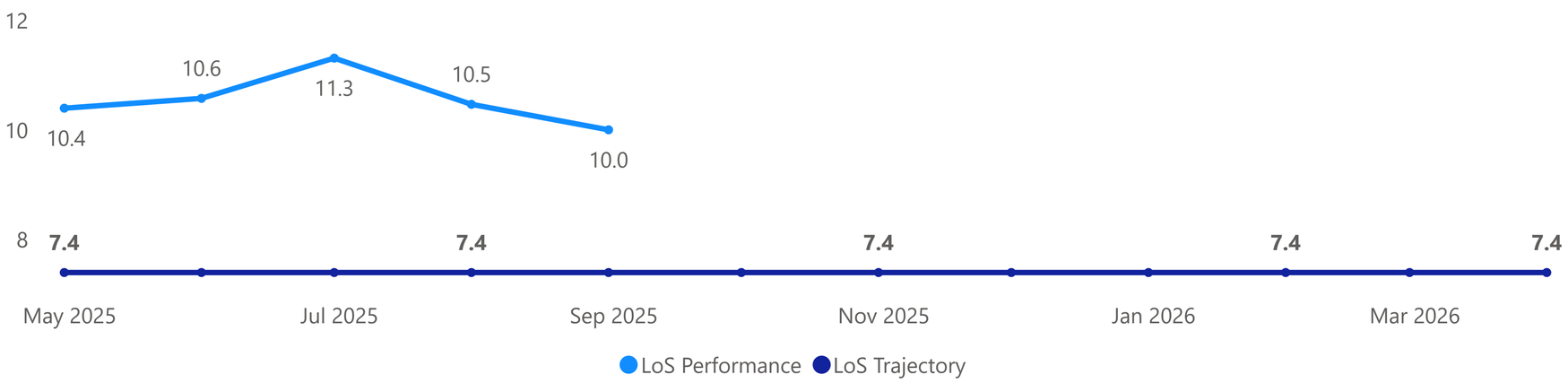
Length of Stay

i-Chart: Average Length of Stay. Non-elective only. Excludes paediatric and obstetric specialties and ITU wards.



Mean Line | 99% Limits | Imp. Trend | Det. Trend | Imp. Ast. Point | Det. Ast. Point | Imp. Shift | Det. Shift

Performance against Trajectory



Month

August 2025

The data shows normal variation however performance is significantly off trajectory. LoS performance has improved steadily since June. Performance for August was 10.0 against a trajectory of 7.4. Improvement is being supported through the IDT., Home First, Hospital at Home and Frailty workstreams.

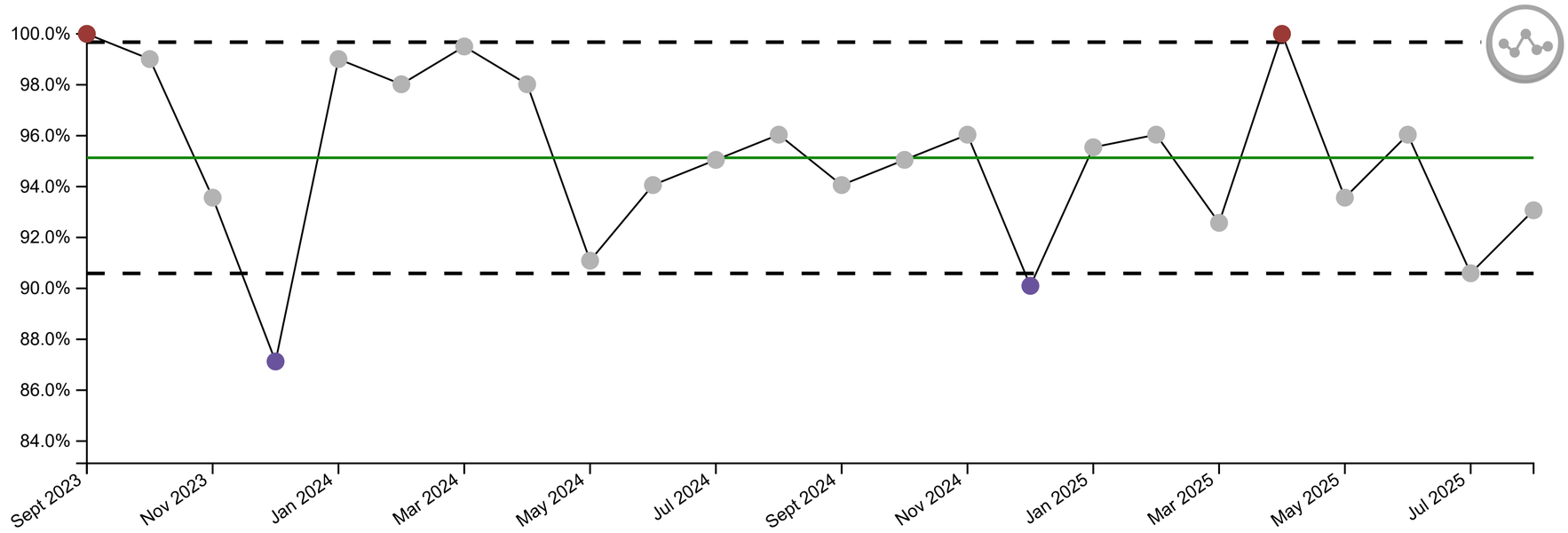
MonthEndDate	Average Length of Stay
August 2025	10.0
July 2025	10.5
June 2025	11.3
May 2025	10.6
April 2025	10.4
March 2025	15.7
February 2025	11.7
January 2025	12.9

Integrated Performance Dashboard - Urgent & Unscheduled Care

NHS Borders

Average Acute Occupancy

p-Chart: Average Number of Acute Occupied Beds



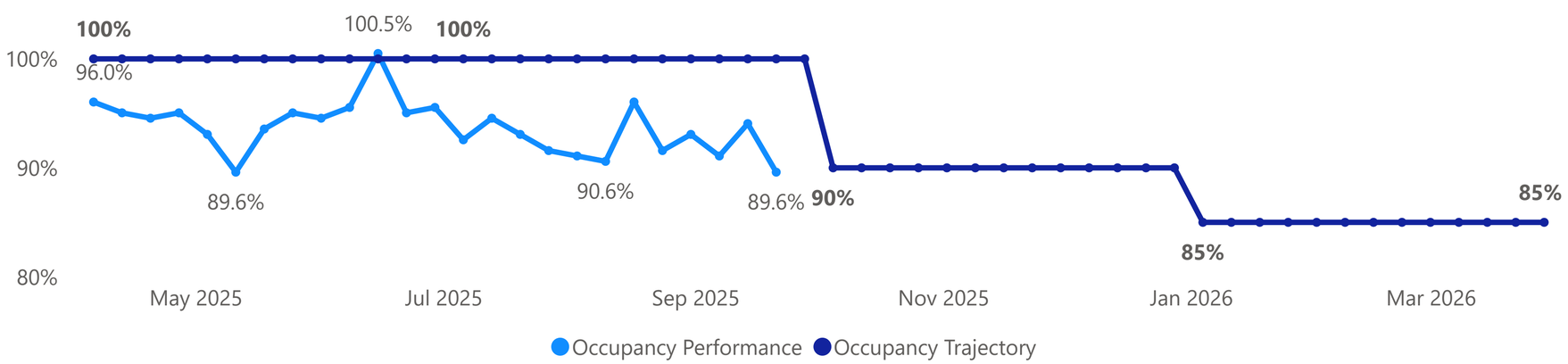
Mean Line | 99% Limits | Imp. Trend | Det. Trend | Imp. Ast. Point | Det. Ast. Point | Imp. Shift | Det. Shift

Month

August 2025

The data shows normal variation.

Performance against Trajectory



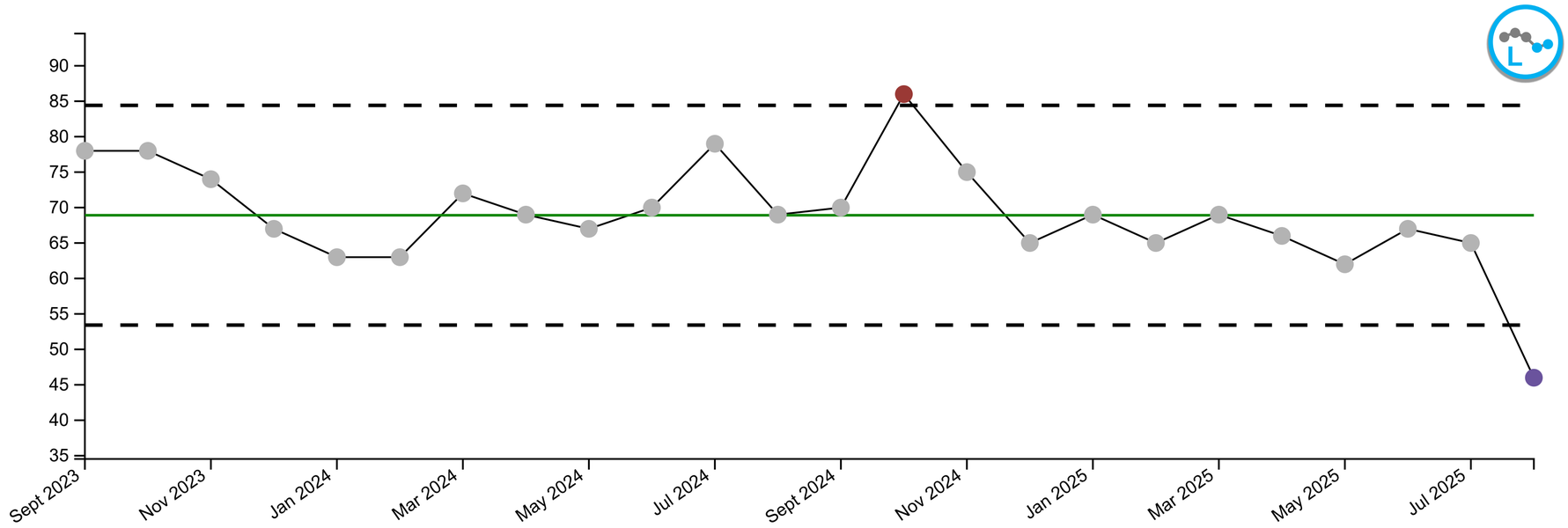
EndOfMonth	Occupied Beds	%
31/08/2025	188	93.1%
31/07/2025	183	90.6%
30/06/2025	194	96.0%
31/05/2025	189	93.6%
30/04/2025	202	100.0%
31/03/2025	187	92.6%
28/02/2025	194	96.0%
31/01/2025	193	95.5%

Integrated Performance Dashboard - Urgent & Unscheduled Care

NHS Borders

Delayed Discharges

i-Chart: Number of Delayed Discharges at end of month



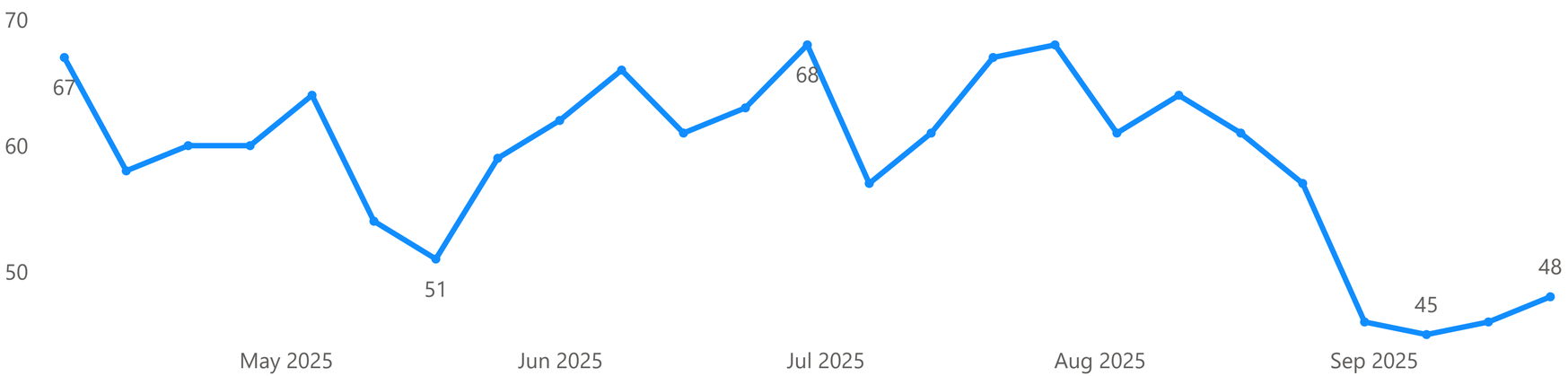
Mean Line | 99% Limits | Imp. Trend | Det. Trend | Imp. Ast. Point | Det. Ast. Point | Imp. Shift | Det. Shift

Month

August 2025

The data shows a significant improving shift in performance.

Performance against Trajectory



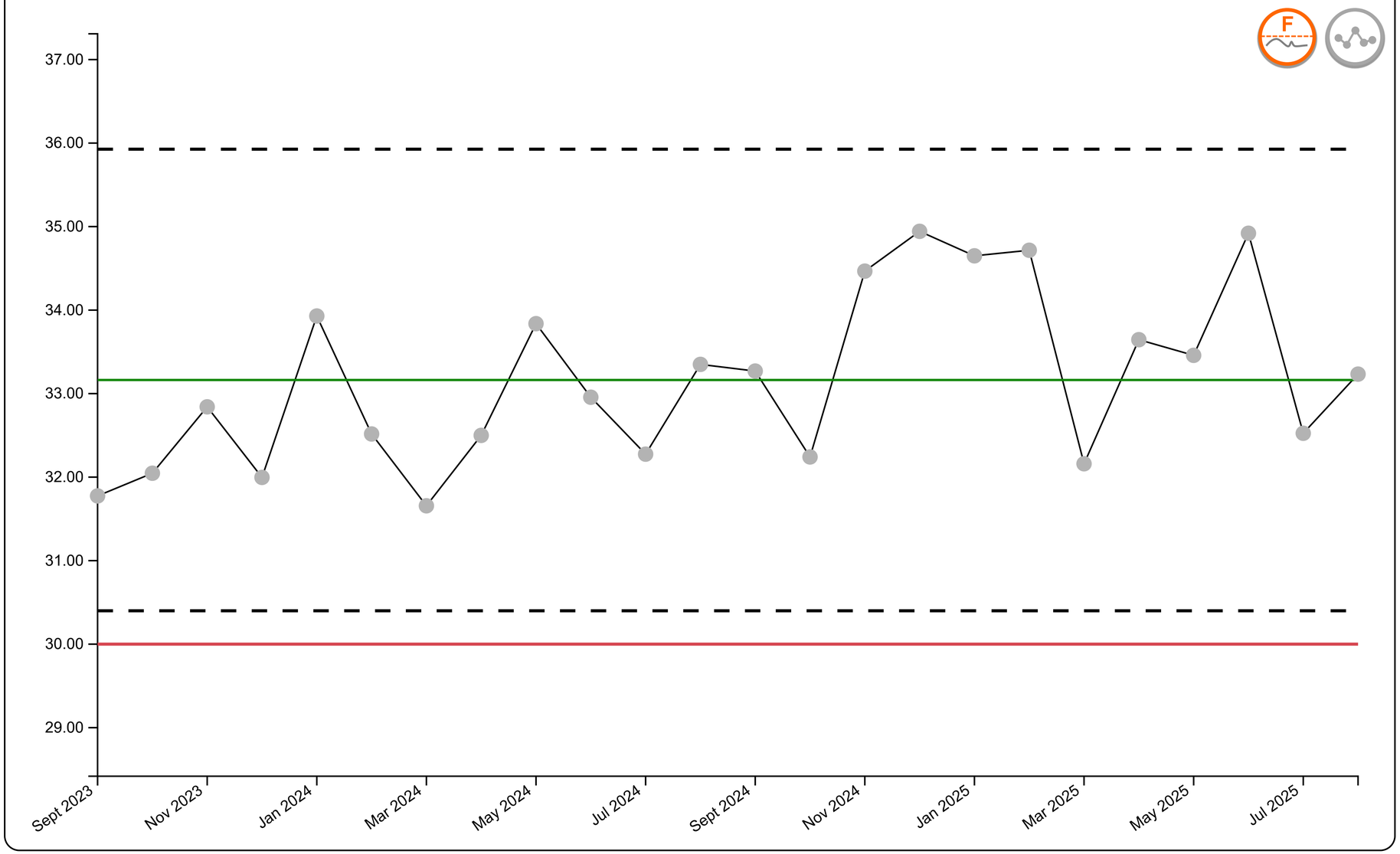
EndOfMonth	Delayed Discharges
31/08/2025	46
31/07/2025	65
30/06/2025	67
31/05/2025	62
30/04/2025	66
31/03/2025	69
28/02/2025	65
31/01/2025	69

Integrated Performance Dashboard - Urgent & Unscheduled Care

NHS Borders

Ambulance Handover Time

i-Chart: Average Ambulance Handover Time in minutes per month



Trajectory — Mean Line — 99% Limits - - - - - - Imp. Trend ● Det. Trend ● Imp. Ast. Point ● Det. Ast. Point ● Imp. Shift ● Det. Shift

Month

August 2025

The data shows normal variation.

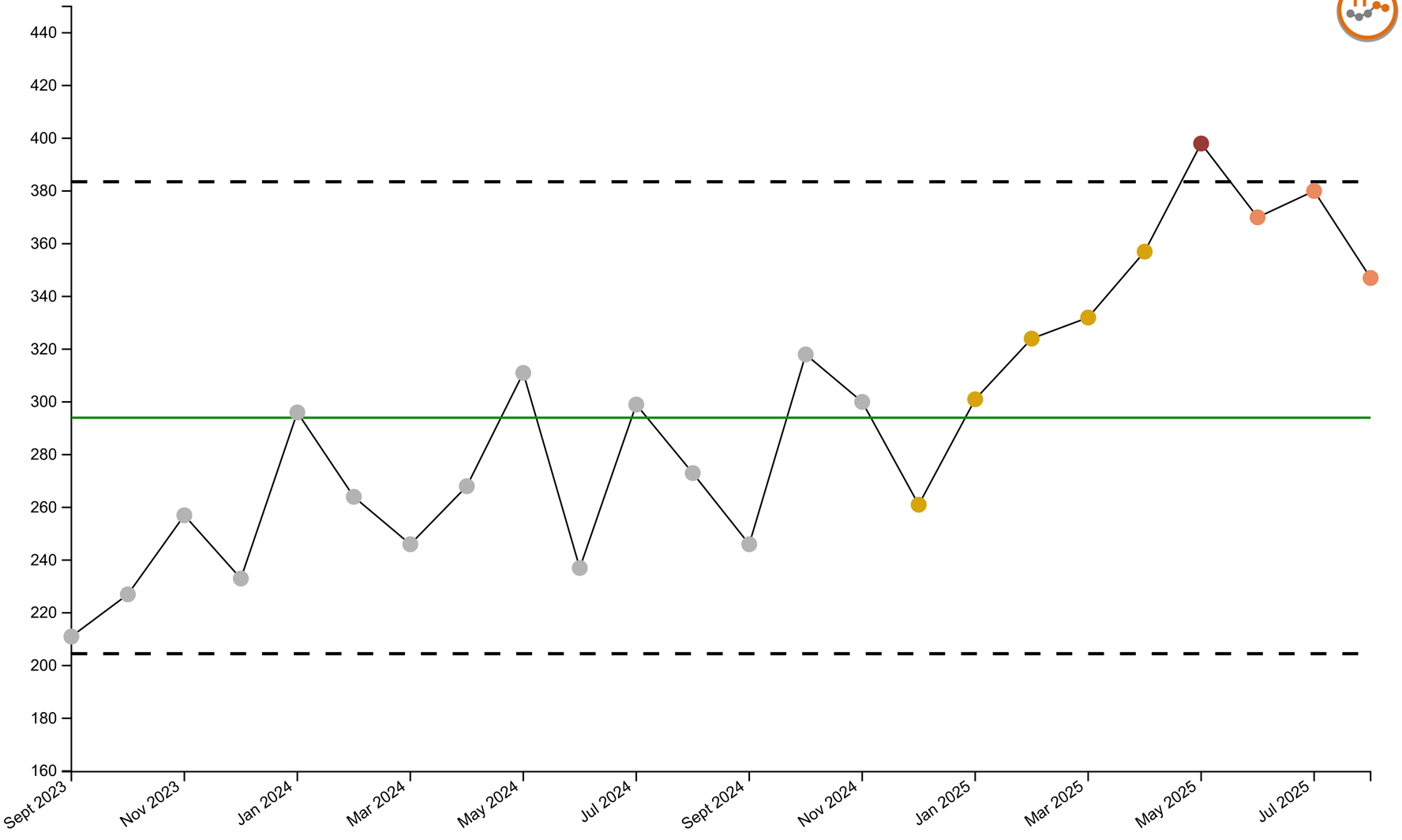
EndOfMonth	Handover Times (Minutes)
31/08/2025	33.23
31/07/2025	32.53
30/06/2025	34.92
31/05/2025	33.46
30/04/2025	33.65
31/03/2025	32.16

Integrated Performance Dashboard - Urgent & Unscheduled Care

NHS Borders

AAU Admissions

i-Chart: Number of Patients admitted to AAU



Mean Line | 99% Limits | Imp. Trend | Det. Trend | Imp. Ast. Point | Det. Ast. Point | Imp. Shift | Det. Shift

Month

August 2025

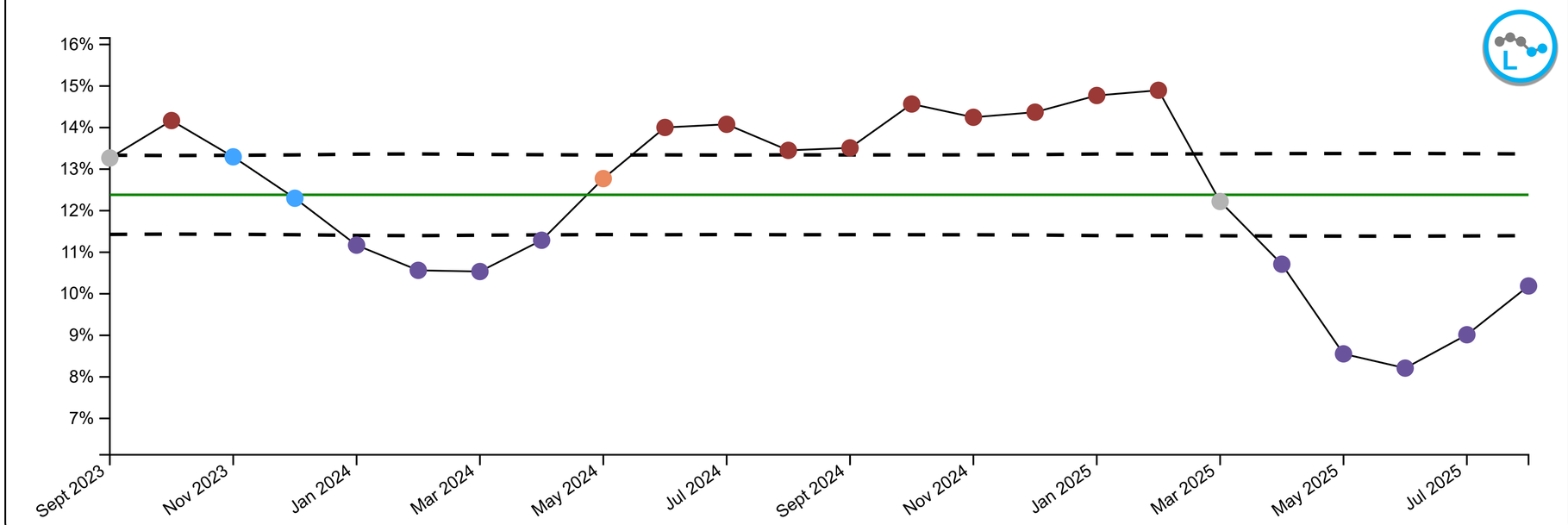
The data shows normal variation. AAU Admissions for August were 347. A decline from June and July, however an improved trend since the trial of a dedicated SCN. Work with the medical team is underway to develop a new clinical model for AAU.

MonthEndDate	Admissions
31/08/2025	347
31/07/2025	380
30/06/2025	370
31/05/2025	398
30/04/2025	357
31/03/2025	332
28/02/2025	324
31/01/2025	301

Integrated Performance Dashboard - Planned Care

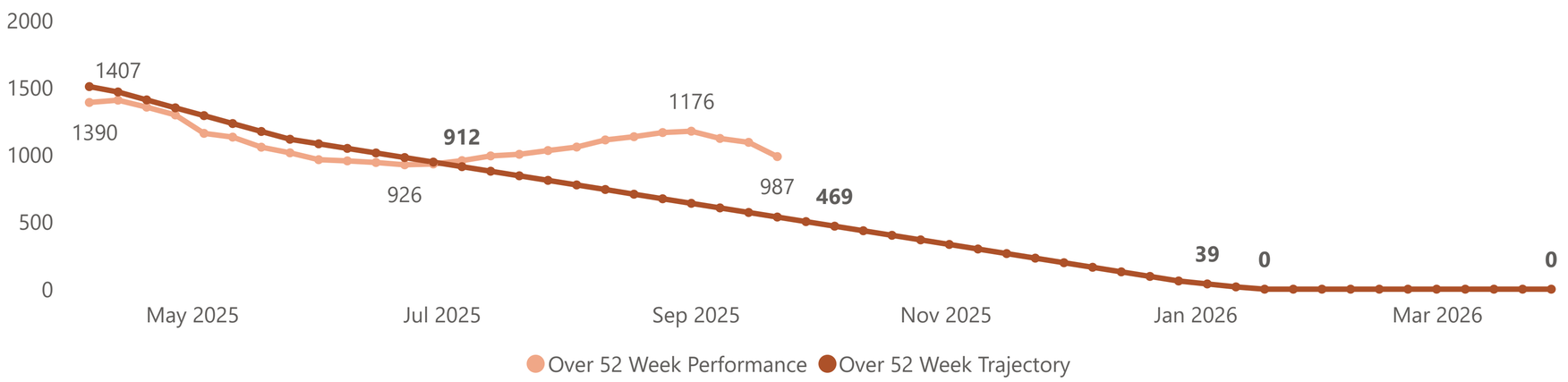
NOP - Over 52 Weeks

u-Chart: Number of Outpatients waiting over 52 weeks



Mean Line | 99% Limits | Imp. Trend | Det. Trend | Imp. Ast. Point | Det. Ast. Point | Imp. Shift | Det. Shift

Performance against Trajectory



Month

August 2025

The data shows normal variation however performance is significantly off trajectory. The actual current position is 1092 in the backlog against a trajectory of 571. This is mainly driven by delivery in Orthopaedics and Dermatology.

Robust plan in place for Dermatology. Orthopaedics is executing delivering plan with additionality and appointing locum consultant to bridge delivery gap. Core capacity plans also being developed.

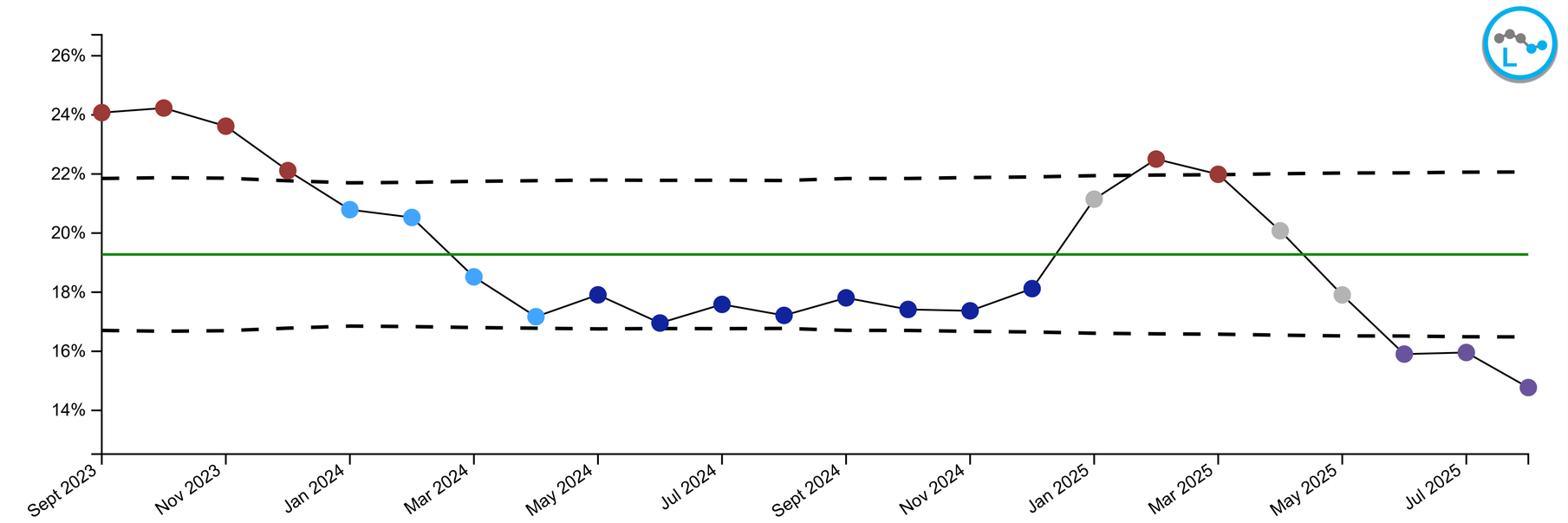
EndOfMonth	Waiting Over 52 Weeks
31/08/2025	1176
31/07/2025	1025
30/06/2025	923
31/05/2025	965
30/04/2025	1213
31/03/2025	1402
28/02/2025	1727
31/01/2025	1710

Integrated Performance Dashboard - Planned Care

NHS Borders

TTG - Over 52 Weeks

u-Chart: Number of Inpatients waiting over 52 weeks



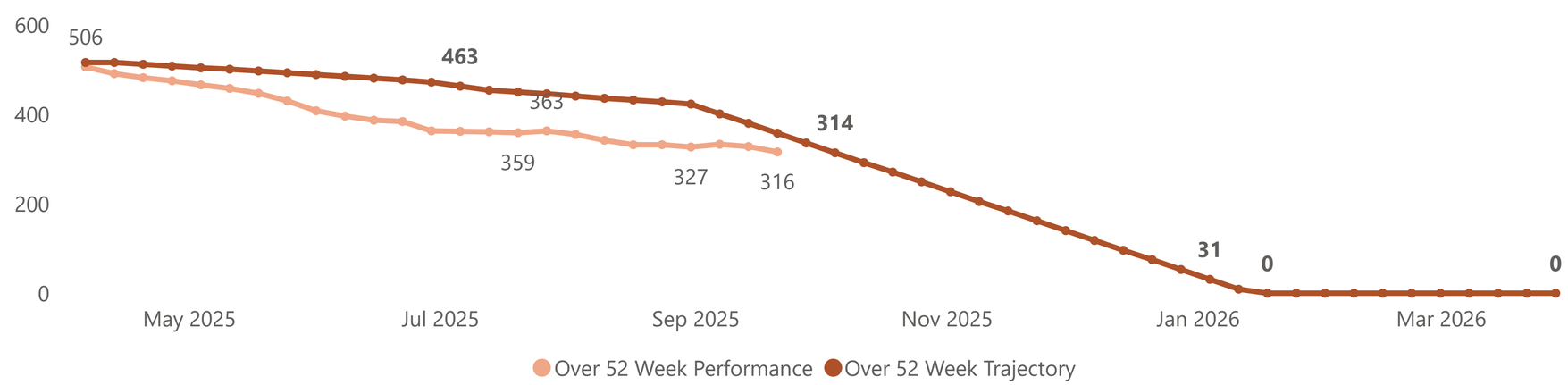
Mean Line | 99% Limits | Imp. Trend | Det. Trend | Imp. Ast. Point | Det. Ast. Point | Imp. Shift | Det. Shift

Month

August 2025

The data shows an improving shift in performance.

Performance against Trajectory



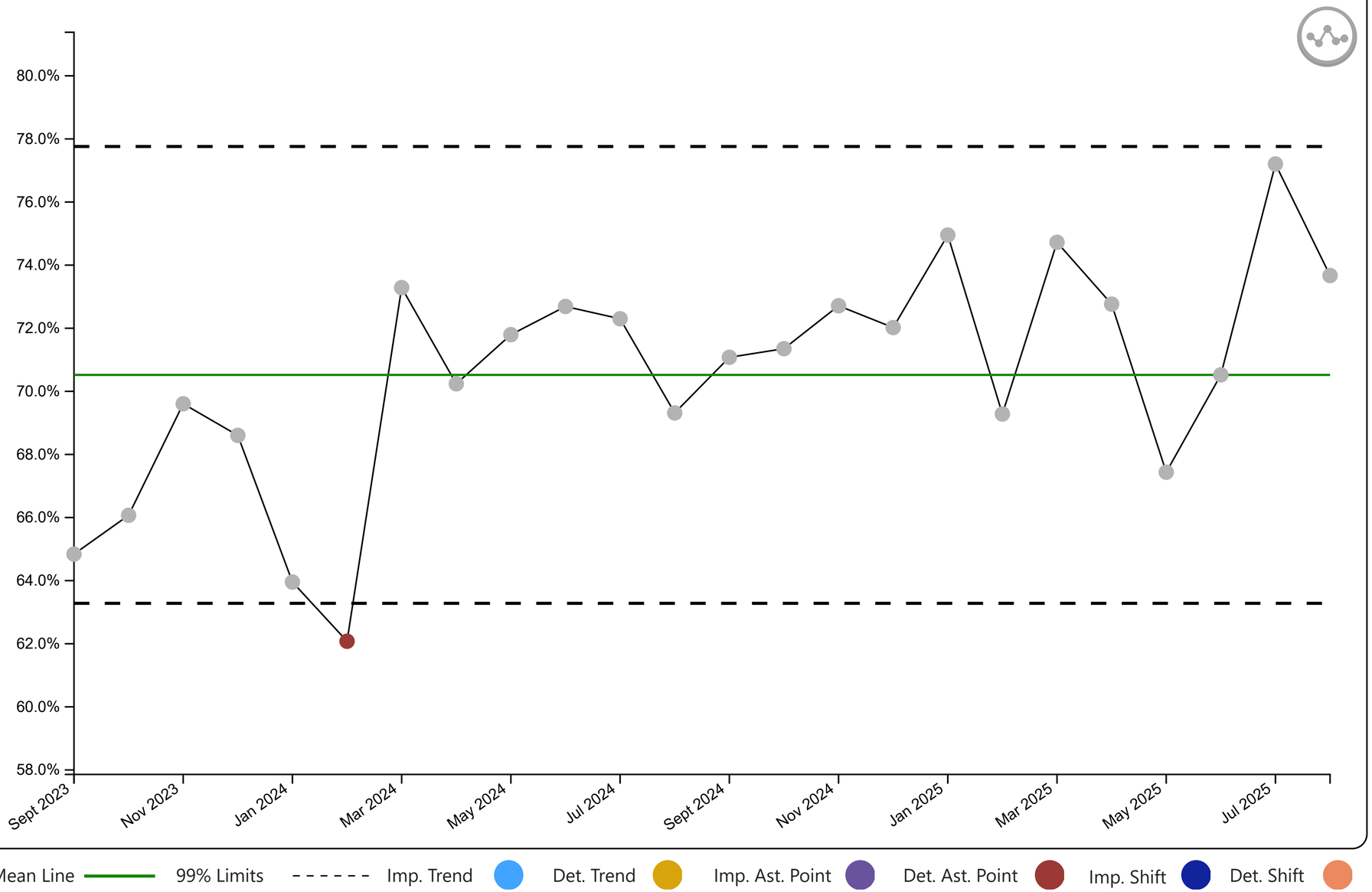
EndOfMonth	Waiting Over 52 Weeks
31/08/2025	329
31/07/2025	357
30/06/2025	362
31/05/2025	409
30/04/2025	467
31/03/2025	524
28/02/2025	541
31/01/2025	516

Integrated Performance Dashboard - Planned Care

NHS Borders

Theatre Utilisation

i-Chart: Theatre Utilisation per month. Elective only, excludes theatre 5



Mean Line | 99% Limits | Imp. Trend | Det. Trend | Imp. Ast. Point | Det. Ast. Point | Imp. Shift | Det. Shift

Month

August 2025

Performance within normal variation. Data chart in progress.

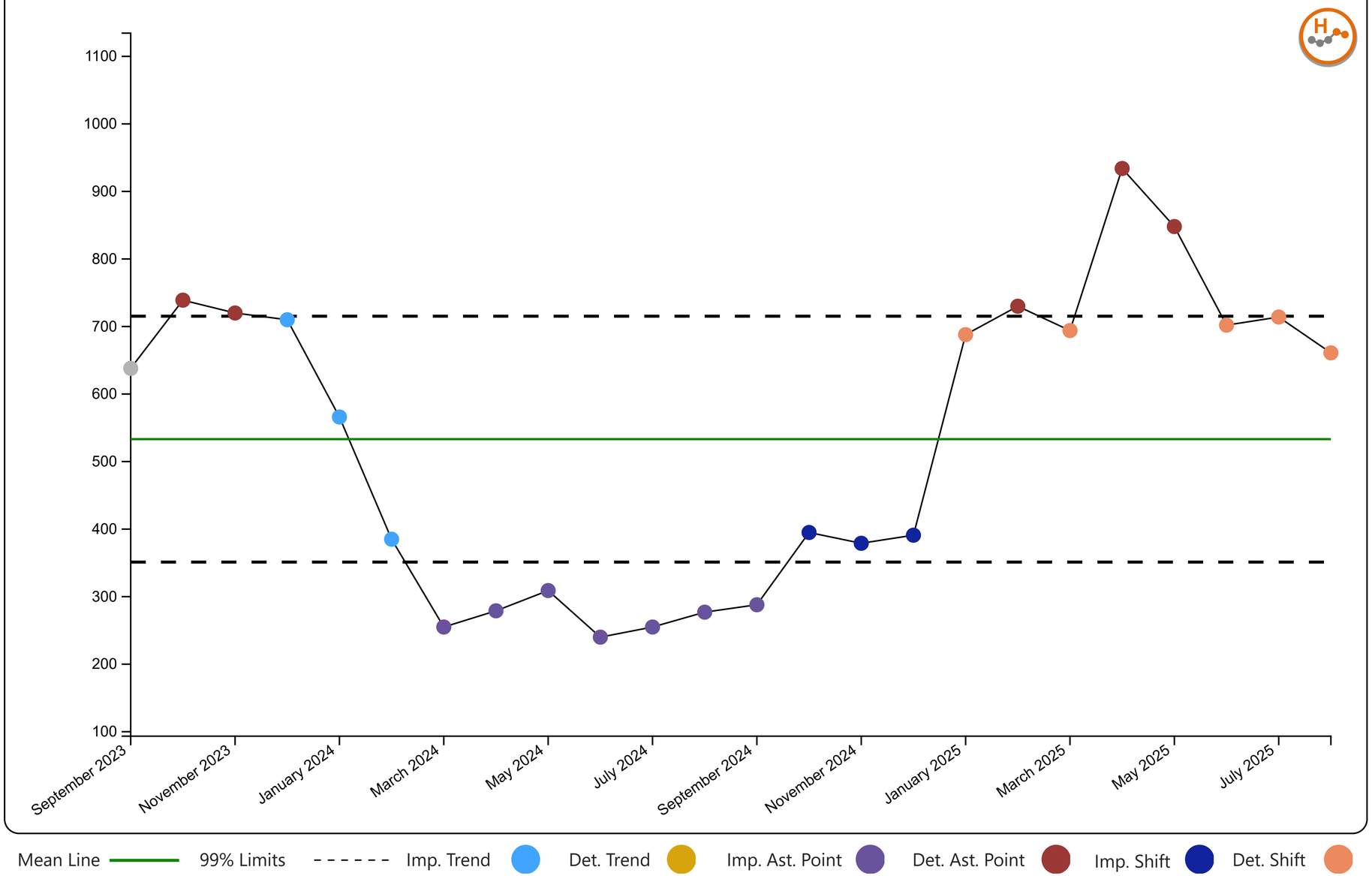
MonthEnding	Utilisation%
31/08/2025	73.7%
31/07/2025	77.2%
30/06/2025	70.5%
31/05/2025	67.4%
30/04/2025	72.8%
31/03/2025	74.7%
28/02/2025	69.3%
31/01/2025	75.0%

Integrated Performance Dashboard - Planned Care

NHS Borders

Diagnostic Waits Over 6 Weeks

i-Chart: Patients waiting over 6 weeks for diagnostic services



Month

August 2025

Special Cause - Performance as of 31st August was 77% overall. (Scottish Average is currently at 55.7%)

MRI at 98%
CT at 87%.

Biggest challenge currently comes from Ultrasound where performance was 47% as of 31st August. This is predominately due to some US scans being Radiologist dependent. There are Radiologist gaps in our workforce, although a new Radiologist is joining in January 2026. This should begin to mitigate performance in Ultrasound.

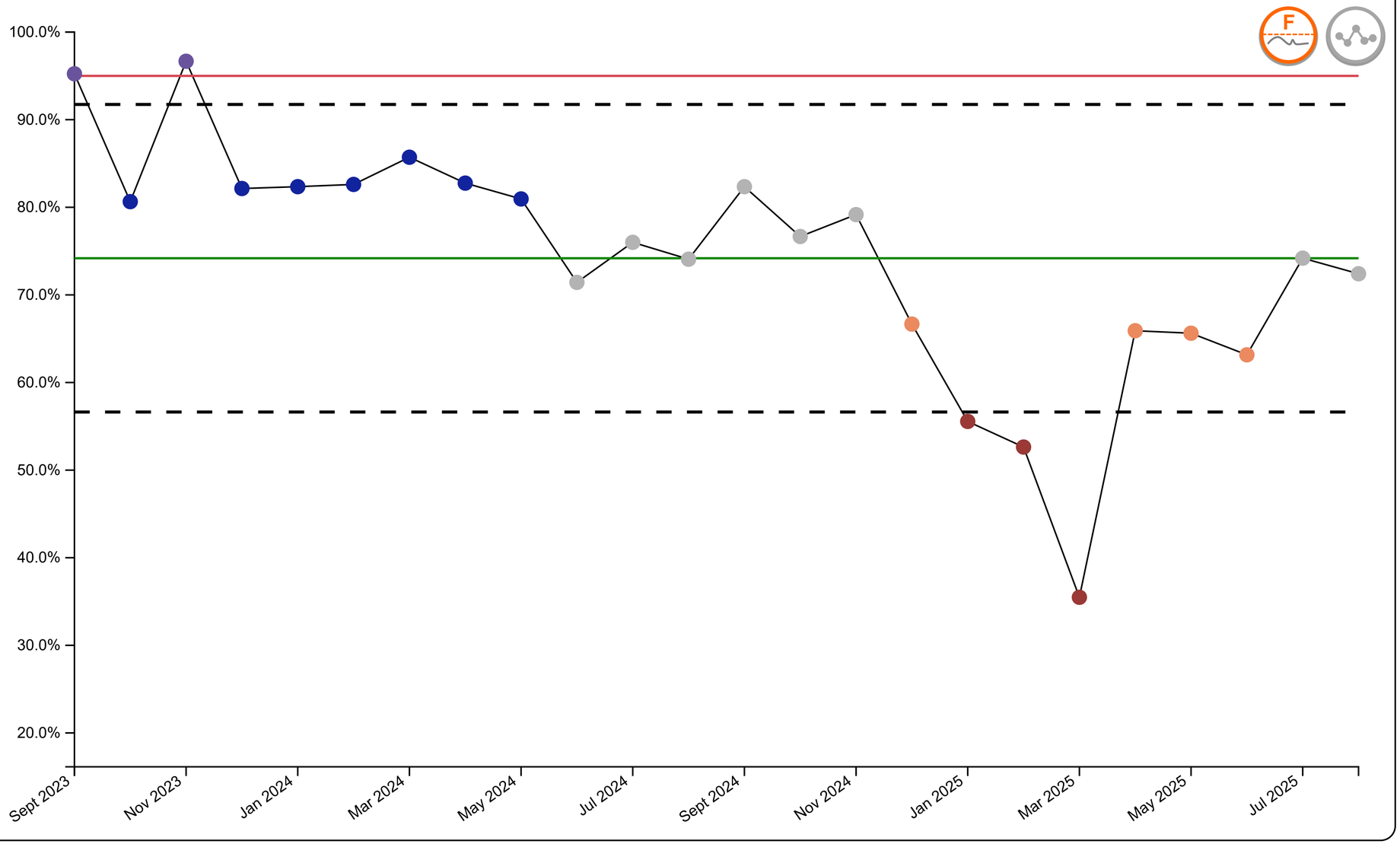
Month/Year	Patients Waiting
August 2025	661
July 2025	714
June 2025	702
May 2025	848
April 2025	934
March 2025	694
February 2025	730
January 2025	688

Integrated Performance Dashboard - Cancer Care

NHS Borders

Cancer - Treated within 62 Days

i-Chart: Percentage of patients treated within 62 days of referral



95% Target — Mean Line — 99% Limits - - - - - - Imp. Trend — Det. Trend — Imp. Ast. Point — Det. Ast. Point — Imp. Shift — Det. Shift

Month

August 2025

The data shows normal variation.

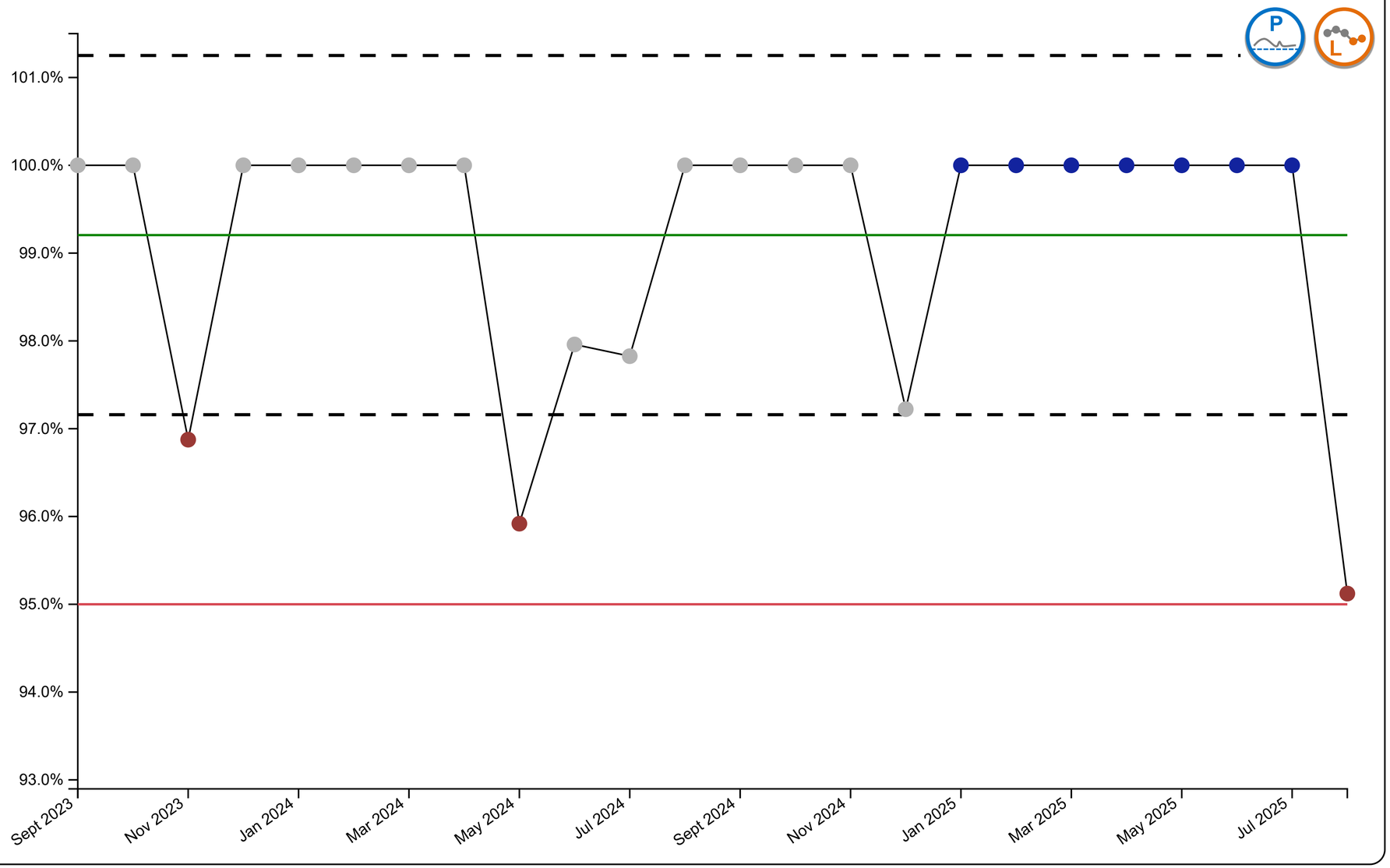
Treat Month	62Day%
August 2025	72.4%
July 2025	74.2%
June 2025	63.2%
May 2025	65.6%
April 2025	65.9%
March 2025	35.5%
February 2025	52.6%

Integrated Performance Dashboard - Cancer Care

NHS Borders

Cancer - Treated within 31 Days

i-Chart: Percentage of patients treated within 31 days



95% Target — Mean Line — 99% Limits - - - - - - Imp. Trend — Det. Trend — Imp. Ast. Point — Det. Ast. Point — Imp. Shift — Det. Shift

Month

August 2025

The data shows special cause of a concerning nature due to lower values. This was due to Consultant absence in General Surgery.

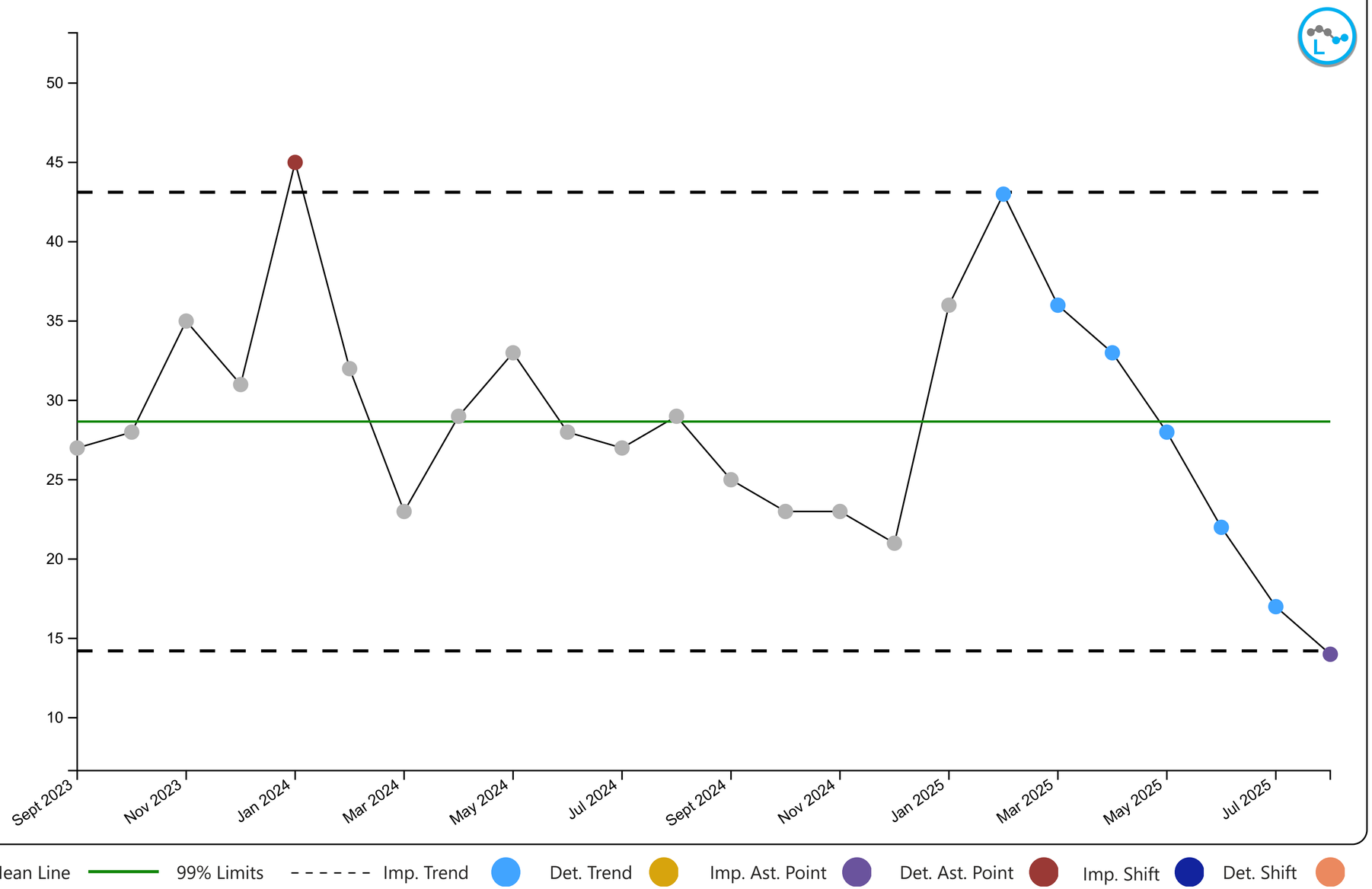
Treat Month	31Day%
August 2025	95.1%
July 2025	100.0%
June 2025	100.0%
May 2025	100.0%
April 2025	100.0%
March 2025	100.0%
February 2025	100.0%

Integrated Performance Dashboard - Cancer Care

NHS Borders

Cancer - Backlog

i-Chart: Number of patients waiting over 62 days for treatment



Mean Line | 99% Limits | Imp. Trend | Det. Trend | Imp. Ast. Point | Det. Ast. Point | Imp. Shift | Det. Shift

Month

August 2025

The data shows an improving shift in performance. This is mainly due to the local diagnostic pathway and NHS Lothian reducing waits for robotic assisted surgery.

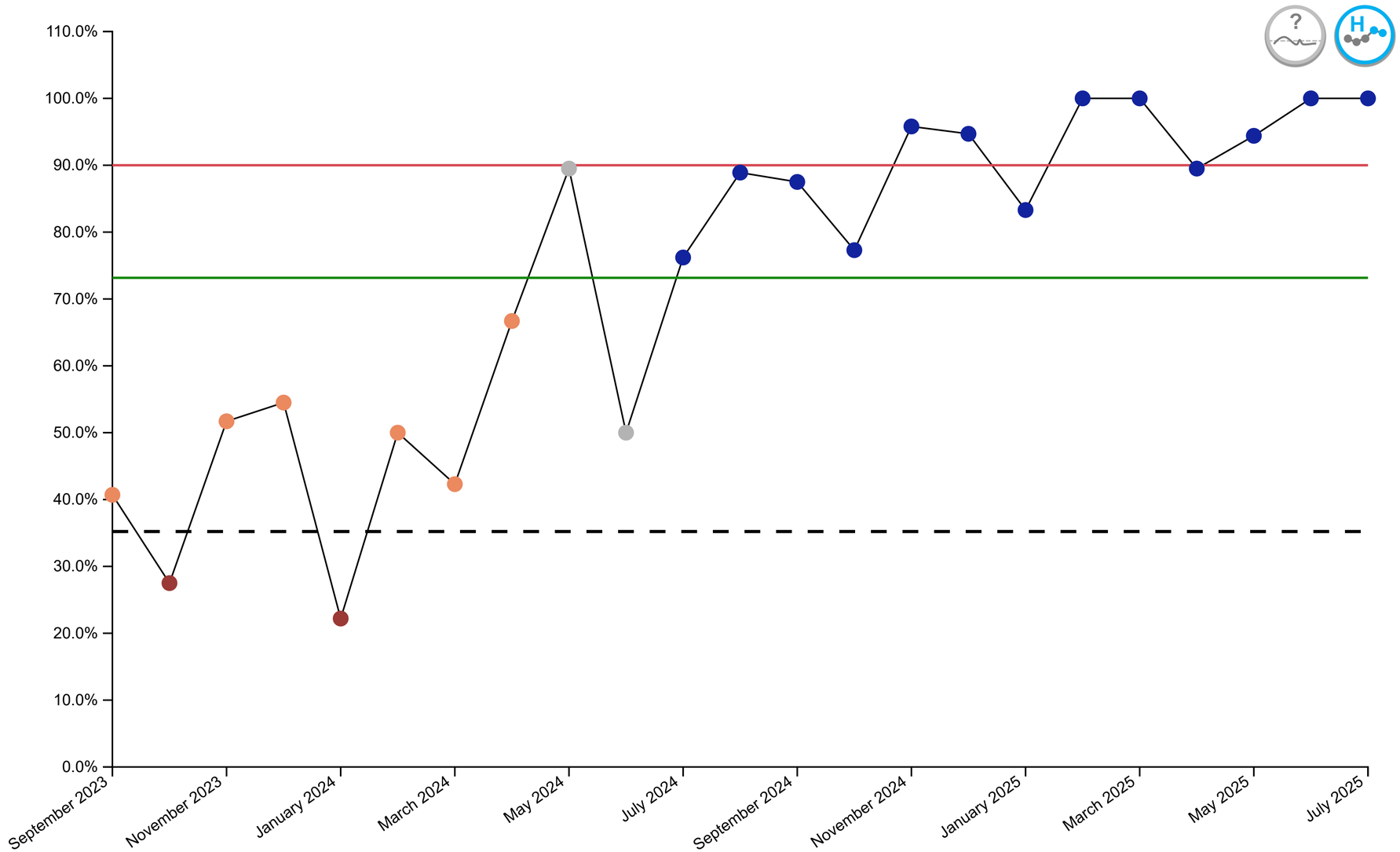
MonthEndDate	Total Backlog
31/08/2025	14
31/07/2025	17
30/06/2025	22
31/05/2025	28
30/04/2025	33
31/03/2025	36
28/02/2025	43
31/01/2025	36

Integrated Performance Dashboard - Mental Health

NHS Borders

CAMHS RTT

i-Chart: Percentage of Patients Received Treatment within 18 weeks of Referral



90% Target — Mean Line — 99% Limits - - - - - - Imp. Trend ● Det. Trend ● Imp. Ast. Point ● Det. Ast. Point ● Imp. Shift ● Det. Shift ●

Month

August 2025

The data shows normal variation and meeting target

Please Note: Data has a 1 month lag time

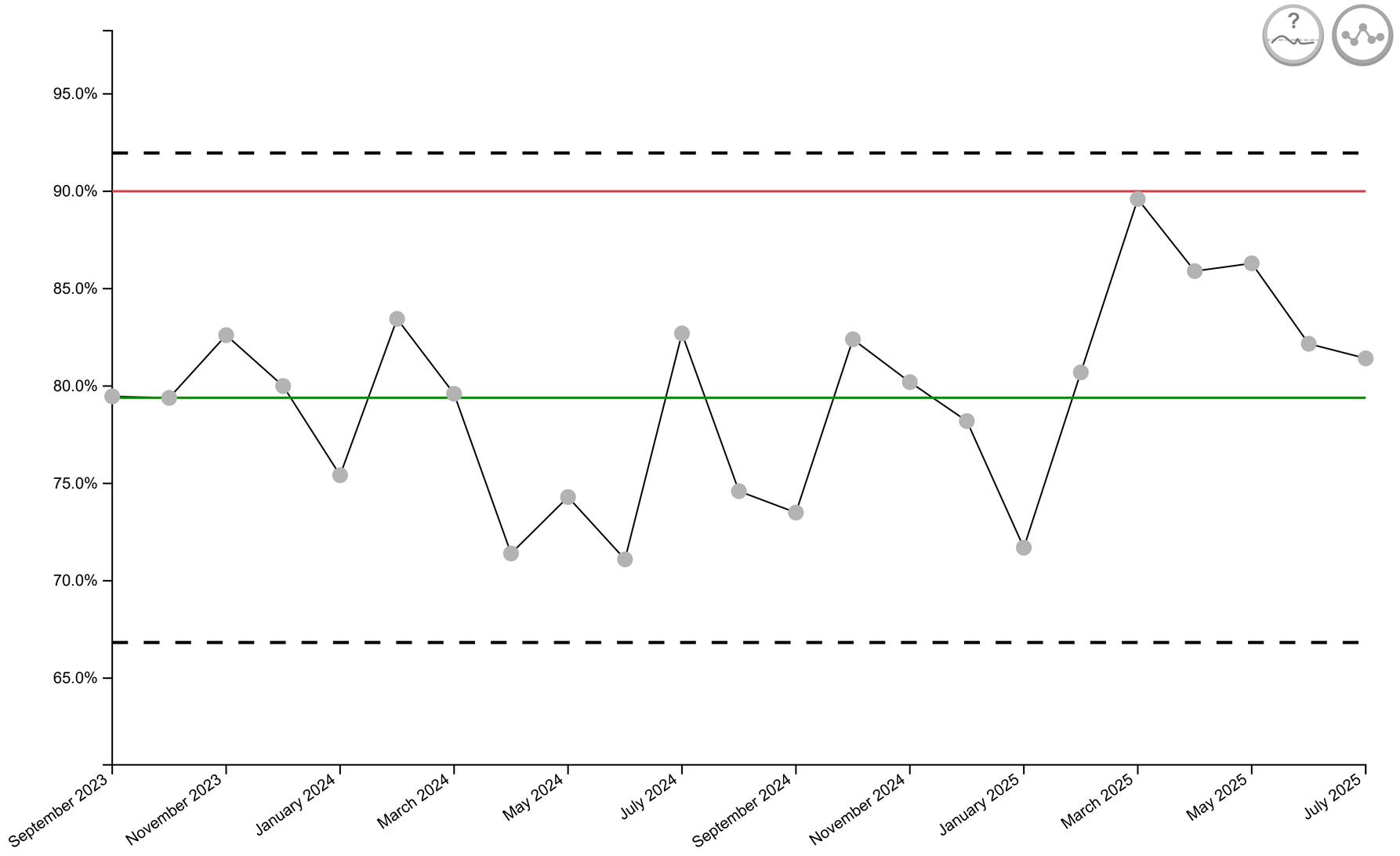
Month	Treatment %
July 2025	100.0%
June 2025	100.0%
May 2025	94.4%
April 2025	89.5%
March 2025	100.0%
February 2025	100.0%
January 2025	83.3%

Integrated Performance Dashboard - Mental Health

NHS Borders

Psychological Therapy

i-Chart: Percentage of Patients Received Treatment within 18 weeks of Referral



90% Target — Mean Line — 99% Limits - - - - - - Imp. Trend — Det. Trend — Imp. Ast. Point — Det. Ast. Point — Imp. Shift — Det. Shift

Month

August 2025

The data shows normal variation but outwith trajectory

Please Note: Data has a 1 month lag time

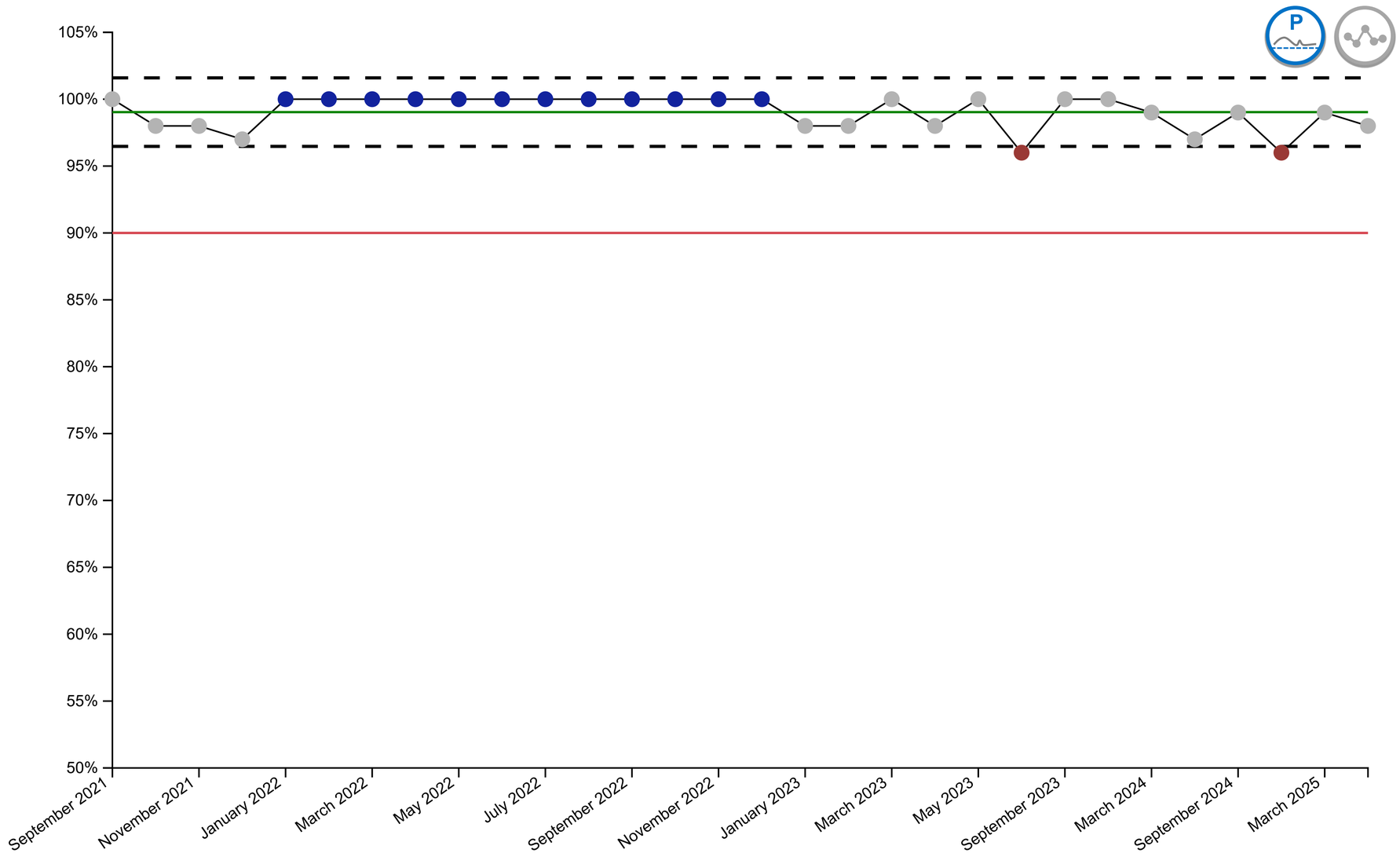
Month	Treatment %
July 2025	81.4%
June 2025	82.2%
May 2025	86.3%
April 2025	85.9%
March 2025	89.6%
February 2025	80.7%
January 2025	71.7%

Integrated Performance Dashboard - Mental Health

NHS Borders

BAS 3 Week Target

i-Chart: Percentage of Patients Received Treatment within 3 weeks of Referral



90% Target | Mean Line | 99% Limits | Imp. Trend | Det. Trend | Imp. Ast. Point | Det. Ast. Point | Imp. Shift | Det. Shift

Month

August 2025

The data shows normal variation with performance consistently meeting the 3 week referral to treatment target

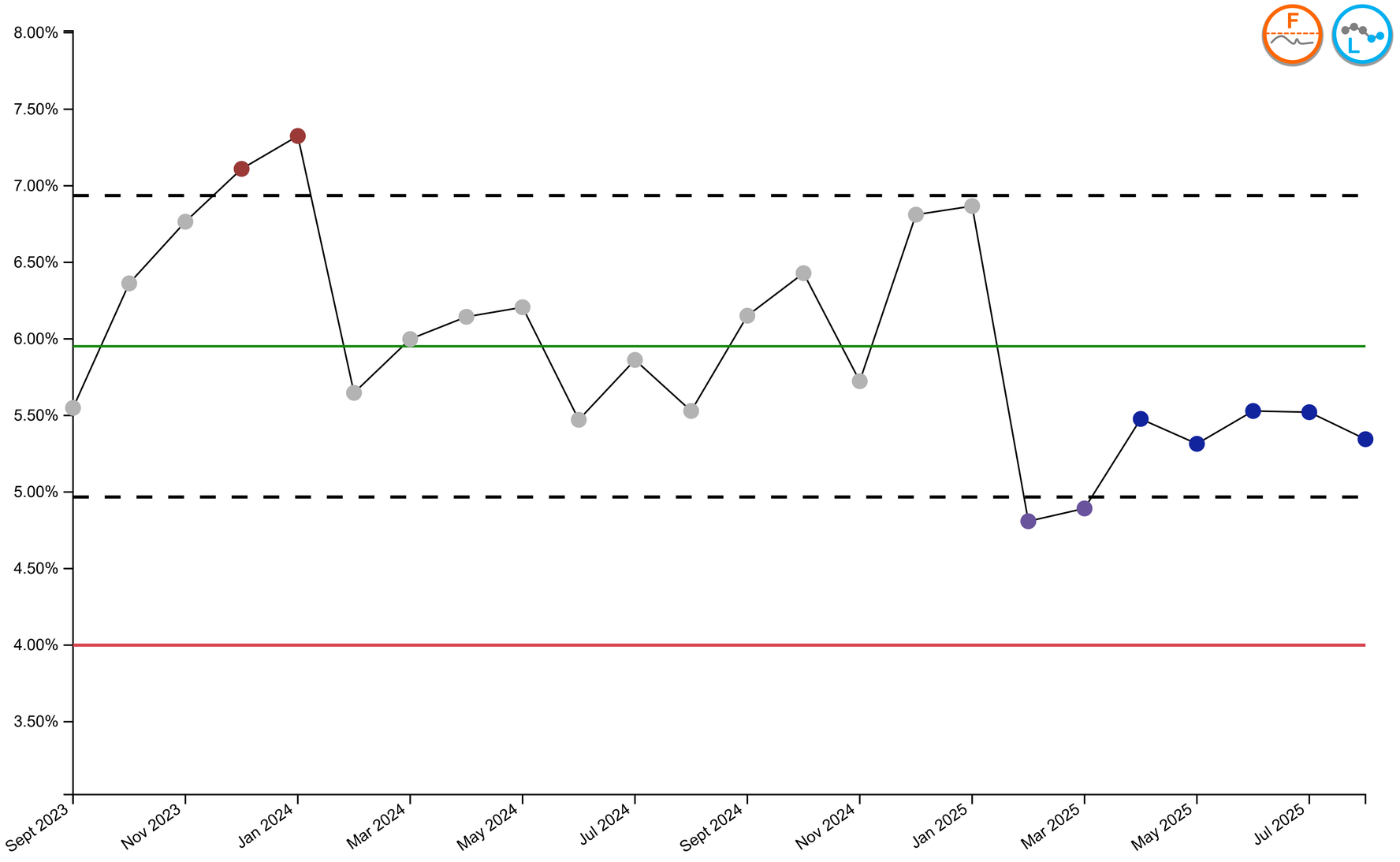
Date	Treatment %
June 2025	98%
March 2025	99%
December 2024	96%
September 2024	99%
June 2024	97%
March 2024	99%
December 2023	100%

Integrated Performance Dashboard - Workforce

NHS Borders

Workforce Absence

i-Chart: % of Hours Lost for all Departments per Month



4% Target — Mean Line — 99% Limits - - - - - Imp. Trend ● Det. Trend ● Imp. Ast. Point ● Det. Ast. Point ● Imp. Shift ● Det. Shift

Month

August 2025

Performance within normal variation but outwith trajectory. Actions taken to improve sickness absence rate include, HR supporting service around training and application of policy, targeted support for line managers particularly where absence "hot spots" identified, wellbeing initiatives including wellbeing week to promote healthy working lives etc. Targeted support will continue to support reduction in SA rates, however 4% target is currently unrealistic with historical trends demonstrating a much higher average over recent years.

Month	Absence Rate
August 2025	5.34%
July 2025	5.52%
June 2025	5.53%
May 2025	5.31%
April 2025	5.48%
March 2025	4.89%
February 2025	4.81%

Integrated Performance Dashboard - Glossary

Number	Topic or Page	Report Element	Indicator Name	Indicator Description	Data Source or Calculation	Known Issues	Refresh Schedule
	All Pages	Chart	Performance against Trajectory	Tracks measure performance against planned trajectory			
	All Pages	Table	Data table	Displays data table for measure			
	All Pages	Table	Narrative	Displays narrative for selected month and measure	Narrative Input		
1	Dashboard	Integrated Performance Dashboard	General Information	Style Guide Examples Dashboard	Source System: Internal table ; Vcontrol.xlsx	Does not contain examples of all visualisations	Weekly
1	Page: Urgent & Unscheduled Care - EAS	Chart: Emergency Access Standard	Emergency Access Standard	Percentage of patients seen within 4 hours	Tableau_ED		Weekly
2	Page: Urgent & Unscheduled Care - 8hr Breaches	Chart: 8 Hour Delays	8 Hour Delays	Number of patients waited over 8 hours	Tableau_ED		Weekly
3	Page: Urgent & Unscheduled Care - 12 hr Breaches	Chart: 12 Hour Delays	12 Hour Delays	Number of patients waited over 12 hours	Tableau_ED		Weekly
4	Page: Urgent & Unscheduled Care - LoS	Chart: Length of Stay	Length of Stay	Average length of stay. Non-elective only. Exlcudes peadiatric and obstetric specialties and ITU wards	Tableau_ADT		Monthly
5	Page: Urgent & Unscheduled Care - Occupancy	Chart: Acute Occupancy	Average Acute Occupancy	Average number of acute occupied beds per week	Tableau_WardMovements		Weekly
6	Page: Urgent & Unscheduled Care - DD's	Chart: Delayed Discharges	Delayed Discharges	Number of delayed discharges at the end of each week	Tableau_DelayedDischarges		Weekly
7	Page: Urgent & Unscheduled Care - Ambulance Handover	Chart: Ambulance Handover Time	Ambulance Handover Time	Average ambulance handover time in minutes per week	Whole Systems Pressures Dashboard		Monthly
8	Page: Planned Care - OP Waiting List	Chart: OP Waiting List	NOP - Over 52 Weeks	Number of outpatients waiting over 52 weeks	Tableau_WaitingList		Weekly
9	Page: Planned Care - IP Waiting List	Chart: IP Waiting List	TTG - Over 52 Weeks	Number of inpatients waiting over 52 weeks	Tableau_WaitingList		Weekly
10	Page: Planned Care - Theatres	Chart: Theatre Utilisation	Theatre Utilisation	% of theatre time utilised against planned session time. Elective only and excludes theatre 5.	Tableau_Theatres		Weekly
11	Page: Planned Care -	Chart: Diagnostic Waits	Daignostic waits over 6	Patients waiting over 6 weeks for	Diagnostics Return	Manually calculated	Monthly

Integrated Performance Dashboard - Version Control

Version	Date	Author	Notes
1.0	11 July 2025	Matthew Mallin	Test version of dashboard
2.0	18 July 2025	Matthew Mallin	Boomarks removed to accommodate export to PDF Trajectory graph added Remaining measures added
2.1	07 August 2025	Matthew Mallin	Addition of a summary page Addition of cover page Scheduled refresh set to run each Monday
2.2	18 August 2025	Matthew Mallin	Astronomical points and shifts turned on, legend updated BAS Tab added Diagnostics tab added LoS changed to monthly Absence for directorates removed Appraisals removed Summary page updated to include variation status
2.3	22 August 2025	Matthew Mallin	Change to variation status on summary page New Cancer treatment measure added Information page updated
2.4	04 September 2025	Matthew Mallin	Report changed to monthly view
2.5	18 September	Matthew Mallin	62 Day Cancer trajectory added

Appendix 2 - Integrated Performance Report (IPR) – Development of Additional Measures

The IPR is in development and does not yet include all measures, it will be continually developed over the coming months to include the deliverables from the Organisational Strategy, the Annual Delivery Plan and other local Key Performance Indicatiors.

The table below shows progress on the development and the measures that will be included in the coming months.

Content	Commitment	Update
Quality & Safety		
• Adverse events • SAERs • Patient falls • Infection Control • Complaints • Care Opinion • Riddor reportable incidents • HSE investigations • FFP3 Fitting compliance • Risk compliance		In Progress - All data available and will be included from August 2025 Scorecard
Planned Care		
P2: Increase Cataract theatre lists from 7 to 8 patients per list.	ADP	To be developed by BI
Cancer		
P9: Improve performance in breast, colorectal, and urology pathways	ADP	In Progress
P10: Increasing capacity for endoscopy and other diagnostic services	ADP	In Progress
W&CS		
Women & Children's Improvement Measures		To be developed by the service.
MH&LD		
P11: CAMHS Cat 1	ADP	To be developed by BI
P13: Implementing National Standards for Mental Health services - there are various initiatives around the standards due to be implemented in 25/26	ADP	Measure for improvement to be agreed with the service.

P14: LD Annual Health Checks	ADP	To be developed by BI
Primary & Community Services		
Primary & Community Services Improvement Measures		To be developed by the service.
Public Health		
Healthcare Public Health • Total number of Did Not Attend and Cannot Attend out patients split by age/ sex/ SIMD **Health Improvement** • Child Poverty: % of Children living in low income families • Tobacco use: Smoking prevalence persons aged 16+ • Alcohol dependency and substance use: 'same day' prescribing for OST. The metric for Scotland is no one to breach 3 days, for rural boards it's not to breach 7 days. • Total number of individuals being supported by the Wellbeing Service, split by age / sex / SIMD **Health Protection** • Uptake of childhood immunisations at 24 months of age **Screening** • Uptake for Breast, Bowel, Cervical, AAA and DES screening		To be developed by the service. Information available however measures for improvement to be agreed.
Finance		
S7: 3% efficiencies	Organisational Strategy	In Progress
Financial Performance: target (within 1% of budget, excluding savings); variance by value (ytd, forecast)		To be developed
Savings: Overall target / forecast and YTD delivery. In addition, there are detailed milestones set within FIP programme and we should use these. They will change at each quarter.		To be developed

Agency staff expenditure: comparison with same YTD period for previous year (no target) – Medical; Nursing; Other		To be developed Measure for improvement to be agreed.
Cost Pressures: individual cost pressures with forecast value > £250k to be listed; mitigating actions identified.		To be developed
Cost per head of population: (budget/actual – annualised)		To be developed
Workforce		
S8: Ensure 100% of available staff receive an annual appraisal	Organisational Strategy	In Progress
S8: Ensure 100% of available staff complete Statutory & Mandatory training	Organisational Strategy	In Progress
• Overtime and Excess Hours • Management & Self-Referrals to Occupational Health • Coaching Interventions • Recruitment Overview • Detail on Hard-to-Fill Vacancies • Staff Turnover • HR Policy Activity • Exit Survey Learning • Staff Health Clearance compliance • OHS attendance/DNA • RTW compliance		To be developed. Information available however measures for improvement to be agreed.

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**2 October 2025**
Title:	**Integration Joint Board Minutes**
Responsible Executive/Non-Executive:	**P Moore, Chief Executive**
Report Author:	**I Bishop, Board Secretary**

1 Purpose

This is presented to the Board for:

- Awareness

This report relates to a:

- Government policy/directive

This aligns to the following NHSScotland quality ambition(s):

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

The purpose of this report is to share the approved minutes of the Integration Joint Board with the Board.

2.2 Background

The minutes are presented to the Board in regard to Freedom of Information requirements compliance.

2.3 Assessment

The minutes are presented to the Board in regard to Freedom of Information requirements compliance.

2.3.1 Quality/ Patient Care

As detailed within the minutes.

2.3.2 Workforce

As detailed within the minutes.

2.3.3 Financial

As detailed within the minutes.

2.3.4 Risk Assessment/Management

As detailed within the minutes.

2.3.5 Equality and Diversity, including health inequalities

An HIIA is not required for this report.

2.3.6 Climate Change

Not applicable.

2.3.7 Other impacts

Not applicable.

2.3.8 Communication, involvement, engagement and consultation

Not applicable.

2.3.9 Route to the Meeting

This has been previously considered by the following group as part of its development. The group has supported the content.

- Integration Joint Board 24 September 2025

2.4 Recommendation

The Board is asked to **note** the minutes which are presented for its:

- **Awareness** – For Members' information only.

3 List of appendices

The following appendices are included with this report:

- Appendix No 1, Integration Joint Board minutes 16.07.25

Minutes of a meeting of the **Scottish Borders Health & Social Care Integration Joint Board** held on **Wednesday 16 July 2025** at **10am** via Microsoft Teams

Present:

(v) D Parker (Chair)
(v) N Richards
(v) E Thornton-Nicoll
(v) L O'Leary, Non-Executive
(v) K Hamilton, Non-Executive
(v) F Sandford, Non-Executive
(v) J McLaren, Non-Executive
L Turner, Chief Financial Officer
R Duncan GP
S Horan, Director of Nursing, Midwifery & AHPs
L McCallum, Medical Director
J Smith, Borders Care Voice
S Burt, Acting Chief Social Work Officer
D Bell, Staff Side, SBC
V Mann, Partnership Chair, NHS Borders
J Amaral, Chief Executive, Borders Community Action
N Istephan, Chief Executive, Eildon Housing Association

In Attendance:

I Bishop, Board Secretary
P Moore, Chief Executive, NHS Borders
D Robertson, Chief Executive, Scottish Borders Council
J Stacey, Chief Internal Auditor
A Bone, Director of Finance, NHS Borders
S Bhatti, Director of Public Health, NHS Borders
A Carter, Director of HR, OD OH&S, NHS Borders
C Myers, Director of Adult Social Work & Care
E Fabry, Project Manager, SBC
S Patterson, Group Manager, SBC
P White, Age Friendly Communities
M Fleming, Finance Manager, SBC
C Oliver, Head of Communications, NHS Borders
D Findley, Public Member

1. APOLOGIES AND ANNOUNCEMENTS

1.1 Apologies had been received from R Tatler, Elected Member, T Weatherston, Elected Member, J Ayling, Non-Executive, P Grieve, Chief Nuse H&SCP and L Jones, Director of Quality & Improvement, NHS Borders.

1.2 The Chair welcomed attendees and members of the public to the meeting.

1.3 The Chair confirmed that the meeting was quorate.

2. DECLARATIONS OF INTEREST

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

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

3. MINUTES OF THE PREVIOUS MEETING

3.1 The minutes of the previous meeting held on 19 March 2025 were approved.

4. MATTERS ARISING

4.1 **Minutes 10: Equality, Human Rights, Fairer Scotland Duty Update:** J Amaral enquired about the equality impact assessment process moving forward given the departure of W Henderson. The Chair confirmed that W Henderson had been contracted to ensure the IJB had appropriate processes in place and that they were mainstreamed into normal practice. The appointment of W Henderson had been time limited, had achieved the outcome required and had concluded. The Board was reassured that once appointed, the new Chief Officer would present a plan to ensure the Board continued to fulfil its obligations under the duty and that it would be included as an agenda item for a future meeting.

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** noted the Action Tracker.

5. PERFORMANCE AND DELIVERY REPORT

5.1 The Chair advised that the report was presented in the absence of a Chief Officer, however activities within the IJB space continued to be taken forward and the report had been pulled together as per normal processes in order to ensure the Board maintained an oversight of progress within certain activities.

5.2 Should anyone have any questions in regard to the content of the report they could email those directly to I Bishop to source any answers outwith the meeting.

5.3 The Board discussed several data quality and reporting issues in the absence of a Chief Officer. S Horan highlighted a duplication error in the social work assessment data and unmet need charts. S Bhatti raised concerns about unclear chart legends, particularly where colour coding was ambiguous.

5.4 S Burt questioned the exclusion of Learning Disability (LD) services data and suggested the inclusion of neurodiversity data from CAMHS to provide the Board with a better understanding of the range of services offered under CAMHS. C Myers confirmed LD data was not currently included and acknowledged the need to improve future reporting.

5.5 K Hamilton and S Horan expressed concern over persistently high delayed discharge figures. The Chair commented that systems were in place, however delayed discharges continued to be a major whole system issue and he suggested that either the route cause

had not been correctly established or the process was flawed and suggested he raise the matter with the Chief Executive's of both organisations.

5.6 F Sandford proposed using the Chief Officer vacancy funds to appoint a dedicated lead for delayed discharges. The Chair commented that there were multiple people working on delayed discharges but the Chief Executive's of both organisations could be asked to consider the suggestion.

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** noted the contents of the Health and Social Care Partnership Delivery Report.

6. DIRECTION: EILDON DAY SUPPORT REVIEW

6.1 C Myers provided an overview of the content of the report and presented the review findings, noting a low level of unmet need in the Eldon area and the recommendation to open the Teviot Day Service to Eildon residents.

6.2 S Burt supported the use of the Shared Lives programme, citing its success in other regions and confirmed contractual readiness.

6.3 K Hamilton requested clarity on outcome measurement for audit purposes. C Myers and S Patterson explained that data on service uptake and outcomes would be collected, including qualitative feedback.

6.4 S Horan requested clarification on the 'equivalency model', which S Patterson explained as a budgeting approach based on assessed needs and individual choice. Mid Lothian had already moved to an equivalency model and S Patterson was keen to replicate it in Borders. S Burt elaborated on the flexibility and innovation possible under self-directed support and emphasised the need to move away from traditional care models.

6.5 L O'Leary asked that both qualitative and quantitative data be captured for monitoring reporting to the IJB Audit Committee.

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** agreed to issue a Direction to Scottish Borders Council to implement the recommendations of the Eildon Day Supports paper, by:

a. using the Teviot Day Service to support appropriate service users from Eildon and from other localities, while work is undertaken to continue to review provision across the remaining three localities;
b. opening up access to the Shared Lives programme for adults with high needs across Eildon and the wider Borders based on the equivalency model;
c. noting that this provides improved outcomes, experience and better value than current arrangements, and is deliverable within the current budget; and
d. leading on work to explore need and appropriate options for day supports in the remaining 3 localities

7. H&SC IJB ANNUAL PERFORMANCE REPORT

7.1 C Myers presented the draft Annual Performance report as it covered the period in which he was the Chief Officer of the IJB. He advised that the report was in draft as national data on outcomes had not yet been published. He suggested the full report be released to the Board for virtual approval once the national data was available and that it then be presented for homologation at the September meeting.

7.2 R Duncan raised concerns about barriers to CAMHS access and the limitations of the current metrics. S Burt confirmed that national reporting focused on a narrow subset of CAMHS activity and offered to provide broader data, including neurodiversity metrics. He advised he would be keen to work with primary care colleagues to ensure the right service was provided.

7.3 L McCallum emphasised the clinical risk posed by unmet need in the community and called for better partnership communication given the perceived potential for decisions to be made in isolation. She was unclear if the decision making body had the correct membership and suggested it be reviewed.

7.4 C Myers clarified that recent decisions had been made by the Children and Young People's Planning Partnership (CYPPP) which included colleagues from the local authority, NHS Borders and the third sector and had not solely been made by education colleagues.

7.5 K Hamilton acknowledged the need to improve representation on the CYPPP given the balance of strategic planning and operational involvement had not been clear.

7.6 D Robertson reassured the Board that recent changes represented a significant enhancement in mental health support for young people.

7.7 J Stacey commented that the report required to be updated in terms of the Chief Social Work Officer change during that period.

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** noted the draft Annual Performance Report.

8. LOCAL CODE OF CORPORATE GOVERNANCE

8.1 Jill Stacey provided an overview of the content of the report.

8.2 L O'Leary suggested that the quality of relationships and the quality of relationship management should be looked at more robustly in future.

8.3 S Burt enquired about the perceived effectiveness of the IJB in terms of compliance and hotspots.

8.4 J Stacey commented that the annual audit opinion had been presented to the IJB Audit Committee and had been fairly positive in relation to activity, governance elements and the interactions of the partnership dimension and that had allowed the Audit Committee to take good assurance.

8.5 D Robertson commented that it had been some time since the last self evaluation of the IJB and he suggested that might be done again to see how far the IJB had progressed and how effectively it was working together and making progress.

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** acknowledged the significant review and update activity undertaken on the Local Code that is outlined in this report and note this is consistent with the CIPFA/SOLACE Framework.

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** approved the updated Local Code of Corporate Governance of the Scottish Borders Health and Social Care Integration Joint Board (Appendix 1).

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** noted that the updated Local Code will be used for the 2024/25 annual assurance process.

9. IJB AUDIT COMMITTEE ANNUAL REPORT 2024/25

9.1 L O'Leary commented that the report had been considered and agreed by the Audit Committee.

9.2 J Stacey provided an overview and background to the report.

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** approved the IJB Audit Committee Annual Report 2024/25 (Appendix 1) which presents the self-evaluation of the IJB Audit Committee's performance, impact and effectiveness, and areas of improvement.

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** acknowledged the assurances from the IJB Audit Committee to the Integration Joint Board (set out in bullet points a-f in Appendix 1) and its identified areas of improvement (nos.1-2 in Appendix 1) to enhance its impact and effectiveness as a scrutiny body.

10. STRATEGIC RISK UPDATE

10.1 J Stacey provided an overview of the content of the report and provided assurance to the Board that the relevant strategic risks that the IJB faced were being routinely reviewed and monitored. She further highlighted that; risk mitigation actions were being assessed; there were increasing demands and financial constraints around risk; and workforce challenges remained an issue.

10.2 P Moore commented that if there were any specific issues in any areas that required the attention of the Chief Officer, they should be shared with both himself and D Robertson whilst the post remained vacant.

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** acknowledged the risk review work undertaken to manage the IJB Strategic Risk Register and the output detailed in Appendix 1.

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** note that a further risk update will be provided in alignment with relevant progress updates on the Delivery Plan in 2025.

11. IJB 2024/25 QUARTER 4 FINANCIAL MONITORING POSITION

11.1 L Turner provided an overview of the Q4 financial monitoring position and highlighted several elements which included: the report outlined the IJB's financial position at the end of the 2024–25 fiscal year; due to meeting schedules, the draft accounts had already been approved by the Audit Committee and submitted to external audit; the report provided the Board with an opportunity to review the outturn position ahead of the final accounts being presented later in the year; there was a net overspend of £5.2m which was made up of a £6.6m NHS overspend and a £1.4m Local Authority underspend; the set-aside budget was overspent by £7.1m, higher than the previous year and unlike delegated services, no additional funding was provided for set-aside overspends.

11.2 In terms of context and mitigation, L Turner advised that the NHS overspend was £2.2m less than initially forecast, thanks to anticipated future-year savings included in the budget and key cost pressures remained in Learning Disabilities (LD) placements and prescribing costs; those pressures were being partially offset by underspends in: generic services and Older people's services.

11.3 In regard to savings and reserves, L Turner reported that In-Year Savings of £5.3m had been achieved and the reserves had decreased by £1.5m between Q3 and Q4, mainly due to the use of Scottish Government funding for specific purposes. The year-End Reserve Balance was just over £9m.

11.4 In relation to the 2025–26 Budget Outlook, an indicative budget was set in March, pending final confirmation from the NHS. The budget had received conditional approval from the Scottish Government, with no changes expected and a full update would be provided with the Q1 2025–26 report.

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** is asked to **NOTE** the final year end position of the IJB for the year ended 31st March 2025.

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** is asked to **NOTE** the ongoing risk to the financial sustainability of the IJB due to current funding levels compared to running costs and anticipated demand.

12. AGE FRIENDLY COMMUNITIES

12.1 P White presented South Ayrshire's Age-Friendly Communities model, based on the WHO framework. He highlighted demographic challenges, including a rising dependency ratio and the need for early intervention. The model included eight domains such as transport, housing, social participation, and civic engagement. Initiatives included Champions Boards, intergenerational programs, Connect Hubs, and micro-enterprise development. E Thornton-Nicol and S Bhatti expressed strong interest in

adopting similar approaches in the Borders. S Burt emphasised the importance of co-production and local area coordination. S Horan and others supported a strategic discussion on implementing an age-friendly model locally.

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

13. IJB AUDIT COMMITTEE MINUTES: 10 MARCH 2025

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

14. STRATEGIC PLANNING GROUP MINUTES: 30 APRIL 2025

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

15. ANY OTHER BUSINESS

15.1 There was none.

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 24 September 2025, from 10am to 12 noon through MS Teams and in person in the Council Chamber, Scottish Borders Council.

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**2 October 2025**
Title:	**Board Business Plan 2026**
Responsible Executive/Non-Executive:	**K Hamilton, Chair**
Report Author:	**I Bishop, Board Secretary**

1 Purpose

This is presented to the Board for:

- Decision

This report relates to a:

- Annual Delivery Plan
- Government policy/directive
- Legal requirement
- NHS Board/Integration Joint Board Strategy or Direction

This aligns to the following NHSScotland quality ambition(s):

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

The purpose of this report is to provide the Board with a focused and structured approach to the known business that will be required to be conducted over the coming year.

2.2 Background

To deliver against targets and objectives, the Board must be kept aware of progress on a regular basis. The Board has a governance responsibility around performance, requiring assurance that targets will be met and that any action required to be taken to keep the organisation on course will be managed properly.

The Board will seek such assurance through the Resources & Performance Committee of the Board.

2.3 Assessment

Public Board Meeting Agendas

Public Board meeting agendas will be focused on main clinical and strategic issues at each meeting in order to facilitate strong debate of items.

Board Development

Board Development sessions have been scheduled for the afternoon after each public Board meeting. A programme of content will be worked up to ensure these sessions are used to the benefit of the Board.

Attached at Annex A is the Business Cycle for 2026 which has been formulated to capture the known business that the Board will be expected to address during 2026.

The Business Plan will remain a live document and will evolve further and flex where appropriate, to ensure the Board can meet its statutory and regulatory requirements.

Meeting Dates 2026

Tabled below are the proposed meeting dates for 2026.

- The Borders NHS Board will meet on 6 occasions.
- The Board will undertake Development sessions on 6 occasions.
- The Resources & Performance Committee (R&PC) will meet on 5 occasions.

Meeting	Jan	Feb	Mar	Apr	May	June	Jul	Aug	Sept	Oct	Nov	Dec
Public Board		5		2		25		6		1		3
Development Session		5		2		25		6		1		3
Resources & Performance Committee	15		5		7				3		5	

- Public Board meetings – 10.00am to 12.00noon
- Development Sessions – 1.00pm to 4.00pm
- Resources & Performance Committee – 9.00am to 11.00am

It is proposed that the meetings remain scheduled for the first Thursday of each month wherever possible in order to ensure reporting cycles for data collection are maximised. Meetings will also be held in person whenever possible with the use of hybrid facilities or full MS Teams whenever necessary.

Due to the need to ensure that the Annual Accounts are duly signed off by the Board in line with statutory requirements the June Borders NHS Board meeting will be pushed back to the last Thursday of the month (25 June).

In line with previous years it is proposed that there are no Borders NHS Board, Resources & Performance Committee, or Board Development sessions held in July.

Policy/strategy implications will be addressed in the management of any actions/decisions resulting from the business presented to the Board.

The SBC Full Council meetings cycle has been taken into account when identifying dates.

2.3.1 Quality/ Patient Care

Patient Safety/Clinical Impact implications will be addressed in the management of any actions/decisions resulting from the business presented to the Board.

2.3.2 Workforce

Staffing implications will be addressed in the management of any actions/decisions resulting from the business presented to the Board.

2.3.3 Financial

Resource implications will be addressed in the management of any actions/decisions resulting from the business presented to the Board.

2.3.4 Risk Assessment/Management

Risk assessment will be addressed in the management of any actions/decisions resulting from the business presented to the Board.

The risks of falling outwith the financial and performance reporting cycle have been recognised and minimised.

2.3.5 Equality and Diversity, including health inequalities

An impact assessment is not required.

2.3.6 Climate Change

Not applicable.

2.3.7 Other impacts

Not applicable.

2.3.8 Communication, involvement, engagement and consultation

Not applicable.

2.3.9 Route to the Meeting

This paper has been prepared directly for the Board.

2.4 Recommendation

- **Decision** – Reaching a conclusion after the consideration of options.

The Board is asked to **approve** the Board meeting dates schedule for 2026.

The Board is asked to **approve** the Board Business Cycle for 2026.

The **BOARD** is asked to **confirm** the level of assurance it has received from this report:

- **Significant Assurance (recommended)**
- Moderate Assurance
- Limited Assurance
- No Assurance

3 List of appendices

The following appendices are included with this report:

- Appendix No1 Business Plan 2026

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O
1	**BORDERS NHS BOARD BUSINESS PLAN 2026**														
2	**Item**	**Recurrence**	**Owner**	**5 February BOARD**	**5 February DEV**	**2 April BOARD**	**2 April DEV**	**25 June BOARD**	**25 June DEV**	**6 August Board**	**6 August DEV**	**1 October BOARD**	**1 October DEV**	**3 December BOARD**	**3 December DEV**
3	**Minutes**	monthly	Board Secretary												
4	**Action Tracker**	monthly	Board Secretary												
5	**Chief Executive's Report**	monthly	Chief Executive												
6	**Clinical Governance & Quality Update**	public	Director of Quality & Improvement												
7	**Healthcare Associated Infection Control & Prevention Update**	public	Infection Control Manager												
8	**Finance Report**	public & R&PC	Director of Finance												
9	**NHS Borders Performance Report**	R&PC & Public	Director of Planning & Performance												
10	**Statutory & Other Committee minutes**	public	Board Secretary												
11	**Consultant Appointments**	public	Director of Workforce												
12															
13	**Patient Story**	each meeting	Director of Quality & Improvement												
14	**Register of Interests**	yearly	Board Secretary												
15	**Annual Delivery Plan (includes winter plan and financial plan)**	yearly	Director of Planning & Performance / Director of Finance					ADP 26/27						ADP and MTP Update & plan for refresh	
16	**Code of Corporate Governance Refresh**	3 yearly	Board Secretary					Sectional							
17	**Public Protection Annual Assurance Report (replaces the separate Adult and Child Protection Reports) (Goes to CGC first for assurance and then the Board for noting)**	yearly	Director of Nursing & Midwifery												
18	**Child Poverty Annual Report (as per Child Poverty (Scotland) Act 2017 - Board required to publish annual report by June each year**	yearly	Director of Public Health												
19	**Risk Appetite**	yearly	Risk Manager			Risk Appetite Policy				Q4 Risk Report 25/26 - Annually					
20	**NHS Borders Annual Report and Accounts**	yearly	Director of Finance												
21	**NHS Borders Endowment Annual Accounts**	yearly	Director of Finance												
22	**NHS Borders Private Patients Funds Annual Accounts**	yearly	Director of Finance												
23	**Board Committee Memberships**	yearly	Board Secretary												
24	**Board Meeting Dates & Business Cycle**	yearly	Board Secretary												
25	**Annual Review Letter and Action Plan - Ministerial Annual Review has a follow up letter - Non Ministerial Review does not have a follow up letter**	yearly	Head of Performance & Planning											Dependent on timing of Annual Review	
26	**DPH Annual report - includes ADP Annual Report / Joint Health Protection Plan / Health Improvement Annual Report**	yearly	Director of Public Health	deferred											
27	**Progress on Mainstreaming the Equality Duty & Equality Outcomes**	2 yearly	Director of Public Health			**Due 2027**									
28	**Mainstreaming Equality Outcomes Report:** to publish on website	4 years	Director of Public Health					**Due 2027**							
29	**Pharmaceutical Care Services Plan -** The NHS (Pharmaceutical Services) (Scotland) Amendment Regulations 2011 (SSI 2011/32) amended regulations so that NHS Boards are obliged to publish Pharmaceutical Care Services Plans and monitor their plan annually to reflect changes in service provision or service need	yearly (3 yearly)	Director of Pharmacy			Update									
30	**Capital Report**	yearly	Director of Finance												

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O
31	**Financial Plan**	Done in R&PC?	Director of Finance			26/27	Financial Recovery Plan								
32	**Resource to the IJB 26/27 (Delegated Budget)**	yearly	Director of Finance												
33	**Board to formally sign off integration board membership (NEDS)**	yearly	Chair			**Every 3 Years due 2028**									
34	**Counter Fraud Services**	every 2 years	Director of Finance												**Due 2027**
35	**External Annual Audit Report**	yearly	Audit Scotland												
36	**Logie Legacy - Zambia Twinning Partnership Annual Update**	yearly	Director of Public Health												
37	**Primary Care Improvement Plan (PCIP)**	Yearly	Chief Officer									Annual Update			
38	**Blueprint of Corporate Governance Update**	yearly	Board Secretary											annual update	
39	**Health & Care (Staffing) (Scotland) Act 2019 - Annual Report on complaince for submission to Scottish Government - Awaiting timeline from Scottish Govt - Bill live from April 2024**	yearly	Director of Nursing, Midwifery & AHPs			Annual Report									
40	**iMatter**		Director of Workforce												
41	**Whistleblowing Annual Report to the Board**	annual	Board Secretary												
42	**Whistleblowing Quarterly Reports 1-4**	annual	Board Secretary	WB Q3 Rpt		WB Q4 Rpt				WB Q1 Rpt		WB Q2 Rpt			
43	**Scheme of Integration Consultation**	Due 2026	Chief Officer	**Due 2026**											
44	**ACF Annual report**	yearly	ACF Chair												
45	**Sustainability and Climate Change Annual Report**	yearly	Director of Finance												
46	**Strategic Framework 2023-26 (Corporate Objectives - to be updated in line with the Strategic Framework)**	3 yearly - FOR APPROVAL	Chief Officer / Director of Planning and Performance					**Corp Objectives due 2026**							
47	**Audit & Risk Committee Assurance Report**	annual	Chair Audit & Risk												
48	**Internal Audit Contract**	as and when	Director of Finance												
49	**Health Inequalities Report**	annual	Director of Public Health												
50	**3 Key Frameworks - Service Renewal Framework - Population Health Strategy - Public Sector Reform Strategy**	as and when	Chief Executive												

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**2 October 2025**
Title:	**Annual Climate Change Report 2024/25**
Responsible Executive/Non-Executive:	**A Bone, Director of Finance**
Report Author:	**F Laidlaw, Head of Soft FM (Facilities)**

1 Purpose

This is presented to the Committee for:

- Discussion

This report relates to a:

- Annual Operational Plan/Remobilisation Plan
- Government policy/directive

This aligns to the following NHSScotland quality ambition(s):

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

The NHS Scotland Policy for Climate Emergency & Sustainability was published in October 2021. This policy requires that all NHS Boards publish an annual report on their progress towards the implementation of net carbon zero emissions targets and sustainable development goals.

The report is expected to be submitted to Scottish Government and published on the Health Board's public facing website following Board approval.

The deadline for publication is November 2025.

2.2 Background

The policy requires that NHS Boards publish their report annually in November, reporting on progress during the financial year preceding. Timescales for publication have subsequently been revised due to availability of national data sources. Boards were previously expected to publish reports annually in January however this has now been reverted to November in line with the policy.

2.3 Assessment

The report was presented to the Resources & Performance Committee as draft for discussion and feedback prior to presentation to the Board.

2.3.1 Quality/ Patient Care

Any issues related to this topic are described within the body of the report.

2.3.2 Workforce

Any issues related to this topic are described within the body of the report.

2.3.3 Financial

There are no immediate financial implications of the report. There is however a lack of resources identified to support implementation of strategy objectives and this is highlighted in the report and via related risk assessment.

2.3.4 Risk Assessment/Management

Climate Emergency is reported on the Board's Strategic Risk Register. In addition, local climate change impact assessments have been undertaken on an East region basis in collaboration with other public sector bodies.

2.3.5 Equality and Diversity, including health inequalities

This report describes activities undertaken during the year 2024/25. The impact on inequalities of Climate Change is described within the report and is subject to separate reporting through the Board's existing structures regarding health inequalities.

2.3.6 Climate Change

This topic is considered within the main body of the report.

2.3.7 Other impacts

There are no other relevant impacts.

2.3.8 Communication, involvement, engagement and consultation

N/A

2.3.9 Route to the Meeting

This has been previously considered by the following groups as part of its development. The groups have either supported the content, or their feedback has informed the development of the content presented in this report.

- NHS Borders Climate Change & Sustainability Group – August 2025
- Resources & Performance Committee – 11 September 2025

2.4 Recommendation

The **BOARD** is asked to approve the report for publication in November 2025.

The Board will be asked to confirm the level of assurance it has received from this report:

- Significant Assurance
- Moderate Assurance
- Limited Assurance
- No Assurance

It is recommended that the Board take the following assurance in relation to the report:

Systems/Processes – Moderate Assurance (recommended)
Outcomes – Limited Assurance (recommended)

3 List of appendices

The following appendices are included with this report:

- Appendix 1 – Annual Climate Change Report, NHS Borders

Annual Climate Emergency and Sustainability Report 2024 - 2025

September 2025

1. Foreword

I am pleased to introduce the fourth NHS Borders annual Climate Emergency and Sustainability Report. Our previous report, covering our activities for the year to March 2024, was published in January 2025.

This report covers the period to March 2025 when we held our second organisational wide Climate Change Conference via MS Teams, increasing awareness of our strategy and progress to date, and enabling staff across the organisation to understand how they can help support delivery of a net zero ambition within NHS Borders.

This year's report presents a mixed position: we are able to describe the positive steps we have made in a number of areas and the impact these changes are having. You will be able to read in the report about our achievements in relation to: waste management, prescription of metered dose inhalers, and business travel. We also made significant progress towards the installation of solar panels at BGH campus which will go live in 2025/26.

Despite this, we have however seen slower than desired progress against our reduction in carbon emissions. There are a number of reasons for this and these are covered within the report, however it is a stark reminder that the actions we will need take to achieve our net zero ambition by 2040 are significant and will require a step change in the level of investment and activities we take forward in future years.

It is clear that the actions we are able to achieve will only be successful if this is undertaken in tandem with greater progress towards decarbonisation of the grid and other nationally delivered measures.

It is thanks to our staff that we have achieved the progress made to date, and much of this is delivered on a voluntary basis. I hope that as we shape our organisational strategy and the accompanying strategy for our climate change priorities we will continue to benefit from the enthusiasm and commitment of colleagues throughout our workforce and in tandem with this that we will be able to demonstrate a renewed commitment to action.

Andrew Bone
Director of Finance, Estates & Facilities
Executive Lead: Climate Change & Sustainability

Further information

More information on NHS Borders and its activities can be found at the following website:**nhsborders.scot.nhs.uk**

Our contact details are listed below.

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Headquarters
NHS Borders
Headquarters
Borders General Hospital
Melrose
Roxburghshire
TD6 9BS

2. Introduction

Welcome to NHS Borders' fourth annual Climate Emergency and Sustainability Report. Our previous report, detailing our activities up to March 2024, was published in January 2025.

In this report, we outline our greenhouse gas emissions for the financial year 2024/25 and provide a comprehensive narrative on the actions we have taken, as well as our future.

NHS Borders serves the healthcare needs of approximately 116,900 residents in the Scottish Borders, supported by a dedicated team of around 3,315 employees. Our region spans 1,827 square miles of largely rural landscape in southeast Scotland. We operate a variety of community and hospital services, including 23 health centres, four community hospitals, a district general hospital, and several specialist community and mental health facilities.

Many of our facilities are older and were built before modern construction methods and energy-efficient designs were standard. To achieve our net zero carbon goals, significant investment is needed to modernise our estate. Additionally, efforts across the public and private sectors are essential to improve energy efficiency and reduce supply chain emissions.

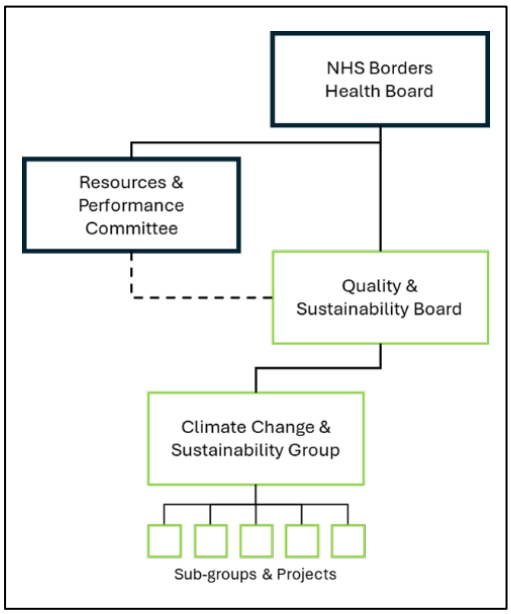
The initiatives detailed in this report align with the NHS Scotland Climate Emergency and Sustainability Strategy 2022-26. You can learn more about this strategy at the following link:

https://www.gov.scot/publications/nhs-scotland-climate-emergency-sustainability-strategy-2022-2026/

3. Leadership and governance

Our previous report set out the governance structure and management arrangements the Board has put in place to ensure that we continue to develop and implement our plans to address the impact of climate change. There have been no significant changes to these arrangements since the previous report.

The role of Sustainability Champion was held by Harriet Campbell, a non-executive member of our Board until 31st March 2025 – covering this reporting period. This role remains vacant and is expected to be filled later in 2025. Executive leadership remains under the remit of Andrew Bone, Director of Finance, Estates & Facilities.



The Board's Climate Change & Sustainability Group has responsibility for developing our response to climate change and supporting NHS Borders in becoming environmentally sustainable. The group meets on a bi-monthly basis to ensure progress against its action plan is regularly monitored. Individual workstreams and projects are managed through sub-groups established as and when required.

For the reporting period of this report the Climate Change and Sustainability Group reports to the Quality and Sustainability Board (QSB), comprising the Board executive management team and senior management representatives from all business units. Updates are provided on a quarterly basis.

The QSB reports[1] to the Health Board and to the Board's Resources & Performance Committee, which undertakes scrutiny of the Board's strategic plans.

Despite significant pressures on both time and resources, NHS Borders has dedicated both Board development time and Executive Leadership time to discuss this important agenda. Development and awareness sessions will continue with both the Board and Senior Leaders on a regular basis.

In March 2025 we held our second all staff virtual Sustainability Conference to enhance understanding across the organisation of our strategy, approach but also to promote "grass root level" action across NHS Borders.

A number of the Executive team lead key projects within their areas or expertise to support the Boards overall Net Zero ambitions.

[1] As at time of publication the Quality and Sustainability Board has been replaced by a new *NHS Borders Delivery Group* and it is expected that future reporting will be via this group.

4. Summary of impacts

NHS Borders aims to become a net-zero organisation by 2040 for the sources of greenhouse gas emissions set out in the table below. The table sets out the amount of greenhouse gas produced annually by NHS Borders.

2040 Net-Zero emissions	2020/21	2021/22	2022/23	2023/24	2024/25	Target (2024/25)
Carbon footprint (tCO2e)	10,236.7 tCo2e	10,344.5 tCo2e	9,677.48 tCo2e	10,470.3 tCo2e	10,297.54 tCo2e	9,2324 tCo2e

The table above describes limited progress towards reduction in Co2 emissions over the past five years. The earlier part of this period is impacted by the COVID pandemic, where activity across NHS facilities was significantly below 'normal' levels. As activity has recovered to pre-pandemic levels this has corresponded with an increase in emissions. It is also worth noting that improvements in the capture and monitoring of emissions data may have resulted in changes to how data is reported within individual periods. Nonetheless it is clear that there is a need for greater momentum if the trajectory to net zero at 2040 is to be achieved.

Greenhouse gas emissions 2023/24 & 2024/25, tonnes CO2 equivalent

Source	2023/24 – emissions	2024/25 – emissions	Percentage change – 2023/24 to 2024/25	2024/25– target emissions reduction	Percentage difference between actual and target emissions – 2024/25
Building energy	7086.4[2] tCO2e	7327.6 tCO2e	+3.4	-10%	Missed by 13.4%
Non-medical F-gas use	498.18 tCo2e	0[3] tCo2e	-100	-5%	Exceeded by 95%
Medical gases	243.3 tCo2e	602.77 tCo2e	+147.7%	-5%	Missed by 142%
Metered dose inhaler propellant	1,937 tCo2e	1,695.94 tCo2e	-12.4%	-5%	Exceeded by 7.4%
NHS fleet use Fleet & Grey Fleet)	256.40 tCo2e	282.29 tCo2e	+10.09%	-10%	Missed by 20.9%
Waste	120.04 tCo2e	116.60 tCo2e	-2.86%	-10%	Missed by 7.14%
Water	30.14 tCo2e	32.64 tCo2e	+8.29%	-10%	Missed by 18.29%
Business travel	298.86 tCo2e	239.70 tCo2e	-19.79%	-10%	Exceeded by 9.79%
Total Emissions	**10,470.32[4] tCo2e**	**10,297.54 tCo2e**	**-1.6%**	**8%**	**Missed by 6.4%**
Carbon sequestration	Not Available	Not Available	Not Available	Not Available	Not Available
Greenhouse gas emissions minus carbon sequestration	**10,470.32[5] tCo2e**	**10,297.54 tCo2e**	**-1.6%**	**8%**	**Missed by 6.4%**

[2] Amended from last year's report, previously reported as 6135.9 tCo2e
[3] In line with guidance figure calculated on F-Gas top up or removal
[4] Amended from last year's report, previously reported as 9519.82 tCo2e
[5] Amended from last years report, previously reported as 9519.82 tCo2e

Progress against Target
We recognise that the reduction of 1.6% against previous emissions falls short of our target reduction (8%) and that there are a number of areas where we are unable to demonstrate any progress towards reduction in emissions. Each of these areas is discussed in detail within the report and where actions have been identified to improve future progress this is described.

Data Quality
As in our previous report we have restated historic figures to reflect improvements to the quality of our data and to ensure consistency of reporting. We continue to strive to provide the most accurate information available and as we improve awareness of carbon accounting requirements across our teams and implement changes to our processes this does mean that some information previously provided is reviewed and amended.

Changes in Resources impacting on Emissions
The table below sets out our usage of key resources impacting on greenhouse gas emissions over the last two years and provides further context to the preceding table.

Source	**2023/24 Use**	**2024/25 Use**	**Percentage change – 2023/24 to 2024/25**
Building energy (MWh)	35,138 MWh	34,875.7 MWh	-.75%
Waste (tonnes)	1,169.5 tonnes	1046.7 tonnes	-10.5%
Water (cubic metres)	112,314 cubic metres	151,137 cubic metres	+34%
NHS fleet travel (km travelled) Includes Grey Fleet	1,645,751 km	1,870,648 km	+13.6%
Business travel (km travelled) Includes Public Transport and Flights)	1,948,677 km	1,606,617 km	-17%

5. Climate change adaptation

Scotland's climate is changing faster than expected according to research published by the James Hutton Institute in December 2023. According to this research:

- "Between 1990 to 2019, February and to a lesser extent April have become wetter, particularly in the west, by up to 60%, exceeding the projected change by 2050 of 45-55%."
- "Scotland is on track to exceed "a 2°C increase in temperature by the 2050s, with the months from May to November experiencing up to 4°C of warming over the next three decades (2020-2049)."
- "The number of days of consecutive dry weather – an indicator for drought and wildfire risk – are also expected to increase in drier months, such as September."

Climate change exacerbates existing health risks and introduces new challenges, ranging from the spread of infectious diseases to the intensification of heatwaves and extreme weather events that will impact the health of the population, healthcare assets and services. NHS Scotland plays a pivotal role in safeguarding the life and health of communities by developing climate-resilient health systems capable of responding to these evolving threats.

The changing climate is increasing risks for health and health services. More information on these risks in the UK can be found in the UK Climate Change Committee's Health and Social Care Briefing available here: www.ukclimaterisk.org/independent-assessment-ccra3/briefings/

NHS Borders completed an Adaptation Risk Assessment in 2023. The main risks identified were in relation to changes to population needs (i.e. increased demand for healthcare services) and the adaptability of environmental controls within our estate (e.g. ventilation systems).

This risk assessment is being used to support the Health Board in planning its future estate strategy, ensuring that our land and buildings are adapted to mitigate the risks arising from climate change. This includes both sustaining the fabric of the estate from potential damages as well as ensuring that the healthcare environment does not present and increased risk of harm to our patients, and that it is suitable to meet the future needs of our population.

Population risks impaction on healthcare needs include a potential increase to chronic conditions affected by seasonal temperature variation, for example more patients requiring hospital admission during prolonged hot weather; admissions relating to dehydration, heat stroke, breathing issues and cardiac issues could be anticipated; with further long-term issues relating to potential increase in skin cancers. We also identified wider societal impacts affecting population mental health, with specific concern regarding the isolation of small communities in rural locations.

Risks in relation to environmental controls are in part related to the age and design of our current estate, with integral plant and equipment likely to be insufficient to mitigate increased healthcare acquired infection risks arising from potential changes to temperature and humidity within the operating environment.

The actions to address increased demand will be a collaborative approach between our clinicians, supported by our Public Health and Communications teams, to ensure residents of the Scottish Borders are engaged in the design of future service models and aware of the actions they can take to ensure that health services are both effective and efficient regarding the impact that these services have on our environment.

In relation to our buildings, we are aware of innovation in building design which offers opportunities to improve natural ventilation and cooling, and we will ensure that these opportunities are considered for both our existing estate and new buildings developed in our long-term property strategy.

During 2024/25 we have begun the work necessary to develop our future property strategy, including commissioning a full review of the design, condition and use of the Borders General Hospital. We expect that the development of this strategy will be informed by the information provided through our climate change risk assessment.

NHS Borders is also working with Climate Ready South East, a regional project considering both impact and adaptations that will need to be made.

6. Building energy

We aim to use renewable heat sources for all the buildings owned by NHS Borders by 2038. NHS Borders has thirty-nine buildings, across 19 sites, such as Borders General Hospital (Acute Hospital), 4 community hospitals, 23 health centres and a range of other facilities.

In 2024/25, NHS Borders used 34,841,571kWh of energy within its buildings, resulting in 7,327.6 tonnes of CO2 equivalent, an increase of 2.3% on previous year emissions (34,042,761kWh and 7,071.3).

Increased energy consumption is attributed to several factors including the following:

- Due to evolving service delivery models within the community - particularly the transition towards more hub-like environments and extended operational hours at facilities such as health centres - it is anticipated that there will be a corresponding increase in both gas and electricity consumption. These changes reflect a broader commitment to accessibility and integrated care, but they also necessitate greater use of heating, lighting, hot water, and other utilities during periods that were traditionally considered out-of-hours.
- This shift in usage patterns should be factored into future energy management strategies, budget planning, and sustainability assessments to ensure continued operational efficiency and environmental responsibility.
- There has been an increased deployment of mobile diagnostic facilities - including endoscopy, mammography, CT, and MRI units - to support essential equipment refurbishment programmes and to help reduce waiting times. This strategic approach enables continuity of diagnostic services while permanent equipment undergoes upgrades and provides additional capacity to meet rising demand across the region.
- Shift to EV Charging – increase in the number of EV chargers available to support the fleet migration from fossil fuel to renewable energy (electric) – average annual consumption 86,000 kWh (based over 5300 sessions), equates to 1% of NHS Borders annual electricity consumption. This effect is offset by a reduction in use of fossil fuels.

In 2024/25, NHS Borders generated 1400 MWh of energy from renewable technologies (Solar PV). This is expected to increase significantly in future years with the introduction of increased Solar PV on the BGH campus.

Building energy emissions, 2015/16, 2021/22 and 2024/25 – tCO2e

	2015/16 energy use	2023/2024 energy use	2024/2025 energy use	Percentage change 2015/16 to 2024/2025
Building fossil fuel use	4681.3 tCO2e	5254.8 tCO2e	5545 tCO2e	+18.5%
District heat networks and biomass	129.7 tCO2e	80.1 tCO2e[6]	56.7 tCO2e	-56.3%
Grid electricity	4340.6 tCO2e	1751.5 tCO2e	1725.9 tCO2e	-60.2%
Totals	**9151.6** tCO2e	**7086.4** tCO2e	**7327.6** tCO2e	**-19.9%**

Building energy use, 2015/16, 2021/22 and 2024/25 – MWh

	2015/16 energy use	2023/2024 energy use	2024/2025 energy use	Percentage change 2015/16 to 2024/2025
Building fossil fuel use	22368MWh	24654MWh	26019.5MWh	+16.3%
District heat networks and biomass	2860.6MWh	1299MWh	1164.4MWh	-59.3%
Grid electricity	8739.6MWh	7785MWh	7658.7MWh	-12.4%
Renewable electricity	2895MWh	Est. 1400 MWh	33.1MWh	-97%
Totals	**36863.2 MWh**	35138 **MWh**	34875.7 **MWh**	**-.76**

Over the past year, NHS Borders has implemented a range of measures aimed at reducing emissions associated with building energy use. These actions reflect our commitment to sustainability and operational efficiency across the estate:

- **LED Lighting Upgrade Programme**: A rolling replacement of fluorescent fittings with energy-efficient LED technology is underway across internal and external areas.
- These installations feature smart lighting systems that incorporate natural light optimisation, motion sensors, and automated timers to maximise energy efficiency and reduce carbon emissions.

[6] Amended based on recalculation

- **Boiler Replacement Programme**: Ongoing replacement of inefficient boiler plant across the estate to improve heating efficiency and reduce fuel consumption.
- **Heating Infrastructure Improvements**: Upgrades to heating pipework insulation and replacement of heating pumps and associated equipment to enhance system performance.
- **Ventilation and Cooling Enhancements**: Lifecycle replacement of inefficient air conditioning units, upgrades to chiller systems, and remedial works to ventilation plant to improve functional efficiency.
- **Building Management System (BMS) Upgrades**: Enhancements to BMS controls to enable better monitoring and optimisation of energy use.
- **Water Efficiency Measures**: Installation of condensate recovery units to reduce water and energy waste.
- **Building Fabric Improvements**: Upgrades to roof coverings and insulation to improve thermal performance and reduce heat loss.
- **Scottish Green Public Sector Estate Decarbonisation Scheme (GPSEDS)**: Delivery of capital projects under this scheme, including fan and pump efficiency upgrades, LED lighting, insulation improvements, solar PV installations, and sub-metering.
    - **Estimated Annual Energy Savings**: 2,398 MWh (electricity and gas combined)
    - **Estimated Lifetime Carbon Reduction**: Approximately 5,470 tCO_2e

Solar PV Panels at Borders General Hospital

In addition to the grant-funded initiatives, rolling programmes for boiler plant replacement and improvements to pressure systems, condensate units, steam traps, and other core infrastructure continue to be progressed through the Board's capital programme.

Work supporting green theatre initiatives and ventilation plant upgrades - particularly at Borders General Hospital - are also expected to deliver further energy efficiency gains. These were included within the scope of the GPSEDS project, which is now largely complete, pending final commissioning activities.

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Forward Plan: Emissions Reduction Measures (2025/26)

Our longer-term strategy for reducing building-related emissions is outlined in the **Net Zero Carbon Roadmap** developed in 2023. Key initiatives planned for the current financial year include:

- **Ventilation System Upgrades**: Remedial works to critical and general ventilation systems, including extract systems, to improve air quality and energy performance.
- **Hot Water System Improvements**: Replacement of existing calorifiers with plate heat exchangers, designed to reduce energy use and eliminate the need for hot water storage.

- **Solar PV Expansion**: Installation of a new photovoltaic array at a Community Hospital as part of a RAAC remedial project.
- **Feasibility Studies**: Development of business cases for future decarbonisation and energy efficiency projects, aligned with the Net Zero Carbon Roadmap and targeting multiple grant and funding streams.

7. Sustainable care

The way we provide care influences our environmental impact and greenhouse gas emissions. NHSScotland has three national priority areas for making care more sustainable – anaesthesia, surgery, and respiratory medicine.

7.1 Anaesthesia and surgery

Greenhouse gases are used as anaesthetics and for pain relief. These gases are nitrous oxide (laughing gas), Entonox (a mixture of oxygen and nitrous oxide) and the 'volatile gases' - desflurane, sevoflurane and isoflurane.

Through improvements to anaesthetic technique and the management of medical gas delivery systems, the NHS can reduce emissions from these sources.

NHS Borders total emissions from these gases in 2024/25 were 602.77 tCO2e, an increase of 359.47 tCo2e from the year before. The change is mainly due to the ordering process which is explained below.

More detail on these emissions is set out in the tables below:

Nitrous oxide and Entonox emissions, 2018/19, 2023/24, 2024/25 – tCO2e

Source	2018/19 (baseline year)	2023/24	2024/25	Percentage change 2018/19 to 2024/25
Piped nitrous oxide	241 tCO2e	29.5 tCO2e	73.91 tCO2e	-69.3%
Portable nitrous oxide	12 tCO2e	15.1 tCO2e	0	-100%
Piped Entonox	265 tCO2e	126.4 tCO2e	406.38[7] tCO2e	+53.4%
Portable Entonox	114 tCO2e	59.8 tCO2e	110.87 tCO2e	-2.7%
Total	632 tCO2e	230.8 tCO2e	591.16 tCO2e	-6.5%

[7] This figure is based on ordering in 2023/2024 ordering in final quarter was reduced. In 2024/2025 a large order was placed in the first quarter and final quarter. It is expected that the figure for 2025/2026 will reduce again.

Volatile medical gas emissions, 2018/19, 2023/24, 2024/25 – tCO2e

	2018/19 (baseline year)	2023/24	2024/25	Percentage change 2018/19 to 2024/25
Desflurane	33 tCO2e	0	0	-100%
Isoflurane	1.1[8] tCO2e	0.2 tCO2e	0	-100%
Sevoflurane	15.3 tCO2e	12.3 tCO2e	11.61 tCO2e	-24%
Total	48.6 tCO2e	12.5 tCO2e	11.61 tCO2e	-76%

We have moved away from using Desflurane for volatile anaesthesia. No Desflurane has been purchased by NHS Borders since August 2021 and it is no longer used. Isoflurane has similarly been phased out so now Sevoflurane or total intravenous anaesthesia is our default.

In previous years we moved to GE Aisys anaesthetic machines which have technology that makes giving anaesthetics at lower gas flows more straightforward. This reduces the amount of volatile anaesthetic used as well as piped oxygen and air.

The nitrous oxide manifolds have now been decommissioned resulting in a significant reduction in CO2e in previous financial years. The timing of orders for replacement cylinders seems to have resulted in an increase in Entonox this year however we would expect that to be compensated by a decrease next year.

A National Green Theatres Programme was officially launched in 2023 to help reduce the carbon footprint of theatres across NHS Scotland and enable more environmentally sustainable care by:

- Working with clinicians and professionals to develop actions that reduce carbon emissions, waste and resource use.
- Supporting Boards to implement, measure and report on these improvements.

We are implementing the green theatre project and have introduced reusable theatre hats for staff, reusable sterile drapes and gowns, embedded waste segregation and oral Paracetamol as the default choice in the peri-operative period. We are working on a process to switch AGS (Anaesthetic Gas Scavenging) and HVAC (Heating Ventilation Air Conditioning) to a background setting out of hours and looking at the business case for alternative surgical suction devices. We have now moved away from in-line fluid warming as default in all theatres resulting in a reduction in consumables and energy use. Rub not scrub has also been firmly embedded and staff are as a result using less water and less energy to heat this.

[8]*Amended from previous reporting following recalculation Isoflurane previously stated as 0.3 tCo2e (2018/2019).*

7.2. Respiratory medicine

Greenhouse gases are used as a propellant in metered dose inhalers used to treat asthma and COPD. Most of the emissions from inhalers are from the use of reliever inhalers – Short Acting Beta Agonists (SABAs). By helping people to manage their condition more effectively, we can improve patient care and reduce emissions.

NHS Borders clinicians have adopted the approach agreed through national Respiratory pharmacy networks. It is the opinion of the Scottish Respiratory Pharmacist SIG, that the best inhaler is 'the one the patient can use [most] effectively'. The cost (financially and environmentally) of Dry Powder Inhalers (DPI) is significantly greater than normal use of MDIs (metered dose inhalers). There are two new (environmentally better) propellants coming to market in the next couple of years and it was agreed the greatest immediate gain clinically and environmentally would be to focus on patients' over-use of SABA inhalers rather than any scheme switching to DPI. It is also worth noting that the current crop of environmental claims is mostly through carbon off-setting and often still results in a plastic product which cannot be recycled.

We estimate that emissions from inhalers in NHS Borders were 1,696 tonnes of CO2equivalent, a reduction 241 tonnes of CO2equivalent from the previous year.

Inhaler propellant emissions, 2018/19, 2023/24, 2024/25 – tCO2e

Source	2018/19 (baseline year)	2023/24	2024/25	Percentage change 2018/19 to 2024/25
Primary care	1,751.27 tCO2e	1,900 tCO2e	1,662 tCO2e	- 5%
Secondary care	41.55 tCO2e	37 tCO2e	33.94 tCO2e	-18%
Total	1,792.82 tCO2e	1,937 tCO2e	1,695.94 tCO2e	-5.4%

There is a Primary Care asthma review project under development which will take into account changes to local Formulary and the recently published National Respiratory Strategy.

In addition, we are involved with Realistic Medicine which will ensure patients are on the most appropriate medicines for the minimum time.

7.3. Other Sustainable Care Action

NHS Borders strives to find ways to deliver sustainable care and actively seek opportunities to deliver exceptional care whilst reducing our carbon footprint.

We are actively seeking opportunities to change practice and look forward to reporting on this next year.

8. Travel and transport

Domestic transport (not including international aviation and shipping) produced 28.3% of Scotland's greenhouse gas emissions in 2022. Car travel is the type of travel which contributes the most to those emissions.

NHS Scotland is supporting a shift to a healthier and more sustainable transport system where active travel and public transport are prioritised.

We are reporting an increase in emissions in relation to both NHS Fleet use and Business Travel. We had anticipated that this would decrease slightly each year and are disappointed with the increase. Much of this increase is associated with moving care into the community and increasingly into people's homes. As an organisation we need to consider how we will address this challenge whilst reducing emissions related to transport.

Some increased mileage will relate to the issue of RAAC at The Knoll in the last quarter of the year, with teams increasing frequency of travel to The Knoll and managing logistics. It is anticipated the same will be true next year as the organisation supports the reoccupation and in addition business miles for displaced staff are captured within reporting. The three additional EV cars are to support temporarily redeployed employees at The Knoll.

As last year the inclusion of air, rail, and passenger journeys we supported are now included for completeness. For bus and rail, due to the number of paper expenses claims the mileage was calculated this year as the average km to pence. This will be the process moving forward until we are able to get more accurate data.

The small increase in air travel emissions relates to a single long-haul journey and without that journey overall flight emissions would have decreased by 22%.

We continue to work collaboratively with Scottish Borders Council to ensure public transport is effective for NHS Borders staff, patients, and visitors. We are pleased that SBC secured funding to upgrade the bus stop at Borders General Hospital and the work will be carried out in 2025/2026.

We continue to enable agile working which enables people to utilise technology such as Microsoft Office Teams to reduce the need to travel to meetings.

NHS Borders recognises that supporting active travel will be a key component of our future travel plans. Our progress to date in this area has been limited however through the development of our Active Travel plan we expect to increase awareness across staff and visitors and to ensure

Two of NHS Borders EV Fleet

that our policies and infrastructure is refreshed to support active travel.

NHS Borders continues to work with SEStran and actively participate in the South Regions Strategic Action on Transport to ensure we leverage opportunities for sustainable transport wherever possible.

We remail committed to removing all petrol and diesel fuelled cars from our fleet as soon as possible. Given the rurality this is challenging due to the range issues and in addition funding constraints.

The following table sets out how many renewable powered and fossil fuel vehicles were in NHS Borders fleet at the end of March 2024 and March 2025:

	March 2024		March 2025		
	Total vehicles	**Number of % Zero Emissions Vehicles**	**Total vehicles**	**Number of % Zero Emissions Vehicles**	**Difference in % Zero Emissions Vehicles**
Cars	23	11	40	14	+3
Light commercial vehicles	43	6	36	11	+5
Heavy vehicles	2	0	2	0	0

The following table sets out how many bicycles and eBikes were in NHS Borders' fleet at the end of March 2024 and March 2025.

	March 2024	**March 2025**	**Percentage change**
Bicycles	0	0	0
eBikes	0	0	0

Due to the rurality of the Scottish Borders the relative distances for journeys are significantly higher than in Health Board regions which have a higher population concentration within urban centres.

Following consultation with key stakeholders NHS Borders has decided to undertake further review before progressing any investment in eBikes.

The following table sets out the distance travelled by our cars (Fleet and Grey Fleet), vans and heavy vehicles in 2024/2025

Distance travelled, kms

Source	**2023/24**	**2024/25**	**Percentage change 2023/24 to 2024/25**
Cars	1,062,215 km	1,297,036 km	+22%

Source	2023/24	2024/25	Percentage change 2023/24 to 2024/25
Light Commercial Vehicles	583,535 km	573,612 km	-1.7 %
Heavy Vehicles	0	0	-
Total	1,645,750km	1,870,648	+13%

Business travel is staff travelling as part of their work in either their own vehicles or public transport. It covers travel costs which are reimbursable and does not include commuting to and from work. The table below shows our emissions from business travel by transport type. This table includes Fleet, Grey Fleet and business miles claims.

Business travel emissions, tCO2e

Source	2023/24	2024/25	Percentage change 2023/24 to 2024/25
Cars	441.6 tCO2e	518.86 tCO2e	+17.49
Public Transport	2.47 tCO2e	3.33 tCO2e	+34.8%
Flights	9.43 tCO2e	10.16 tCO2e	+7.7%
Total	453.5 tCO2e	532.35 tCO2e	+17.38%

NHS Borders is investigating how to effectively capture commuter miles for inclusion in future reports.

9. Greenspace and biodiversity

Biodiversity
Biodiversity, or the wide variety of living organisms within an environment, has declined at a rapid rate in the last 50 years. Evidence demonstrates that these trends are attributed to human activities, such as land use change, habitat degradation and fragmentation, pollution, and the impacts of climate change. The State of Nature report published in 2023 has highlighted the decline of nature across Scotland, with 11% of species now classed as threatened with extinction.

Public bodies in Scotland have a duty under the Nature Conservation (Scotland) Act 2004 (Nature Conservation Scotland Act 2004) to further the conservation of biodiversity, taking care of nature all around us. Furthermore, the Wildlife and Natural Environment (Scotland) Act 2011 (Wildlife and Natural Environment Scotland Act 2011) requires every public body to summarise their activities to meet this duty, through the production of a publicly available report.

We are fortunate to be in a beautiful and rural part of Scotland and are continuing to work on a long-term strategy to address the identification, protection, and enhancement of biodiversity across our estate. As part of our climate change adaption plans, we will consider how nature-based solutions may align across both the climate and biodiversity emergencies. We recognise this is a complex area and will work with relevant bodies (e.g. Nature Scotland) to ensure that plans are aligned to best practice.

We submitted our data for NHS Scotland Estate Mapping programme and look forward to progressing this work. The ongoing mapping works by PHS has provisionally calculated that greenspace accounts for 53% of the NHS Scotland's 15.8km2 total estate. This work will be published in a high-level report summary and an update will be provided in the near future.

Following on from last year we have maintained our reduced number of cuts of 10 cuts a year at a height of 75mm. We have also further increased the number of areas within all NHS Borders grounds that are planted with new pollen rich planting and wildflowers.

We continue to assess how we can minimise the use of pesticides across our estate and have reduced the times it is used each year, also working alongside Risk, Health & Safety to ensure the correct products are being used.

We are seeking to embed the principles of biodiversity into all our estate planning and management. We are also investigating opportunities on how to best monitor and assess biodiversity across the Estate.

Finally, we have used our regular communications to highlight Biodiversity and increase understanding of the issues to all our employees.

Greenspace
The design and management of the NHS Scotland green estate for human and planetary health, offers an opportunity to deliver a range of mutually beneficial outcomes. These include action on climate change (both mitigation and adaptation), biodiversity, health and wellbeing for patients and staff, community resilience building and active travel.

To support this our grounds & gardens team continue to assist in the "Space to Grow" project at Huntlyburn House. The "Space to Grow" area is used for carrying out workshops that assist in the rehabilitation of our mental health patients and is widely accessed by staff and visitors.

We have also continued to develop new outdoor spaces for staff members at all our NHS Borders Hospitals by providing areas in greenspace which promote improved staff wellbeing. These areas are being planted with pollinator plants and shrubs. Healthcare workers often experience high levels of stress, especially in demanding environments like hospitals. Green spaces provide staff with a place to decompress, enhancing job satisfaction and potentially reducing burnout.

Following on from the grassland guidance, we joined other boards across Scotland taking part in No Mow May and other actions to change the way we manage grassland.

No mow May May 2024 Signage

The table below outlines our key greenspace projects and their benefits.

Project name/ location	Benefits of project	Details of project
Public Health Collaboration	Wide Stakeholder engagement Anchor Organisation Work	We are working with PH to ensure our Green spaces provide the best environment for everyone in the Scottish Borders
Rainwater Harvesting	Reduced Water consumption	We are implementing rainwater harvesting to support the watering of plants across our sites. Currently in place in the Estates Gardening Team workshop.
Increased Tree Planting	Improved environment and Carbon Sequestration	New hedge/trees were planted behind Car Park 3 at Borders General Hospital. All materials were funded and supplied by CGI and our estates team received assistance from volunteers and Carbon Footprint Ltd with planting.
No Mow May	Supporting our country's flora and the wildlife that relies on it – particularly pollinators such as bees.	Additional areas of the Borders General Hospital Grounds were added this year including the main entrance area of the Borders General Hospital and additional signage was used to communicate information on this project.

10. Sustainable procurement, circular economy, and waste

Earth Overshoot Day marks the date when our demand for resources exceeds what earth can regenerate in that year. In 2024, Global Earth Overshoot Day is 1 August.

For the UK, the picture is more worrying. In 2024, the UK's Earth Overshoot Day is 27th May. The current level of consumption of materials is not sustainable and is the root cause of the triple planetary crises of climate change, biodiversity loss and pollution.

We aim to reduce the impact that our use of resources has on the environment through adopting circular economy principles, fostering a culture of stewardship, and working with other UK health services to maximise our contribution to reducing supply chain emissions to net-zero by 2045.

In the last year, to reduce the environmental impact of the goods and services we buy we have continued to procure over 80% of our products through National Contracts or Frameworks. The National Distribution Service supply over 80% of our medical consumables (economies of scale, consolidation of deliveries).

The majority of goods used by our services are supplied through national procurement hosted by NHS Scotland. For all of our deliveries, including those ordered locally, we aim to minimise the frequency of deliveries whilst retaining effective supply chain management. National deliveries are scheduled once daily via a single distribution centre. Orders placed directly with suppliers are consolidated across multiple departments in order to limit the number of journeys to a minimum achievable.

NHS Borders Procurement work with NHS NSS (National Services Scotland) National Procurement. Our Head of Procurement is a member of the Sustainable Procurement Steering Group.We will continue to be actively involved in this group and ensure delivery of initiatives and ensure our efforts are targeted effectively within our Board.

NHS Borders has signed up to the Community Benefits Gateway. The Community Benefits Gateway is a facilitation platform, enabling procurement services and suppliers to further improve lives, and support healthier communities.

When undertaking procurement activities, NHS Borders considers community benefits within the tender evaluation criteria (where relevant).

In 2021 NHS Borders became a Living Wage Accredited Organisation (working with the Poverty Alliance). Fair Work principles are embedded in appropriate contracts.

The Head of Procurement is a member of the National Efficiency Operational Group (commercial optimisation key objective).

In the next year to reduce the environmental impact of the goods and services we buy we will have a continued presence within the National Groups.

Our Head of Procurement is an active member of the working groups set up.

Sustainability training is now a mandatory requirement for staff who have a Procurement remit (using the SG (Scottish Government) eLearning) on Sustainable Public Procurement, Climate Literacy and Circular Procurement & Supply.

During 2025/26 NHS Borders will remain committed to delivering on Climate and Sustainability objectives and utilising the benefits of being an active member of the various national groups.

We will continue to work with other NHS Scotland Health Boards to maximise our contribution to reducing supply chain emissions to net-zero by 2045.

We have a commitment to ensuring that waste generated through procurement activities will continue to be reduced and that we will increase how much of this waste is recycled.

The table below sets out information on the waste we produce and its destination for the last three years. The data for 2020/2021 is incomplete. Percentage change has been measured against 2021/22 to ensure comparability of figures.

Type	2022/23 (tonnes)	2023/24 (tonnes)	2024/25 (tonnes)	Percentage change from last year
Waste to landfill	10	10	0.61	-93.9%
Waste to incineration	63.62	49.82	50.36	+1.08%
Recycled waste	715.9	679.2	460.27	-32.2%
Food waste	15.5	19	30.36	+59.7%
Clinical waste	360.9	326.4	322.64	-1.15%

In October 2024 NHS Borders implemented the new waste contract for recycling and general waste. The new contractor is fully compliant with the Environmental Protection Act 1990 duty to provide accurate weighing and tracking of waste. As expected, this has impacted the figures contained within this report. It should be noted that because the contract came into effect part way through the year, we do not expect the full impact of the change of contractor to be shown till next years report.

The significant reduction in Waste to landfill is because of the final treatment of waste provided by the new contractor who can process more waste as recycled or recycled to energy.

The recycled waste reduction figure is, following an investigation, due to the over inflated estimates by the previous contractor regarding the volume of waste uplifted.

We have initiated a programme to increase recycling through the removal of personal bins to encourage the correct segregation. This was successfully piloted by the executive leadership team.

A key change in the last year is we no longer process food waste through a macerator for disposal int the sewage network, which reduces the risk of blocked drains, changes to microbial communities and production of methane.

This has resulted in an increase to our food waste reported. This food waste is now processed via anaerobic digestion. The catering manager and waste manager are working collaboratively to ensure the food waste is reduced. Again, it should be noted this is a part year figure and we anticipate this may rise as we receive a full year's data even as mitigations are put into place.

To reduce the amount of incinerated waste we are reinforcing our education of what should be included in this waste stream and asking for increased vigilance that all recycling packaging is placed in the correct waste stream. In addition, we have worked with infection prevention control to remind clinicians about the correct use of sharps bins.

NHS Borders is pleased to see our continuing reduction in clinical waste and are confident that further improvements can be made.

The all staff virtual Sustainability Conference in March 2025 provided a deep dive into waste management and this ongoing education will support reducing our waste and ensuring waste is correctly segregated.

There are nationally agreed targets setting out reduction to the amount of waste produced across NHS Scotland; the tables below provide information on our performance against those targets. It should be noted that until April 2018 NHS Borders operated an onsite incinerator which was how most of our waste was processed; this means that we do not have segregated data from 2012/2013.

Reduce domestic waste by a minimum of 15%, and greater where possible compared to 2012/2013 – by 2025	
Target – reduce domestic waste by	No 2012/13 baseline data available. Based on 'straight line' methodology, anticipate 1.25% reduction per year. Target = 1.25% x 2021/22 tonnes
Performance – domestic waste reduced by	2023/2024 - 315 tonnes 2024/2025 - 294 tonnes (6.6% Reduction)
Outcome	Not achieved yet*
Further reduction required	3 x 1.25% of 2021/22 less any reduction achieved in 2022/23

**On basis that reduction of 1.25% is expected each year from point where base data is available.*

Ensure that no more than 5%, and less where possible, of all domestic waste is sent to landfill – by 2025	
Target – reduce waste sent to landfill by	Target (total landfill at 5% of overall waste)
Performance – waste sent to landfill reduced by	0.61 tonnes (1.3% of all domestic waste based on SBC (Scottish Borders Council) provided data)
Outcome	Achieved

Ensure that no more than 5%, and less where possible, of all domestic waste is sent to landfill – by 2025	
Further reduction required	None

Reduce the food waste produced by 33% compared to 2015/16 – by 2025	
Target – reduce food waste by	3.3% per year based on 33% over 10 years. Use 2021/22 as baseline
Performance – food waste reduced by	0 tonnes
Outcome	Not achieved yet
Further reduction required	3.3% x remaining year

Ensure that 70% of all domestic waste is recycled or composted – by 2025	
Target – recycle or compost	500 tonnes
Performance – recycled or composted	679.2
Outcome	Achieved
Further increase required	None

11. Environmental stewardship

Environmental stewardship means acting as a steward, or caretaker, of the environment and taking responsibility for the actions which affect our shared environmental quality.

This includes any activities which may adversely impact on land, air, and water, either through the unsustainable use of resources or the generation of waste and pollution. Having an Environmental Management System (EMS) in place provides a framework that helps to achieve our environmental goals through consistent review, evaluation, and improvement of our environmental performance.

We continue to work on EMS. This work is ongoing and through our Climate Emergency and Sustainability Group we are aligning EMS to our overall action plan to ensure that as work is undertaken to review and/or introduce our plans, policies, and procedures these will be recorded within our EMS. The work on EMS impacts a wide number of stakeholders and we will work collaboratively to ensure the EMS is robust with organisational wide engagement and teams aware of their responsibilities.

We recognise that resource will impact the EMS work and are frustrated that this will impact the full adaptation of an EMS.

12. Sustainable communities

Anchor Organisations
Anchor organisations can make a significant contribution to climate change and community health and wellbeing by reducing health inequalities through their procurement practice, training, employment, professional development and buildings and land use. Anchor organisations use a Community Wealth Building approach which is a person-centred approach to local economic development, this redirects wealth back into the local economy, and places control and benefits into the hands of local people.

We made a commitment last year to working further with non-health Anchor Organisations around our shared goals to maximise the positive impact for us here in the Scottish Borders and we have made good progress:

Workforce
NHS Borders are represented on the Local Employability Partnership by Human Resources and Public Health. Working in partnership we have submitted two applications for No-One Left Behind funding to progress employability projects in the following areas:

- Wellbeing Service through the recruitment of an Employability Advisor. This was successful at the end of the financial year 2024-25, with recruitment starting in 2025.
- Clinical and Professional Development to recruit two cohorts of participants to NHS Borders Employment Readiness Programmes. The programme has been shaped by lived experience research, aiming to reach our priority groups by offering a family friendly approach, paid placements and where possible sustained employment. This programme will include sessions on the Ways to Be Well to build participant capacity for health improvement.

Public Health have supported Human Resources with the delivery of two values-based presentations for groups of high school pupils from across the Scottish Borders who were starting work experience in a range of settings within NHS Borders. This included a mixed methods approach; a presentation, a patient experience video clip and an interactive discussion, to build knowledge and understanding of NHS Scotland Values, Communication and interpersonal Skills.

Our Anchors objectives for our Workforce workstream are:

1. Monitor and evaluate No One Left Behind-funded NHS post to support employability.
2. Improve staff wellbeing by supporting progress towards Menopause Friendly Accreditation.
3. Facilitate information exchange between Princes Trust Project and potential links to Scottish Borders Council's12-week placements programme.
4. Facilitate Anchor Institutions Self-Assessment process with our Community Planning Partners using Anchors Progression Framework (with support from Public Health Scotland).

Procurement of Goods, Services and Infrastructure
The Community Benefits Gateway promotions are ongoing, in partnership with voluntary (third sector) and community groups in the Scottish Borders. This has led to a total of 7 applications in the last financial year.

The table below provides a summary of Third Sector Organisations/Community Groups and needs for the period 1st April 2024 to 31st March 2025:

Third Sector Organisation/ Community Group	Need
Chirnside Development Group	Replacement Chairs
Springwood Retirement Village Residents Association	Springwood Retirement Village Defibrillator
Live Borders	Defibrillators for the Live Borders mobile library vans
Borders Carers Centre	Equipment: Everyday Essentials for Carers
The Lavender Touch	Equipment: Support for people living with Cancer in the Scottish Borders
Borders Carers Centre	Short Breaks Co-ordinator
Tweed Valley Mountain Rescue	Rescue Boxes

Of the seven applications listed in the table above, there have been four successful notifications of bids against local needs.

The Lavendar Touch received a successful notification of a national bid against their need from Ricoh UK who had work colleagues who wanted to donate their time; this is our first successful case study for Scottish Borders.

Our Anchors objectives for our Procurement workstream are:

1. Increase local promotions and third sector engagement with the NSS Community Benefits Gateway
2. Systematically apply community benefit goals and scoring in competitively tendered contracts for Quick Quotes

Land and Assets

Our Anchors objectives for our Land & Assets workstream are:

1. Scope out and develop a plan for embedding anchor sustainability activities in existing health board sites.
2. Progress next phase of the Sustainable Communities Plan (which is part of the wider NHS Borders Emergency Climate Change Plan) by building on established relationships with third sector partners.

Products and Service Delivery and Design

Public Health have continued to work in partnership with Scottish Borders Council to ensure policies and services are designed in a way that reduces inequalities caused by socioeconomic disadvantage. The mainstreaming equalities report has included contributions from Public Health relating to:

- Money Worries App
- Royal Environmental Institute for Health Food and Health Cooking Skills
- Trauma Informed Services
- Walk It

- Borders Alcohol and Drugs Forum
- THIS Borders
- Stigma
- Creating Hope Action Plan
- ALISS (A Local Information System for Scotland)
- Social Prescribing

Public Health have supported the facilitation of the British Sign Language Equalities & Human Rights Impact Assessment and developed the role of the Borders Older People's Partnership as a key group for age as a protected characteristic.

A further example of this was research undertaken by the Barriers Insights group, led by the Department of Work & Pensions and supported by Public Health which has influenced service planning within Clinical and Professional Development.

Working in Partnership across a wider area or place
There are three examples of partnership work in a wider area or place over the last year:

1. **Borders College** who supported the dissemination of the Women's Health Plan Long-Acting Reversible Contraception Survey. Borders College shared our social media assets to invite students and staff to complete the survey. While it is not possible to determine how many responses were from Borders College we can confirm they contributed to 153 responses we received. The survey included questions about access preferences and transport needs to influence service planning and improvement.

2. Scottish Borders **Housing Association** invited NHS Borders Public Health team to contribute to their draft housing strategy which already reflects an Anchors approach. Public Health were able to further influence the strategy from an anchors and health inequalities perspective, and this feedback has been welcomed by SBHA.

3. **LIVE Borders** carried out a consultation on the Scottish Borders Sport and Physical Activity Strategy and Public Health submitted a co-ordinated response reflecting key considerations from a health inequalities perspective to influence LIVE Borders role as an Anchor Organisation in the Scottish Borders. This has led to ongoing communications and we are planning a joint health related CPD in the future.

The above contributions will stand us in good stead for partnership work on the application of the Anchors Progression Framework.

Sustainability as part of our Anchors Mission
Looking ahead, we are excited about the work that Public Health Scotland are doing to map the green estate across Scotland which will be helpful for us locally to support further action. We are also hoping to build on other Whole Systems Work our Public Health team has been involved in in the community around Eyemouth to promote an established outdoor activities pack during Green Health Week in May 2025.

Active Travel
NHS Borders Department of Public Health Communities Team supports the Active Travel Links network which began in August 2024 and meets on a quarterly basis. This is a working group of like-minded people who support walking, wheeling and cycling in the Scottish Borders, and membership includes Cycling Hubs, SBCAN, Scottish Borders Council Active Travel, Walk it and others.

NHS Public Health developed a pictorial directory of the Cycling Hubs in the Scottish Borders, and this has been shared with partners across the network, including NHS Borders and Scottish Borders Council. One of the aims of the group is to share and learn from each other to reduce duplication and share experience in relation to funding, as most of the members are from the third sector.

Energy Efficiency and Home Renewables
Sustainable Borders (previously Sustainable Selkirk) is a funded project with key objectives to reduce the Scottish Borders' carbon footprint by providing advice to local residents and businesses. This advice covers practical and cost-effective ways to reduce energy and resource consumption, promote sustainable modes of transport and increase public awareness of both the causes and consequences of climate change. Sustainable Borders have provided tabletop information services based at Borders General Hospital Dining room to NHS Borders staff, and through September and November 2024 home visits or advice for NHS staff.

Information from Sustainable Borders covering the services they offer has been shared with NHS staff through the NHSB intranet site. As well as promoting energy efficiency, they also promote access to the E-Bike lending scheme, to support active travel.

Scottish Borders Climate Action Network (SBCAN)
A representative from NHS Borders Public Health Team is a member of the Advisory Group for Scottish Borders Climate Action Network (SBCAN). SBCAN is a Scottish Government funded project that sits with Southern Uplands Partnership. The project aims to build awareness of the climate emergency and actions local groups and communities can take to mitigate and adapt to climate change.

NHS Borders Public Health team and SBCAN have worked collaboratively to ensure the anticipated impacts on health are included in ongoing conversations about climate change and have jointly promoted the Climate Change Health Impacts in the Scottish Borders report on their website and during community events.

Plans are being developed to produce a resource that will support both NHS staff and community groups to communicate about the health impacts of climate change.

Mental Health and Wellbeing - Ways to be Well
Ways to Wellbeing is a guide developed by NHS Borders Public Health Team that offers ideas about how to look after mental health and wellbeing. Adverse impacts on mental health and wellbeing have been identified through the NHS Borders climate adaptation planning process as a risk to certain groups, especially those who are at risk of flooding or work in agriculture. In addition to this, there is evidence to suggest that young people are already experiencing climate anxiety as a result of expected climate change impacts.

NHS Borders Public Health Team has worked collaboratively with Scottish Borders Climate Action Network (SBCAN) to raise awareness of the links between climate change and mental

health and wellbeing. This was a key consideration during Green Health Week 2025 and SBCAN are developing a section on their website, committed to health and wellbeing, where the Ways to Be Well resources are publicised.

The Good Food Nation (Scotland) Act 2022

The Good Food Nation (Scotland) Act 2022 provides a legislative framework that enables the government to take forward a vision for Scotland to be a Good Food Nation with the aim that the people of Scotland can access and enjoy locally produced food that keeps them happy and healthy, and that our food industry continues to thrive. Other key aims are that the environment is protected, biodiversity loss reversed, and our net zero ambitions achieved. A Good Food Nation enables flourishing rural and coastal communities.

Under the Act ministers are required to produce a Good Food Nations Plan and this is expected to be developed by Spring 2026. In the Borders, a multi-agency Food Steering Group is in the process of developing the plan; NHS Borders is in attendance to contribute both from a Public Health perspective, and also as a key local employer and Anchor. Other key partners in the group include Scottish Borders Council, Abundant Borders and the Borders Food Forum.

NHS Borders Emergency Planning and Resilience

The NHS Borders Emergency Planning and Resilience (EPR) Team continues to work closely with Scottish Borders Council (SBC) to support and strengthen Resilient Community Planning across the region. This joint approach is particularly focused on enhancing local preparedness and response to the increasing frequency and severity of weather-related events driven by climate change.

In the lead up to summer, NHS Borders provided direct input to the SBC Resilient Communities Newsletter, offering practical advice on managing the health implications of climate change. This included guidance on staying safe during heatwaves and storms, maintaining access to medication and care during disruptions, and supporting vulnerable groups during prolonged adverse conditions.

Our health-focused contribution complemented our operational response to Storm Eowyn, which brought widespread wind and rainfall to the region. Although there was no significant damage to healthcare infrastructure, the storm impacted staff travel and led to a moderate increase in weather-related presentations. NHS Borders activated severe weather protocols in close coordination with SBC, ensuring continuity of care and support to patients throughout the disruption.

As part of ongoing partnership working, NHS Borders remains an active contributor to the development and refinement of community-led resilience strategies. These efforts ensure that local communities are not only prepared for extreme weather—such as flooding, snow, and heatwaves—but are also equipped to recover and maintain access to essential health and social care services.

NHS Borders continues to provide tailored, seasonal health advice to Resilient Communities groups, particularly in preparation for winter. This includes:

- **Health Preparedness:** Guidance for households on securing access to medication and care during disruptions.
- **Cold Weather Health Risks:** Information on protecting vulnerable individuals from cold-related illness and supporting community flu prevention efforts.

- **Access to Services:** Clear messaging around how to contact NHS services during adverse weather, including through NHS 24, Near Me (telehealth), and community-based alternatives.

Formal NHS Borders representation is in place at Resilient Communities meetings during winter planning sessions, providing local groups with advice and resources to embed health resilience into their winter planning. This collaboration with SBC and community stakeholders forms a key pillar of NHS Borders' climate change adaptation strategy. By integrating health considerations into local resilience efforts, we are collectively strengthening our ability to withstand and recover from climate-related challenges.

Maintaining Service Delivery During Severe Weather
NHS Borders has a well-established framework to manage severe weather events including storms, snow, flooding, and extreme heat. These plans are tested regularly and have been adapted to reflect the growing risks linked to climate change.

Working alongside SBC Emergency Planning and Transport teams, joint arrangements are in place to safeguard access to health and care services, including:

- **Staff Mobility:** Ensuring health and care staff can travel safely via priority routes, 4x4 support, and partnerships with community transport providers.
- **Patient Access:** Supporting continued home visits and alternative service delivery (e.g., telehealth, mobile units) where travel is not possible.
- **Risk Monitoring and Communications:** Real-time monitoring and proactive communication to staff, patients, and the public about service disruptions and contingency plans.
- **Strategic Resource Allocation:** Ensuring essential supplies—such as fuel, PPE, and emergency medications—are available during sustained incidents.

Scenario-based training exercises simulating major flooding, heatwaves, or snow events have been integrated into annual preparedness efforts. These exercises test cross-service responses and support continuous improvement of our severe weather plans.

Healthcare in Non-Traditional Settings
Recognising the impact of climate-related disruptions, NHS Borders is developing flexible approaches to healthcare delivery. This includes exploring how non-traditional spaces—such as community halls or mobile units—can be used to deliver essential services when hospitals or clinics are inaccessible.

Joint planning with SBC is focused on expanding the health offer within rest centres established under the Care for People Plan, ensuring access to basic healthcare, medication, mental health support, and assessments for those displaced by severe weather or extended power outages.

Key elements of this work include:

- **Health Provision in Rest Centres:** Embedding NHS staff to support displaced and vulnerable individuals.
- **Alternative Healthcare Locations:** Identifying and equipping community spaces to provide flexible, scalable services.
- **Logistical Coordination:** Aligning health provision with wider emergency response, transport, and social care planning.
- **Continuity of Care:** Safeguarding access to essential treatments and ongoing support for high-risk individuals during periods of disruption.

NHS Borders is also developing detailed protocols and training to support staff in adapting to these roles, ensuring safe, high-quality care regardless of setting.

Looking Ahead

By embedding healthcare into broader resilience frameworks and aligning with partners at SBC, NHS Borders is helping to build a system that can respond flexibly and compassionately to the evolving challenges of the climate emergency. Our focus remains on maintaining continuity of care, supporting vulnerable groups, and ensuring the health needs of our communities are met - no matter the changing climate.

13. Conclusion

We are reporting reduction of 1.6% against previous year emissions (10,297.54 tCO2e from 10,470.3 tCO2e). This is disappointing and is a sobering reminder of the challenge presented by our target to achieve net zero carbon emissions by 2040. Without a significant increase in momentum it will not be possible to deliver the progress required.

It should be noted that this position is set within the context of continued efforts to improve the accuracy, comprehensiveness, and transparency of our reporting.

Reducing carbon emissions in a healthcare environment is challenging due to both the complexities of the operating environment and the necessary use of products which presently have a high carbon emissions footprint. We hope that this report demonstrates the commitment of our clinical teams and support services to finding innovative solutions to reduce our carbon emissions, without compromising patient care.

The scale of investment and action required to deliver net zero cannot be achieved through individual organisations and local action alone: it will require Government level investment in infrastructure adaptation, including actions which will address at source the efficiency and use of renewables in national grid.

Nonetheless, as a healthcare provider we will need to ensure that we are taking the actions available to us locally, and in collaboration with our supply chain, to support changes in both clinical and broader staff working practices and to mitigate where possible the impact of our services upon the wider environment.

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**2 October 2025**
Title:	**Consultant Appointments**
Responsible Executive/Non-Executive:	**A Carter, Director of HR & OH&S**
Report Author:	**B Salmond, Associate Director of Workforce**

1 Purpose

This is presented to the Board for:

- Awareness

This report relates to a:

- Local policy

This aligns to the following NHSScotland quality ambition(s):

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

The purpose of this report is to notify the Board of recent consultant appointments offered by the Chair or their deputy on behalf of NHS Borders Board.

2.2 Background

Board members were briefed in December 2017 on revisions to the NHS Borders guidance on medical consultant appointments. As a result, the Chair of the Board or his/her deputy have delegated authority to offer consultant appointments on behalf of the Board.

2.3 Assessment

Since the last report to the Board, 1 new consultant has been interviewed, offered and accepted a consultant post.

New Consultant	Post	Start Date
Dr Rishi Ramessur	Consultant Ophthalmologist	September 2025

2.3.1 Quality/ Patient Care

The Senior Medical Staffs Committee receives a quarterly report on forthcoming medical vacancies, new long term Consultant appointments (including locums) and consultant posts filled by long term locums.

2.3.2 Workforce

Successful recruitment to substantive consultant posts supports the sustainability of services.

2.3.3 Financial

Not applicable.

2.3.4 Risk Assessment/Management

Not applicable.

2.3.5 Equality and Diversity, including health inequalities

An impact assessment has not been completed in the preparation of this paper. However Equality and Diversity obligations are fully complied with in the recruitment and selection process.

2.3.6 Climate Change

Not applicable.

2.3.7 Other impacts

Not applicable.

2.3.8 Communication, involvement, engagement and consultation

Not applicable.

2.3.9 Route to the Meeting

Not applicable.

2.4 Recommendation

The Board is asked to note the report.

- **Awareness** – For Members' information only.

The Board will be asked to confirm the level of assurance it has received from this report:

- **Significant Assurance (recommended)**
- Moderate Assurance
- Limited Assurance
- No Assurance

3 List of appendices

Not applicable.