Public Question & Answers for Annual Review 131125

Public Questions Received:

- Community Hospitals
- Dermatology Waits
- Falls
- Early Intervention and Community Based Support Pathways
- Patient Transport Services
- Digital Connectivity

Community Hospitals – Update on Knoll Hospital

- **What is the frequency and health care and financial impacts of bed-blocking within NHS Borders due to the inability to discharge patients to appropriate external care?**

  Delayed discharges, often referred to as 'bed blocking,' impose significant financial and clinical challenges for NHS Borders. Each additional day a patient remains in hospital beyond their clinically required stay incurs costs related to accommodation, staffing, and overheads—varying across acute hospitals, community hospitals, and mental health wards—but collectively exerting substantial pressure on the overall budget. Prolonged occupancy reduces capacity for new admissions and elective procedures, creating inefficiencies and limiting flexibility for investment in service improvements. At the same time, delayed discharge negatively affects patient outcomes, particularly for older, frail individuals who risk deconditioning during extended hospital stays, which can hinder recovery post-discharge. Systemically, high bed occupancy restricts availability for non-delayed patients, contributing to longer waits for admission and crowding in Emergency Departments, where national evidence links extended waits to poorer outcomes.

  We are pleased to say we are in the best position we have been since before 2023 with 41 Delayed Discharges reported at the end of October 2025.

- **Would increased investment in capacity and capability at local cottage hospitals (post operation remediation services and hospice capabilities for example) provide a value for money solution to at least part of this problem?**

  NHS Borders is working with Scottish Borders Council as the Health and Social Care Partnership to increase capacity in our communities. The focus of this work is to support more of our population to receive care in the comfort of their own home.

  We are currently increasing capacity in our Home First service, a service designed to care for patients immediately after discharge, to reduce the time that patients need to remain in hospital.

We are also expanding our Hospital at Home service which provides consultant-led care in the community thus avoiding the need for admission into hospital, or supporting earlier discharge from hospital.

These services replicate successful models from across the UK. Community Hospitals continue to provide an important part of our healthcare system in the Scottish Borders and work is planned to review their function to ensure they support a model of care that helps as many people return home, as possible.

This work will consider whether we can increase the number of post-Acute care patients cared for in Community Hospitals. A separate piece of work is planned to review palliative care services across the Scottish Borders and this will include the use of Community Hospitals within it's scope.

- **If so, would such investment not provide better overall community health outcomes rather that investment in state of art medical capabilities?**

  NHS Borders is focused on expanding community services to help more people avoid hospital admission and enable more patients to recover at home. Evidence from across the UK demonstrates that investment in these services supports better long term outcomes for patients, and thus provides better value for money over the long term in Health and Social Care spend. This approach also aligns with what patients are telling us is important to them.

Dermatology Waits

- **Why is it taking 2 years for a dermatologist appointment after being referred from a GP because there is nothing else they can do for you? Also why can the GP not take any responsibility after referring patients to hospital specialists- thank you!**

  Referrals to the dermatology service have been increasingly significantly over several years. NHS Borders has experienced significant waits in excess of 2 years for routine appointments for two main reasons. The first, is because 'urgent suspicion of cancer' and other urgent referrals have been prioritised on grounds of clinical priority over 'routine' referrals. For some time, we have been unable to secure the necessary clinical workforce to be able to meet demand. There is a national shortage of dermatologists and therefore it has been extremely difficult to make appointments at NHS Borders. However, we have recently appointed a new Consultant Dermatologist and have made several other improvements to the service and I am pleased to report that the number of patients wating over 2 years to be seen is now reducing dramatically and we are committed to ensuring that no patient waits more than 52-weeks to be seen or treated by March 2026.

Falls

- **How are individuals who have experienced falls, and who may be at increased risk of loneliness or isolation, identified and referred to supportive services such as the Royal Voluntary Service (RVS)?**

NHS Borders has developed a HSCP Falls prevention strategy which sets out a HSCP approach to preventing and managing falls across the Borders. Falls and frailty remain one of the leading causes of hospital admissions and adverse events across NHS Borders, and the organisation is committed to delivery of a preventative approach relating to falls and frailty across all services. Community rehabilitation teams, Home First reablement teams, and District Nursing work alongside partners such as Scottish Ambulance Service, Scottish Borders Council and Scottish Fire and Rescue to identify and refer appropriate individuals at risk and following a fall. A pilot project in locality 'What matter's hubs' is providing support and advice to those at risk of falls to be signposted to local third sector or health services.

Early Intervention and Community Based Support Pathways

- **What opportunities exist to strengthen early intervention and community-based support pathways, particularly for individuals at risk of isolation, declining health, or delayed engagement with services?**

  NHS Borders is committed to early intervention and prevention across our clinical pathways in line with Scottish Government's 'Population Health framework' and 'Service Renewal Framework' and will be reinforced through NHS Borders Clinical Strategy. Service management and clinical leads across Primary and Community services are aware of the need to deliver services 'upstream' in order to provide best outcomes for individuals. Our focus on prevention and keeping people well can be evidenced by some specific examples:

  Oral Health:

  - NHS Borders Oral Health Improvement Team actively engage with communities and services for priority group populations delivering preventative interventions and supporting vulnerable people to access oral care

  - The Public Dental Service provide dental care for individuals who are unable to receive treatment in routine dental services as a result of additional needs, vulnerabilities or medical complexity

  Primary Care MDTs:

  - Ongoing Development of Multi-Disciplinary Team working in local health centres alongside General Practice to identify and support individuals at risk of isolation or decline through proactive, preventive care.

  - Strengthening of Community Treatment and Care (CTAC) hubs and community vaccination delivery, improving accessibility to preventative care and routine interventions closer to home.

  - CTAC services provide local access to diagnostic and treatment services, improving engagement and continuity of long-term conditions. CTAC services provide 6000 appointments a week including those with LTC monitoring. This additional capacity has the potential to improve access to Practice Nurse management appointments.

- Continued collaboration with Primary Care and 3rd Sector partners to build local resilience and connect people earlier to community-based supports.

Children & Young People

- Strong links are being built between Primary Care, Schools and Health Visiting to support early identification of need and engagement with wellbeing.

- With rising concerns around social isolation, delayed service engagement, and health inequalities, NHS Borders is advancing early intervention and community-based support in children's services through multi-agency collaboration, whole-family approaches, and targeted health improvement initiatives. These efforts aim to reduce inequalities, improve access, and support children at risk of isolation or delayed service engagement.

Patient Transport Services

- **How is patient feedback on transport services gathered and used to inform service improvements and strategic planning?**

  We are about to begin a review of our transport services and as part of this review we will be seeking feedback from service users. At present feedback is through normal NHS Borders patient feedback channels and is passed to service management for review.

- **What criteria and processes are used to assess patient eligibility for NHS transport, particularly for cancer treatment?**

  Patients are normally expected to make their own travel arrangements when attending NHS services, however arrangements are in place where individuals require additional support. Patients attending services outside of Scottish Borders are able to seek reimbursement for travel costs, and may be able to access transport through our transport hub.

- **How is transport demand managed for patients requiring ongoing treatment, such as regular appointments at BGH?**

  Regular hospital attenders can discuss their transport requirements with their clinical team and if eligible will be directed to Scottish Ambulance service or to our local patient transport service.

- **How does NHS Borders' transport service performance and driver capacity compare to other NHS regions?**

  We do not have any comparative information which identifies how our transport service compares with other regions. This is something we will be considering as part of our transport service review.

- **To what extent is community transport (e.g. RVS) integrated into NHS Borders' transport provision, and how do costs compare with continued reliance on taxis?**

  We do not currently use RVS transport although we have used them in the past. Cost effectiveness is always considered in identifying how our services are delivered and we will revisit current service provision as part of the review. We do use taxis for some journeys where regular transport routes are not supported. This is limited in scope with the majority of our transport services provided in house.

- **How does NHS Borders' transport service performance and driver capacity compare to other NHS regions and as part of the transport review will you be looking at the operational times of the NHS Transport?**

  There is not a method of benchmarking driver capacity across all NHS Boards. The operational hours will be reviewed as part of the Transport Hub review.

Digital Connectivity

- **Digital connectivity is a problem across the Borders. Finding mobile signal at the BGH itself can often be challenging. It was more to raise that there's a push towards digital first e.g. virtual appointments, but there's not necessarily the infrastructure in place including issues at the BGH around phone signal and wifi speed. Is there a plan to address this?**

  Thank you for raising this – it's an important point. We absolutely recognise that digital connectivity across the Borders, including at BGH, can be challenging. Mobile signal and Wi-Fi performance are critical for supporting digital-first initiatives such as virtual appointments.

  There is a wider programme of work underway to improve digital infrastructure across NHS Borders sites. This includes:
  - **Wi-Fi upgrades** to increase speed and reliability for staff and patients.
  - **Discussions with network providers** to address mobile coverage issues at key locations like BGH.
  - **Exploring alternative connectivity solutions** (e.g., signal boosters, dedicated 4G/5G access points) for areas with persistent issues.

  While progress is being made, we know this is a priority and will continue to push for improvements to ensure digital-first services are practical and accessible.

Public Session Q&A (Live)

I am a resident of West Linton. Thank you for a very clear presentation and for outlining a number of local initiatives, which I welcome, particularly the hospital at home initiative, which I think is an excellent idea.

My concern is whether such welcome local initiatives will be sustainable if NHS Borders was to be amalgamated with another health board. And the reason that's at the top of my mind, that the minute, is that I notice that other health boards have advertised for new Chairs, but despite the fact that your long serving and successful chair announced her retirement quite some time ago, that her position has not been advertised.

I guess I'm looking for reassurance that there is not a plan to merge NHS Borders with another Board.

Answer from Vice Chair, Fiona Sandford
You're right, Karen's post has not yet been advertised. I think this is largely due to a backlog in the system of public appointments, when they had a large number of different Chair's roles to fill. I had already said that I would be content to be Interim Chair, so the post is not being left vacant and it is my understanding that the intention is to advertise the post in the New Year.

Additional response from Chief Executive, Peter Moore
In terms of the structure of territorial boards, there are no plans afoot to merge organisations. We are currently developing our clinical strategy, and for complex services we are looking to increase how we will collaborate with other boards in delivering those. The rationale for that is because some of the resources that we have across Scotland are really scarce and we've got to work out how we make sure everybody across our population has equitable access to the right services.

Question from the floor:
Could you please summarise what facilities there are for patients who've been treated at home.

Answer from Director of Nursing, Sarah Horan
Almost 90% of all care is carried out at home or close to home in a community setting. Services like Hospital at Home and Home First we aim to deliver as a 'one stop shop'. So if you need something, it would be organised in the community and delivered to you at home by district nurses and other health professionals.

Home First is about reablement, so if you've been in hospital we want to get you home or to your homely setting as soon as possible, and the care you need will then be delivered at home, by allied health professionals, healthcare support workers and registered nurses.

Additional response from Laura Jones, Director of Quality and Improvement
We started with 10 ‘beds’ last year to test whether it was going to be something that we could deliver for our population. We had to adapt the approach quite significantly to meet the needs of our remote and rural population. We have 20 'beds’ today and will be moving towards 25 early in the new year. We have yet to achieve total population coverage but we hope to test some really exciting new technology as a part of hospital at home as well which is a really exciting development.

Patient and staff feedback about our services is vital: we want to develop our services in partnership with our population, and the more feedback we receive the faster we can assess the effectiveness of our service developments.

Question from the floor:
We work for the Royal Voluntary Service (RVS) serving the community across the Scottish Borders, but we also are part of the Third Sector here as well. One of our missions is ‘Open Hands’ and helping people in the community. Previously we were more focussed on older people, but we are working with people aged 18 and over now, which is a shift.

There have been some really good initiatives described but what opportunities exist to connect with the third sector? One of the things that we really do want to look at is how we work with people early on, because it is more difficult when we work with people at a later stage because their needs may have become more complex and that can impact the support we can offer them.

So my question is are there opportunities to strengthen intervention and community-based support pathways?

Answer from Sarah Horan and Dr Lynn McCallum, Medical Director
Focussing on prevention is absolutely key to the work that we're going with the Clinical Strategy. We all know how important the Third Sector is and how we work closely together for the good of the citizens of the borders.

What has come out really clearly from the clinical teams participating in the development of our Clinical Strategy is the need to work more closely, with a real focus on early intervention.

Whatever age you are, the sooner we can intervene and actually prevent and enable people to pay attention to their own health within their own environment.

A multi-agency approach has been a really common theme amongst all the clinicians we've spoken to and there's no question that the next 5 years will definitely involve

active engagement across multi sectors, including the local authority, education, and critically the Third sector.

Social isolation is a really significant risk factor for future health, and is a significant problem in the Borders. We hear from people who describe how socially isolated they have become, particularly if, for example, for health reasons, they lose their driving license which impacts on their ability to reach their social networks in a rural area.

Additional response from Peter Moore, Chief Executive
In addition to the Clinical Strategy we are developing a set of enabling strategies and plans that sit beneath it; one of which is our Partnerships Strategy. This recognises the importance of working across sectors, including the third sector, and also the ongoing dialogue that we have with our patients.

The presentation you saw today touched on the engagement events that took place across the Borders last January, and I want to highlight that these were not one off conversations, but part of a continuing conversation with our patients, partners, staff and communities to ensure we develop and deliver services that meet the needs of our communities.

Question from the floor:
I would like to ask what criteria are used for assessing whether people receive patient transport?

Response from Andrew Bone, Director of Finance, Estates and Facilities
The general expectation is that individuals who are using our services will utilise their own means of transport to access services. In the cases where that is not possible we have systems in place to provide support.
When patients are referred and access care out of the Borders (for example at the Golden Jubilee) we reimburse travel costs and in some cases arrange journeys.

We have our own patient transport service that we manage locally within the hospital. We also use a range of other providers as well, where we need to do that, and we're constantly reviewing the service. There is a transport review underway at the moment, which is about looking at the shape and configuration of the services that are available.

Our model is based upon providing the (transport) services in house as far as possible. We don't have a big reliance on taxis; we use them for individual journeys, for particular people who are usually coming from locations where they're not well served by other transport connections, and the service is based on their individual needs.

I am absolutely open, as part of our transport review, to look at all the options that are available, and we will engage with the RVS and other providers to make sure that we're looking at the best possible use of our resources and the best possible provision for our patients.

Question from the floor:
With an ageing population in the Borders and people living with co-morbidities what are you doing in relation to access for patients, for example to outpatient services? The reason for my question is, we have an elderly neighbour who and was very grateful for being offered four different appointments to four different specialties all in the space of a week. But from our geographical area, that added up to nearly 300 miles of travel in the space of a week!

Could something be done to look at appointment requests for individual patients to marry them up so that people do not need to travel excessive distances unnecessarily?

Answer from Dr Lynn McCallum
There are several underpinning principles to our new clinical strategy, the first of which is moving care closer to home. In developing the strategy we have been asking ‘how can we deliver care in different ways?

One solution is carrying out clinics in communities, when they would normally be provided in the BGH. We are also looking at virtual consultations and how we support them, whether that is by telephone or using other technology. I have been told off on multiple occasions for saying that our older population are not technologically enabled(!) so it's really important to make sure they we are offering the right solution to people.

The second fundamental principle of the clinical strategy is the concept of patient centred care. So whilst we strive to meet targets and be financially sustainable, we also, most importantly, have people at the centre of everything that we deliver. And I think what's really, really critical here is that we are asking people what they want. This is called Values Based Health and Care, and is about not doing things ‘to you’ but finding out what is important to people about their treatment, which sometimes will lead to a patient deciding they don’t want treatment, or asking their clinician for their opinion to help them make the decision that is best for them and their personal wishes and circumstances. It’s about seeing the person, not the condition.

On Monday at our Executive Team meeting we actually discussed a proposal looking at how we reshape and restructure the delivery of outpatients, so there will be lots to talk about with patients and our communities on this subject.

Question from the floor:
How do we work in partnership across the public, independent and third sectors to help people in the community? For example encouraging people to go to the GP and advocating for them / going with them? It has been done in the past, so is there any possibility of that happening again?

Response from Sarah Horan
So we are talking about working with partners here again, and how we understand the needs of people in the community and how we can support them. We have heard examples during this session of good neighbours and the support they can offer, but not everyone has neighbours. For some people in the Borders who live in very isolated places neighbours don't exist so it is about how we connect the system to itself and use everything we possibly can to keep people safe at home.

Question from the floor:
What opportunities do you think there are in relation to engaging with big national companies like Tesco and Asda, in relation to supporting the health of the population? What responsibilities do you think that they could take for example to support people with diabetes, or people who need support and advice in relation to their diet?

Response from Dr Sohail Bhatti, Director of Public Health
When it comes to the determinants of health, health services contribute about 20% to that, but the environment that people live in, in terms of access to income has a disproportionately big impact.

Along with the council I think we need to have some of those active conversations and work with those organisations, in our role as an 'anchor institutions', to consider planning applications for example. That's why public health was moved from health into local authorities within the English system, so that the broader determinants of health are considered.

There was some population healthcare work that was co-produced between COSLA and Directors of Public Health that was released a couple of months ago, in which the second priority is the obesogenic environment. There are a number of policies around that such as the 'good food nation' but in answer to your questions as to whether we can work together as a whole society to address these problems, the answer is yes!

Recognising that large supermarkets and other businesses have their own aims, they do collect some really good data about our consumer habits, and I think there is definitely potential for us to build relationships with our local supermarkets.