Borders NHS Board

A meeting of the **Borders NHS Board** will be held on **Thursday, 4 December 2025** at 9.30am in Room 1.005, Borders College, Main Campus, Unit 1 Nether Rd, Galashiels TD1 3HE

AGENDA

Time	No		Lead	Paper
9.30	**1**	**ANNOUNCEMENTS & APOLOGIES**	Chair	*Verbal*
9.33	**2**	**DECLARATIONS OF INTEREST**	Chair	*Verbal*
9.35	**3**	**MINUTES OF PREVIOUS MEETING**	Chair	*Attached*
9.40	**4**	**MATTERS ARISING** Action Tracker	Chair	*Attached*
9.45	**5**	**CHIEF EXECUTIVE'S REPORT**	Chief Executive	*Appendix-2025-85*
9.55	**6**	**STRATEGY**		
9.55	6.1	NHS Borders Organisational, Clinical and Enabling Strategies	Chief Executive Director of Planning & Performance	*Appendix-2025-86 To Follow*
10.55	6.2	Nursing Midwifery Allied Health Professions (NMAHP) Education	Director of Nursing, Midwifery & AHPs	*Appendix-2025-87*
11.05	6.3	Health Inequalities Progress Report	Director of Public Health	*Appendix-2025-88*
11.15	**7**	**FINANCE AND RISK ASSURANCE**		
11.15	7.1	Resources & Performance Committee minutes: 11.09.25	Board Secretary	*Appendix-2025-89*
11.16	7.2	Endowment Board of Trustees minutes: 12.06.25	Board Secretary	*Appendix-2025-90*
11.17	7.3	Finance Report	Director of Finance	*Appendix-2025-91*
11.25	**8**	**QUALITY AND SAFETY ASSURANCE**		
11.25	8.1	Clinical Governance Committee minutes: 10.09.25	Board Secretary	*Appendix-2025-92*
11.26	8.2	Quality & Clinical Governance Report	Director of Quality & Improvement	*Appendix-2025-93*
11.35	8.3	Infection Prevention & Control Report	Director of Nursing, Midwifery & AHPs	*Appendix-2025-94*
11.40	**9**	**PERFORMANCE ASSURANCE**		

11.40	9.1	NHS Borders Performance Scorecard	Director of Planning & Performance	*Appendix-2025-95*
11.55	**10**	**GOVERNANCE**		
11.55	10.1	Blueprint for Good Governance Update	Board Secretary	*Appendix-2025-96*
11.58	10.2	Consultant Appointments	Chief Executive	*Appendix-2025-97*
11.59	**11**	**ANY OTHER BUSINESS**		
12.00	**12**	**DATE AND TIME OF NEXT MEETING**		
		Thursday, 5 February 2026 at 10.00am	Chair	*Verbal*

Borders NHS Board

Minutes of the Borders NHS Board meeting held on Thursday, 2 October 2025 at 10.00am in the Council Chamber, Scottish Borders Council and via MS Teams (Hybrid).

Present:
K Hamilton, Chair
F Sandford, Vice Chair
L Livesey, Non Executive
J Ayling, Non Executive
L O'Leary, Non Executive
P Williams, 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
O Bennett, Interim Director of Acute Services
G Clinkscale, Director of Acute Services
M Clubb, Director of Pharmacy
S Whiting, Infection Control Manager
R Pullman, Nurse Consultant
S Errington, Head of Planning & Performance
C Oliver, Head of Communications & Engagement
T Martin, BBC
I Todd, ITV

1. Apologies and Announcements

1.1 Apologies had been received from D Parker, Non Executive, J Smyth, Director of Planning & Performance, A Carter, Director of HR, OD & OH&S, and L Jones, Director of Quality & Improvement.

1.2 The Chair welcomed a range of attendees to the meeting including members of the public and press.

1.3 The Chair confirmed the meeting was quorate.

1.4 The Chair recorded the thanks of the Board to A Carter as it was his last Board meeting as he was due to retire from his Director of HR, OD & OH&S role in November.

1.5 The Chair announced that Healthcare Improvement Scotland would publish their report that morning following their unannounced inspection visit to the Borders General Hospital that took place from 5-6 August 2025.

1.6 The Chair announced that the NHS Borders Annual Review would be held on Thursday 13 November at 2pm at the Great Tapestry of Scotland in Galashiels and the public were invited to attend.

2. Declarations of Interests

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

The **BOARD** approved the inclusion of the Declaration of Interests for P Williams, Non Executive Director in the NHS Borders Register of Interests.

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

3. Minutes of the Previous Meeting

3.1 The minutes of the Extraordinary meeting of Borders NHS Board held on 7 August 2025 were approved.

4. Matters Arising

4.1 **Action 2025-4:** The report would be presented to the Staff Governance Committee at its next meeting on 6 November 2025.

4.2 **Action 2025-5:** J McLaren to confirm the updated APF ToR would be available for formal board sign off as part of the next Code of Corporate Governance Sectional Refresh.

The **BOARD** noted the Action Tracker.

5. Chief Executive's Report

5.1 P Moore commented on the progress that had been made over the previous 12 months and thanked the Executive Team for their support in making key decisions on a 24/7 basis. He highlighted the new organisational strategy, changes to the performance landscape and improvements in delayed discharges, cancer diagnostics and long wait patients. He further highlighted the challenging financial situation and the improvements made.

5.2 Discussion focused on: coverage of the Director of HR role and its wider responsibilities; clinical strategy and the enabling strategies for review by the Board in December; engagement with clinicians across the organisation; and engagement with primary care clinicians including independent contractors.

The **BOARD** noted the update.

6. Scottish Borders Health & Social Care Integration Joint Board update

6.1 P Moore provided an update on the vacancy for a Chief Officer to the Health & Social Care Integration Joint Board and advised that a job description had been agreed and the recruitment process would proceed shortly.

The **BOARD** noted the update.

7. Public Protection Report

7.1 R Pullman provided an overview of the content of the report and highlighted several key elements which included: strengthening staff roles and responsibilities for public protection; developing systems and processes; capturing data; sharing and embedding the learning from reviews to support practice and patient outcomes; and succession planning.

7.2 S Horan commented that the Clinical Governance Committee had received the report and were mindful of the critical work that the small service undertook around safe guarding. She highlighted the risks and constraints in data sharing. She commented that the Clinical Governance Committee were keen for public protection to be an item at a future Board Development session.

7.3 Discussion focused on the work of health inequalities in relation to public protection.

The **BOARD** noted the contents of the Public Protection Report and supported ongoing efforts to build capacity, foster a culture of safeguarding, and ensure that all staff clearly understood their roles and responsibilities.

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

8. Primary Care Improvement Plan Annual Programme Report

8.1 G Clinkscale provided an overview of the content of the report and O Simpson joined the meeting and presented a slide deck to highlight the achievements and highlights over the previous 12 months and highlighted: PCIP commenced in 2018 with a primary objective to remove activities from GPs and GP nurses that they didn't need to do to release their time to be general experts; it was a comprehensive piece of work and in summary highlighted that progress was made with: CTAC Phlebotomy in all Border GP Practices; CTAC admin hub established; demonstrator site established; and risks and issues moving forward.

8.2 Discussion focused on several key areas including: GP engagement; public engagement; creation of equality across the region to get to the point of standardisation of delivery; continual evolution of the change process; teething issue with GP IT systems transitioning; simulated patient experience in terms of appointment bookings; process one rolled out to every practice and each practice has their own communications to roll out; advocated for QI approach methodology; impact of work on costs elsewhere in the system; ensure the resources and money and expertise shift toward more preventative services; encouraging staff to embrace the QI champions programme to seek opportunities to improve service delivery; and the findings of a week of care audit that was undertaken with practices.

The **BOARD** noted the report.

The **BOARD** confirmed it had received significant assurance for systems and processes and moderate assurance for outcomes.

9. Policy on Prescribing Following Private Consultation

9.1 M Clubb provided an overview of the content of the report.

9.2 Discussion focused on: requests to transfer from private to NHS care for weight loss medication that had increased in price; no prescriber will prescribe outwith their competency areas; significant patient safety and governance issue; IVF criteria for 2 cycles on the NHS and then patients move to private care; gender reassignment changes would be seen when puberty blockers were prescribed; theme of obesity is strong through the clinical strategy; regional processes across south east Scotland in relation to complex areas of health care provision and expertise; and patient leaflets are provided to patients by GPs when referrals to private health care are made.

The **BOARD** noted the report.

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

10. Resources & Performance Committee minutes: 08.05.25

The **BOARD** noted the minutes.

11. Audit & Risk Committee minutes: 19.06.25, 26.06.25

The **BOARD** noted the minutes.

12. Finance Report

12.1 A Bone highlighted: the 5 month position and nearly a £6m overspend; improvement in the financial plan projections; overall improvement in operational performance; poor performance in terms of savings delivery; slippage on core budgets; and the use of agency workforce was in relation to medical workforce and within that the majority of spend was concentrated on long term locums to support services with sustainability issues.

12.2 Discussion focused on: expensive agency spend; drag on performance due to savings not being identified; the use of resources to be linked to the value for patients; clinical staff groups move to preventative models and an element of optimising on changing future spend on how services are delivered; if services operated at the full establishment that was planned for they would operate at different levels; impact of vacancies and recruitment difficulties affects performance of services, waiting times, and sometimes bank and agency if not available for some more specialist roles.

The **BOARD** noted the report including:

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)

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

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

13. Clinical Governance Committee minutes: 23.07.25

The **BOARD** noted the minutes.

14. Quality & Clinical Governance Report

14.1 F Sandford commented that the key issue in the report was the vulnerability of certain services which was a major concern. She further highlighted the mortality review work that had been taken forward.

14.2 S Horan commented that delayed discharges remained a significant issue. There had been improvements in community hospitals but further work was required in the acute hospital. In terms of medical education an action plan was in place to address the issues raised with the deanery to ensure all areas were addressed. She updated on the Coming Home project for those living with complex learning difficulties outwith the Board areas of at home being supported to transition to their own accommodation.

14.3 G Clinkscale appraised the Board on urgent and unscheduled care and the work that was being taken forward in regard to changing the model of care for frail and older people and the expansion of Home First capacity. The movement of frail elderly patients into a new Frailty Unit and changes to discharge processes to make it simpler to ensure swift transfer to the right care destination post acute.

The **BOARD** noted the report.

The **BOARD** confirmed it had received moderate assurance for systems and processes and limited assurance for outcomes.

15. Infection Prevention & Control Report

15.1 S Whiting provided an overview of the HIS unannounced inspection report and highlighted: it had been a positive report; identified good practice on mealtime support; positive, kind and compassionate care was described by patients and families; action plan to be published in relation to 5 actions that were completed in September.

15.2 In terms of the substantive report he highlighted: hand hygiene compliance was at 71% and had been 66% in previous audits and doctors compliance had risen to 67%; quality and improvement activity in specific areas; and further hand hygiene audits were due in November; Section 3.3 on audit and spot check activity had achieved an amber score and had been revised to green and one area was outstanding and due to be visited again the following week; Section 3.4 on care homes, he highlighted that the NHS provided support to care homes via advice only and did not have a regulated role in relation to care homes.

The **BOARD** noted the report.

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

16. Whistleblowing Quarter 1 Report, Whistleblowing Quarter 2 Report

16.1 I Bishop presented the Quarter 1 and Quarter 2 Reports.

16.2 F Sandford enquired if the INWO Investigation report referred to in the Quarter 1 Report had been received. I Bishop confirmed that it was still awaited.

16.3 P Moore welcomed both reports and reminded the Board of the opportunities for the workforce that Speak Up Week provided in empowering staff and contractors to raise matters of concern.

16.4 L Livesey welcomed the reference to Speak Up Week and reminded the Board that a nil return did not necessarily mean there weren't any issues and she encouraged people to speak up and reiterated the point that one of the most positive ways to encourage staff to speak up was to demonstrate that you had listened to them and provide responses to their concerns. She encouraged strongly as part of Speak Up Week that follow up work was put in place to circulate examples of what had been done and fedback to staff.

The **BOARD** noted the Whistleblowing Quarter 1 report.

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

The **BOARD** noted the Whistleblowing Quarter 2 report.

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

17. Integrated Performance Scorecard

17.1 S Errington provided an overview of the content of the report and highlighted: performance levels remained a work in progress: the narrative would move beyond static reporting and into a quality improvement approach; the current position in terms of trajectories; and outlined risks and mitigations.

17.2 O Bennett drew out various highlights which included: urgent and unscheduled care performance remained static and improvement was expected over the coming months; elective care was seeing a reduction in waiting lists with the ambition to reduce 52 waits by March; cancer performance had improved significantly from 45% to 64% at the end of Q1 and continued to increase to 74% by July; there remained challenges with prostate cancer and improvements were happening within that space; lung cancer was also a challenge and the issue was being managed effectively; in terms of diagnostics the back log of those who had waited beyond 63 days had dropped since April by 69% which demonstrated the work that teams were doing across the Boards.

17.3 G Clinkscale referred to CAMHS performance and the positive trajectories in relation to core CAMHS activity; he spoke of neurodiversity; and highlighted that psychological therapies were struggling to reach the national standard and a plan to address that was being drawn up.

17.4 Discussion focused on: psychology, arts therapies and therapy choices; third sector provision of services for neurodiversity needs; spectrum of professions across the psychological therapies work; suggestion of a week long audit to speak to admitting clinicians to see if other services should have seen the patient before they turned up in ED; and the radiology team who ensure everyone for a CT or MRI scan is seen within 6 weeks.

The **BOARD** noted the report.

The **BOARD** confirmed it had received moderate assurance for systems and processes and limited assurance for outcomes.

16. Scottish Borders Health & Social Care Integration Joint Board minutes: 16.07.25

The **BOARD** noted the minutes.

17. Board Business Cycle

17.1 I Bishop presented the Board Business Cycle. The Chair suggested the meetings be extended to run for two and half hours in future.

The **BOARD** approved the Board meeting dates schedule for 2026.

The **BOARD** approved the Board Business Cycle for 2026.

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

18. Annual Climate Change

18.1 A Bone presented the annual climate change report as previously discussed at the Resources & Performance Committee meeting. He highlighted the key points of: zero significant improvement in carbon emissions over the past 12 months; positive work in terms of clinical changes in theatres, energy and waste management. Overall emissions had not moved significantly and some of that could be attributed to increased water usage and fleet usage and was directly linked to activity. It illustrated the scale of challenge and there were a number of things being progressed to address it.

18.2 A Bone recorded his thanks to F Laidlaw and those who had contributed to the report.

The **BOARD** approved the report for publication in November 2025.

The **BOARD** confirmed it had received moderate assurance for systems and processes and limited assurance for outcomes.

19. Consultant Appointments

The **BOARD** noted the report.

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

20. Any Other Business

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

21. Date and Time of next meeting

21.1 The Chair confirmed that the next scheduled meeting of Borders NHS Board would take place on Thursday, 4 December 2025 at 10.00am.

Borders NHS Board Action Point Tracker

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. **Update 02.10.25:** The report would be presented to the Staff Governance Committee at its next meeting on 6 November 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. **Update 02.10.25:** J McLaren to confirm the updated APF ToR would be available for formal board sign off as part of the next Code of Corporate Governance Sectional Refresh.

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:	**4 December 2025**
Title:	**Chief Executive's Report**
Responsible Executive/Non-Executive:	**Peter Moore, Chief Executive**
Report Author:	**Iris Bishop, Board Secretary**

1 Purpose

This is presented to the Board for:

- Awareness

This report relates to a:

- 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

In this update I want to recognise the value of our staff and local communities, note the progress with our organisation and clinical strategies and highlight the ongoing importance of national initiatives.

2.2 Background

Non Ministerial Annual Review: Our non ministerial annual review took place on 13 November at the Great Tapestry in Galashiels and was well attended by members of the public.

Organisational Strategy Update: We will be presenting the Organisational and Clinical Strategies to the Board today.

Compassionate Leadership: I have been undertaking our internal programme on compassionate leadership.

Industrial Action: We are awaiting the outcome of negotiations between the BMA and the Scottish Government in regard to Resident Doctors pay.

Scottish Approach to Change: I attended the Scottish Approach to Change launch event held on 21 November 2025 in Edinburgh, which focused on Stepping into Health and Social Care Renewal: why a new approach is needed.

Health Care Support Workers Forum: Our Health Care Support Workers meet and greet was held on 26 November.

Business Services Programme Planning Day: I am the SRO for the Business Services Programme and we held our first event on 27 November 2025 in Edinburgh.

Tree of Light: Our annual Christmas Tree Light Switch On Ceremony takes place on Tuesday 2nd December.

2.3 Assessment

Non Ministerial Annual Review: Our non ministerial annual review took place on 13 November in Galashiels and was well attended by members of the public. We provided a presentation that focused on our mission which is to enable our communities to keep themselves well, and work towards long-term health equity for our communities. When our communities need us, we are easily accessible, delivering compassionate, efficient, high-quality, person-centred care at the right time and place.

Organisational Strategy Update: We will be presenting the Organisational and Clinical Strategies to the Board today. Several of the enabling strategies are included and the remaining will be delivered to the Board in April 2026. The enabling strategies will support the delivery of the overarching organisational strategy. It has been a great achievement of the staff that have been involved in the formulation of these strategies and the engagement with the wider workforce that has enabled us to produce such key documentation that we can build on year on year.

Compassionate Leadership: I am enrolled on our internal programme for compassionate leadership which is a leadership style that emphasises empathy, understanding, and care for others while still driving performance and achieving goals. It's about creating an environment where people feel valued, respected, and supported, especially during times of stress or change. I am half way through the programme and enjoying it and learning about myself as well as others and I would recommend it to any members of our staff.

Industrial Action: The British Medical Association (BMA) Scotland has entered a formal dispute with the Scottish Government in regard to Resident Doctors pay. They are preparing to ballot members for industrial action after accusing the government of reneging on a 2023 agreement to make "credible progress" toward restoring pay to 2008 levels over three years. A ballot for strike action is expected in the coming weeks. The union insists it wants a negotiated settlement, not confrontation.

Scottish Approach to Change Launch Event: The launch event was held on 21 November 2025 in Edinburgh. It was organised by Healthcare Improvement Scotland in response to a commission from the Scottish Government to support delivery of the Health and Social Care Service Renewal Framework. The purpose of the event was to introduce the Scottish Approach to Change, a framework designed to help health and social care organisations manage quality and change effectively. It combines evidence-based methods and tools into a practical approach for both organisational-level change and smaller projects. The key objectives were: to explain why a new approach to change is needed in health and social care; present the components of the Scottish Approach to Change and its evidence base; share real-world examples of its application across Scotland; and to discuss future development and refinement of the approach.

Health Care Support Workers Forum: We were supported on site by the Royal College of Nursing for our Health Care Support Workers meet and greet on 25 November and it was great to see so many people attend and hear about the enthusiasm they have about their roles. These roles play a key part of the care we provide to our patients and their compassion and skill is something that we need to celebrate. There were some great ideas about how we support our existing HCSWs but also about how we attract more into these roles in the future.

Business Services Programme Planning Day: I am the SRO for the Business Services Programme and we held our first event on 27 November 2025 in Edinburgh. This event was a pivotal moment in shaping NHS Scotland's future business services. It brought together a range of professionals from across NHS Scotland to address challenges, share ideas, and co-create a plan that accelerates progress toward a modern Business Services solution, transforming operations aligned to industry best practice for Finance, HR, Payroll, and Procurement processes. It was the first of two events:

- **Event 1 (November):** Scene setting, motivation, and identifying a new way of working. We will make a clear ask of Boards, teams, and individuals to pull forward vital parts of the programme.
- **Event 2 (February):** Review and share progress against those commitments.

Tree of Light: Our annual Christmas Tree Light Switch On Ceremony takes place on Tuesday 2 December. The event starts with refreshments being served from 6pm in the Chaplaincy Centre with the actual ceremony starting at 6.30pm just outside.

2.3.1 Quality/ Patient Care

None arising from this report.

2.3.2 Workforce

None arising from this report.

2.3.3 Financial

None arising from this report.

2.3.4 Risk Assessment/Management

None arising from this report.

2.3.5 Equality and Diversity, including health inequalities

An impact assessment is not required.

2.3.6 Climate Change

None arising from this report.

2.3.7 Other impacts

None arising from this report.

2.3.8 Communication, involvement, engagement and consultation

Not required.

2.3.9 Route to the Meeting

This report has been produced specifically for the Board.

2.4 Recommendation

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

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 (recommended)**
- Limited Assurance
- No Assurance

3 List of appendices

The following appendices are included with this report:

None.

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**4 December 2025**
Title:	**Nursing Midwifery Allied Health Professions (NMAHP) Education**
Responsible Executive/Non-Executive:	**Sarah Horan**
Report Author:	**Michelle O'Reilly Chief Nurse Clinical and Professional Development**

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 NHSScotland quality ambition(s):

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

This report provides an overview of activity within Clinical and Professional Development (C & PD) specifically in relation to NMAHP professionals.

2.2 Background

The C & PD department remains committed to providing safe, high-quality learning experiences for staff, despite the significant challenges posed by workforce shortages and system pressures. The department includes educators for NMAHP, the medical education team, the library team, and the administration team. However, for the

purpose of this paper, the data presented relates solely to NMAHP education and does not include the wider department.

2.3 Assessment

2.3.1 Resuscitation

The Resuscitation Council UK recommends face-to-face resuscitation training at induction and regular intervals, with employers responsible for enabling staff time to train. NHS Borders delivers bi-weekly Basic Life Support (BLS) sessions, with 328 sessions provided to 2,489 staff over the past 18 months, though overall completion remains low except within Women's and Children's Services, where compliance is notably higher. From October 2025, BLS renewal has shifted from annual to biennial, with a new deteriorating patient module introduced in between. Immediate Life Support (ILS) courses began in NHS Borders in 2023 and run monthly for specialist staff. Advanced Life Support (ALS) has increased from biannual to quarterly delivery, with ringfenced places for Emergency Department charge nurses (75% completion) and Advanced Nurse Practitioners (100% completion).

In November 2025, following collaboration with NHS Highland, we hosted our first European Trauma Course with 12 participants from anaesthetics, ED, and surgery completing the programme together as a full trauma team. Delivering the course in this way strengthened teamwork and collaboration by allowing the entire team to train side by side, practise shared decision-making, and build mutual understanding of roles in real-time scenarios. Unlike the usual approach where candidates attend separately at centres across the country, this model ensured consistent learning, improved team cohesion, and enhanced communication under pressure. It was also more efficient and cost-effective, eliminating the need for travel and accommodation expenses while keeping staff within the local service.

2.3.2 Practice Education and Nursing & Midwifery Council (NMC) Standards

The NMC Standards (2020) introduced a shift from the traditional mentor role to two distinct roles: Practice Supervisor (PS) and Practice Assessor (PA) for undergraduate nursing programme. All registrants in Practice Learning Environments (PLE) clinical areas that support students, are expected to act as PS, while those undertaking the PA role must be appropriately prepared. Within our structure, PAs are automatically recognised as PS, ensuring consistency in supervision and assessment. NHS Borders reports compliance at 29% for PAs and 46% for PSs, with staff citing lack of time for preparation and assessment reflecting national trends.

The role of the Practice Education Facilitator (PEF) is to enhance the quality of the learning environment by providing educational input and development activities for PA /PS and both Nursing and Midwifery programmes. Currently NHS Borders has two PEFs for 80 PLE and one Care home Education Facilitator (CHEF) 18.75 hrs who provides care home education support for the above. Currently our CHEF is collaborating with Care Home Support Team to enhance care home Service Level Agreement (SLA) utilisation and capacity, resulting in increased SLA at one site and new PLEs coming on board. We're also working to secure Scottish Borders Council (SBC) engagement. An improvement project is underway to expand care home PLEs for Open University students, aiming to improve the student experience through earlier, local placement notifications.

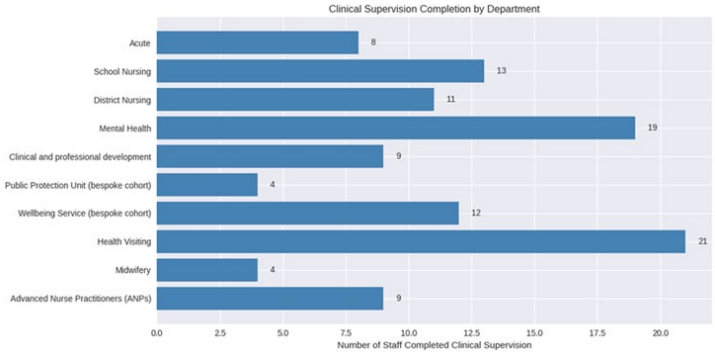
NHS Education for Scotland (NES) have commended the PEF /CHEF team for their continuous hard work and dedication, particularly impressive given their small size. Their

contributions to national developments were recognised, highlighting their commitment to advancing practice education across the wider professional landscape.

2.3.4 Clinical Supervision for Nursing/ Midwifery and Support and Supervision for AHP

Scotland's position statement on supervision for AHP's states that 'all AHP practitioners, irrespective of their level of practice or experience, should have access to, and be prepared to make constructive use of supervision. This outlined that all AHP's receive the minimum of 4-6 sessions of support and supervision per year. To ensure we stay in line with National expectations this was made role mandatory for AHP across NHS Borders in December 2023.

NES has launched National Clinical Supervision Frameworks for nurses and midwives, supporting a "Once for Scotland" approach. These frameworks promote equitable, structured, and supervisee-led supervision aligned with the Scottish model's professional, practice, and restorative components. Boards will be responsible for implementation from 2026. Since 2020, 178 staff across 25+ cohorts—including bespoke groups—have completed a 5 half-day restorative-focused Supervisor preparation programme. See completion rates below per area.



From 2026, a core skills programme will include four TURAS modules and a 4-hour face-to-face or virtual session. All staff will be expected to engage with the TURAS unit: Clinical supervision supporting you to develop and thrive in your role.

2.3.5 In person Staff Study days

We delivered 674 study days last year, excluding resuscitation and simulation sessions. The multi-professional development day, our most frequent session after BLS, requires mandatory attendance and focuses on themes linked to adverse events and patient complaints, aiming to reduce future incidents. Attendance remains inconsistent, often due to staff being recalled to clinical duties amid workforce pressures.

A total of 35 courses were scheduled for the Development Day across the last 12 months, but only 23 were delivered, with 12 cancelled due to poor uptake (34% cancellation rate). This significantly reduced the learning opportunities available to staff.

- Places Offered: 1,108
- Places Booked: 352 (31.8% uptake)
- Attendance: 306 (86.9% of bookings)
- DNA (Did Not Attend): 43 (12.2% of bookings)

Key Insights:

- High cancellation rate, driven by poor uptake, and low booking levels indicate barriers to engagement and scheduling challenges.
- Strong attendance among those who booked demonstrates the value staff place on development when able to attend.
- DNA rate of 12.2% represents wasted resource and planning effort.

Current participation levels limit progress on workforce development goals. Addressing poor uptake, reducing course cancellations, improving booking engagement, and minimising DNAs will enhance efficiency and maximise impact.

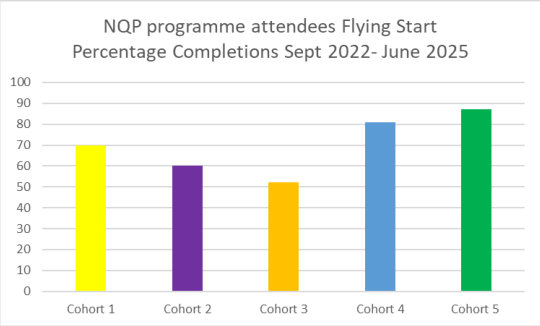
2.3.6 Simulation Based Education

In 2025 alone, the programme engaged 658 learners, with over 70% of sessions delivered in interprofessional formats enabling staff to learn with, from and about each other to enhance collaboration and patient outcomes. Comparative analysis shows strong growth since 2023: simulations increased from 47 to 55, training hours nearly doubled (132.3 to 227.75), and attendees rose from 256 to 446. Delivery evolved from medical-focused sessions to diverse interprofessional learning now incorporating all healthcare professionals. In 2025, a notable diversification in participants' professional backgrounds was observed. While medical professionals remained engaged, there was a significant rise in participation from nursing and AHP staff, underscoring the programmes growing emphasis on interdisciplinary collaboration. This trend aligns with the overarching objective of cultivating a more inclusive and representative learning environment across the healthcare continuum.

2.3.7 Newly Qualified Programme NMAHP

Flying Start NHS® is a national development programme launched in 2005 to support newly qualified nurses, midwives, and allied health professionals (NMAHPs) in their first year with NHS Scotland. Developed by NES in partnership with NHS Scotland and HEIs, it is endorsed by the Scottish Government, which expects all Boards to demonstrate active support for NMAHPs through this programme.

To improve completion rates, NHS Borders developed an integrated NQP programme combining Flying Start and Preceptorship—becoming one of the first Boards to do so. This approach has led to a steady rise in completion from 2022–2025. Feedback from nursing NQPs highlighted a lack of supernumerary time and support in the first six months. In response, the SCN forum agreed to provide all NQPs with four weeks of protected time on commencing employment.



2.3.8 Leadership Programmes

2.3.9 Compassionate Leadership Programme

The organisation-wide Compassionate Leadership programme is administered, organised, and delivered by the C&PD team, with most action learning sets facilitated by clinical educators. Each session is actively supported by members of the Executive and Senior Management Team who contribute to the taught content and reinforce leadership principles in practice. To sustain the programme's credibility and impact, continued support and prioritisation of taught content delivery by the Executive Team is essential. The C&PD team have gained a significant amount of knowledge on Michael Wests work and are invaluable as part of the ongoing success and review of the programme.

Launched in 2023 and now in its ninth cohort, the programme continues to see low uptake from clinical managers such as senior nursing staff and medical staff. Increasing their participation would offer valuable insight into frontline challenges, foster open dialogue about their own, and strengthen collective, inclusive leadership across the organisation.

2.3.10 Florence Nightingale Leadership Programme

NHS Borders has partnered with the Florence Nightingale Foundation (FNF) for three years, gaining access to both funded and free leadership programmes. During this time, five Clinical Nurse Managers completed the FNF Fellowship, and 12 Senior Charge Nurses undertook leadership training in 2024. Eight international recruits completed a tailored programme, and four Band 5 staff are set to complete the Emerging Clinical Leadership programme in 2026.

2.3.11 NMAHP Senior Clinical Leadership Programme

Throughout 2026, we will design and implement a dedicated NHS Borders Clinical Leadership Programme for colleagues at Bands 6 and 7. This programme will strengthen professional aspects of clinical leadership, embed principles of shared governance, and enhance care assurance. It will also focus on developing leadership behaviours that drive quality improvement, empower teams, and support evidence-based decision-making in practice. This will support the board wide delivery of the new Care Assurance programme and will be run in conjunction with the lead Nurse for Excellence in Care.

2.3.12 AHP Advance Practice

In October 2024, Chief Allied Health Professions Officers across the UK issued a joint statement defining, regulating, and governing advanced practice for AHPs. Advanced practice should be underpinned by a post-registration master's level award (or equivalent) aligned to the four pillars: Clinical practice, Leadership, Education, and Research, with robust employer governance ensuring safe and effective implementation.

Building on this, the Scottish Government's *Transforming Roles Paper 6* (published 13 November 2025) sets out:

- **Job Title Format:** Advanced Practice [AHP profession], optionally including clinical specialty (e.g., *Advanced Practice Occupational Therapist in Frailty*).

- **National Approach:** Sustainable delivery through integrated workforce planning, appropriate regulation, strong clinical governance, structured education and training pathways with clinical supervision, and measurable impact on outcomes.
- **Education & Training:** Development of Knowledge, Skills, and Behaviours (KSB) frameworks and structured pathways to align training with role and practice area.

Locally we have begun engagement with Advanced Practitioners and leads and are undertaking a scoping review to identify and support any learning needs across our Advanced Practitioners and have started funding master's-level programmes to support future readiness.

2.3.13 Quality/ Patient Care

2.3.14 Deteriorating Patient Clinical Educator

Failure to recognise and respond to patient deterioration remains a leading cause of preventable harm across NHS Borders, contributing to five serious adverse events in the past year. Incorrect use of the National Early Warning Score 2 (NEWS2) chart has led to missed changes in clinical condition, delayed escalation, and increased critical care admissions. NEWS2 is a standardised tool used across the NHS to assess and monitor the severity of illness in adult patients by scoring vital signs to identify early signs of clinical deterioration. In response, NHS Borders has standardised its NEWS2 chart to align with national guidance, integrating ABCDE for a more comprehensive assessment. The ABCDE assessment is a systematic approach to evaluating and managing critically ill or injured patients by prioritising life-threatening conditions in order of importance. To support the smooth rollout and staff education, funding has been secured for a one-year, part-time Deteriorating Patient Educator to lead training, develop materials, and embed clinical competencies across the NMAHP and medical staff. The efficacy of this week will be monitored over 2026/26 and reported via the TED Board.

2.3.15 Role Mandatory Compliance

Mandatory training requirements for clinical roles are extensive, yet staff often lack protected time to complete them, affecting wellbeing and raising concerns about patient safety and care quality. While some areas have uplift time allocated, provision varies significantly across the Board. Training compliance is tracked through LearnPro dashboards, but data accuracy depends on regular updates by line managers. Overall compliance remains critically low, with inconsistent uptake across departments now recorded as a very high organisational risk. Staffing pressures frequently lead to last-minute training cancellations, further worsening the issue. The matter was recently escalated to the Training Education Development (TED) Board, where new recommendations on compliance and monitoring were approved and are now being implemented.

2.3.16 Lack of Dedicated Space

Patient safety relies on clinical staff maintaining current knowledge and practical skills through ongoing education. However, our current facilities severely limit this. The education centre has only two small rooms, each with a maximum capacity of six, dedicated solely to training. This constraint means mandatory sessions, such as clinical skills and BLS, take significantly longer to deliver, reducing efficiency and delaying staff competency. This space is shared across NMAHP and Medical staff, with growing demand driven by initiatives like Health Care Support Worker (HCSW), the King's Trust, Bridge to Health Care (BTHC)

programme, international nurse onboarding, and mandatory medical training. A larger, dedicated training space is urgently needed, not only to meet rising demand but also to increase training capacity and pace, ensuring timely, efficient delivery of education across all staff groups.

2.3.17 Workforce- C & PD

C and PD is currently sitting with a compliance rate of 100% for statutory and mandatory training.

The below provides an updated overview of staffing across Clinical Education for the NMAHP group *(63% of our overall workforce)* and is relevant to the following teams only:

- **Clinical Education** for NMAHP across NHS Borders
- **Practice Education** to support students and assessors

This small team is responsible for delivering education and development across multiple professional groups across all Boards. Despite this wide remit, the department operates with a very small team.

Clinical Education Staff

- **1 x HCSW Educator** – Full-time, permanent (funded by Mental Health)
- **1 x Clinical Educator** – Full-time, permanent (funded by Acute)
- **1 x Simulation-Based Educator NMAHP** – Full-time, fixed-term (funded by Endowments)
- **1 x Simulation-Based Educator Medical** - half a day week fixed term (funded by Endowments)
- **1 x Deteriorating Patient Educator** – Part-time, fixed-term (funded by TED)
- **1 x Educator** – Part-time (funded by Additional Cost of Teaching) – works across clinical and medical education
- **3 x Clinical Educators** – Part-time, permanent (funded by C&PD)
- **1 x Resuscitation Officer (Training Post)** – Part-time (funded by C&PD)

Practice Education

- **2 x Practice Education Facilitators** – Part-funded by NES/HEI and NHS Borders
- **1 x CHEF** – Part-time (funded by NES)
- **1 x AHP Practice Education Lead** – Part-time (funded by NES)

Hosting all these roles within one department creates efficiencies, but the limited staffing means capacity is stretched across critical areas such as student support, simulation, clinical educator, and resuscitation training.

Compared to the scale of work required, the department is significantly under-resourced.

- **Impact:** Increased workload pressures, risk of gaps in education delivery, and limited ability to expand or innovate.
- **Efficiency Gains:** Current model avoids duplication, but additional investment is essential to sustain quality and meet growing demands.

2.3.18 Nursing Workforce Ageing and Retirement Risk-Bed based Model

By 2030, NHS Borders will see a 43.8% rise in staff aged 55+, with over 150 Whole Time Equivalent WTE retirements expected between 2026–2030. Mental Health and Unscheduled Care are most at risk due to high proportions of staff nearing retirement, while Planned Care faces the largest single-year registered nurse retirement in 2026 (9.78 WTE). Scotland has missed over 2,400 student nurse places since 2021, with the 2024 intake falling 800 short of target. NHS Borders relies heavily on local graduates, but struggles to attract external candidates, and projected graduate numbers won't offset retirements and attrition.

Over the past decade, recruitment has centred on students from Scottish Borders postcodes, with limited success drawing applicants from neighbouring areas. National and local trends pose a serious risk to workforce sustainability, threatening safe service delivery. Applicant numbers are now at a six-year low, compounding pressures. To mitigate this, C and PD have been working to expand and retain its local nursing workforce through collaboration with local Higer Education Institutions (HEIs).

2.3.19 HCSW Development

C&PD continues to lead efforts to strengthen the HCSW pipeline into undergraduate nursing programmes by working closely with local universities and Borders College. Over the past year, three new structured pathways have been established to support HCSWs progressing directly into year two of the undergraduate nursing programme. Background work is ongoing to further expand development opportunities and improve long-term recruitment into nursing.

2.3.20 Regional Delivery Undergraduate Nursing Programme

Nationally, financial pressures have been cited as a reason for declining student nurse numbers. Locally our students need to travel to Edinburgh which has huge financial implications. To mitigate this and to grow student numbers locally, C& PD is actively supporting the validation of a regional undergraduate nursing programme with Edinburgh Napier University (ENU), aiming to launch in September 2027. This initiative is a key step in improving local access and boosting recruitment by delivering the programme locally.

2.3.21 Human Health and Innovation Hub

To further enhance local training capacity, NHS Borders alongside Borders College, the private care sector, and ENU has submitted a Borderlands bid to establish a Human Health and Innovation Hub in the Scottish Borders. A decision is expected by December 4th, 2025. This collaborative project will provide integrated practical, theoretical, and digital learning spaces aligned with national and regional workforce strategies. The hub will play a vital role in supporting the regional nursing programme and strengthening recruitment and retention across the health and care workforce.

2.3.22 Bridge to Health Care (BTHC) Programme

Child poverty remains a major challenge in the Scottish Borders. In line with the Child Poverty (Scotland) Act 2017, C & PD—working with Human Resources and Public Health—secured No One Left Behind funding to deliver a bespoke programme for unemployed parents. The 16-week course prepares participants to become HCSW, combining 8 weeks of classroom-based learning with 8 weeks of paid clinical placements via SBC's employment support service, ensuring no financial impact on benefits. C &PD

leads the programme in collaboration with local Anchor Organisations. Cohort one is currently in placement, with five participants already securing nurse bank roles; cohort two is progressing through the theoretical phase. Early outcomes show strong success.

2.3.24 Work Experience, Careers Fairs, Health Sector Session

C&PD continues to support school engagement across S3–S6, promoting NHS careers and pathways through talks, virtual work experience, and face-to-face placements. To broaden impact, a more formal approach is needed to reach pupils earlier and highlight opportunities in Health and Social Care. A strategic meeting with C & PD, Borders College and Education Department leads is planned for early 2026.

2.3.25 Financial

2.3.26 Clinical and Professional Development financial Overview

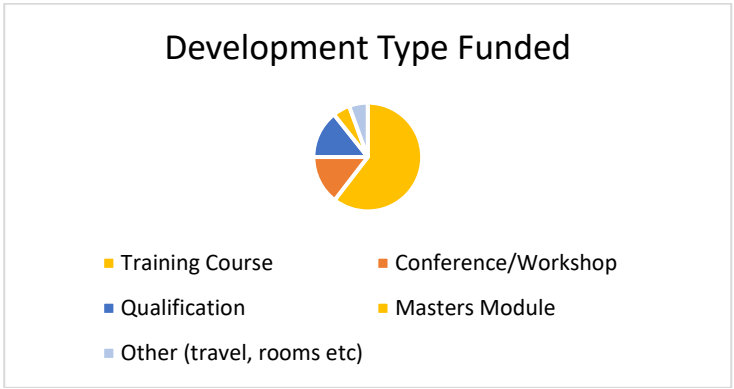
As of the end of Month 7 (October), C&PD is reporting an underspend of £32,528. We have successfully met our 2025 savings target and have a scheduled financial plan in place for 2026. All teams are actively working towards implementing the reduced working week in line with the Agenda for Change pay agreement, while ensuring continuity of service delivery.

2.3.27 Income Generation

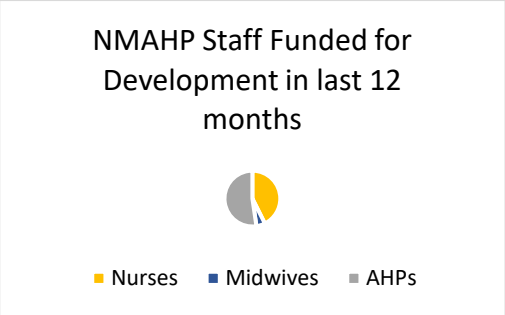
C& PD continues to generate moderate income through resuscitation programmes, including £8,690 from BLS, with additional profit from Immediate and Advanced Life Support (ILS/ALS) of £10,088. Furthermore, we secured £55,000 through the No one left behind Scheme to deliver the BTHC programme, a highly competitive funding stream. NHS Borders has been commended for the quality and innovation of the programme design.

2.3.28 Funding Allocation

In 2025, we partnered with Friends of the BGH to secure £20,000 annually to support registered staff. Combined with planned funding from endowments and the Director of Nursing budget, this has enabled significant, consistent and fair investment in staff development over the past year. In the last 12 months, we have funded staff participation in the following programmes and training opportunities:



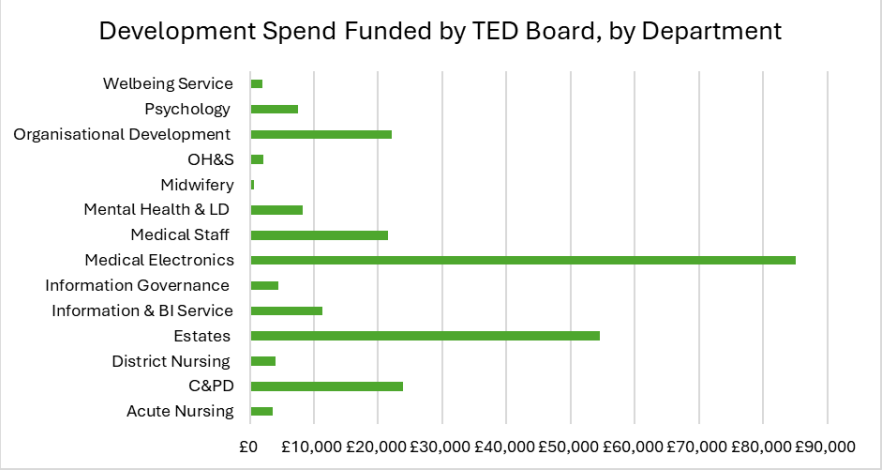
From the three professional groups form NMAHP, AHP were the most supported group, followed by nursing and then midwifery.



Profession	numbers
Nurses	101
Midwives	12
AHPs	124

2.3.29 Training Education and Development Board

The TED Programme Board manages an annual £250,000 budget—held within the C&PD portfolio—to support education and development across NHS Borders. This year, funding was successfully distributed system-wide, marking a key milestone.



Funding is prioritised based on risks linked to gaps in education, development, or training. All applications are shortlisted, reviewed, and discussed by the TED Programme Board, with quarterly reporting to the Staff Governance Committee. Allocation and expenditure are on track to meet the £250,000 target by year-end from across the below departments.

Department	**Places Funded**
Acute Nursing	7
C&PD	1
District Nursing	1
Estates	46
Information & BI Service	32
Information Governance	2
Medical Electronics	37
Medical Staff	46
Mental Health & LD	62
Midwifery	11
OH&S	2
Organisational Development	10
Psychology	28
Welbeing Service	20

2.3.30 Risk Assessment/Management

The Resuscitation Council UK advise that one whole-time-equivalent Resuscitation Officer (RO) is recommended for every 750 members of clinical staff. Depending on the size and geographical distribution of the organisation, more than one RO may be needed to fulfil training requirements and additional responsibilities relating to resuscitation. Given the RCUK guidance and to mitigate the risk we have increased on resuscitation officer to a resuscitation team utilising existing team members and developing them to support our RO. This is a short-term solution to support the increase in training; however, going forward this is not sustainable as other areas are being impacted, and an additional RO is required.

2.3.31 Equality and Diversity, including health inequalities

This is an update paper so a full impact assessment is not required.

2.3.32 Climate Change

None identified

2.3.33 Other impacts

None identified

2.3.34 Communication, involvement, engagement and consultation

This report has not been subject to any prior consultation or engagement although some of the data is presented to

- Quality Partnership Forum 20th August 2025
- National Strategic Group for Practice Learning- 9 September 2025

2.3.25 Route to the Meeting

This report has not been submitted to any prior groups or committees but much of the content will be presented to the following meetings

- Resuscitation Committee 19th August 2025
- Deteriorating Patient Committee 24th September 2025
- Training Education and Development Board- 1 October 2025

2.4 Recommendation

Board members information only:
- **Awareness**

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

- **Systems and Processes –** Significant Assurance.
- **Outcomes –** Limited Assurance on compliance with role mandatory training

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**4 December 2025**
Title:	**Health Inequalities Progress Report**
Responsible Executive/Non-Executive:	**Dr Sohail Bhatti, DPH**
Report Author:	**Kirsty Kiln, Public Health Consultant**

1 Purpose

This is presented to the Board for:

Discussion

This report relates to a:

- NHS Board/Integration Joint Board Strategy or Direction

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

- Effective
- Person Centred

2 Report summary

2.1 Situation

Following the health inequalities strategy published in 2024, this report provides a progress update on the work completed to date and provides a work plan for actions to be undertaken through the CPP.

2.2 Background

Health inequalities are the avoidable differences in society where people's chances of living a long, healthy life are unequal and unjust. Higher rates of chronic illness, mental health issues, and premature death are concentrated in areas of deprivation.

For the health and care system, these inequalities create rising demand, over-stretched services, and avoidable costs. Tackling health inequalities is essential for building a sustainable, resilient NHS. By addressing inequalities, we can help people live healthier lives, reduce pressure on services, and contribute to broader goals such as climate resilience.

2.3 Assessment

Health inequalities in the Scottish Borders are persistent and enduring, we must have a strong plan of action to deliver preventative solutions to address them. Becoming a population health organisation requires us to move expenditure upstream and to work in new innovative ways. Addressing inequalities requires a place-based, whole-system approach that integrates health with education, housing, transport, and community development. The Community Planning Partnership and the Theme 3 Inequalities Working Group provide key platforms for aligning efforts and driving change. NHS Borders must continue to embed prevention, strengthen local intelligence, and co-design services with communities to ensure equitable access and outcomes.

2.3.1 Quality/ Patient Care

Addressing health inequalities would reduce demand on services.

2.3.2 Workforce

N/A

2.3.3 Financial

Investing in upstream interventions can reduce demand for costly acute and emergency services. Although benefits may accrue over the long term, they help avoid future expenditure on complex care and hospital admissions.

By identifying and addressing health disparities, we can better target resources to areas of greatest need. This leads to more efficient use of funding and improved outcomes, particularly in deprived communities where health burdens are highest.

Evidence suggests that preventative and equity-focused interventions yield positive ROI. For example, social prescribing and early intervention can reduce GP visits, medication use, and hospital admissions, freeing up capacity and reducing costs.

2.3.4 Risk Assessment/Management

N/A

2.3.5 Equality and Diversity, including health inequalities

Health inequalities often disproportionately affect people with protected characteristics (e.g. age, disability, race, sex). By identifying and addressing these disparities, we help eliminate indirect discrimination in access, outcomes, and experience of care.

2.3.6 Climate Change

Many interventions that reduce health inequalities—such as promoting active travel, improving housing, and increasing access to green spaces—also reduce carbon

emissions and environmental degradation. These are considered *co-benefits* that support both population health and climate goals.

2.3.7 Other impacts

2.3.8 Communication, involvement, engagement and consultation

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

State how his has been carried out and note any meetings that have taken place.

- Community Planning Partnership, including Theme 3 Delivery Group and Wellbeing Board
- Child Poverty Working Group
- Good Food Nation Network Meetings
- Anchors Development Group
- Ongoing discussions with colleagues in housing, education and community planning at Scottish Borders Council
- Building on previous workshops on Health Inequalities with staff and third sector organisations – throughout 2023 – 24.

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 on 12th November 2025

2.4 Recommendation

- **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**

3 List of appendices

The following appendices are included with this report:

- Emerging High Level Work Plan for CPP on Health Inequalities
- CPP Delphi Consultation on Health Inequalities

Tackling Health Inequalities in the Scottish Borders: Progress Report October 2025

Introduction

In April 2024, NHS Borders published the *THIS Borders* (*Tackling Health Inequalities in the Scottish Borders*) Strategy with the aim of highlighting the impact of health inequalities in our region. The strategy brought together a large amount of data on the causes and consequences of health inequalities and, building on the good work that had gone before, identified ways in which we could work together with partners to address them.

Health inequalities matter because they reflect the avoidable differences in society where people's chances of living a long, healthy life are shaped by factors such as income, education, housing, and environment. These disparities lead to poorer outcomes for individuals and communities, with higher rates of chronic illness, mental health issues, and premature death concentrated in areas of deprivation.

For the health and care system, these inequalities create rising demand, over-stretched services, and avoidable costs. Tackling health inequalities is essential for building a sustainable, resilient NHS. Doing so, requires coordinated action across sectors, recognising that good health is created in homes, schools, workplaces, and communities long before people reach hospital. By addressing these inequalities, we can help people live healthier lives, reduce pressure on services, and contribute to broader goals such as climate resilience.

This report provides a progress update on the ongoing work to address health inequalities across the Scottish Borders, building upon the strategy published in April 2024. Since then, partners across health, social care, and the third sector have continued to work together to tackle the root causes of inequality, such as poverty, isolation, and unequal access to services. This update outlines emerging areas of impact and identifies opportunities for further collaboration and innovation.

The Board is invited to consider the progress made and support the next phase of activity to ensure that every person in the Scottish Borders has the opportunity to live a healthy, fulfilling life regardless of their background or circumstances.

Policy context

The Population Health Framework

Since *THIS Borders* was published, the Scottish Government has developed the *Population Health Framework 2025–2035.* The framework defines population health as "an approach aimed at improving the health of an entire population." This involves

improving physical and mental health outcomes, reducing health inequalities, and addressing the wider determinants of health such as income, education, housing, and environment. The framework highlights the importance of prioritising prevention, equity, and collaboration across sectors. It requires working with communities and partner agencies to create the conditions for healthier lives, shifting focus from reactive care to proactive, system-wide action that supports wellbeing at every stage of life.

The guiding principles of the population health framework are:

- **A prevention-focused system**: Shifting from treating illness to preventing it;
- **Support for those most at risk**: Prioritise communities experiencing the poorest health outcomes; and
- **Whole-system approach**: Collaboration across health, local government, third sector, and business.

The Good Food Nation Plan

The Scottish Government has published its Good Food Nation Plan, which recognises that inequitable access to healthy food is a driver of health inequalities. It calls for coordinated action to ensure that all communities, including rural and deprived areas, can access affordable, nutritious food. Local areas are tasked with developing their own plans to amplify these objectives in 2026 by bringing together partners in local authorities and the third sector.

The Plan outlines six overarching outcomes that guide Scotland's food policy:

1. **Health and Wellbeing** – Ensuring that people in Scotland eat well and have access to nutritious, safe, and affordable food that supports physical and mental health.
2. **Environmental Sustainability** – Promoting food systems that protect the environment, reduce emissions, and support biodiversity.
3. **Economic Prosperity** – Supporting a thriving food industry that contributes to Scotland's economy and provides fair work.
4. **Social Justice** – Tackling food insecurity and ensuring equitable access to good food for all, particularly those in poverty or marginalised communities.
5. **Cultural and Social Wellbeing** – Recognising the role of food in community life, identity, and social connection.
6. **Education and Skills** – Promoting food education and skills development across all ages to support healthier choices and sustainable practices.

Women's Health Plan

Reducing health inequalities for women in the Scottish Borders is a priority, given the persistent disparities in health outcomes shaped by socio-economic and gender-based factors. Recent data (as reported in *THIS Borders* Strategy) reports that women in our region face significant challenges across the life course, including lower healthy life expectancy and higher rates of long-term conditions, particularly in deprived areas of Borders. Nationally, the Scottish Government's Women's Health Plan underscores systematic issues such as gender bias in medical research and service design, which have led to diagnostic delays and unmet health needs for women across Scotland. Locally, the recent Borders Equality Mainstreaming Report identifies gaps in service accessibility and outcomes for women, especially those from underrepresented groups, and calls for more inclusive service delivery. Addressing these inequalities is not only a matter of fairness but also essential for improving population health overall.

Evidence for ongoing action

The *THIS Borders* strategy provided a review of the data across the life course that highlighted that persistent inequality starts in early life and impacts many aspects of health and wellbeing thereafter.

The table below updates the indicators provided previously and shows the huge percentage differences in health outcomes and service use between the most and least deprived in our region. Again, across a range of indicators from maternal health to childhood development and hospital admissions, the data reveals significant disparities that reflect the deep-rooted impact of socioeconomic disadvantage.

It should be noted that the data included here uses SIMD to compare population quintiles. In the previous strategy, we highlighted that SIMD can be a poor measure for health inequalities in rural areas and we continue to make the case for an improved measure in the Scottish Borders. Given this, we anticipate that in reality, the percentage differences may be even more stark.

Table 1: Summary of the differences between the most and least deprived people living in the Scottish Borders (by SIMD) across a range of indicators

Indicator	Most Deprived	Least Deprived	Difference	Percentage Difference (+/-%)
Years of healthy Life Expectancy Male	47.7	70.8	23.1	**32.6**
Years of healthy Life Expectancy Female	49.6	71.3	24.7	**30.4**
Maternal Obesity (%)	39	29	-10	**34.5**

Maternal Smoking (%)	31	1	-30	**3000**
Childhood Developmental Concerns (%)	26.4	6.5	-19.9	**306.2**
Childhood Oral Health – no cavities (%)	57.4	84.9	28.5	**32.4**
Childhood Obesity and Overweight – healthy weight (%)	58.3	81.6	23.3	**28.6**
Psychiatric Admissions to Hospital	402.1	136.1	-266	**195.4**
Asthma Hospital Admissions	83.3	34.6	-48.7	**140.8**
Alcohol Related Hospital Admissions	634	140.4	-493.6	**351.6**
Drug-Related Hospital Admissions	194.8	51.9	-142.9	**275.3**
Cancer Rates	701.1	586.5	-114.6	**19.5**

We know that Health inequalities can begin before birth and are shaped by the social and economic conditions into which children are born. Factors such as parental health, income, education, and access to support services influence outcomes from the earliest stages. Maternal health data further reinforces this picture, showing a strong social gradient in the likelihood of being overweight during pregnancy and smoking while pregnant. These patterns are not random; they reflect the cumulative impact of socioeconomic disadvantage on health outcomes and life chances.

Graph 1: Maternal obesity by SIMD in the Borders (2024 – 2025

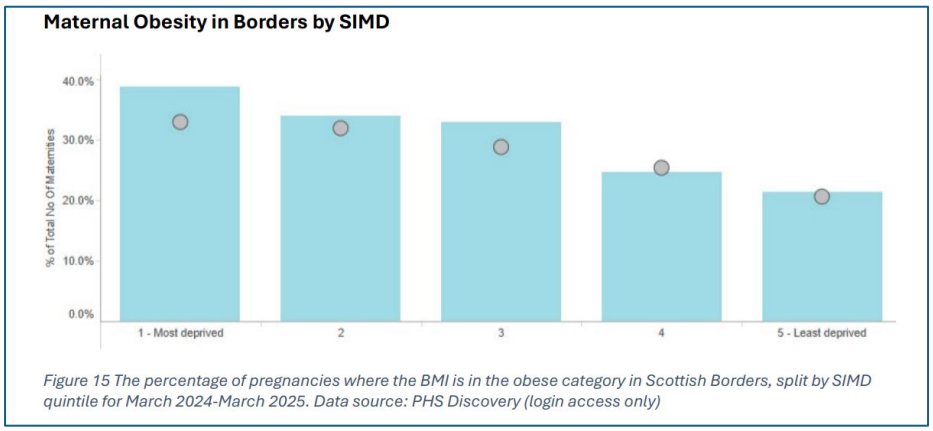


Figure 15 The percentage of pregnancies where the BMI is in the obese category in Scottish Borders, split by SIMD quintile for March 2024-March 2025. Data source: PHS Discovery (login access only)

Graph 2: Maternal Smoking by SIMD in the Borders (2024 – 2025)

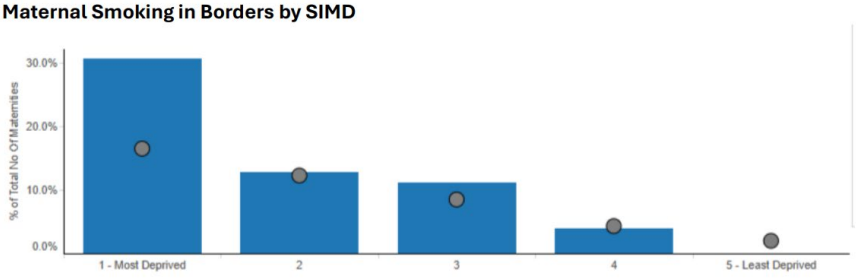


Figure 17 The percentage of pregnancies where the mother is a current smoker in Borders for March 2024-March 2025 by SIMD quintile. Data source: PHS Discovery (login access only)

In recognising that we need to better understand how to address inequalities in the early years, our Health Visiting service have begun some work to begin collecting data around Adverse Childhood Experiences (ACEs). It is, of course, vital that this information is collected carefully and ethically to make sure that people are able to provide information in a way that is sensitive and appropriate. With that in mind, collecting data on Adverse Childhood Experiences (ACEs) can provide insight into the long-term impact of early adversity on health and wellbeing. For example, abuse, neglect, household substance use, or parental separation is strongly associated with increased risk of chronic physical and mental health conditions, including depression, heart disease, and substance misuse well into adulthood.

In the UK context, Public Health Wales started collecting ACE data through large-scale, population-level surveys in 2015. By using anonymous, validated surveys across a representative sample, Public Health Wales was able to quantify the prevalence and impact of ACEs, shaping national policy and service design. We will continue to work with the health visiting service to support collection of ACE data whilst considering how this information can be collected in a wider sample of the Borders population.

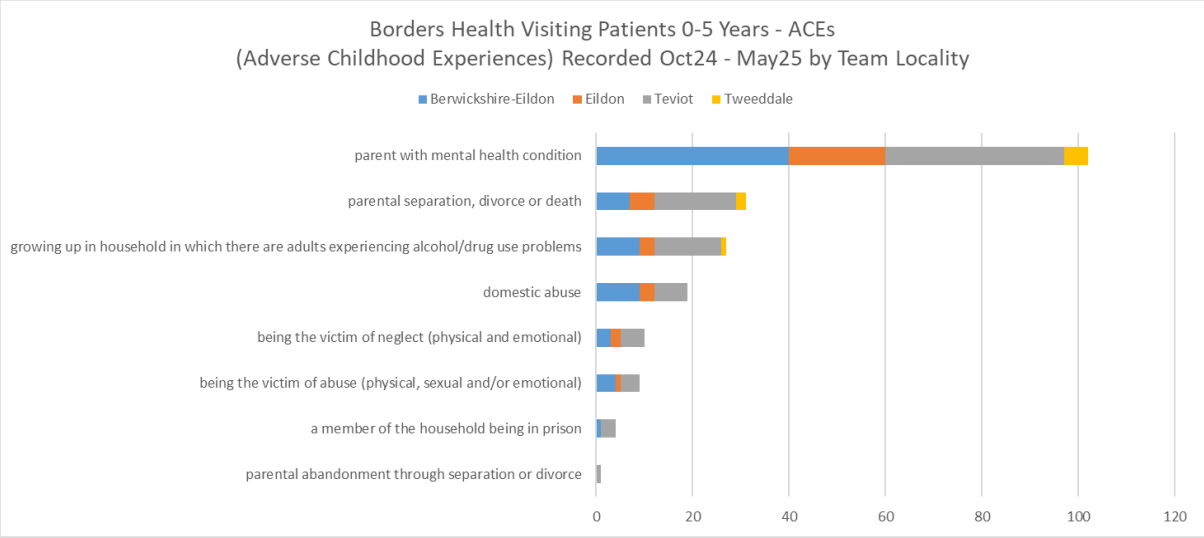
The table below shows the geographical patterns we are observing in the emerging health visitors' data. However, it should be noted that there are ongoing barriers around comprehensive collection of this information in the early years which we will support the health visiting team to explore.

Table 2: Proportion of the population seen by Health Visitors in the Scottish Borders with 3 or more ACES recorded by locality.

Locality	3+ ACEs
Berwickshire-Eildon East	1.7%
Eildon	1.2%
Teviot	5%
Tweeddale	0.7%

From October 2024 to March 2025, the most commonly recorded adverse childhood experience in those 0-5 years old was ‘having a parent with a mental health condition’. This was followed by ‘parental separation, divorce or death’ and then ‘growing up in a household in which there are adults experiencing alcohol/ drug use problems’. ACEs categorised as 'Other' Reason have been excluded; these were 6% (13 cases) of the total number recorded (216).

Figure 3: Adverse childhood experiences recorded by health visiting team in Scottish Borders in 2024 for children 0-5 years old.

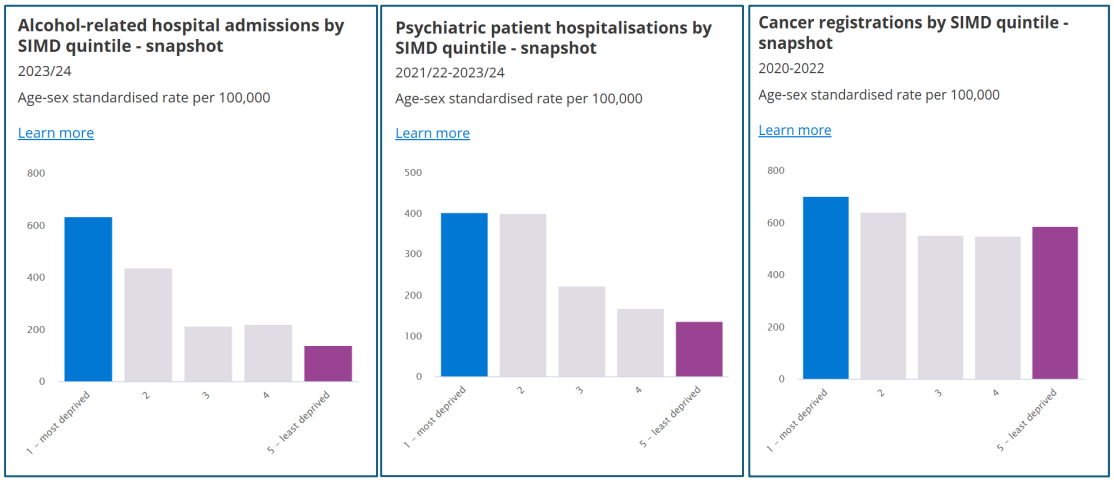


Data source: NHS Borders Business Intelligence team

The *THIS Borders* strategy demonstrated the connection between inequalities and the impact upon use of hospital services. The graphs below show that, in the Borders, service use in adulthood follows a clear social gradient. People in more deprived communities experiencing higher levels of ill health and making greater use of acute and emergency services, while often having less access to preventative and early intervention support. Conversely, those in more affluent groups are more likely to engage with planned care and health-promoting services, reinforcing inequalities

in outcomes and resource use. With regards to cancer services, we know that people in less deprived communities are more likely to get a cancer diagnosis earlier and, as a result, experience better outcomes.

Graphs 3 to 5: service use by SIMD in the Scottish Borders



Source: SCOTPHO

Since the development of the *THIS Borders* strategy, and the engagement that took place to support that, we have developed a plan to create a dashboard of health inequalities local data. Public Health Scotland are working on a similar request, which will inform and support our work to achieve this.

NHS Borders: responding to the challenge

Becoming a population health organisation

NHS Borders needs to consider how to transform into a population health organisation. This strategic shift redefines the Board's role from delivering healthcare services to becoming a proactive partner in improving the broader determinants of health. The Framework calls for NHS Boards to work collaboratively across sectors to address the root causes of ill health, reduce inequalities, and improve life expectancy. For NHS Borders, this means embedding prevention into every aspect of our operations.

We need to apply these population health principles into strategic planning, workforce development, and service delivery. This includes prioritising anticipatory and preventative care, using data to identify and address health disparities, and co-designing services with communities.

This approach will not only be about improving clinical outcomes but about reshaping the conditions in which people live, work, and age to build a fairer, healthier future for the population we serve.

The Population Health Framework calls for reform in planning, delivery, budgeting, and accountability mechanisms to prioritise prevention and early intervention. This includes embedding preventative approaches in how services are commissioned and evaluated. Capturing preventative spend within NHS Borders is helpful for understanding the true value of early intervention and upstream investment. Preventative activities, such as immunisation, screening, income maximisation, early years support, mental health promotion, can reduce the need for more intensive and costly interventions later in life. However, these benefits often accrue over the long term and across sectors, making them harder to quantify within traditional budgeting and performance frameworks. By identifying and tracking preventative spend, health systems can better demonstrate the return on investment, support evidence-based decision-making, and shift resources toward interventions that improve population health and reduce inequalities. This approach may help us to ensure that limited resources are used to greatest effect.

Developing a social prescribing offer

Social prescribing offers an opportunity to address the non-clinical drivers of poor health and wellbeing, including loneliness, inactivity, and financial stress, by connecting individuals to community-based support. In the Scottish Borders, we lack clear and consistent pathways, particularly around exercise referral, and are falling behind other areas of Scotland where structured models are already improving outcomes. Our Wellbeing Service is well placed to lead and coordinate a local approach, given its existing relationships across health, social care, and community sectors. To move this forward, we propose developing a social prescribing work programme that includes: mapping current assets and referral routes; engaging third and community sector partners to co-design pathways; piloting targeted interventions (e.g. physical activity, arts, volunteering); and establishing a governance framework to monitor impact and ensure sustainability. This would align with national priorities and help reduce pressure on clinical services while improving population health and equity. Social prescribing is an integral element of demand management within the new clinical strategy.

Community Planning

The Scottish Borders is a predominantly rural region, covering a large geographical area with a dispersed population and no major urban centres. Communities are spread across small towns, villages, and remote rural areas, which can make access to services, including healthcare, particularly challenging. The geography contributes to longer travel times and difficulties in sustaining a wide range of services locally. These factors can compound barriers to timely and equitable access to health and social care. This can result in delayed diagnoses, reduced access to preventative services such as immunisations or mental health support, and increased reliance on emergency care. Addressing health inequalities in this context requires place-based

approaches that account for the unique resource challenges of delivering services here.

In response to the DPH report, Real Action for Prevention: a vision of population health in the Scottish Borders, a Wellbeing Programme Board was setup in concert with SBC. This identified 4 main priority areas for action:

- Loneliness/isolation,
- Lack of Physical Activity
- Social Issues of living (including poverty and inequality)
- Self-Care

Place-making and local Place Plans became a mechanism for capturing local issues, in the context of the JSNA. The recommendations made to the Wellbeing Board included:

1. **Community engagement**

Foster strong relationships with local communities to understand their specific health needs and preferences. Can be achieved through regular community meetings, surveys, and partnerships with local organisations.

2. **Resource allocation**

Ensure fair and equitable distribution of resources based on the population size, health needs, and geographical challenges of each locality. May help address disparities and improve overall health outcomes.

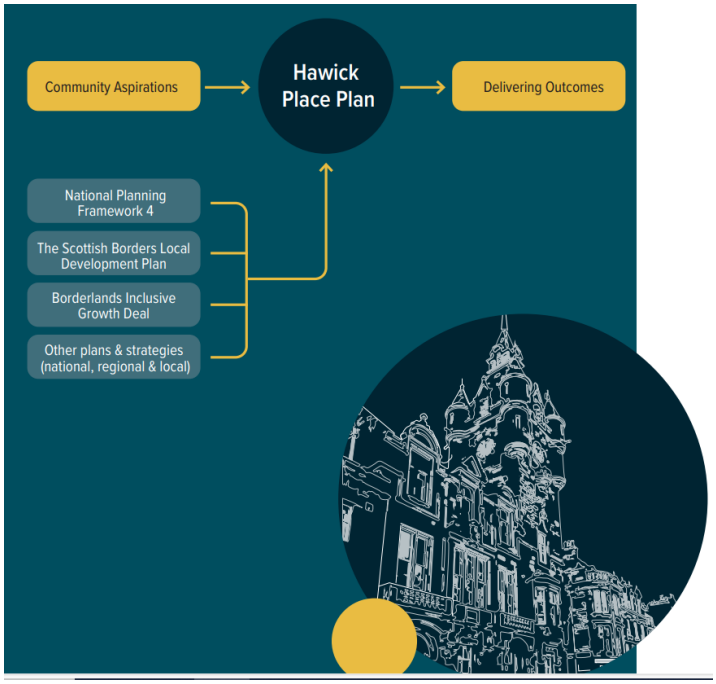
3. **Integrated care models**

Promote integrated care models that bring together health, social care, and community services. Enhances coordination, reduces duplication, and provides more holistic care to residents.

4. **Digital health solutions**

Leverage digital health technologies to improve access to healthcare services, especially in remote and rural areas. Use telehealth services in localities with limited healthcare facilities.

This led to a high level plan (Annex B), and upon the dissolution of the Wellbeing Board in 2025, the workplan was transferred to the Community Planning Partnership (CPP). It is in the process of being turned into SMART actions.



Community Planning Partnerships (CPPs) were established to bring together public sector bodies, third sector organisations, and communities to improve outcomes and reduce inequalities at a local level. In the Scottish Borders, the CPP provides a vital forum for aligning priorities and coordinating action across sectors such as health, education, housing, and social care. The NHS plays an important role within the CPP, contributing health intelligence, service expertise, and leadership in prevention and early intervention. By working collaboratively through the CPP, the NHS can help address the wider determinants of health, such as poverty, housing, and education, and ensure that services are designed around the needs of communities. This partnership approach is essential for tackling complex, interlinked challenges and delivering sustainable improvements in population health and wellbeing.

Since the publication of the *THIS Borders* Strategy, we created an Inequalities Working Group (under Theme 3: Good Health and Wellbeing) of the CPP. The purpose of this group is to bring together a range of partners to consider how we best take forward actions to address disparities in health outcomes. The Theme 3 working group, over the last year, has taken on the Wellbeing Board and the Social Prescribing Board in an attempt to bring together these related activities in one place. We know that we need to be strategic and focused, using the time of partners and other agencies most effectively.

We need to develop the CPP as we continue to embrace joint working. To maximise its impact, the partnership must move beyond information sharing to coordinated action, with clearer accountability, shared outcomes, and a stronger focus on tackling the root causes of health inequalities. A more dynamic and outcomes-focused CPP could play a transformative role in improving population health and reducing inequalities across the region. We have begun prioritisation, and conducted a Delphi approach to coming up with agreed issues (Annex C) which will be linked in with the emerging workplan (Annex B)

Our role as an anchor institution

NHS Borders has a powerful voice in where and how resources are spent locally and can help to influence inequalities faced in our local area. By deliberately adopting strategies to support our local community, NHS Borders has the potential to further support Scotland's ambition for a 'Wellbeing Economy' and reduce inequalities caused by socioeconomic disadvantage through:

1. Our workforce and employment capacity
2. Our procurement, commissioning and purchasing of goods and services
3. Creative use of our land and assets, as well as our work to increase our environmental sustainability

It is important to develop three areas of work forward in partnership with other local Anchors, via the development and use of networks, shared approaches and shared objectives and collective thinking.

Making a difference

Building on the *THIS Borders* strategy, the case studies outlined here demonstrate the good work of NHS Borders and local partners in tackling health inequalities. They show how partnership working, community-led approaches, and upstream prevention can reduce barriers, reach underserved populations, and influence the social determinants of health. We are proud of the work we have done to date to tackle health inequalities, but we are ambitious to do more.

Case Study 1: Creating Hope Awards – A Whole-Community Approach to Mental Health Equity

The Creating Hope Awards is an initiative led by NHS Borders in collaboration with local partners, aiming to promote mental health and suicide safety across the Scottish Borders. Launched in June 2024, the scheme invites groups, organisations, and communities to commit to fostering mentally healthy and suicide-safer environments. It offers two levels of recognition:

1. *Creating Hope Award* – Foundation level, focusing on good mental health practices, supportive environments, and basic training.
2. *Creating Hope Champions Award* – Enhanced level, emphasising safe spaces, advanced training, and designated suicide prevention champions.

The scheme is open to all groups and organisations in the Scottish Borders, including businesses, schools, and community groups, and provides free training to help communities become more informed and confident in supporting mental health.

The scheme uses an asset-based approach to build capacity, confidence and resilience across all sectors - the community, voluntary and private sectors as well as

the public sector. The scheme aims to engage the whole system in promoting the conditions that protect against poor mental health and suicide risk and really nurture positive environments within all of our communities - recognising, supporting and promoting mentally healthy and suicide safer communities that are caring, compassionate and inclusive. In addition to using the scheme as a whole-community approach, we are also able to target it and strengthen those communities where there is a higher risk of mental health inequalities. There is an impact plan available and the scheme will be evaluated over the coming months.

Case Study 2: Youth Nicotine Prevention Toolkit – Co-Produced Action on Health Inequalities

On 28 May 2025, the Scottish Borders became the first region in Scotland to launch a Youth Nicotine Prevention Toolkit, a pioneering initiative co-produced with young people to address rising rates of nicotine use. Aligned with the United Nations Convention on the Rights of the Child (UNCRC), the toolkit reflects a rights-based approach that listens to and empowers young people to shape the solutions to issues affecting their health and wellbeing.

Led by NHS Borders and the Scottish Borders Nicotine Prevention Working Group, the toolkit is grounded in the principles of the National Tobacco and Vaping Framework, with a focus on the themes of People, Product, and Place. It includes evidence-based messaging, educational resources, robust support pathways, a youth-specific cessation service, and a Charter for Change to encourage nicotine-free environments in schools and community settings.

The initiative aims to reduce the uptake of nicotine products among young people by increasing awareness of harms, streamlining education across schools and youth services, and providing tailored support for quitting. Crucially, the toolkit was co-designed with young people, ensuring relevance, authenticity, and impact. Training, youth-led campaigns, and strategic communications are central to its rollout, alongside ongoing evaluation and collaboration with national partners such as ASH Scotland, IAMME, and the Scottish Government.

This case study highlights how a locally led, youth-driven approach can tackle health inequalities by addressing the social and environmental factors that influence behaviour. It demonstrates the power of co-production, partnership working, and targeted intervention in creating healthier futures for young people in the Scottish Borders.

Case study 3: Operating as an Anchor Institution: Bridge to Healthcare programme

The ‘Bridge to Healthcare’ programme’s goal is to support parents into healthcare roles, with flexible hours and a clear route into employment. It combines 8 weeks of classroom-based learning, including practical training and simulated exercises, with 8 weeks of hands-on clinical experience in healthcare settings. The first cohort of the ‘Bridge to Healthcare’ programme have finished their training and are now ready to start placements as Healthcare Support Workers.

Throughout the programme, participants were supported by clinical educators, HR colleagues and Public Health leads and have covered a wide range of topics - including the core values of the NHS, our organisational structure and the everyday realities of working in healthcare.

The programme has supported people within the community to have access to meaningful and flexible working opportunities and boosted the NHS Borders workforce. This is part of our Anchors mission to improve accessibility to quality work.

Challenges faced in tackling health inequalities

Staff working in public health across the Scottish Borders have consistently highlighted the complexity and persistence of health inequalities. They tell us that while the ambition to reduce inequalities is shared across sectors, the reality on the ground is often challenging. Many of the root causes of these inequalities, such as poverty, poor housing, limited transport, and digital exclusion, lie outside the direct control of health services, requiring sustained collaboration with partners.

Staff also describe the difficulty of balancing universal service provision with the need to target support where it’s needed most, often with limited data and resources. Engaging communities meaningfully takes time and trust, and progress can be slow, especially when structural barriers remain. Despite these challenges, public health teams remain committed to driving change, using evidence, relationships, and innovation to improve outcomes for those most at risk.

Making progress and monitoring impact

The *This Borders* Strategy (2024) outlined good practice and identified areas to focus energies to tackle health inequalities. To progress those recommendations, and to maintain focus on these recommendations, we have developed an action plan that sets out the measurable actions we will take to address health inequalities over the next 12 months and beyond. This action plan will be presented to the Theme 3 Delivery Group of the CPP with clear responsibilities and timescales attributed to these measures to ensure that progress continues to be made.

Strategic Action	Description	Progress Measures
1. Strengthen data, monitoring, and preventative investment	Develop an NHS Borders health inequalities dataset, including deprivation measures that better reflect the population and access to preventative spend to inform upstream investment.	1. Establish a Health Inequalities Dashboard that will allow us to easily share local data and monitor trends over time. This should include seeking to disaggregate local healthcare data by age, sex and SIMD.
		2. Develop a shared view of preventative spend in NHS Borders by defining categories or spend and understanding preventative activities across the organisation.
2. Embed upstream, community-led, and partnership-based approaches	Build upon local initiatives (e.g. Whole Systems Approach), promote 'Health in All Policies', and develop CPP partner organisations as anchor institutions to tackle social determinants of health.	3. CPP Theme 3 working group to be re-established and project management approach taken to monitoring progress across partners.
		4. Ensure that health considerations are embedded in partner policies and planning and monitored through the CPP.
		5. Anchor institution principles adopted and monitored across NHS Borders and partners.
		6. Develop Good Food Nation Plan with partners across SBC and the third sector, developing group practice for community-based approaches.
3. Expand prevention, early intervention, and supported self-management	Target chronic disease prevention, increase uptake of screening, promote ACE-informed approaches, and support self-management of conditions such as Type 2 diabetes, prioritising	7. Improved screening and early intervention uptake building on the Equity in Screening Strategy.
		8. Build up knowledge and capacity to use ACE-informed practices across services;

	historically underserved populations.	review the work done by health visiting services. Support data collection and analysis.
		9. Influence development of locality plans led by SBC and the consideration of health resources within that.
4. Develop an integrated, equitable social prescribing system	Coordinate social prescribing services (Wellbeing Service, Local Area Coordinators, What Matters Hubs, housing, localities) to reduce isolation, improve wellbeing, and tackle barriers to access, including support for people on waiting lists for secondary care.	10. Development of a social prescribing programme and network with third sector and other partners.
		11. Uptake of social prescribing offer to be monitored by disadvantaged populations monitored and increased.
		12. Development of “Waiting Well” initiatives, including exercise referral schemes with LIVE Borders.

To ensure accountability, we need a clear approach to managing progress across all priority areas. For each project, this should include:

- Defined success measures and a timeline for achieving them;
- Baseline data to monitor change over time; and
- Regular reporting established through the CPP working group.

Looking to the future

Harnessing Technology and AI for Prevention

Technology and artificial intelligence (AI) offer transformative opportunities to strengthen prevention in public health, particularly in addressing loneliness, fostering social connectedness, and improving access to health information. For NHS Borders, embracing these innovations can help mitigate health inequalities and support population wellbeing in some cases. Of course, whilst technology offers huge potential, its deployment must be ethical, transparent, and inclusive. The Glasgow Centre for Population Health emphasises the need for robust governance to ensure AI/ technology enhances, rather than replaces, human-led care.

Opportunities for future consideration:

- Loneliness and social isolation are recognised public health challenges, with disproportionate impacts on older adults, disabled people, and those living alone. The JSNA showed that some 30% of adults experienced loneliness in the Borders. AI-enabled technologies, such as social robots, voice assistants, and emotion recognition tools, have shown promise in reducing loneliness by facilitating meaningful interactions, but this would need careful evaluation so as not to exacerbate inequalities.
- AI can personalise health information delivery, making it more accessible and relevant to diverse populations. Natural language processing tools can translate complex medical information into plain language, while voice-enabled systems can support individuals with low literacy or visual impairments. There may be value in access to inclusive digital health platforms that offer multilingual, culturally sensitive content and support self-management of chronic conditions.
- Digital health hubs and mobile apps can also bridge gaps in access, particularly in rural areas. These tools can provide timely information on services, appointments, and health advice, empowering individuals to make informed decisions.
- The Scottish Government's *Just Transition Plan for Transport* highlights the need for equitable, low-carbon mobility solutions that reduce reliance on private cars while improving access for underserved communities. Emerging technologies, including autonomous vehicles (driverless cars), offer both opportunities and challenges. NHS Borders can play a role in shaping local transport strategies by advocating for technology that supports health equity, such as demand-responsive transport, AI-enabled route planning for health appointments, and community-based mobility hubs. Collaborative public-private partnerships with Scottish Borders Council could help attract providers of driverless cars to pilot in our area. These facilities would be more convenient and less expensive than current provision of public transport

Climate change and the net zero agenda

Climate change is a growing public health emergency that disproportionately affects the most vulnerable in society. In the Scottish Borders, communities already facing health inequalities, such as older adults, people with long-term conditions, and those living in rural or deprived areas, are at heightened risk from climate-related impacts including extreme weather, poor air quality, and energy insecurity. NHS Borders recognises that climate change is not only an environmental issue but a profound social determinant of health and is committed to embedding climate resilience and equity into its strategic planning. Collaboration with Scottish Borders Council and community partners is essential to ensure that climate actions also reduce health

disparities. For example, improving access to green spaces and public transport can support physical and mental wellbeing while reducing emissions.

The Institute of Health Equity has reviewed the impact of fuel poverty on health and inequalities and has resulted in policy changes in England.

Around 34% of households in Scotland were in fuel poverty in 2023. GP prescribing of energy in Gloucestershire, and more recently in Aberdeen and Teesside showed significant benefits. These build on significant evidence established in Liverpool Healthy Homes Programme and Wigan Council's Affordable Warmth Access Referral Mechanism which were both reported by NICE.

Healthcare buildings are among the largest contributors to NHS Scotland's carbon footprint, primarily through heating and electricity use. NHS Borders is working to significantly reduce its reliance on fossil fuels while improving energy resilience across its estate. These efforts not only lower emissions but also contribute to healthier environments for patients and staff.

Future consideration could be given to how we develop community approaches to the climate change issue. Emerging Energy Clubs allow local consumers to be connected to renewable energy sources. Discounted energy tariffs can be offered during periods of high generation allowing local residents to purchase cheaper energy and the provider to be paid more than they would if selling back to the grid. As we develop our approach to sustainability, we should consider how we can identify ways to maximise our role an anchor institution to benefit local residents.

Our local Registered Social Landlords already generate energy from roof spaces, and on the BGH site we have now installed solar panels. Identifying people with higher needs and less resilience, including those currently being treated by our services enables us to socially prescribe energy to these most vulnerable people as part of their therapeutic discharge plan.

Next steps

Our top priority must be to progress the action plan against the four strategic actions, as below:

- Strengthening data, monitoring, and preventative investment;
- Embedding upstream, community-led, and partnership-based approaches;
- Expanding prevention, early intervention, and self-management; and
- Developing an integrated, equitable social prescribing system.

Doing so will require detailed project plans for each measure with defined responsibilities, resources, and timelines. We also need a robust framework for tracking progress through the CPP to ensure that we have collective understanding of the steps needed to deliver progress.

We continue to be challenged by not having an inclusive measure for deprivation in rural settings. SIMD works best in metropolitan areas, whereas our deprivation is distributed much more diffusely in all our towns and villages. The Institute of Health Equity shows that there is clustering of ACEs by deprivation and that the number of ACEs is linked to adverse health outcomes not only in childhood but also later in life. We need to develop a systematic way of collecting ACEs and use this as a supplement to SIMD.

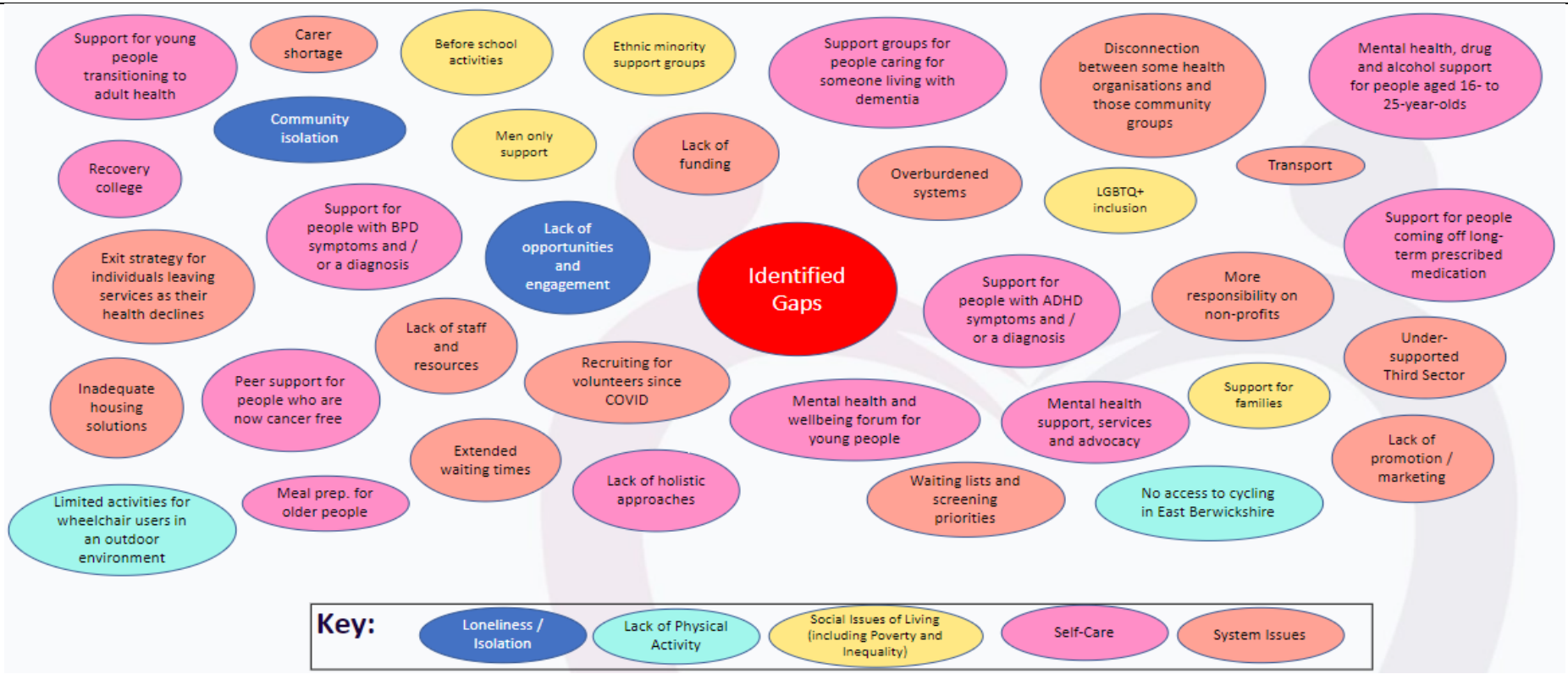
The work done to tackle health inequalities should align with the clinical strategy and be responsive to the issues being faced by our patients. By embedding prevention and equity at the heart of service design, and by working collaboratively with partners and communities, we can turn evidence into action and achieve meaningful improvements in health outcomes in the Scottish Borders.

Annex A: Description of data outlined in evidence chapter

Indicator	Description
Healthy Life Expectancy Male	Healthy life expectancy at birth for males
Healthy Life Expectancy Female	Healthy life expectancy at birth for females
Life Expectancy Male	Estimated male life expectancy at birth in years
Life Expectancy Female	Estimated female life expectancy at birth in years
Maternal Obesity	Pregnant women recorded as obese (BMI > 30) at antenatal booking
Maternal Smoking	Women with known smoking status at first antenatal booking appointment recorded as 'current smoker'
Childhood Developmental Concerns	Children with one or more developmental concerns at 27-30 month review
Childhood Oral Health	Number and percentage of Primary 1 children receiving a letter 'C' (no obvious decay experience but should continue to see the family dentist on a regular basis) at basic inspection
Childhood Obesity and Overweight	Number and percentage of Primary 1 children (with a valid height and weight recorded) whose BMI is in the healthy weight range
Psychiatric Admissions to Hospital	Patients discharged from psychiatric hospitals
Asthma Hospital Admissions	Patients discharged from hospital diagnosed with asthma
Alcohol Related Hospital Admissions	General acute inpatient and day case stays with diagnosis of alcohol misuse in any position
Drug-Related Hospital Admissions	General acute inpatient and day case stays with diagnosis of drug misuse in any position
Cancer Rates	New cancer registrations

Annex B: Emerging High Level Work Plan for CPP on Health Inequalities

For Information
The Wellbeing Programme Board has been tasked to improve the life satisfaction of Scottish Borders residents by addressing key wellbeing issues of: Loneliness / Isolation, Lack of Physical Activity, Social Issues of Living (including Poverty and Inequality), and Self-Care. These priorities were agreed as the Real Action for Prevention: A Vision of Population Health in Scottish Borders Report (available here: https://www.nhsborders.scot.nhs.uk/media/991727/NHSB-DPH-Annual-Report-2023.pdf) underpins our approach to wellbeing and by supporting people to take responsibility of their own health and wellbeing for them to find ways to feel better that do not rely on support from statutory services, this will reduce their probability of admission and / or re-admission into social care and health services. This Work Plan has been created to assist the Wellbeing Programme Board by detailing what progress has been made to date for each of these priorities by the Wellbeing Programme Board, partner services and organisations, and the Health and Social Care Partnership and suggests tasks that should be taken forward to continue the support of these priorities. It also details how a social wellness eco-system can be created in the Scottish Borders to create an overarching system to support people's wellbeing and address inequalities in the Scottish Borders.
Creation of a Social Wellness Eco-System
Description: It was recognised there is partnership and collaborative working happening in pockets in statutory wellbeing services, however; there is a requirement for a more strategic and coherent approach to this across the Borders. A joined-up approach is beneficial to understand what is working and what should be improved, address any actual gaps, and review how services can come together. It was agreed that by combining the good work of these services, third sector and voluntary organisations, and community networks, this would allow us to develop a social wellness eco-system that optimises the physical, emotional, and social wellbeing of all who live in the Scottish Borders.
Creation of a Social Wellness Eco-System – Notable Progress to Date
• To develop our understanding of existing wellbeing services and activities, and to understand if there is demand for wellbeing activity which cannot be met through existing services and activities, a survey was circulated to services, community groups, organisations, etc. that provide wellbeing support in April 2024, which was then closed in May. Following the closure of this survey, several gaps to providing and accessing wellbeing services and activities were identified. A high-level summary of the gaps identified through community mapping, which have been colour-coded to highlight which priority the Wellbeing Programme Board they fall under or if they are due to the overall system, is below:



- The Wellbeing Programme Board also held an in-person Wellbeing Pathway Workshop on the 30th of September 2024 which was attended by representatives from NHS Borders's Public Health Team, Eildon Housing Association, Adult and Social Care, Health in Mind, SBC's Financial Inclusion Team, the Community Equipment Store, Live Borders, SBC's What Matters Hubs, Borders Care Voice, Scottish Care, SBC's Community Learning Development Team, NHS Borders's Health Visitor's Team, SBC's Employability Team, Health and Social Care, the Local Area Coordination Service and other key stakeholders to gain an understanding of existing pathways to wellbeing services.
- It is important to note two distinct approaches to social wellness, both of which are important:
    - 1. Strengths based practice and developing individual resilience (Social Work, Community Led Support / What Matters Hubs, Local Area Coordination, Community Learning and Development); and,
    - 2. Service / capacity development to support individuals – (Public Health Wellbeing service, Social Prescribing).

Creation of a Social Wellness Eco-System – To Do			
Task:	Assigned To:	Timescale:	Notes:
1. Create a Community Website: Create a community website that allows members of communities to:	Borders Community Action		• This would be like the Connect Devon website which states it is: This.platform. is.a.free.community.resource.for.

• Ask for volunteers at a community and individual level and also allow volunteers to offer their time for tasks that match their skills (i.e., providing digital support, painting, etc.) using a timebank model. • Allow for job and work experience opportunities to be posted to further promote them. • Allow partner organisations of the Health and Social Care Partnership, and any other relevant organisations, to post information they feel would support communities (i.e., training opportunities, useful webinars, etc.) and to provide information on their services. • Have an events calendar that would allow partner organisations and community groups to share upcoming events that would support communities.			anyone.wanting.to.share.or.find. information.about.activities?events? volunteering.opportunities.and. conversations.across.Devon¡.It¿s.also.a. social.networking.platform.for.you.to. connect.and.collaborate.around.the. things.that.matter.in.your.community¡. Further information on this site can be found here: About us - Devon Connect. • Is this something that ALISS could be expanded to include or that CGI could support? • Could also link in with other organisation events calendars (i.e., SSDA) which is being added to the Culture Strategy. We would need to tie into this work. • The events calendar may tie in with ongoing work such as implementing an online directory through ALISS (ALISS - A Local Information System for Scotland | ALISS) and other work programmes such as the development of the Culture Strategy, work being undertaken for Community Engagement and Youth Engagement, and the booking systems work with the school estate. • Would need to make sure it is legally and GDPR compliant. • Would need to consider digital exclusion. • Would need to make sure it is kept updated regularly. Would need someone dedicated to support this (i.e., to support people adding events, etc.). •

2. Community Builders and Wellbeing Coordinators: Establish a pool of Community Builders and Wellbeing Coordinators who can support communities.	Sohail Bhatti (Public Health)		• May come under the Wellbeing Service (Public Health). • Need each service to understand what each service does / does not do to identify opportunities for improvement. For example, following a review of Local Area Co-ordination (LAC) in the Scottish Borders, the IJB approved the recommendations which included addressing the drift away from what LAC is designed to deliver. Transformation work is ongoing. LAC is a local, accessible, inclusive, connected approach to supporting individuals and their families/carers who may be facing inequality, exclusion, isolation to build and pursue their vision for a good life within more welcoming, inclusive and supportive communities. The Local Area Coordination 'Purpose' is to: · Increase the capacity and resilience of individuals, families, communities and service systems and to · decrease the risk of avoidable harm and crisis and the need for and reliance on formal services and funding, wherever possible. This helps to support clarity on the LAC purpose and it would also be useful to have similar information on other services that are mentioned so there is clarity all round and we can be clear on what we have in the Borders and how we work together. • Further information on Community Builders can be found here: Torbay Communities | Community Building. Further information on Wellbeing Coordinators can be found here:

			Wellbeing co-ordinators - Torbay and South Devon NHS Foundation Trust. However, we'd need to consider what would work well for the Borders and what is already happening across the different services. • This would most likely require support from the LAC Service (who will work collaboratively with all service partners building on what they've done to date to build strong partnership working although clarification would be required on what actions would be required for this work), the Community Engagement Team, and Public Health, but others may be required. This would be a similar model to Torbay Community Development Trust, which details this model on P2 of Social-Prescribing-Ecosystems-FINAL-1.pdf. •
3. 'Outside the Box' Partners: Along with working alongside partners through the Wellbeing Programme Board and the Health and Social Care Partnership, work with other organisations, staff members and groups who may not necessarily be considered when thinking of Health and Social Care, but who could signpost individuals to a central location for support. For example: • The Scottish Ambulance Service: Will be able to identify patients who call requesting medical assistance when it is not required on a regular basis. • Homecare Providers: Support Workers are interacting with vulnerable people on a regular basis and have a good understanding of their needs and outcomes. • Guidance Teachers / Pastoral Support: Work with a wide range of pupils across primary, secondary and tertiary education institutions. • Churches / Places of Worship: Will be aware of when members of their congregations need further support.	For Social Care / Social Work: Shirley Cumming For Education: Wellbeing Leads, Community and Learning Development Team, and via Education Cluster model For Health flow Navigation Work: to be undertaken separately by Oliver Bennett via Urgent and Unscheduled Care Board		• Would also tie in with having a community website to allow all organisations to signpost to the one location. • These partners could also add posts to the community website as and when required about any groups or events they are running or support they can offer. • Hawick are trialling supporting the Teviot & Liddesdale Wellbeing Lead (for primary and secondary schools) which has been a huge success. It is hoped that this will be rolled out. • Local Area Co-ordinators are highly connected and deeply embedded in the communities in which they work. Working in an area with a population of up to 10k (allowing for rural and remote)

			per full-time LAC. They are accessible and have a real understanding of the community informed by people who live in that community. • Passing information to Ambulance Service on community provision which may avoid unnecessary hospital admission. (change of pathway). •
4. Link in with Place-Based Planning	Kenny Harrow (Community Engagement Team and Community and Learning Development Team), Shirley Cumming, Claire Veitch and wider CCP		• In first instance, prioritise areas of greatest deprivation (i.e., Burnfoot, Langlee and Bannerfield), but work to spread across the wider Borders area as recognise that inequalities exist in other areas too. • To tie in with work ongoing in any other 'places and spaces' programmes (i.e., the SBC / Live Borders Joint Transformational Change Programme). •

Priority 1: Loneliness / Isolation			
Concerns: At least one third of the population suffers from loneliness and the Scottish Borders has one of the highest proportions of elderly and retired people. The Scottish Borders also has higher levels of people with lower-than-average wages and access issues means it is more costly to travel. Positives: The pandemic showed how e-Connectivity is possible, there are a large cohort of people who are time rich and there are a large cohort of people who have rich life experiences. The link with Mental Health work is already active.			
Priority 1: Loneliness / Isolation – Notable Progress to Date			
• The Wellbeing Programme Board agreed that a strengths / asset-based community development (ABCD) approach would be adopted in the Scottish Borders as our preferred approach to this programme. Asset-based community development changes the relationship between a local authority, its citizens, and communities by focusing on 'what's strong, not what's wrong' and further information on asset-based community development can be found through the following report: https://media.nesta.org.uk/documents/Asset_Based_Community_Development.pdf. • It was agreed with Borders Community Action that the Community Mental Health and Wellbeing Fund approval process would be consolidated to be overseen by the Wellbeing Programme Board due to its approach and membership. This fund, allocated by the Scottish Government, is aimed at supporting initiatives which promote mental health and wellbeing at a small scale, grassroots and community level addressing priority issues of social isolation and loneliness, suicide prevention, poverty, and inequality. This Fund is now closed, with thirty-five successful applications and the projects will start from April 2025. Further information on this Fund can be found here: https://borderstsi.org.uk/bca-funding/.			
Priority 1: Loneliness / Isolation – To Do			
Task:	Assigned To:	Timescale:	Notes:
1. Community Engagement Initiatives: Organise regular community events and social gatherings to foster connections among residents. Includes things such as: • Organising small, weekly coffee mornings in different towns and using local cafes or community halls as venues. • Organising monthly social events such as book clubs and hobby groups and partnering with local community centres to host these events.	Borders Community Action and Public Health (Sohail Bhatti)		• Is this something that the Town Teams, Community Councils, etc. could take forward? • Live Borders will be doing elements of this through their library / cultural service. It would be good to understand what hobby groups and book clubs are available. • Needs to be mapped into the Community Builders and Wellbeing Coordinators and the events calendar actions. • Need to define what this would entail. •
2. Volunteer Programmes: Develop and promote volunteer opportunities that encourage social interaction and community support. Includes things such as:	Borders Community Action – formally Community and Learning Development Team / Pam Rigby, Generations		• We would need to understand what volunteering support is currently available to decide what actions are appropriate for the Wellbeing Programme Board.

• Developing a volunteer buddy system where volunteers regularly visit or call isolated individuals, by matching volunteers with individuals based on interests and availability. • Collaborating with local volunteer organisations to recruit and train volunteers from local communities. • Providing resources and support for volunteers to ensure sustainability.	Working Together and CPP – informally Services that promote individual resilience – informal volunteering development		• Could link in with supported living and extra care housing facilities too. • What health and safety and GDPR issues would need to be covered? • This can support referred people along with the people volunteering to be more sociable and less isolated: 7 steps to wellbeing through volunteering: How to link to social prescribing. • Need to promote informal volunteering to facilitate friendships and connections. • Intergenerational work – local youth organisations look for opportunities for their members to achieve their badges such as Kings Badge Boys Brigade, Duke of Edinburgh – links to volunteering. • Need to also ensure we consider 'informal' opportunities, low level. Actively facilitating opportunities for individuals to contribute/share skills, experiences, knowledge. To support communities in a nurturing way and work alongside to develop opportunities taking a strengths-based approach – not statutory services coming in with their own ideas, however well-intentioned they may be. •
3. Digital Inclusion: Provide training and resources to help residents use digital tools to stay connected with family and friends. Includes things such as: • Offering free digital literacy workshops to teach residents how to use video calls, social media, and other online communication tools. • Distributing tablets or smartphones to those without access, in partnership with local businesses or charities.	Borders Community Action and Community Learning and Development Team		• Is this something that Connecting Scotland, Scottish Borders Social Enterprise Chambers, Borders College, Live Borders and CGI could support? • Go Fibre have a Social Value & Community Commitment and will have a grant available for digital inclusion. • Need to ensure that people can access information in letters and not just through links. •

• Setting up a helpline for ongoing digital support. • Hosting weekly drop-in sessions at local libraries to help residents learn how to use digital communication tools. • Partnering with local tech-savvy volunteers or students.			
4. Support Groups: Signpost to support groups for various demographics (e.g., elderly, single parents) to provide a sense of community and belonging. Includes things such as: • Facilitating regular meetings and provide trained facilitators to lead discussions. Hold these meetings in accessible locations like community centres or libraries and create a safe and welcoming environment for participants to share their experiences.	Borders Community Action		• Link with Red Cross and Red Cross Calendar. • Reference – comment at point 2.
5. Open Days: Organise open days with organisations and projects that regularly require or could use volunteers. Includes things such as: • Facilitating open days that allow potential volunteers to see what may be required of them with no commitment. • Having a mechanism in place so that volunteers can ask questions before and after the open day.	Borders Community Action		• Could include supported living facilities and animal rescues. •

Priority 2: Lack of Physical Activity			
Concerns: There are growing levels of obesity in our population (>30k with BMI 30+), ultra-processed foods are unregulated, and there is avoidance of structured sports activities. There are also low levels of physical activity in older ages and pain through arthritis limits ambition. Positives: Social aspects can be linked to physical activities, and there are a large cohort of people who are time rich and a large cohort of people who have rich life experiences.			
Priority 2: Lack of Physical Activity – Notable Progress to Date			
• A Sport and Physical Activity Strategy is being developed for the Scottish Borders which hopes to break down barriers to participation, encourage behaviour change, create opportunities for involvement in all forms of physical activity including sport, and ensure that people have the support they need to stay physically active every day, so that everyone in the Borders benefits from participating in sport and physical activity. • Live Borders have a Health Programme which aims to reduce health inequalities and improve health outcomes and quality of life for adults living in our communities, by providing opportunities to increase physical activity levels in a safe and accessible environment with the support of qualified Health Instructors. So far for 2024/2025, there have been approximately eight hundred received referrals with referrals being received from 25 GP surgeries and from thirteen different health and social care roles. 50% of referred clients are also engaged with the service. Further information on this Programme can be found here: https://www.liveborders.org.uk/exercise-referral/. • Active Schools is a national programme, invested in jointly by Sportscotland and the local authority, dedicated to developing and supporting the delivery of quality sporting opportunities for children and young people across the country. Active Schools aims to provide more and higher quality opportunities for pupils to get active before school, during lunchtimes and after school through nine Active Schools Co-ordinators and 750 volunteers (in 2023/24). Using 23/24 participant data, this showed that the Scottish Borders's participation percentages were higher than the national average for primary and secondary school pupils. Further information on Active Schools can be found here: https://www.scotborders.gov.uk/schools-learning/active-schools.			
Priority 2: Lack of Physical Activity – To Do			
Task:	Assigned To:	Timescale:	Notes:
1. Public Exercise Programmes: Offer low-cost exercise classes such as yoga, aerobics, and walking groups in parks and community centres. Includes things such as: • Scheduling classes at various times to accommodate different schedules and using local parks and trails for routes. Could also partner with local fitness instructors to lead classes.	Live Borders and SBC Sports Development Team		• Is this something that SBC'S Parks & Environment Team and Borders College could support? •
2. Active Transport Initiatives: Promote walking and cycling through improved infrastructure and awareness campaigns. Includes things such as:	SBC Economic Development Active Travel Coordinator		• Could the Walk It (SBC) and Walking for Wellbeing (Live Borders) programmes be extended? • Link with Border Wheels re: walk-it groups, walk-it to music groups, etc.

• Launching awareness campaigns to encourage walking and cycling as daily transport options. • Partnering with local schools to implement "walking buses" for students.			• Are there opportunities to make use of transport attached to services / schools at times it's not required to support developments – aware this isn't under active transport banner though? •
3. School Programmes: Implement physical activity programmes in schools to encourage healthy habits from an early age. Includes things such as: • Providing training for teachers to incorporate physical activity into their lessons. • Organising inter-school sports competitions to foster a culture of physical activity. • Implementing monthly physical activity challenges in local schools and rewarding participation with small incentives like certificates or healthy snacks. Also, need to involve parents and caregivers in the challenges.	SBC Active Schools and Sports Development Teams		•
4. Workplace Wellness: Encourage local businesses to adopt workplace wellness programmes that include physical activity breaks, fitness challenges, and incentives. Includes things such as: • Providing resources and support for businesses to implement these programmes. • Encouraging local businesses to organise step challenges for their employees and provide simple tracking tools like pedometers or mobile apps.	SOSE, Public Health and CPP		• Are there any resources available or preferred apps. to assist with this? •
5. Energy-generating equipment: Encourage the installation of equipment which uses movement to generate energy in local gyms and sports facilities. Includes things such as:	Live Borders and Neil Robertson (SBC's Energy Efficiency Strategy and Policy Officer)		• This would help with increasing physical activity and supporting Net Zero. •

• Providing support for businesses to install this equipment. • Holding competitions to encourage the use of this equipment.			

Priority 3: Social Issues of Living (including Poverty and Inequality)			
Concerns: There is a cost-of-living crisis which has left some people with few resources. There is also a dependency culture, which has left some people with a lack of agency and self-solving skills. Common issues prevalent are relationships, legal disputes, shelter and welfare needs, and there is also confusion as to the best routes of resolution. Positives: The pandemic showed how e-Connectivity improves access, but it does create barriers amongst those without equipment. There are a large cohort of people who are time rich and a large cohort of people who have rich life experiences.			
Priority 3: Social Issues of Living (including Poverty and Inequality) – Notable Progress to Date			
• A Winter Poverty Plan has been created to reduce poverty fuel and food support for the winter. The priorities of this Plan are to take a preventative approach to those most at risk of a crisis, including hospital admission, and to respond to those most in need. Actions for this Winter Poverty Plan include using SPARRA (Scottish Patients at Risk of Readmission and Admission) data to identify those locally at particularly high risk of admission to hospital, progressing with the Child Poverty Practice Accelerator Fund Project, which will provide holistic support for families, including income maximisation and debt advice via CAB (Citizens Advice Bureau), and providing support via the Financial Inclusion Team with a Discretionary Fund.			
Priority 3: Social Issues of Living (including Poverty and Inequality) – To Do			
Task:	Assigned To:	Timescale:	Notes:
1. Financial Support Services: Provide access to financial advice, budgeting workshops, and emergency financial assistance. Includes things such as: • Offering emergency financial assistance programmes for those in immediate need and partnering with local banks and financial institutions to deliver these services. • Hosting monthly financial literacy workshops at community centres that cover topics like budgeting, saving, and managing debt. • Reducing stigma for people to be able to ask for and access support.	Financial Inclusion Team, Citizen's Advice Bureau and Customer Advice and Support Service		• CAB provide budgeting support and advice. • CASS could develop a directory of where the financial support is as this is often pockets of this by way of food vouchers / fuel voucher. •
2. Affordable Housing Initiatives: Work on increasing the availability of affordable housing options through new developments and renovations. Includes things such as: • Collaborating with housing associations and developers to ensure a mix of housing types.	Housing Team		• Housing is a key determinant of health and wellbeing. We have a Housing Strategy that aims to address this. •

• Implementing policies to protect tenants and support first-time homebuyers. • Organising quarterly forums to discuss affordable housing options and resources and inviting local housing authorities and developers to participate. • Providing information on tenant rights and support services.			
3. Employment Programmes: Develop job training and placement programmes focusing on in-demand skills and industries to improve employment opportunities. Includes things such as: • Partnering with local businesses to create apprenticeship, internship, and work experience opportunities. • Providing career counselling and job search assistance through community centres. • Offering job readiness workshops focusing on resume writing, interview skills, and job search strategies. • Partnering with local businesses to provide mock interviews and feedback.	SBC Employment Support Service and Developing the Young Workforce (DYW)		• Could apprenticeships, work experience and / or certifications be provided through sports clubs? • Could there be a public SB Learn-type video archive made available for the public to support their training and skills development? • The Employability Service provide pre-employability support, employability training and specialist supported employment • Could include Alasdair Scott from SBC's Employment Support Service (who also has a role with the Local Employability Partnership) and Jennifer McInulty (Parental Employability Support Worker) support this? •
4. Advocacy and Policy Change: Advocate for policies that address systemic inequalities and support vulnerable populations. Includes things such as: • Engaging with local and national policymakers to influence legislation and funding priorities. • Organising community forums to gather input and raise awareness about social issues. • Forming small advocacy groups to address specific social issues. • Holding regular meetings to discuss strategies and actions.	CPP and SBC Policy Team		• This may be quite big for the Wellbeing Programme Board to take on. However, there are elements that could be taken forward. • Elements of this will be being done through the annual Community Conversations. •

• Engaging with local policymakers and community leaders.			
5. Pay What You Can Surplus Food Cafés: Encourage the creation of Pay what You Can Surplus Food Cafés in the Scottish Borders (like Café Recharge in Galashiels). Includes things such as: • Providing support for communities to start up and run their cafés.	Sarah Culverwell (Community Engagement Officer) and Amy Alcorn (Greenspace Programme Officer who supports food security)		• Needs to be predominantly community led. • Is this something that the Town Teams, Community Councils, etc. could take forward? •

Priority 4: Self-Care			
Concerns: The pandemic left many dependent and with loss of agency, and the atomisation of households have also left people with poor social networks. NHS Inform is a trusted source of information, but it is not understood how used it is locally. There is also confusion as to the best routes of seeking help. Positives: The pandemic showed how e-Connectivity improves access, but it does create barriers amongst those without equipment. There are a large cohort of people who are time rich and a large cohort of people who have rich life experiences.			
Priority 4: Self-Care – Notable Progress to Date			
• A new Local Area Coordination (LAC) model is being implemented in the LAC Service. The Local Area Coordination 'Purpose' is to increase the capacity and resilience of individuals, families, communities, and service systems and to decrease the demand for and reliance on formal services and funding, wherever possible. The implementation of this new model will allow the Scottish Borders LAC Service to be catalysts for change and is more in keeping of the model defined by 'Local Area Coordination Scotland.' Further information on the LAC Service Review can be found under Item 6 of the documents received for the Health & Social Care Integration Joint Board held on the 18/09/24: https://scottishborders.moderngov.co.uk/ieListDocuments.aspx?CId=218&MID=7037#AI55560			
Priority 4: Self-Care – To Do			
Task:	Assigned To:	Timescale:	Notes:
1. Educational Campaigns: Run campaigns to raise awareness about the importance of self-care, including mental health, nutrition, and sleep, and provide practical tips. Includes things such as: • Distributing self-care guides and toolkits through community centres and healthcare providers.	Public Health		•
2. Mental Health Resources: Increase access to mental health services, including counselling and therapy, through local clinics and online platforms. Includes things such as: • Providing training for healthcare providers to recognise and address mental health issues. • Establishing peer support networks to offer additional emotional support. • Setting up weekly drop-in clinics for mental health support at community centres. • Providing access to counsellors and therapists for brief consultations.	Public Health, Mental Health, Psychology and the CPP		• Could elements of this be tied in with the What Matters Hubs? • Mental Health Information Stations are available in some What Matters Hubs monthly (please check). Not currently in all areas but being developed. • Berwickshire next on What Matters list (Steph Mackenzie?). •

• Offering information on local mental health services and resources.			
3. Workshops and Seminars: Offer workshops on stress management, mindfulness, and other self-care techniques. Includes things such as: • Scheduling workshops at convenient times and locations to maximise participation. Could also partner with local experts and organisations to deliver these sessions. • Offering monthly workshops on topics like stress management, mindfulness, and healthy eating. Could also partner with local health professionals to lead sessions.	Public Health (e.g. Steph Mackenzie) and CPP. Do Live Borders have an opportunity in this area?		• Could wellbeing and mindfulness workshops be recorded and uploaded to the SBC and NHS websites? • Work already well progressing looking at Recovery & Wellbeing Course being re-established. Joint work with Steph Mackenzie (Health Improvement), CMHT & Peer Workers, MH&W Forum, Health in Mind. Steph would be best person to contact for detail on plans. •
4. Resource Distribution: Provide self-care resources such as guides, toolkits, and online materials through community centres and healthcare providers. Includes things such as: • Developing an online portal where residents can access self-care information and resources, with self-care tips, resources, and interactive tools. Would need to ensure resources are available in multiple languages and accessible formats. • Distributing self-care kits with items like stress balls, journals, and relaxation guides, and make kits available at community centres and health clinics. Could also include information on local self-care resources and support groups.	Public Health (e.g. Steph Mackenzie) and CPP. Do Live Borders have an opportunity in this area? Management Committees in Community Centres		• ALISS could be key for online resource distribution if it allows for this. Alternatively, we will need a section on the SBC and / or NHS website(s). • NHS Borders Wellbeing Point already has a wealth of information and resources. • Are there tangible resources (i.e., stress balls, journals, etc.) available for distribution? •

Annex C: Delphi Consultation of CPP on Health Inequalities

Introduction

This Delphi exercise is a structured research method used to gather expert opinions and achieve consensus on a specific topic through multiple rounds of questionnaires. Thanks to everyone who took the time to respond. After each round, a summary of responses is shared with the group. Participants can revise their answers based on the feedback, encouraging convergence of views over time. The process continues until a level of agreement is reached. The Delphi method minimizes bias, leverages collective intelligence, and supports informed, well-rounded conclusions.

The aim of this initial first-round Delphi report is to summarize and analyse the expert opinions gathered through the first round of the Delphi study. It aims to identify key themes, areas of consensus, and differing viewpoints. It is hoped that the report will help to clarify uncertainties, highlight emerging trends, and guide the development of subsequent survey rounds.

The next step involves sharing this summary with participants, allowing us to review the collective feedback and reconsider initial responses. In the second round, participants rate or rank the identified items, helping to refine priorities and move toward consensus. This iterative process may continue for additional rounds until stability or agreement is reached.

The following pages summarise the answers to the questions in each of the sections of the initial questionnaire. For each question, Key themes which emerged are shown in a word map and summarised in text form.

- General and Contextual Questions
- Goal-oriented Questions
- Questions about Resource and Capacity
- Questions about Policy and Innovation
- Questions about Sustainability and Equity

The final section considers the next steps in further detail.

1 General and Contextual Questions

This section asked participants to consider three key areas about the population we serve, looking for views about current challenges, potential barriers and urgent areas for action.

a: What are the key health and wellbeing challenges faced by the communities we serve?

A key theme related to access to services, jobs etc in a rural environment. Services can be centralised, subject to complex referral pathways and waiting lists. There is a lack of community-based support. Lack of access to local opportunities for physical activity or sports was mentioned. There is also poor access to community based mental health support.

Mental health of our population figured strongly in the responses to this question. Loneliness, hidden poverty and increasing child poverty featured prominently. Mental wellbeing of students and issues around support for neurodiversity figured strongly.

Fuel poverty, the low wage economy and cost of living crisis add further complexity to this picture.

It was pointed out by one respondent that there are already of number of documents detailing this area, such as Scottish Borders HSCP Strategic Vision which sets out the strategic issues faced. There are also objectives and ways of working which have been developed to deliver against the needs assessment undertaken previously. It was felt that reviewing these as a group would be a way of prioritising the work of THIS Borders and may be a good starting point.

b: Which populations or demographics require the most urgent attention?

Annex C: CPP Delphi Consultation on Health Inequalities

The Borders has ageing population demographic. In addition, more than 50% of the population live in rural areas. Many have no family or close connections nearby and rely on the kindness of neighbours for support. This has a detrimental impact on many people who feel cut off. Respondents noted worsening in mental health and younger people, again compounded by living in remote settings.

Resource allocation was also raised. Often resources are allocated to areas of multiple deprivation as per SIMD but this measure is not accurate in rural settings such as the Scottish Borders, so some rural

dwellers miss out relatively. This is not to deny the well documented persistence of inequalities in communities such as Burnfoot, Langlee and Bannerfield.

Mental health in young people was raised as a priority by several respondents, and those with caring responsibilities were also highlighted.

The low wage economy was again raised in this section, and the working poor highlighted as a demographic requiring urgent attention.

People living with disabilities or limiting health conditions were highlighted.

The Scottish Borders Health and Social Care Partnership's newly revised Equality Outcomes and Mainstreaming Framework and the Equality and Human Rights "Is Scotland Fairer" report highlights the areas of persistent inequality from an equalities perspective in relation to the National Health and Wellbeing Outcomes.

c: What barriers currently exist in delivering effective health and wellbeing services?

Many respondents cited structural issues. Services have been subject to funding cuts and / or rely on grant funding. There are also staffing issues around too few people being recruited, and then difficulties with pathways and career progression. Workforce shortages in health and social care were highlighted - difficulties in attracting, recruiting and retaining staff. This is not helped by the lack of degree programmes within Borders Region in Health & Social Care (although this is being addressed). Capacity is an issue, particularly mental health services, social care and access to GP services resulting in longer waiting times, deterioration in health and increased pressure on hospital admissions.

People may not be aware of services.

Access to services and general transport problems are an issue. Services are often located in towns- limited public transport and the cost and travel time are all barriers. Berwickshire community have long expressed frustration at having to travel to central borders for treatment when health care could be available in neighbouring areas.

Some participants mentioned digital exclusion - poor connectivity and digital literacy limiting access to telehealth and online services.

Community responses are a way to tackle this issue, using local centres to ensure opportunities for physical activities, mental stimulation and social connections exist. However, this type of preventative intervention is often overlooked as it is difficult to measure the return on investment in these types of community-led responses.

Public sector services are often delivered in isolation of one another. People's health and wellbeing covers all aspects of their life so you can't support one aspect of their situation (poor housing, lack of

access to transport) without considering the impact on their health. Sometimes services are disjointed and are working in silos.

There was a general theme of disjointed working. Comments referred to an inability to work strategically, just focussing on operational issues, lack of flow/sharing of information and a system largely focussed on treatment rather than prevention. Complexity in the system leads to waste and inefficiency. There may be geographical variations. There is an underutilisation of technology and a resistance to change and innovation.

Housing shortages were also a common theme. The lack of availability of suitable quality, affordable housing to increase demand and meet evolving and changing needs is an issue. Cuts to adaptation and new build funding and rising construction costs are impacting on more hospital admissions and delayed hospital discharge to suitable housing.

Investment is centralised. Staff in primary care are struggling to cope with demand because the buffer that the third sector historically provided is reducing due to lack of sustainable investment. Over the years. investment and access to funds have been reduced with only small grants available, which adds further pressure on third sector organisations who are 'currently living hand to mouth', with little consideration of the role of the third sector in supporting service delivery as equal partners. Often the third sector is considered only when volunteers are required or for low-cost interventions. Natural networks of support in rural communities can only happen through human interaction and need to be fostered by enabling civic activities and community engagement. Whole family support needs to be available within the third sector and not as a statutory provision as well as link workers and other, non-primary support.

2 Goal-Oriented Questions

a: What specific outcomes should this group aim to achieve in the next 12 months?

Several participants highlighted that an urgent task was to identify gaps and needs from all demographics, but with a focus on those most excluded and where inequality is exacerbated. We need to move from clinical models to social models of health and wellbeing improvements and to explore innovative solutions and partnerships to develop very local solutions working with communities.

We should explore prevention in its true sense and investment in social capital and community cohesion. The Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS) could be used to measure wellbeing and develop learning about the impact of community-based activities on people's health and wellbeing in the long term. We need to explore how a cross sector partnership can support people to stay well in the Scottish Borders.

We should be prioritising health needs - an asset map and connectedness map.

We should ensure there is a poverty plan. Transport infrastructure needs to improve. We need to make sure that affordable healthy eating options are available.

Many people suggested joint working with other areas and partnerships, such as by data collection and sharing to achieve goals, and support work of other regional partners with similar ambitions. We should explore opportunities to engage, support and influence work of Regional Economic Partnership which is working on alleviating / solutions to the region's 3 grand challenges (Transport; Housing and Skills). There are synergies here that could be exploited by the CPP. We might also look to insights from community transport strategy implementation and provision in Dumfries & Galloway - where providing access to healthcare to rural communities is a key driver for action.

b: What are the top three measurable indicators of success for improving health and wellbeing in the Borders?

More people express satisfaction with life, more people experience physical and mental health improvement, more people feel connected with the community where they live, increase participation in community life and feeling of belonging.

Many possible indicators were suggested. Amongst the most common ideas were:

- Reduced waiting lists
- Living healthier lives
- Greater life expectancy
- Improved perception of physical, cognitive and social improvement
- Better transport

It was suggested that the National Health and Wellbeing Outcomes be used as a guide to determine this.

c: Can you list some health and wellbeing initiatives have been most effective in the past?

Initiatives cited included social gatherings providing healthy lunch options, physical activity in the community using local community spaces such as walking football/ netball, food growing and cooking sessions, outdoor walks and wellbeing sessions.

Local based physical and sports activities available in rural communities (village halls), Access to nutritional food as part of the skills development initiatives happening at a very local level. Food sharing initiatives such as lunch clubs and coffee mornings bring communities together. Mental stimulation activities such as arts, crafts, Men's Sheds, older people's groups, youth-based provisions.

Preventative measures that are delivered through housing adaptations and the work of the Borders Care & Repair service which has been operating for 20 years and, with small amounts of additional support, could achieve an even greater impact on a system under pressure.

Other measures include things like emergency food provision, income maximisation, energy advice and employability support - however, these are all seeking to mitigate wider systems that are failing and are not in themselves solutions to these challenges."

Specific themes are listed below:

Nutrition

- Community-based activities where people are involved in preparing their own meals
- Curry and a chat aimed at supporting people struggling with mental health.
- You Can Cook Community Sessions (nutrition, independent living, social inclusion)

Mental health support

- Support for students that provide skills to cope with mental health crises.
- Money Worries App
- Mental health work/awards
- Several people highlighted the NHS Borders - Small Changes, Big Difference Campaign.
- BeFriend Services

Exercise

- Live Borders Exercise Referral Programme

Housing & Fuel Poverty

- Warm & Well services
- Warm Spaces
- Housing First (BHA)
- 16+ Transitions Housing Project (pioneering project for transitional housing for young people leaving care) - example of homelessness prevention model
- Young Persons Housing Protocol (SBC & RSLs)
- The Real Living Wage Initiative

Domestic Violence

- Domestic Abuse Unified Policy (RSLs & SBC)

Health Service Delivery

- Attend Anywhere teleconsultation platform
- Social Prescribing in some practices
- Vaccines for young people

Community Cohesion

- Connecting Scotland (digital inclusion)
- Relational Mentoring - Scottish Borders by Wyse Group (support - vulnerable families/child poverty)
- Employee Assistance Programmes
- Schools Summer Programme (child poverty)

Wellbeing Services

- What Matters Hub (small scale)
- Walk-it

3 Questions about Resource and Capacity

a: What resources (personnel, funding, infrastructure) are currently under-used in promoting health and wellbeing?

Service Users with Positive Outcomes would be good ambassadors for health and wellbeing: “word.of.mouth.of.a.good.service.travels.further.than.a.brochure.or.social.media.post‹¡

Organisational and funding issues were raised: Personnel, funding and infrastructure are mainly focused on clinical interventions and we need to start considering the social model of care if we want to focus on prevention. Social capital assets are also underused because there is an expectation that these things are entirely free. Even voluntarily led activities have incurred costs such as volunteer expenses so people are not out of pocket for transport, training and any other needs. Hire of spaces and associated utilities costs for example. These things need to be taken into consideration when looking at allocation of resources.

Online interventions and services were highlighted, such as online support for mental health, telecare & telehealth.

Several people mentioned community resources:

- Community pharmacies - raise public awareness and share positive real-life experiences of using the pharmacies for minor ailments and health advice to increase confidence and use to reduce burden on GP and emergency services.
- Community hubs - to promote and facilitate community led initiatives, raise awareness of Community Mental Health and Wellbeing Fund to support such projects and share skills for applying and delivery.

Social prescribing initiatives were raised and it was suggested that we strengthen the “offer” if there were scope to expand this.

Partnership Working

Many respondents talked about the power of partnership working.

- Registered Social Landlords- community anchor organisations that have an established trusted relationship with tenants and existing engagement frameworks (reach of 25% of households in the Scottish Borders) which could be utilised for awareness, engagement and opportunities for integrated responses.
- Shared training programmes across sectors
- Need to focus on working tactically and with partners rather than trying to deliver everything
- Using existing resources more efficiently - and joining up more effort - could be a key focus to get better outcomes. For example, there are a range of organisations involved in things like energy advice that can overlap and pull in different directions.
- Bringing the Third sector as a key partner not only to deliver voluntary led (or what is often perceived to be 'free)' activities but with investment plans in place. Understanding the social value of community-based activities and the social return on public investment by allocating funding to local based initiatives.
- Invest in rural communities and provide services and a hyper local level. As a result of lack of tangible funding, the infrastructure of third sector provisions is crumbling, with reduced personnel capacity to respond to need - these are not separate matters and need to be considered as a whole when discussing the need for resources.

(Active) transport

- Natural capital and green space
- Active travel provision
- Vehicle sharing & DRT

b: What additional resources would be necessary to fill current gaps in service delivery?

Suggestions fell into the following themes:

Kick-Starting Funding

- Explore lottery funding etc. even if only for kick-starting funding.

Funding to help collaboration

- Funding to pilot community-based activities and coordination of efforts in order to ignite community led responses and bring further external investment such as lottery funds and others.
- Managerial leadership for disparate initiatives, working to one strategic direction
- Not sure if there is a resources required (although this always help) but a clear strategic oversight from the CPP to drive efficiency and effectiveness in our collective efforts would be welcomed.

- More collaborative work between college and NHS Borders on general health
- Potential to link in with students to free up GPs such as Blood Pressure checks etc.
- Integrated data sharing to evidence need and enable co-ordinated approach and deliver true partner initiatives

Transformational funding

- To fund the shift from acute crisis intervention to prevention.
- Alleviating existing funding pressures based on spend to save principles

Service Funding

- Additional mental health professionals to reduce wait times
- Expansions of Mobile health clinics?
- People who need access to exercise facilities access should be able to do so at no cost.
- We should be progressing with social prescribing
- More access to mental health services for both children and adults
- Clarity about the role of the third sector in prevention and how both the third and statutory partners can work alongside each other to reduce demand on an already stretched primary care service.

4 Questions about Policy and Innovation

a: What existing policies help or hinder multi-agency collaboration in promoting health and wellbeing?

One participant gave a comprehensive analysis of this:

Policies that Facilitate Multi-Agency Collaboration

- Community Empowerment (Scotland) Act 2015: strengthening the role of communities and the third sector by ensuring public bodies work in partnership.
    - Challenges: capacity to effectively deliver
- Public Bodies (Joint Working) (Scotland) Act 2014: requiring NHS boards and local authorities to integrate services and work collaboratively with third-sector partners.
    - Challenges: Third-sector organisations may face difficulties influencing decision-making processes dominated by statutory bodies.
- The Christie Commission (2011) and Prevention Agenda: Encourages preventative approaches and co-production between public bodies and third-sector organisations.
    - Challenges: Despite support, funding constraints can limit preventative work.
- “Getting it Right for Every Child” (GIRFEC) framework: emphasize multi-agency collaboration.

    - Challenges: Coordination can be complex, and some third-sector groups report challenges in fully integrating into service planning.

Policies that Hinder Multi-Agency Collaboration

- Funding and Procurement Challenges: Short-term, competitive funding cycles for the third sector create instability and hinder long-term collaboration.
- Data Sharing and Confidentiality Issues: Legal and bureaucratic barriers (e.g., GDPR compliance) can make it difficult for third-sector organisations to access or share information needed for effective collaboration.
- Workforce and Capacity Constraints: The third sector lacks the same financial and workforce stability as statutory services, leading to power imbalances in partnerships.

Other responses had similar themes:

Things which help included:

- IJB encourages multi agency collaboration across sectors and Scottish Borders Health & Social Care Partnership improves the co-ordination of services
- Public Health Priorities promotes whole system approaches, prioritising mental wellbeing, physical activity and reducing health inequalities, encouraging social prescribing.
- Key worker housing priorities seeks to encourage attraction and retention
- Community Empowerment encourages community led health initiatives and funding opportunities for grassroots projects

Things which hinder included:

- Top-down policies – risk of causing push back from service users and lack of engagement.
- Sharing information and signposting. There is a massive barrier to multi-agency collaboration because of the red tape in information sharing.
- GDPR
- Funding complexity & short-term regime - difficult to navigate available funds and short term make sustainability of projects difficult, losing confidence and trust of public as ending of support or disruption to service from established support can leave people feeling more vulnerable
- Differing IT systems make data sharing difficult and GDPR prevent effective information sharing for integrated and co-ordinated care and partnership approaches"
- Financial challenge means everyone is focussed on salami-slicing, rather than looking at outcomes. Children's strategy is non-existent. Not clear about the role, function and extent of collaborative working by the Anchors Institutions
- Policy intent is, in my view, clear and points in the right direction. Traction however is lacking or at least inconsistent. This lack of traction is reinforced by firefighting because of the system being under pressure - but also by unhelpful professional barriers.
- Data sharing agreements - there is an opportunity to improve data sharing agreements across REP partners to realise macro scale socio-economic goals. Current protocols could be reviewed to allow improved data sharing.

b: How can we leverage technology to improve access to health and wellbeing services?

One response highlighted the very real benefits but also significant risks in relying on large scale use of information technology. This.is.difficult.and.experience.of.the.deployment.of.technology.for.public.policy. aims.is.littered.with.real?significant.and.expensive.failures¡.However?I.don't.think.there.is.enough.system. wide.(cross_organisational).consideration.of.adoption.of.compatible.and.inter_operable.technologies.that. serve.our.communities._.resulting.in.wasting.of.effort.as.different.parts.of.the.system.pursue.different. options.

Better IT Infrastructure is a prerequisite

- especially in very rural areas
- better coverage of fibre across all borders
- Improved digital connectivity could assist with improving ease of access. However, this should not be to the detriment of improving transport connectivity also.
- Some groups (eg the older population) are not necessarily able to access online services:
    - digital healthcare can help us keep people healthier, however, without skills development and support to encourage people to use technology, these approaches may only serve to widen the inequality gap between those who have access to resources and those who don't
    - By ensuring that any move to technology enabled care takes account of the barriers and challenges faced by the intended users e.g. digital exclusion, non access to Apps or systems which host the technology

Directory of Services

- Investment in a local directory of activities based in each community would help people identify activities of their interest and professionals to sign post community activities to those who come in contact with their services.
- Develop local wellbeing app providing local health service directory, appointment booking and wellbeing resources
- We need apps that people can access that provide local help

Joined-Up Information on the Web and Data Sharing (recognising GDPR constraints)

- Service level agreements
- Develop single integrated digital health record to improve coordination as people move between NHS, Social care, and third sector services to increase effectiveness and reduce inefficiencies
- Enable third sector organisations to contribute to relevant parts of patient records

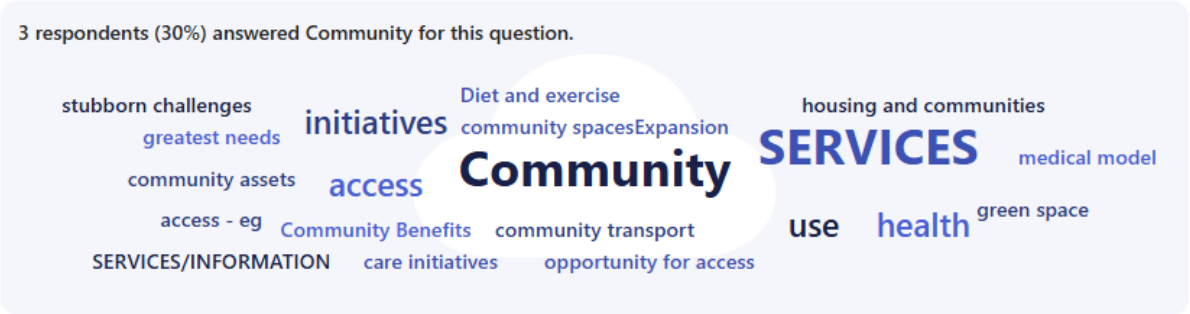
Telehealth methods

- Increase the use of telehealth and telecare, teleconsultations via platforms such as Attend Anywhere, Patient Access and extend home monitoring programs such as remote blood pressure tracking to alleviate pressure on overstretched services

Artificial Intelligence to increase efficiency

- Use trusted Ai and predictive data analytics to identify high risk early and reduce emergency admissions - AI stratification tools and data dashboards for trends and predict demand. Develop Trusted AI Chatbots for triage and system check and AI social prescribing matching referral system "
- "AI gives the opportunity to work at scale and bring in skills we otherwise lack
- Use of AI and development of advanced data technology in the South could assist with efficiencies and productivity whilst offering new supply chain opportunities. "

c: What innovative approaches could we adopt to tackle long-standing health disparities?



Community Involvement

- Have all age groups help design the services and information they want.
- Community lead health hubs and mobile clinics - using community spaces
- Harness Community Benefits to fund community led initiatives and enhance sustainability of initiatives that demonstrated success.
- Stop doing to and move to a culture of person led coproduced care initiatives which are designed to be fully inclusive. Recognise the contributions of commissioned services and what they can bring to the discussions

Technology

- Expansion of broadband access - eg SBHA has partnered with BT to expand access in amenity housing and communities
- "Deployment of drone technology for delivery of prescriptions to hard to reach areas.

Infrastructure

- DRT and community transport networks to build resilience to transport options and greater opportunity for access.
- Invest in infrastructures able to mobilise community assets to tackle health inequalities
- Better use of natural capital and green space to compliment medical model.

Better Targeting

- Let's use Adverse Childhood Experiences as a way for measuring current and future disadvantage, and then build support and wrap-around services to meet those is greatest needs. The SIMD doesn't really work in rural settings.

5 Questions about Sustainability and Equity

a: How can we ensure that health and wellbeing initiatives are sustainable over the long term?

Collaboration

- Look at bringing the right people around the table and agree who is able to deliver what and what investment would be required to drive action.
- Invest in bottom-up approach and in community led solutions rather than top down. When communities are involved in the co-design of their own solutions, these initiatives are easier to sustain over time if they are done by and with communities compared to when they are done for people in communities.
- Test a pool of service users along their journey, understand what works and what needs improving.

Funding Models

- Shift from short term funding to multi year funding models to give projects time to scale and demonstrate impact.
- Public and private partnerships with local businesses and charities to diversify funding sources
- Embed success initiatives into mainstream services as routine rather than stand alone projects eg Live Borders Exercise Programme integrated into NHS referral pathways"
- Ensure long term business plans are robust and financial resilience / sustainability is core to future initiatives.
- Good proactive approach to medium and long term planning. Using a continuous improvement framework, adopting Lean principles, planning, doing, studying and acting on findings. Remove small grants, short term funding proposals.

Asset-Based Approaches

- Building an asset-based approach means we have a large community-based set of activities supported by and facilitated by limited statutory sector input
- I don't have an answer to this - but it must be a combination of arguing for more and better targeted resources, whilst generating greater efficiencies and effective working practices within the system.
- Invest in them as core service requirements/ make sure we use all services that are linked to health and wellbeing increasing both choice and access
- Explore initiatives that simultaneously offer opportunities for innovation and entrepreneurship - and support sustainable regional growth.

b: What steps should be taken to promote equity in access to health services for marginalized groups?

- Engage with the groups in question – communication is something that many of us struggle with.
- Ensure that information is accessible and that professionals and organisations working with marginalised groups involve them in the co-design and/or support is available for people who may feel anxious about attending sessions for the first time - link with the LAC service for example.
- Accurately measuring and reporting on outcome. Why are reports not, by default, reporting on protected characteristics when it is a legal requirement not to discriminate. How will we know we aren't discriminating against a specific gender or age-group or ethnicity unless we get regular, accurate reporting
- Improve our data and analytical capacity - and share more effectively across the partnership.
- These groups should be sought out and helped to engage with planning of services. They should be asked before decisions made. Professionals and managers need to stop make assumptions.
- Invest in communications and marketing strategy that analyses demographic groups, explores barriers in detail and suggests options and solutions. Use of social media campaigns that target certain groups.
- The undertaking of robust involvement from an equalities perspective at the beginning and throughout the development stages of new initiatives and the review of current services.
- Look at engaging with people where they are so they can help shape services.

Next Steps

Following discussion at the May CPP Theme 3 meeting, participants will be invited to reconsider in the light of the discussions. We will then embark on the second round – again online - where participants will be asked to rate or rank the identified items. This will help us to define our priorities and move toward consensus for future action.

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**4 December 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 6 November 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 11.09.25

Borders NHS Board

Minutes of a meeting of the **Resources and Performance Committee** held on Thursday 11 September 2025 at 9.00am via MS Teams.

Present:
K Hamilton, Chair
F Sandford, Non Executive
J Ayling, Non Executive
L O'Leary, Non Executive
L Livesey, Non Executive
D Parker, Non Executive
P Williams, Non Executive
J McLaren, Non Executive
P Moore, Chief Executive
A Bone, Director of Finance
L McCallum, Medical Director
S Bhatti, Director of Public Health
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
K Lawrie, Partnership Chair

In Attendance:
I Bishop, Board Secretary
S Errington, Head of Planning & Performance
C Oliver, Head of Communications & Engagement

1. Apologies and Announcements

1.1 Apologies had been received from S Horan, Director of Nursing, Midwifery & AHPs and J Smyth, Director of Planning & Performance.

1.2 The Chair welcomed P Williams, Non Executive to his first Resources & Performance Committee 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 8 May 2025 were approved.

4. Matters Arising

4.1 **Action: 2024-4:** The Chair suggested that as the matter was now complete it could now be closed on the action tracker. She recorded her thanks to all those involved in bringing the matter to a close.

4.2 **Action 2024-5:** The Chair suggested as Length of stay was now being taken forward by the new Urgent and Scheduled Care Board it should also now be closed on the action tracker.

The **RESOURCES AND PERFORMANCE COMMITTEE** agreed to close Action 2024-4 and Action 2024-5.

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

5. Integrated Performance Report

5.1 S Errington introduced the first iteration of the new Integrated Performance Report (IPR), developed using Power BI, marking a significant shift from static reporting to a dynamic, quality improvement-focused methodology. The report aligned with NHS Borders' organisational strategy, annual delivery plan and national ambitions and replaced the previous scorecard system. The key features of the new IPR included: consistent data presentation across business units; monthly reporting cadence to both the Resources & Performance Committee and the Board; benchmarking against other boards to ensure relevance and comparability; and planned expansion to include underrepresented areas such as Women & Children's Services and Primary & Community Care.

5.2 S Errington emphasised that the report was a work in progress, with future iterations to include: additional performance indicators (listed in the appendix); deeper integration of improvement actions and their impacts; and enhanced transparency and narrative around risks and mitigations.

5.3 O Bennett provided a detailed breakdown of performance across several domains: Unscheduled Care - a new improvement plan was in its delivery phase; delayed discharges had significantly reduced with September showing the lowest figures in two years; length of stay was improving, though 4-hour and 12-hour ED waits remained off trajectory. In terms of Elective Care: waiting lists and 52-week breaches were reducing; orthopaedics and Dermatology are behind trajectory; recovery plans were in place; NHS Borders remained on track to eliminate 52-week waits by March 2026. In terms of Cancer Pathways: prostate pathway improvements had elevated NHS Borders to joint 5th nationally for the 62-day standard; lung cancer pathway was deteriorating; recovery depended on external board support. In terms of Diagnostics: 6-week diagnostic waits were improving and Endoscopy remained a concern.

5.4 G Clinkscale added insights on community service contributions including: £3.5m funding from Scottish Government which was enabling: Expansion of reablement capacity; establishment of a frailty unit (target opening: 1 November); creation of an integrated discharge team; and transition of Hospital at Home into a substantive service. In terms of Mental Health Services: CAMHS performance was improving, meeting 18-week targets; psychological therapies remained static; a service review was underway; learning disabilities therapy waits were being addressed with short-term resources; and there was an aim to elevate internal metrics (eg neurodiversity waits, community mental health follow-ups) to board-level reporting. In terms of the Acute Assessment Unit (AAU): L McCallum highlighted the under-utilisation and the need to divert patients from the Emergency Department (ED); she also suggested the inclusion of AAU metrics in future Integration Performance Reports.

5.5 Discussion focused on: Seasonal vs. structural variations in delayed discharges; Sickness absence aggregation masking workforce fragility; Medical workforce sustainability as a strategic risk; Embedding Quality Improvement (QI) principles into dashboards; National collaboration to improve urgent care performance; 94.5% workforce availability, attributing success to - Line manager training, granular data analysis and targeted support for high-absence areas; potential inconsistencies in cancer charts (31-day vs. 62-day) which were clarified as 62-day measures referral to treatment and 31-day measures diagnosis to treatment.

5.6 Suggestions for improvement included: clarification of chart labelling and definitions; inclusion of AAU metrics in future reports; addressing seasonal variation visibility; a full orthopaedics recovery plan be presented to the next meeting; and a detailed paper on frailty pathway developments also be brought to the next meeting.

The **RESOURCES & PERFORMANCE COMMITTEE** noted the change to Board Performance Reporting as of September 2025.

The **RESOURCES & PERFORMANCE COMMITTEE** confirmed that it had received moderate assurance on systems and processes and limited assurance on outcomes.

6. Efficiency Opportunities identified by external parties

6.1 S Errington presented a comprehensive update on the efficiency opportunities identified through three key external reviews: Deloitte Report (2022); Scottish Government's 15-Box Grid; and Buchan Associates modelling work. The reviews collectively identified 71 opportunities for NHS Borders to improve performance, productivity, and cost-effectiveness.

6.2 She outlined the current status: 31 opportunities were either completed or actively in progress; 28 required further investigation or prioritisation; and 12 were newly identified, primarily from the Buchan Associates work. Rather than creating new structures, NHS Borders had embedded those opportunities into existing programmes, such as: Planned Care; Urgent & Unscheduled Care Programme; and Financial Improvement Programme (FIP).

6.3 J Ayling raised a critical point about the lack of financial impact analysis. He questioned how NHS Borders prioritised opportunities when balancing performance improvement against financial sustainability. He suggested that each initiative should be assessed not only for performance gains but also for potential cost

savings, especially given the current fiscal pressures. A Bone responded, acknowledging that: No formal prioritisation exercise had been conducted to rank opportunities by financial return; the current approach was distributed, with ownership delegated to relevant programme boards; and there was a need to develop a financial strategy that integrated those opportunities into a five-year path to balance, as requested by the Scottish Government. A Bone committed to bringing a structured framework to the Committee to track and assess those opportunities more systematically.

6.4 A Bone proposed that the Delivery Group could serve as the central oversight body for those opportunities. However, he noted that: there was no single mechanism currently tracking all 71 opportunities; efficiency metrics should be either integrated into the Integrated Performance Report (IPR) or presented as a separate dashboard.

6.5 P Moore emphasised the importance of embedding these opportunities into the annual planning cycle. He argued that: treating those reports as isolated documents risked duplication and drift; planning should be activity-based, incorporating cost, productivity, and quality metrics; a rhythmic planning and delivery cycle would improve clarity and reduce mid-year investment requests. P Moore proposed that a paper be brought to the Committee outlining how those opportunities would be integrated into the 2026/27 planning process.

6.6 L O'Leary cautioned against siloed implementation. She stressed that: efficiency actions in planned care could impact unscheduled care, and vice versa; NHS Borders must understand the interdependencies to avoid unintended consequences. This was echoed by the Chair, who noted that the Buchan report's recommendations must be enacted holistically to realise system-wide benefits.

6.7 A Bone proposed a directed savings scheme related to the closure of Borders View: the closure yielded a £1.6m saving, of which only £600k has been booked; he recommended booking the full value against the acute savings programme, given the organisation's savings shortfall. L Jones supported the proposal but requested that it be part of a broader financial transformation narrative, especially considering the unscheduled care investment gap. The Committee agreed in principle, with caveats around monitoring reinvestment needs and ensuring transparency.

The **RESOURCES & PERFORMANCE COMMITTEE** noted progress on exploring and implementing opportunities

The **RESOURCES & PERFORMANCE COMMITTEE** noted identification of any opportunities that should be prioritised for further exploration

The **RESOURCES & PERFORMANCE COMMITTEE** confirmed that it had received limited assurance from the report, recognising the progress made but noting the need for structured oversight and financial prioritisation.

7. Finance Report

7.1 A Bone presented the Month 4 Finance Report, providing a snapshot of NHS Borders' financial position as of the end of July 2025. The report highlighted a year-to-date overspend of £5m, with a projected year-end overspend of £15m if current

trends continued. However, the official forecast had been revised to £11m, reflecting anticipated improvements in savings delivery and cost control. He further emphasised that the primary driver of the overspend was the slippage on savings delivery, rather than unexpected cost pressures. The organisation had delivered £1.5m in recurring savings against a target of £9.1m, leaving a significant gap.

7.2 A Bone further highlighted: Table 1 which showed the breakdown of overspend across directorates, noting Acute services were the largest contributor, with a £2.46m operational overspend, driven by: Medical workforce costs; Nursing pressures; and Drug and instrument costs: Table 7 which highlighted a £568k increase in agency spend, primarily in medical workforce. The trend was concerning and exceeded the assumptions made in the financial plan: Table 8 & 9 which detailed the savings programme - £7.5m in full-year savings plans identified; 50% of savings schemes remain at Gateway 1, indicating early-stage development and high risk.

7.3 A Bone emphasised that whilst the forecast was stable, the lack of recurring savings delivery undermined confidence in long-term sustainability.

7.4 Discussion focused on: concern that the savings trajectory was not aligned with expectations, and that the Gateway 1 status of many schemes reflected a lack of maturity in planning; accelerating the development of savings schemes; improving governance and escalation mechanisms through the Financial Improvement Programme (FIP); the fragility of medical services, particularly in specialties with only two consultants; prediction that agency spend would increase unless structural changes were made to improve service resilience; agency spend trend was upward, especially in medical staffing; a data-driven assessment of service vulnerability was underway, with a report expected in October or November; regional collaboration was being explored to network services and reduce reliance on agency staff; no brokerage would be available from Scottish Government this year; NHS Borders had the highest brokerage debt in Scotland (£50 million); focus was on delivering 3% savings and developing a five-year financial recovery plan; and actually NHS Borders was currently the only board improving its financial forecast through continued pressure on cost reduction and strategic investment.

The **RESOURCES & PERFORMANCE COMMITTEE** noted the contents of the report which included:

YTD Performance	£5.17m overspend
Outturn Forecast at current run rate	£15.51m overspend
Projected Variance against Financial Plan (current run rate)	£2.71m adverse
Actual Savings Delivery (current year effect)	£1.53m (actioned)
Projected gap to FP Forecast	Best Case £11.00m (Forecast Q1) Worst Case £15.29m (trend)

The **RESOURCES & PERFORMANCE COMMITTEE** noted the assumptions made in relation to Scottish Government allocations and other resources.

The **RESOURCES & PERFORMANCE COMMITTEE** confirmed that it had received moderate assurance on systems and processes and limited assurance on outcomes.

8. Quarter One Review

8.1 A Bone presented the Quarter One Financial Review, based on the month 3 position, noting that the month 4 data did not materially alter the conclusions. The review has been submitted to the Scottish Government, and their feedback was included in the paper. The revised forecast for the year-end was an £11m overspend, an improvement from the original £12.8m. It was attributed to: increased slippage in planned investments; lower-than-expected cost pressure growth; and greater reliance on non-recurring savings and flexibility. However, A Bone cautioned that the improvement did not reflect progress in recurring savings delivery, which remained a significant concern.

8.2 A Bone highlighted the key points received from the Scottish Government feedback which included: no brokerage would be available in 2025/26; NHS Borders had the highest brokerage debt in Scotland (£50 million); Boards were expected to deliver 3% recurring savings; NHS Borders must submit a five-year financial recovery plan; and NHS Borders was categorised under "financial sustainability risk" in the new escalation framework, but not under governance or financial controls. He confirmed that a draft of the five-year plan would be shared with the Scottish Government in September, with a full version expected in October.

8.3 Discussion focused on several key elements including: directed savings from Borders View closure of £1.6m credited to the acute savings programme; the need for a strategic narrative around reinvestment, particularly in unscheduled care services; funding fell short of what was needed to fully realise the Buchan report's recommendations; appetite for financial control measures for areas failing to delivery savings; fragility of medical services, particularly in specialties with minimal staffing; medical workforce vulnerability assessment was underway; regional collaboration was being explored to network services and reduce reliance on agency staff;

8.4 J Ayling queried the apparent £1m saving from the LIMS programme. A Bone clarified that: the saving was not from an underspend but from the risk provision made for potential delays; and the successful June go-live meant that provision was no longer needed and could be reallocated to support the digital refresh programme.

The **RESOURCES & PERFORMANCE COMMITTEE** noted the improvement on forecast outturn against financial plan and that there remains a requirement to achieve no greater than £10m deficit in 2025/26.

The **RESOURCES & PERFORMANCE COMMITTEE** noted the level of forecast savings and that this is below the level of savings target set by Scottish Government (3%).

The **RESOURCES & PERFORMANCE COMMITTEE** noted the further actions set out in the Scottish Government letter issued in response to Q1 Review.

The **RESOURCES & PERFORMANCE COMMITTEE** considered its appetite for greater financial control measures including localised/directed pause on recruitment.

The **RESOURCES & PERFORMANCE COMMITTEE** approved direction that residual savings achieved through closure of Borders view ward are mandated against savings targets.

The **RESOURCES & PERFORMANCE COMMITTEE** confirmed that it had received moderate assurance on systems and processes and limited assurance on outcomes.

9. Strategic Risk: Public Involvement

9.1 C Oliver presented a paper addressing the strategic risk associated with public involvement, and highlighted the potential for escalation from medium to high risk due to: the scale of upcoming strategic developments (e.g. clinical and organisational strategies); limited capacity to meet statutory duties under the Planning with People guidance; and the removal of the Public Involvement Officer post due to savings requirements. She further outlined the hazards associated with poor public involvement: reputational damage; delays in service change; legal consequences, including judicial reviews; and Government intervention via Healthcare Improvement Scotland's Community Engagement team.

9.2 She emphasised that while NHS Borders had a governance framework in place (eg the Involving People Framework), the organisation was vulnerable due to: lack of dedicated resource; reliance on ad hoc support; and challenges in engaging seldom-heard voices.

9.3 J Ayling enquired whether engagement with third sector organisations could be considered sufficient for reaching seldom-heard voices, or whether direct engagement was required. He also suggested exploring the use of volunteers to support public involvement. C Oliver commented that NHS Borders had a structured network for engaging with third sector partners (e.g. Borders Care Voice, Carers Centre, Ability Borders Forum) and volunteers were engaged via the Public Involvement Partnership Group, but facilitation of meaningful engagement required specialist skills and training. The newly reappointed Volunteer Coordinator would explore expanding volunteer roles in that space.

9.4 D Parker expressed strong dissatisfaction with the current state of public involvement, and cited: the absence of a dedicated committee or officer; lack of response to public correspondence (e.g. regarding adult changing facilities); and a failure to engage meaningfully with the public. He stated that he would take no assurance from the paper and called for a substantive piece of work to rebuild public engagement structures.

9.5 L O'Leary echoed concerns about reaching marginalised groups, noting that some communities were resistant to engagement from formal agencies. She supported the suggestion to explore creative and community-led approaches.

9.6 L Jones noted that while capacity was limited, NHS Borders had undertaken significant engagement, particularly during the development of the organisational strategy. She requested a mapping exercise to identify: where engagement had been required; where it has occurred; and where gaps remained, as it would assist in determining the appropriate level of assurance.

9.7 P Moore clarified that the paper was framed as a risk response, not a strategic plan. He recommended developing a clear plan for improving engagement and bringing it back to the Committee in a more positive and structured format. C Oliver confirmed that the paper's second recommendation was to review the public involvement resource model and was intended to address that matter.

The **RESOURCES & PERFORMANCE COMMITTEE** noted the strategic risk around public involvement.

The **RESOURCES & PERFORMANCE COMMITTEE** noted a review of the public involvement resource model to explore potential solutions to strengthen the resources available in order to ensure statutory compliance and mitigate reputational and operational risks.

The **RESOURCES & PERFORMANCE COMMITTEE** confirmed that it had received moderate assurance on systems and processes and limited assurance on outcomes with the exclusion of D Parker who took no assurance from the paper.

10. Strategic Risk: Emergency Planning and Resilience

10.1 S Errington presented an update on the strategic risk associated with Emergency Planning and Resilience (EPR), following its initial presentation to the Board in January 2025. The paper outlined significant progress made in strengthening NHS Borders' emergency preparedness, including: establishment of a permanent EPR team within the planning directorate; recruitment of two permanent staff members, with a third (fixed-term Resilience Officer) joining shortly to support high-risk service areas; updates to key policies and plans, including the Major Incident Plan, Hazard-specific plans and a new Evacuation Framework, informed by the live response to the Knoll Hospital decant.

10.2 She further highlighted improved multi-agency coordination, with regular engagement now in place with Scottish Borders Council and regional resilience partners and performance targets had been introduced to ensure timely updates to joint plans.

10.3 S Errington reported that despite progress, several material risks remained including: Business Continuity not fully embedded as pperational pressures continued to impact engagement and EPR was not yet treated as "business as usual" across all services; Budget constraints which meant limited access to specialist tools and training and inadequate funding for plan testing and simulation exercises; Decontamination capability and Digital dependency. Whilst vulnerabilities remained, the organisation was in a stronger position to meet its obligations under the Civil Contingencies Act, supported by a structured programme of work and improved governance via the Operational Planning Group.

10.4 Discussion focused on: the professional competencies of public health in emergency planning and multi-agency coordination.

The **RESOURCES & PERFORMANCE COMMITTEE** noted the strategic risk around emergency planning and resilience.

The **RESOURCES & PERFORMANCE COMMITTEE** confirmed that it had received moderate assurance from the report.

11. Annual Climate Change Report 2024/25

11.1 A Bone presented the Annual Climate Change Report for NHS Borders, a statutory requirement mandated by the Scottish Government. The report covered the period up to March 2025 and was due for submission in November 2025. It followed a prescribed format, which limited flexibility in presentation but ensured consistency across Boards.

11.2 He acknowledged that while the report included examples of positive activity, the overall picture is not encouraging in terms of progress toward net zero targets. The headline figures showed that NHS Borders was not on track to meet its carbon reduction goals. He provided the key data highlights from the report in regard to Carbon emissions and target emissions in 2024/25; the positive developments of solar panel installation; medical gases; fleet transition and pharmacy waste reduction.

11.3 Discussion focused on resource constraints; food waste and community benefit; peer benchmarking; and governance and non executive oversight.

The **RESOURCES & PERFORMANCE COMMITTEE** examined and considered the implications of the matter.

The **RESOURCES & PERFORMANCE COMMITTEE** confirmed that it had received moderate assurance on systems and processes and limited assurance on outcomes.

12. Regional Health Protection Update

12.1 S Bhatti provided a verbal update on the regionalisation of Health Protection services, a statutory function of public health. The update marked a significant milestone in a process that had spanned over a decade, aiming to build resilience and consistency across the East Region (Borders, Fife, Lothian, and Forth Valley). The regional model was designed to provide a 24/7, 365-day health protection service, ensure rapid response to outbreaks, environmental hazards, and pandemics and share expertise and resources across boards.

12.2 S Bhatti confirmed that a daytime service was already operational and functioning well. The out-of-hours service was in advanced planning, with a proposed launch in December 2025. NHS Borders would contribute approximately £220k annually for access to the regional service. The service would cover three consultants and 15 hours of Band 7 nursing time, representing a modest but impactful investment.

12.3 S Bhatti outlined several barriers that had delayed full implementation which included: data sharing issues with inconsistent access to patient data across Boards and concerns about visibility and the governance of shared information; workforce grievances raised by nurses in NHS Lothian regarding scope of practice which was upheld; scope limitations in terms of certain areas that remained outwith the current scope including, tuberculosis (TB) case management and blood-borne viruses (e.g. HIV, Hepatitis C); and governance coordination.

12.4 During discussion several issues were highlighted including: value for money and resilience; enhanced ability to respond to future pandemics; reduced reliance on local capacity during emergencies; provision of a second-tier resilience through regional surge support; final paper was expected to be presented to the Board in December, depending on regional coordination; NHS Borders would retain oversight through monthly monitoring meetings and regular reporting.

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

The **RESOURCES & PERFORMANCE COMMITTEE** agreed that the expectation of a report in December be placed on the action tracker.

The **RESOURCES & PERFORMANCE COMMITTEE** confirmed that it had received moderate assurance from the verbal update.

13. Any Other Business

13.1 **Leadership Conversations:** P Moore provided a brief update on plans to reinvigorate board-level engagement with services and staff. He proposed the reintroduction of leadership walkarounds and structured conversations between board members and service areas; Strengthening the link between non-executive directors and operational teams, including ward-level connections; and incorporating patient stories into committee and board meetings, acknowledging the resource required to gather and present those narratives meaningfully.

13.2 P Moore further confirmed that a paper would be developed and brought to a future Board Development session to outline the proposed framework.

13.3 The Chair welcomed the initiative, noting that it aligned with the Board's commitment to visibility, assurance, and cultural alignment. She acknowledged the challenges in sourcing patient stories but emphasised their value in grounding strategic decisions in lived experience.

13.2 **Friends of the Borders General Hospital – Governance and Cultural Alignment:** The Chair informed the Committee of recent concerns regarding the activities of the Friends of Borders General Hospital (BGH). She noted: some practices and processes within the Friends group did not appear aligned with NHS Borders' current cultural direction and governance standards; an email had been circulated to board members outlining the issue; and a follow-up document was expected but had been delayed, pending discussions with the new Chair of the Friends group.

13.3 The Chair confirmed that: The Friends Chair had requested time to review their organisational structure and activities. In the interim, any requests or offers of support from the Friends or other charities were to be channelled through the NHS Borders Fundraising Team, led by K Wilson. That approach would ensure consistency, transparency, and alignment with NHS Borders' strategic priorities.

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

14. Date and Time of Next Meeting

14.1 The Chair confirmed the next meeting of the Resources & Performance Committee would be held on Thursday, 6 November 2025 at 9.00am via MS Teams

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**4 December 2025**
Title:	**Endowment Fund Board of Trustees Minutes**
Responsible Executive/Non-Executive:	**Andrew Bone, Director of Finance**
Report Author:	**Iris 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 Endowment Fund Board of Trustees with the Board.

2.2 Background

The minutes are presented to the Board as per the Endowment Fund Board of Trustees 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 Endowment Fund Board of Trustees 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.

- Endowment Fund Board of Trustees 6 October 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, Endowment Fund Board of Trustees minutes 12.06.25

Minutes of a Meeting of **Borders NHS Board Endowment Fund Board of Trustees** held on Thursday, 12th June 2025 @ 1 p.m. via Microsoft Teams.

Present:
J Ayling, Trustee
A Bone, Trustee
K Hamilton, Trustee (Chair)
L McCallum, Trustee (Joined at 1.10 p.m.)
P Moore, Trustee (Joined at 1.10 p.m.)
L O'Leary, Trustee
F Sandford, Trustee

In Attendance:
C Barlow, Grant & Fund Engagement Manager
B Everitt, PA to Director of Finance (Minutes)
S Harkness, Senior Finance Manager
S Swan, Deputy Director of Finance (Head of Finance) (Left at 1.10 p.m.)
K Wilson, Fundraising Manager

1. **Introduction, Apologies and Welcome**

Karen Hamilton welcomed those present to the meeting.

Apologies had been received from L Livesey, D Parker and S Horan.

2. **Declaration of Interests**

There were no declarations of interest.

3. **Minutes of Previous Meetings : 5th May 2025**

The minutes were approved as an accurate record.

4. **Matters Arising**

Action Tracker
James Ayling noted that a target of 10% unrestricted/undesignated donations to be achieved by 31st March 2027 had been added as an objective to the Fundraising Workplan. James highlighted that the last meeting had not been quorate when this item was discussed so would require to be approved at today's meeting and queried if the 10% target was adequate. Karen Wilson explained the rationale behind this and confirmed that it would be kept under review and could be revised if necessary.

Trustees approved the Fundraising Workplan and agreed the target of 10% which would be kept under review.

The action tracker was noted.

Capital Projects Update
Andrew Bone provided an update on capital projects where it was noted that all resource within the Estates Department was currently dedicated to dealing with issues rated as high risk across the organisation and any other work outwith this had been paused. It was noted that there were currently around 200 minor work requests outstanding,

included amongst these were the projects which had secured charitable funding. Andrew went on to explain that there is currently not enough resource within Estates to deal with these and consideration could not be given to using external contractors due to the legal obligations involved.

Andrew advised that he had spoken with the Estates team and they were going to look at developing a proposal to try and establish a ring fenced resource which would be protected to deal with minor work projects that did not overlap with the core Estates function.

In addition to this a policy would require to be produced to lay out how the complexities of smaller scale projects could be dealt with, i.e. building warrants, infection control assessments, health and safety risks etc.

Andrew advised that it was his intention, following discussion with relevant parties, to bring a proposal back to Trustees which would include looking at how to resource a dedicated team for smaller scale projects.

Fiona Sandford commented that if it was made a stipulation for all applications to include full economic costings this would ensure that bids coming forward were more realistic.

Karen Wilson welcomed anything which would help provide a solution, however felt that a stage was currently missing from the process, namely review of a project to understand the requirements / cost and if this could be built in, in the shape of a forum which included health and safety and infection control, amongst others, to get a full understanding to allow a proposal to be pulled together, would be extremely helpful.

It was agreed for an update on progress to be provided at the October meeting.

The Board of Trustees noted the update.

5. **Strategy & Fundraising**

5.1 *External Funding Options Report*

Karen Wilson spoke to this item which provided details of two external funding opportunities which were available to the charity, namely the Margaret Carlaw Charitable Trust and the Royal Voluntary Service (RVS).

Karen provided background to the Margaret Carlaw Charitable Trust and advised that there had been an introductory meeting and highlighted the current/future projects which had been discussed, including the one being put forward as a recommendation to support the development of a QI programme with the QI Faculty.

In regard to the RVS it was noted that there were funds available to draw down for projects, providing a proportion of these were retained to refurbish the existing shop area within the BGH foyer, assuming a suitable extension to their lease was agreed. Karen highlighted the recommendation asking Trustees to approve refurbishment of the RVS shop at the BGH and to draw down funds in support of the Admiral Nurse post and potentially a further sum of unrestricted funds.

Fiona Sandford was aware of the Margaret Carlaw Charitable Trust and felt if Trustees wished to take this further it would be worthwhile having a discussion with the Chair of the Trust.

Lynn McCallum referred to the potential refurbishment of the RVS shop and could not see how this would increase revenue as patients/staff/visitors were already limited with the facilities available on the BGH site.

Lynn also advised that the Admiral Nurse proposal had recently been discussed by the GP Sub Committee where concern had been raised around access due to this post being in one location.

Andrew Bone suggest asking the RVS for a proposal on the shop refurbishment and what they felt would be achieved from undertaking this.

The Board of Trustees agreed that further discussion should take place with the Margaret Carlaw Charitable Trust to explore options.

The Board of Trustees agreed that the RVS should be asked to provide a proposal on the BGH shop refurbishment.

5.2 *Update on Role of Fund Managers*

Colleen Barlow spoke to this item which outlined the roles and responsibilities of Fund Managers and the improvements proposed to uphold governance structures. Colleen highlighted that there was currently a severe lack of engagement with Fund Managers.

Colleen went on to take Trustees through the proposals detailed within the paper which would improve governance and stressed that this should not be a change in governance, only a change in practice.

The Board of Trustees noted the update.

6. **<u>Endowment Fund Annual Accounts 2024/25</u>**

7.1 *Draft 2024/25 Report from Trustees and Annual Accounts*

This item was taken first on the agenda

Susan Swan spoke to this item and referred to the draft audit memorandum from Thomson Cooper, the External Auditor, where it noted an unqualified opinion had been received. Susan referred to the table detailing the changes to the previous version seen by Trustees and highlighted the 4 adjustments which had been made. It was noted that the final memorandum was awaited and any further changes would be communicated to Trustees although none were expected.

The Board of Trustees approved the 2024/25 Report from Trustees and Annual Accounts.

The Chair, on behalf of Trustees, thanked Susan for her sterling contribution to the Endowment Fund over a considerable number of years.

7. **Any Other Business**

7.1 *Care Around Dying Enhanced District Nursing Model Funding Application*
Michelle Scott spoke to this item which was a funding request, following the Palliative Care review undertaken the previous year, to introduce a one year model for care around dying through enhanced district nurse staffing and Marie Curie commissioned services. This would strengthen co-ordination between acute and community settings as well as see unnecessary admissions into hospital and allow individuals to have the required care to die at home if that was their wish.

Trustees discussed the application where it was noted that there was no exit strategy. Lynne McCallum indicated her concern regarding inclusion of the Clinical Nurse Specialist role as she felt this post required further consideration and that there was more work to be taken forward with Junior Doctors and Charge Nurses around co-ordination when an individual expresses a wish to die at home. Concern was also shown around the collaboration with Marie Curie and the need to make sure that there is clarity around the roles of each organisation to ensure value for money.

Following discussion it was suggested to remit this application to the Endowment Advisory Group due to the issues being raised and to bring recommendations back to Trustees. This was agreed and due to having had the discussion at today's meeting this could be undertaken virtually if required.

The Board of Trustees requested that the application be considered by the Endowment Advisory Group with recommendations coming forward for approval which could be undertaken virtually if required.

8. **Date and Time of Next Meeting**

Monday, 6th October 2025 @ 10 a.m.

BE
18.06.25

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**4th December 2025**
Title:	**Finance Report – October 2025**
Responsible Executive/Non-Executive:	**Andrew Bone, Director of Finance**
Report Author:	**Samantha Harkness, Senior Finance Manager** **Paul McMenamin, Finance Business Partner** **Maryam 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, 18th November 2025
- BET, 1st December 2025

2.4 Recommendation

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

3 List of appendices

The following appendices are included with this report:

- Appendix 1 – Finance Report for the period to the end October 2025

FINANCE REPORT FOR THE PERIOD TO THE END OF OCTOBER 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 October 2025 and the impact on year-end forecast.

2 Recommendations

2.1 Committee Members are asked to:

2.1.1 **Note** the contents of the report including the following:

YTD Performance	£6.46m overspend
Outturn Forecast at current run rate	£11.07m overspend
Projected Variance against Financial Plan (current run rate)	£1.73m improvement
Actual Savings Delivery (current year effect)	£6.95m (actioned)
Projected gap to Forecast	Best Case £10.00m (Forecast Q2) Worst Case £11.07m (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 October 2025.

Table 1 – Key Financial Indicators

	Financial Plan £m	Month 7 £m
Summary		
Year to Date (forecast/actual)	(7.47)	(6.46)
Core Operational	(6.71)	(2.24)
Board Reserves & Flexibility	8.51	4.96
Savings	(14.60)	(9.19)
Average Monthly Run Rate	(1.07)	(0.92)
Outturn Forecast (pro-rata)	(12.80)	(11.07)
Outturn Target (Scottish Government)	(10.00)	(10.00)
Updated Forecast Q2	-	(10.00)
Savings		
Full Target	(19.66)	(19.66)
In year target	(12.15)	(12.15)
Forecast Delivery	12.15	12.15
Recurring Schemes		
Implemented		3.90
Planned/Mandated Schemes	6.44	3.63
In Development / At Risk	2.68	1.58
Non Recurring Schemes		
Implemented	-	3.05

	Financial Plan	Month 7
Planned/Mandated Schemes	2.19	0.05
In Development / At Risk	-	-
Cost Avoidance Measures		
YTD Achieved		0.20
Forecast at Current Run Rate	0.85	0.34
Slippage at Risk	-	-
Brokerage Memo		
Accumulated Brokerage Mar-25	48.83	48.83

4 Summary Financial Performance

4.1 The board's financial performance as at 31st October 2025 is an overspend of £6.46m. This position is summarised in Table 2, below.

Table 2 – Financial Performance for seven months to end October 2025

	Opening Annual Budget £m	Revised Annual Budget £m	YTD Budget £m	YTD Actual £m	YTD Variance £m	Forecast Outturn as at Q2 £m
Revenue Income	350.15	391.19	227.08	227.37	0.30	0.25
Revenue Expenditure	350.15	391.19	211.35	218.11	(6.76)	(10.25)
Surplus/(Deficit)	-	-	(15.73)	(9.27)	(6.46)	(10.00)

4.2 Operational Performance (year to date)

4.2.1 Overall financial performance at Month 7 is £6.46m overspent. This position is driven by expenditure variance against budget, with a slight over-recovery of income netted against this position.

4.2.2 Excluding savings, the year to date operational overspend is £3.26m. This is driven by operational pressures as described in section 5.2. Offsets to this position (anticipated funds not yet allocated) reduce the net overspend to £2.24m.

4.2.3 Within expenditure budgets there is £9.19m unmet savings year to date, as reported against Business Unit targets.

4.2.4 This includes £6.18m non-delivery (year to date) as projected within the 2025/26 financial plan, representing the level of savings target deferred to year 3 of the plan as set at April 2024. This element is included within the financial plan forecast deficit.

4.2.5 The unplanned element of savings non-delivery is therefore £3.04m[1] (year to date) with a full year effect of £5.21m. This represents savings not yet delivered (£3.05m) against plan, and a further £2.16m of savings not identified against target. This is discussed further in section 6.8 of this report.

[1] £9.19m year to date undelivered, less £6.15m 'planned' non-delivery (year 3 target), equals £3.04m year to date unachieved against in year target.

4.2.6 Offsetting the above pressures is £4.96m (£8.51m full year) in respect of additional non-recurrent measures, comprising Scottish Government support (£5.5m) and release of corporate flexibility to savings (£3m).

4.2.7 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.

4.2.8 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 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.

4.3.2 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 £6.18m after seven months. The year-to-date position of £9.19m unmet savings highlights the extent to which savings are either not identified, or are phased to deliver in later periods.

4.4 As previously advised, there are mitigations in place to offset non-delivery of savings in 2025/26. As at M07 additional non-recurrent savings have been transacted and are included in the amended year end forecast. 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 M07, the recurring savings delivered to date have a current year effect of £3.90m. 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 October 2025.

Table 3 – Income by Category, year to date October 2025/26

	Opening Annual Budget £m	Revised Annual Budget £m	YTD Budget £m	YTD Actual £m	YTD Variance £m	Forecast Outturn as at Q2 £m
Income Analysis						
Revenue Resource Limit	329.25	359.73	209.84	209.84	-	-
Family Health Services	10.24	18.85	10.93	10.93	0.00	-
External Healthcare Purchasers	4.55	4.65	2.67	2.80	0.12	0.06
Other Income	6.11	7.96	3.63	3.80	0.17	0.19
Total Income	**350.15**	**391.19**	**227.08**	**227.37**	**0.30**	**0.25**

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 There is a slight over recovery on External Healthcare Purchasers. This over recovery is likely to continue to year end and is largely driven by revised estimates for Scottish SLA activity, which have been adjusted using a rolling average approach. Emergency care income from Scottish UNPACs and OATS has also increased due to higher-than-expected costs per patient, although activity volumes remain stable. These areas are inherently variable and may fluctuate with seasonal trends.

5.2 Operational performance by business unit

5.2.1 Table 4 describes the financial performance by business unit at October 2025.

Table 4 – Operational performance by business unit, October 2025

	Opening Annual Budget £m	Revised Annual Budget £m	YTD Budget £m	YTD Actual £m	YTD Variance £m	Forecast Outturn as at Q2 £m
Operational Budgets - Business Units						
Acute Services	84.73	97.40	55.77	57.26	(1.50)	(1.58)
Acute Services - Savings Target	(4.08)	(3.54)	(2.08)	-	(2.08)	(3.54)
TOTAL Acute Services	**80.65**	**93.85**	**53.69**	**57.26**	**(3.58)**	**(5.12)**
Set Aside Budgets	34.52	36.06	21.23	24.34	(3.10)	(5.31)
Set Aside Savings	(3.83)	(2.04)	(1.20)	-	(1.20)	(2.49)
TOTAL Set Aside budgets	**30.69**	**34.02**	**20.04**	**24.34**	**(4.30)**	**(7.80)**
IJB Delegated Functions	121.69	166.74	92.88	92.44	0.44	0.26
IJB – Savings	(5.00)	(4.12)	(2.41)	-	(2.41)	(4.06)
TOTAL IJB Delegated	**116.69**	**162.62**	**90.47**	**92.44**	**(1.98)**	**(3.81)**
Corporate Directorates	23.41	26.68	15.39	14.44	0.95	1.70
Corporate Directorates Savings	(1.73)	(1.65)	(0.96)	-	(0.96)	(1.65)
TOTAL Corporate Services	**21.68**	**25.03**	**14.43**	**14.44**	**(0.01)**	**0.05**
Estates & Facilities	24.75	26.20	15.14	14.72	0.42	0.37
Estates & Facilities Savings	(2.10)	(1.97)	(1.15)	-	(1.15)	(1.97)
TOTAL Estates & Facilities	**22.65**	**24.23**	**13.99**	**14.72**	**(0.73)**	**(1.60)**
External Healthcare Providers	36.61	39.07	22.79	23.55	(0.76)	(1.06)
External Healthcare Savings	(2.75)	(2.39)	(1.39)	-	(1.39)	(2.33)
TOTAL External Healthcare	**33.86**	**36.68**	**21.40**	**23.55**	**(2.16)**	**(3.39)**
Board Wide						
Depreciation	5.87	5.87	3.42	3.42	(0.00)	-
Year-end Adjustments	1.28	(11.55)	(12.08)	(12.08)	(0.01)	(0.15)
Planned expenditure yet to be allocated	32.00	12.67	4.27	-	4.27	14.67
Central Unallocated Savings Target	-	(0.05)	(0.03)	-	(0.03)	(0.05)
Central Unallocated NR Savings Achieved	-	3.00	1.75	-	1.75	3.00
Board Flexibility	-	4.83	-	-	-	(6.05)
Total Expenditure	**345.37**	**391.19**	**211.35**	**218.11**	**(6.76)**	**(10.25)**

5.2.2 **Acute[2] Overall**.
The position is £7.87m overspent with £4.60m relating to operational overspend and £3.27m 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. The Acute Board has a savings plan for £1m and are currently working on the feasibility of all savings commitments. The proportion of saving anticipated in 25/26 is a minimum of 3% or £3.1m recurring cash releasing savings. At month 7 there has been retraction of full year recurring saving of £2.32m.

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 fixed surge beds and variable front door escalation beds) which contribute to 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 substantial cost pressures.

5.2.3 **Acute Services (excluding Set Aside)** is reporting a YTD overspend of £3.58m, of which £1.50m relates to operations and £2.08m 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 across many services. There is notable increase in sickness/absence in some ward areas which are being reviewed. 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 also include ongoing clinical demand, staffing constraints, and the use of external reporting support in radiology.

5.2.4 **Set Aside.** The set aside budget is overall, £4.30m overspent, at the end of October 25. This overspend is broken down into £3.10m operational overspend and £1.20m related to savings. The unmet savings reported in the position relate to seven 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.

[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.

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 which will take time for benefits to be realised.

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 £0.440m. Within Mental Health (net **£0.300m underspend** excluding savings), medical agency use (locums) continues to be a pressure (£0.563m at M07), together with an unfunded Physician Associate (£0.420m)and savings of £0.150m in the MH Drugs budget. Nursing and Psychology pay budgets are reporting net underspend of £0.422m and £0.120m respectively), including and partly offset by additional bank / agency costs. Admin is also reporting pay underspends due to ongoing vacancies of £0.115m whilst there are other miscellaneous underspends across the Business Unit of £0.102m, primarily as a result of slippage in the use of MH Outcomes Framework funding.

5.2.7 The largest area of financial pressure across Delegated Functions again relates to Learning Disability **(£1.070m)** attributable to out-of-area placements (£1.130m) at the end of the M07 offset by pay vacancies of £0.060m.

5.2.8 Primary Care Prescribing is reporting an underspend position of **(£0.230)** at M07. A higher than average trend in the volume of items dispensed (7.5% c/f 2023/24) continues, although the average cost per item has been again lower during the second quarter of the financial year, and volumes, whilst variable, remain lower than previously forecast, resulting in the current underspend position following £1.480m of investment earlier in the financial year.

5.2.9 Within Primary and Community Services (excluding Allied Health Professionals) there is a net underspend at M07 of **£0.750m**. Dental Pay savings from vacancies amount to £0.352m supplemented by associated underspends in the Supplies budget of £0.150m. Income however remains lower than budgeted (£0.075m).

5.2.10 Community Hospitals are reporting vacancy underspends of £0.423m again supplemented by associated savings in Supplies of £0.027m.

5.2.11 Community Nursing Pay budgets are again reporting significant underspends resulting from vacancies of £0.181m. These however are significantly offset by Supplies overspends (£0.148m), primarily attributable to Dressings.

5.2.12 Vaccination and Immunisation continues also to report an overspend (£0.258m) mainly driven by Shingles vaccination costs. The 2025/26 allocation from Scottish Government however has not yet been received so this position may change.

5.2.13 Finally, there balance of underspend is attributable in the main to the post of Associate Medical Director which remained vacant from the start of the financial year until the 31 October 2025, at a saving of £0.110m together with other miscellaneous underspends / slippage of £0.060m within PCIP and Winter Planning.

5.2.14 Allied Health Professional Services vacancies amounting to £0.220m continue to be reported.

5.2.15 **Corporate Directorates** are reporting a net under spend of £0.95m 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.

5.2.16 **Estates & Facilities** are reporting an operational underspend of £0.42m. 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.

5.2.17 **External Healthcare Providers** Excluding savings there is an over-spend of £0.76m. Factors driving this overspend position are linked to updated data received from NHS Lothian, which reflects higher costs than initially estimated. Additionally, there has been a notable increase in emergency care costs, particularly neonatal cases, which are low in volume but high in cost.

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 October 2025.

Table 5 – Current year savings achieved as at October 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)	2.24	0.00	2.24	0.57
IJB Directed Services	(2.26)	0.86	0.00	0.86	(1.40)
Prescribing	(1.02)	0.16	0.00	0.16	(0.86)
Corporate Directorates	(1.07)	0.08	0.03	0.10	(0.97)
Estates & Facilities	(0.90)	0.13	0.00	0.13	(0.78)
External Healthcare Providers	(1.68)	0.37	0.03	0.39	(1.29)
Central Unallocated Target	(1.05)	0.00	3.00	3.00	1.95
Total	**(12.16)**	**3.90**	**3.05**	**6.95**	**(5.21)**

6.6.2 Against the 2025/26 target, £6.95m 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 £5.21m, 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 Section 6.8 sets out the value of schemes identified not yet enacted within the financial position. This indicates a forecast savings delivery of £7.53m (recurring) in 2025/26. Achievement of the forecast recurring savings would meet the minimum requirements as set out in the financial plan, and focus should be given to ensure progress of those related schemes.

6.6.5 The level of unmet savings remaining against the three year target (10%) is £15.62m. 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 Agency use is monitored against the projected £0.85m improvement within the Financial Plan as cost avoidance. This target will not be met in 2025/26 with the key driver for this being the continuation of vacancies against specialty medical posts.

6.7.2 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-Oct			Ave Monthly (FYE)		
	2024/25 £k	2025/26 £k	Movement (increase/ -decrease) £k	2024/25 £k	2025/26 £k	Movement (increase/ -decrease) £k
Medical	1,100	2,520	1,420	151	360	209
Nursing	168	290	123	40	41	2
Other	287	182	-105	130	26	-104
	1,555	**2,993**	**1,438**	**321**	**428**	**107**

6.7.3 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 September of this year compared to 2024/25.

6.7.4 This increase in agency within Medical and Nursing over the first six 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.

6.7.5 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 identified by business units for 2025/26, as at end September. 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[3]	31	(3.13)	*3.36*	*3.13*

[3] Figures shown are subject to further adjustment (reduction) where schemes identified in plan are subject to further review.

Commissioning	4	(1.26)	0.56	0.46
Corporate	13	(0.79)	0.33	0.26
Estates	7	(0.30)	0.26	0.26
Facilities	19	(0.38)	0.27	0.26
IJB - MH/LD	14	(0.61)	0.98	0.86
IJB - PACS	13	(1.08)	0.35	0.31
Organisation Wide	1	(0.80)	0.15	0.08
Primary Care Prescribing	38	(0.77)	1.54	1.00
	140	(9.12)	*7.79*	*6.61*

6.8.5 At M07 the forecast delivery has been further amended, and this now represents a delivery of £6.61m in year (£7.79m FYE).

6.8.6 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	2.60	1.64	65
Gateway 2	0.64	0.59	17
Gateway 3	0.50	0.49	14
Gateway 3 - Blue	4.05	3.90	44
Total Schemes	**7.79**	**6.61**	**140**

6.8.7 Approximately 50% of schemes remain at Gateway 1 and this falls below the level of progress expected by this point in the year as 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 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.

7.2 The amended forecast presented within this report indicates that delivery of £10m deficit in year is now achievable and this has been reported to Scottish Government.

7.3 The continued risk to delivery of 3% recurring savings remains a concern and contingency measures to identify non-recurrent savings as offset in 2025/26 are in place. Despite this it is critical that a higher level of recurring savings is achieved during the remainder of 2025/26.

7.4 A draft financial recovery plan has been developed and will be presented to the Board following discussion with executive and operational teams. At this stage it does not present a five-year path to balance, and it is expected that this work will continue to be undertaken in parallel with the development of the Board's financial plan for 2026/27.

7.5 Brokerage accumulated to date is £48.83m[4]. 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.

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.

8.2 In line with the enhanced monitoring arrangements in place with Scottish Government, a separate operational risk is being developed against the in year financial performance risk. Key risks identified which require in year management are as follows:

- Medical workforce / locums
- Prescribing growth
- SG anticipated allocations where funding is conditional on performance outcomes (e.g. planned care, unscheduled care)
- IJB commitments in relation to Social Care, where there are contingent benefits or impacts upon NHS performance
- Non-delivery of savings targets
- Impact of pay negotiations

8.3 These risks are expected to be managed within the tolerances of the year-end forecast and any deviation out-with this position will be highlighted in future reports.

Appendices

- Appendix 1 – Income and Expenditure Analysis as reported to Scottish Government via FPR
- Appendix 2 – Key Expenditure Trends

[4] Amended from £49.33m previously reported following clarification of prior year support by Scottish Government.

Author(s)

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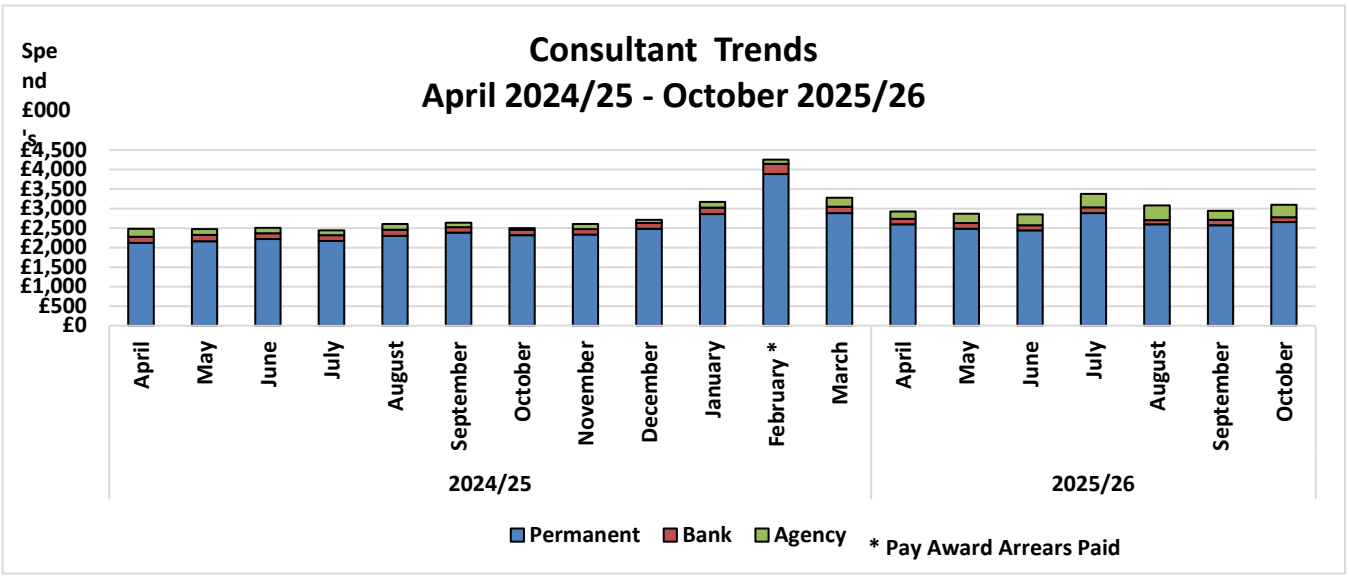
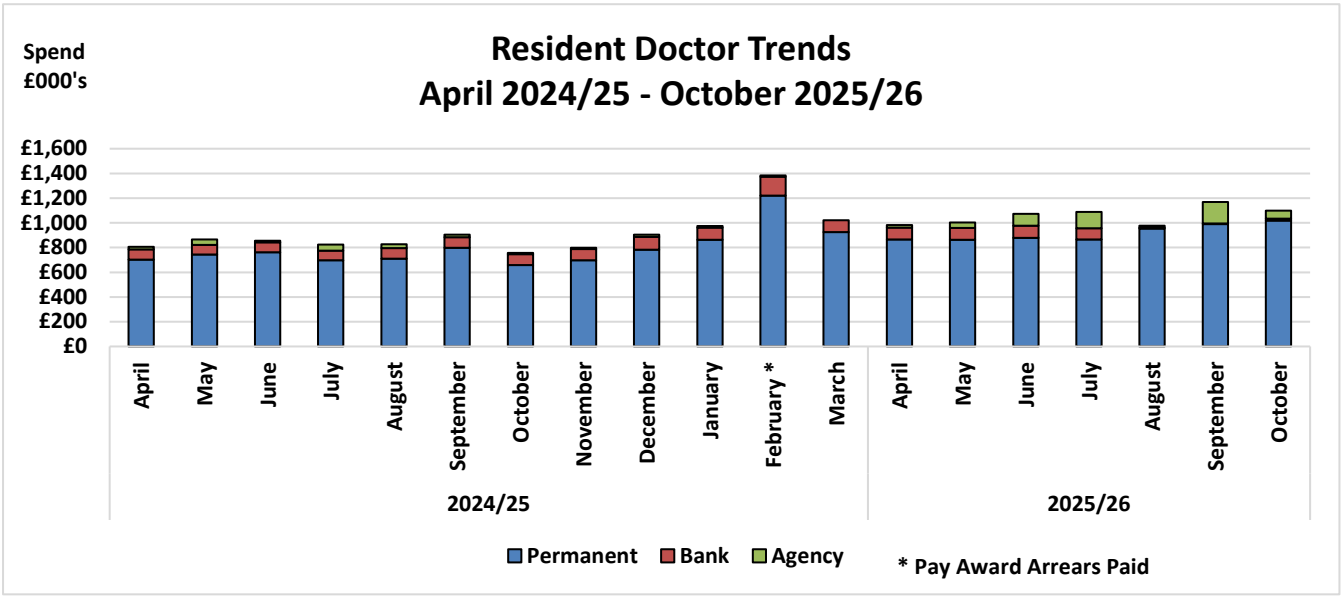
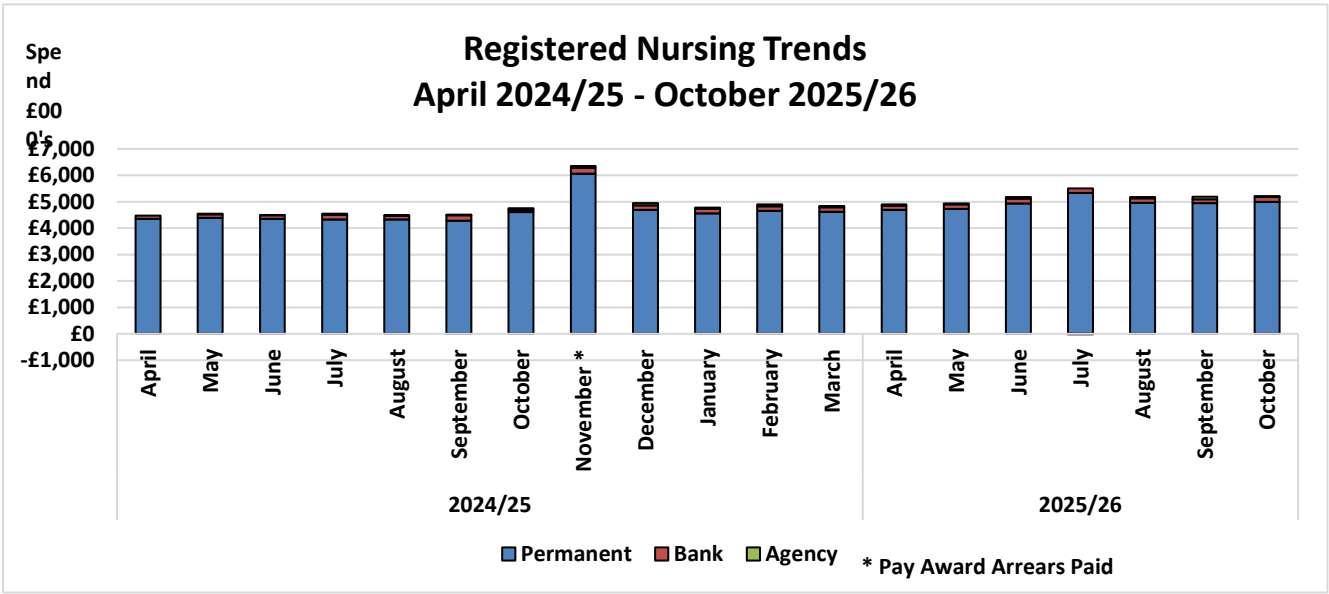
Appendix 1 – Income and Expenditure Analysis as reported to Scottish Government via FPR

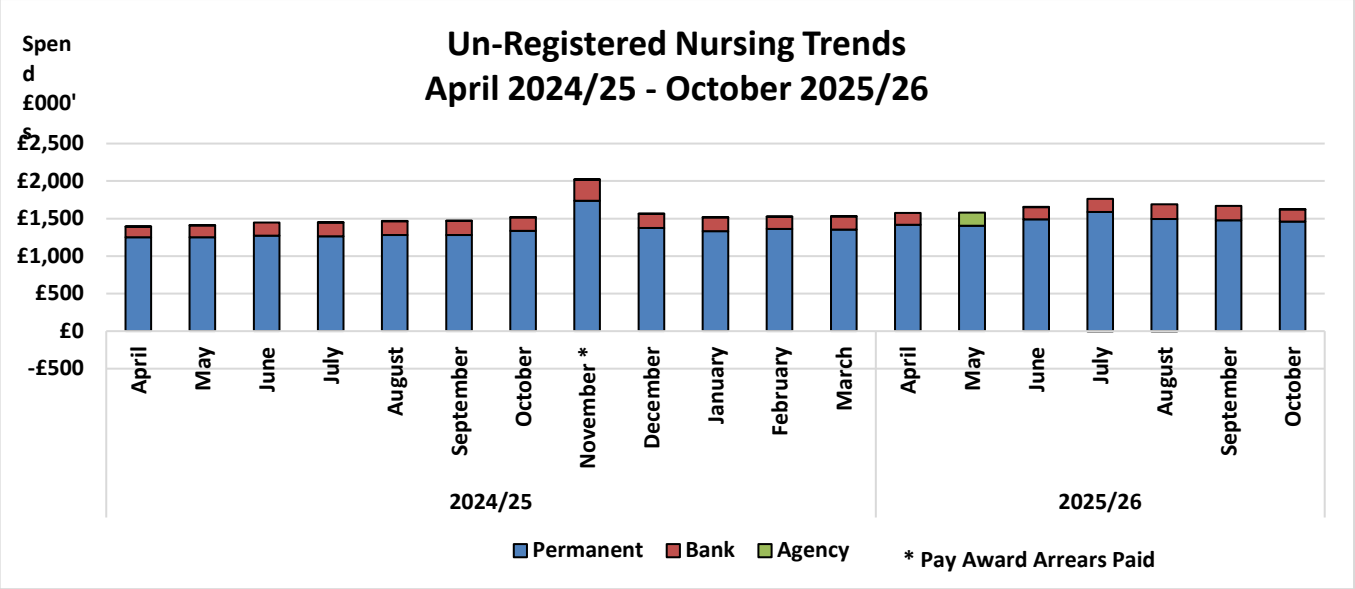
	Opening Annual Budget £m	Revised Annual Budget £m	YTD Budget £m	YTD Actual £m	YTD Variance £m
Pay					
Medical & Dental	42.78	46.09	27.02	27.88	(0.86)
Nursing & Midwifery	72.78	81.79	47.75	47.58	0.17
Other	69.66	82.45	48.14	44.65	3.50
Sub-total	**185.22**	**210.33**	**122.92**	**120.10**	**2.81**
Non Pay					
Independent Primary Care Services					
General Medical Services	22.94	26.10	15.21	15.27	(0.06)
Pharmaceutical Services	4.02	7.09	4.14	4.14	(0.00)
General Dental Services	5.75	9.51	5.47	5.47	0.00
General Ophthalmic Services	1.63	2.25	1.31	1.31	0.00
Sub-total	**34.35**	**44.96**	**26.14**	**26.20**	**(0.06)**
Drugs and medical supplies					
Prescribed drugs Primary Care	25.72	26.81	15.64	16.18	(0.55)
Prescribed drugs Secondary Care	14.10	16.46	9.64	10.63	(0.99)
Medical Supplies	7.31	8.00	4.64	5.98	(1.34)
Sub-total	**47.13**	**51.27**	**29.92**	**32.80**	**(2.87)**
Other health care expenditure					
Goods and services from other NHSScotland bodies	34.27	36.12	21.10	21.97	(0.87)
Goods and services from other providers	5.45	5.95	3.43	4.45	(1.02)
Goods and services from voluntary organisations	0.17	0.17	0.10	0.10	0.00
Resource Transfer	2.81	2.77	1.62	1.62	0.00
Loss on disposal of assets	0.00	0.00	0.00	0.00	0.00
Other operating expenses	44.60	40.76	7.40	12.07	(4.66)
External Auditor - statutory audit fee & other services	0.00	0.00	0.00	0.17	(0.17)
Sub-total	**87.30**	**85.78**	**33.65**	**40.38**	**(6.73)**
Income Analysis					
Income from other NHS Scotland bodies	(6.39)	(8.27)	(4.53)	(4.69)	0.16
Income from NHS non-Scottish bodies	(2.73)	(2.79)	(1.59)	(1.67)	0.08
Income from private patients	(0.06)	(0.06)	(0.04)	0.00	(0.04)
Patient charges for primary care	(11.41)	(18.85)	(10.93)	(10.93)	0.00
Non NHS					
Overseas patients (non-reciprocal)	0.00	0.00	0.00	0.00	0.00
Other	(4.17)	(8.49)	(4.85)	(5.03)	0.18
Total Income	**(24.76)**	**(38.46)**	**(21.93)**	**(22.32)**	**0.39**
Net Total Expenditure	**329.25**	**353.87**	**190.69**	**197.16**	**(6.47)**

Appendix 2 - Key Cost Charts








Un-Registered Nursing Trends
April 2024/25 - October 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
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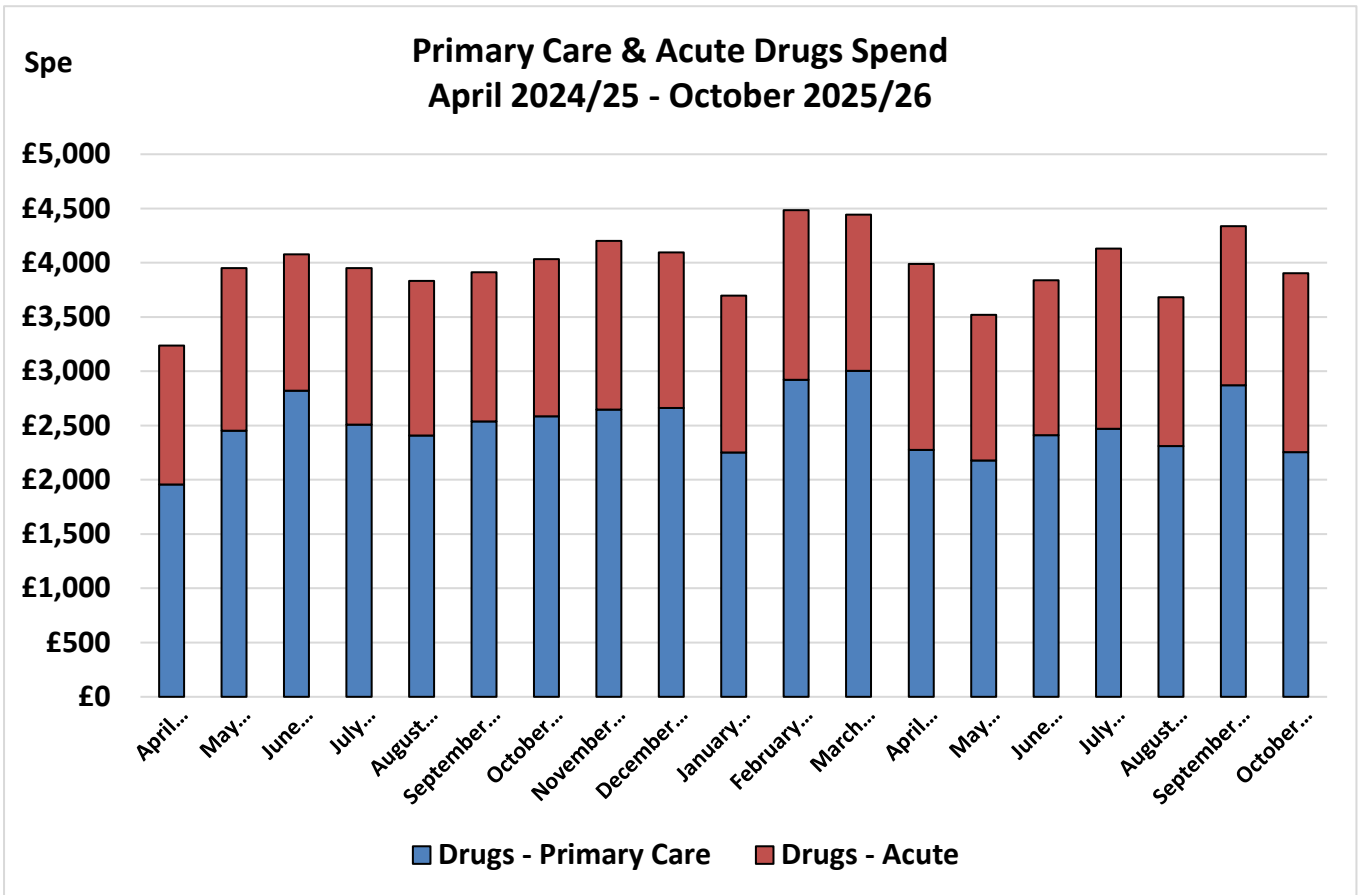
July
August
September
October
2024/25
2025/26
Permanent
Bank
Agency
* Pay Award Arrears Paid


Spe
Primary Care & Acute Drugs Spend
April 2024/25 - October 2025/26
£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...
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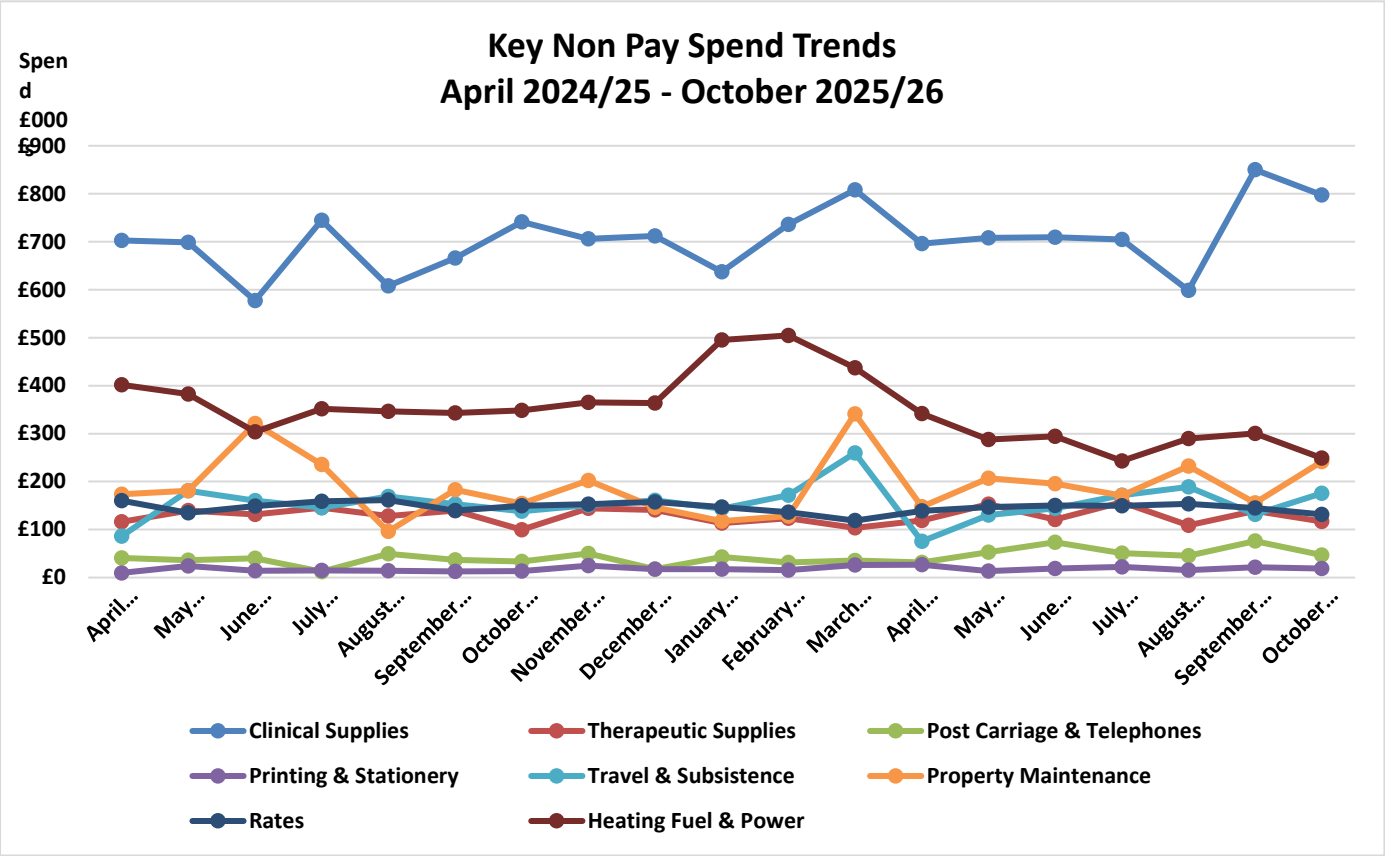
Drugs - Primary Care
Drugs - Acute


Key Non Pay Spend Trends
April 2024/25 - October 2025/26
Spend £000
£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...
September...
October...
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:	**4 December 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 12 November 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 10.09.25

Borders NHS Board
Clinical Governance Committee
Approved Minute

Minute of meeting of the **Borders NHS Board's Clinical Governance Committee** held on **Wednesday 10 September 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)
Laura Jones, Director of Quality & Improvement
Gareth Clinkscale, Director of Urgent Care, Community Services and Mental Health
Oliver Bennett, Interim Director of Acute Services
Lynn McCallum, Medical Director
Sohail Bhatti, Director of Public Health
Malcolm Clubb, Director of Pharmacy
Jonathan Manning, Associate Medical Director, Planned Care
Sarah Horan, Director of Nursing Midwifery and Allied Health Professionals
Philip Grieve, Interim Associate Director of nursing, Acute Services
Paul Williams, Associate Director of Nursing, Allied Health Professionals
Peter Lerpiniere, Associate Director of Nursing, Mental Health, & Learning Disabilities
Kirsteen Guthrie, Associate Director of Midwifery & GM for Women & Children's Services
Julie Campbell, Lead Nurse for Patient Safety and Care Assurance
Sam Whiting, Infection Control Manager
Rose Roberts, PA to Director of Quality & Improvement

1 Apologies and Announcements

Apologies were received from:
Amanda Cotton, Associate Medical Director, Mental Health Services (virtual attendee)
Olive Herlihy, AMD/Director of Medical Education
Caroline Cochrane, Director Psychological Services

Absent
Peter Moore, Chief Executive
Imogen Hayward, Associate Medical Director, Unscheduled Care
Lettie Pringle, Risk Manager

The Chair confirmed the meeting was quorate.

The Chair welcomed:

Jasmine Woolley, Social Worker, Learning Disabilities	(item 5.2)
Dawn Coventry, Assistant Service Manager	(item 5.4)
Gavin McLaren, Head of Estates	(item 6.2)

There were no announcements from the Chair however she commented on the use of AI to assist with writing executive summary for papers members to inform her on how they found the tool to use. The secretariat will email paper authors regarding their experiences.

2 Declarations of Interest

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

2.1.2 The **CLINICAL GOVERNANCE COMMITTEE** noted there were no declarations made.

3 Minute of Previous Meeting

3.1.1 The minute of the previous meeting of the Clinical Governance Committee held on Wednesday 23 July 2025 was approved.

4 Matters Arising/Action Tracker

4.1.1 Matters Arising from the previous meeting were noted and action Tracker was updated accordingly.

5 Effectiveness/Annual Assurance

5.1 Clinical Board update – Mental Health & Psychological Services

5.1.1 Peter Lerpiniere presented the Mental Health update, highlighting progress and ongoing challenges. He noted the CAMHS deep dive will be brought to the Committee with November's update. Sohail Bhatti made a request for demographic breakdowns to be included in the CAMHS deep dive report.

5.1.2 Concerns had been raised in relation to death by suicide, particularly under age 25. Data remains limited due to small sample sizes, but trends are being monitored and any changes will be noted.

5.1.3 Following recommendations from Mental Welfare Commission adult services review, substantial work for the service was undertaken. The review highlighted the need for increased psychology input into inpatient wards, Peter commented this position was changing. Lindean underwent an inspection from the Commission, results will be include in next service report to the Committee, however he did note that they had a positive feedback.

5.1.4 Scottish Government led Mental health Nursing review is underway, this will plan future workforce needs and will be taken to the Borders Professional Nursing & Midwifery Leadership Committee in October.

5.1.5 Lynn McCallum commented on the continuing critical challenges in medical staffing within Mental Health, which is putting significant pressure on incumbent staff, she noted her concerns around sustainability of these services. Discussion followed regarding support amongst and for medical colleagues did not appear to be the same as for nursing colleagues, although with hard work from Caroline Cochrane and her team this position was improving. The team are still relying heavily on locum support. Lynn noted that the Scottish Government is exploring long term solutions for this significant issue which is being seen Nationally.

5.1.6 Lynne Livesey enquired about the environmental risks in mental health, in particular ligature risks associated with electric heaters. Peter assured the Committee this work is

expected to be completed before winter, however it is not a quick fix and will mean quite major work to remedy, Estates appear to have found a solution.

5.1.7 The **CLINICAL GOVERNANCE COMMITTEE** noted contents of the report and confirmed **Limited Assurance** primarily due to medical staffing risks.

5.1.8 Psychological Services
Caroline Cochrane was not present to talk to the paper. Peter Lerpiniere and Lynn McCallum offered to take any questions to Caroline. A brief overview was given by Peter Lerpiniere, noting positive developments in mental health settings, particularly the increased availability of psychology staff to support inpatient teams.

5.1.9 Lynn McCallum highlighted a strong desire from clinical strategy engagement to expand psychological support beyond mental health into areas such as cancer, stroke, and forensic services.

5.1.10 It was noted that stress, depression, and anxiety are major contributors to staff sickness across the organisation, and expanding psychological services could help reduce absence rates.

5.1.11 A governance framework was being developed to clarify roles and responsibilities and differences between psychology as a profession and psychological therapies delivered by other professional groups. Sarah Horan supported the need for clarity to ensure the Committee recognises that psychological support can be delivered by a range of professionals, not just psychologists.

5.1.12 The **CLINICAL GOVERNANCE COMMITTEE** noted contents of the report and confirmed **Moderate Assurance**

5.2 Clinical Board update – Learning Disability Services

5.2.1 Peter Lerpiniere gave committee a brief update on the report and highlighting the coming home project. He also noted that requested updates around finance had not been included as financial decisions had not progressed at time of paper being written.

5.2.2 Appendix 2 of the paper relating to annual health checks saw NHS Borders team being commended nationally for their innovative and imaginative way in which health checks had been approached within a limited financial envelope.

5.2.3 Peter invited Jasmine Woolley to present an update on the service developments and mortality reviews. presented an update on mortality reviews and service developments within Learning Disability (LD) services.

5.2.4 Jasmine noted the team had conducted 11 mortality reviews over three years, with an average age of death at 56.4 years, highlighting early mortality in this population. The work was initiated due to the lack of inpatient beds and low incidence of significant adverse events, which limited learning opportunities. The programme has received national recognition, winning an award at the Learning Disability Nurses Forum. Emerging themes align with the LeDeR programme in England.

5.2.5 Key Points from Presentation were;

- Emphasis on data collection, learning from early deaths, and health action plans.
- Call for a national strategy to support consistent mortality review across Scotland. Scottish Government has shown interest, with discussions underway to potentially commission this work through a university.

- Borders team may support other boards, but additional resources and appropriate leadership are essential.
- Majority of reviewed cases were male; gender imbalance noted but attributed to random sampling.

5.2.6 The **CLINICAL GOVERNANCE COMMITTEE** noted contents of the report and confirmed **Moderate Assurance**

5.3 Clinical Board update- PCS Services

5.3.1 Paul Williams presented the Primary & Community Services (PCS) update, highlighting key risks, developments, and service pressures. He noted ongoing impact from the closure of Knoll Community Hospital and temporary bed closures at Kelso Community Hospital. Although beds have reopened, and delayed discharges are trending downward, winter pressures remain a concern.

5.3.2 Care Home Support Team funding has been reduced, requiring a redesign of service delivery to maintain clinical impact

5.3.3 Podiatry Services staffing gaps due to sickness are affecting urgent foot care clinics, discussions are ongoing about balancing centralised vs peripheral delivery.

5.3.4 Paul commented on the various service improvements

- School Nursing Clinics – Piloted during summer holidays to support care-experienced children, showing positive impact on waiting times and early intervention.
- GLP-1 Weight Management – A multi-disciplinary team is developing a robust service delivery plan following board approval. However, concerns were raised about the limited scale of provision and the need for a broader obesity strategy. Lynn McCallum raised her concerns about this provision but will take her concerns directly to the Board.

5.3.5 Primary Care teams are supporting the new frailty unit and integrated discharge team at BGH, contributing significantly to system-wide flow improvements.

5.3.6 An increase in pressure damage events had been noted, with contributing factors including delayed discharges and hospital-acquired deconditioning. A review is underway via the Tissue Viability Group.

5.3.7 The Committee congratulated Paul on his appointment as Chair of the Area Clinical Forum, with a commitment to strengthen ACF representation at governance and board level.

5.3.8 ACTION: Lynn will raise her concerns regarding GLP-1 provision directly with the Board

5.3.9 The **CLINICAL GOVERNANCE COMMITTEE** noted contents of the report and confirmed **Limited Assurance**

5.4 Clinical Board update - Acute Services

5.4.1 Philip Grieve presented the Acute Services update, highlighting several areas of concern and improvement. He noted the decline in cancer pathway performance with

60-day standards dropping from 95% to below 65%, particularly in prostate and lung due to diagnostic and outpatient delays.

5.4.2 Stroke unit access and Emergency Department overcrowding remain a great concern and are under national scrutiny. Workforce gaps also persist in acute medicine, cardiology, paediatrics, and urology, with reliance on locums due to recruitment challenges. Lynn McCallum raised concerns about the sustainability of services and cost to the organisation due to recruitment difficulties, especially in generalist roles within a District General Hospital model, she would like to see this point raised at Board level. Sarah Horan shared nursing workforce audit findings and a forthcoming five-year workforce plan.

5.4.3 Philip noted that outpatient waiting times are improving, with only two patients waiting over 104 weeks, there had also been an improvement in colonoscopy and gastroenterology where they are showing no routine waits over 52 weeks.

5.4.4 Kirsteen Guthrie flagged high risks in Tier 2 and consultant workforce in paediatrics and obstetrics, worsened by a key resignation and suggested separating Women & Children's Services report from the broader Acute paper for better visibility. The Women & Child Health annual report was due at this meeting but was not available so will be presented at Novembers meeting.

5.4.5 Dawn Coventry was invited to update the Committee ongoing QI work in maternity and paediatrics which included:

- CTG monitoring (antenatal phase focus).
- Maternity early warning scores.
- Theatre checklist redesign.
- Project Leap (staff wellbeing initiative).
- Ward 15 nutrition audits following inspection.

5.4.6 ACTION: Escalate sustainability of services and workforces to the Board.

5.4.7 The **CLINICAL GOVERNANCE COMMITTEE** noted contents of the report and confirmed **Limited Assurance** relating to performance statistics however the agreed a **moderate overall assurance** relating to quality improvement work and monitoring. **for**

5.5 Public Protection Annual Assurance Report

5.5.1 Sarah Horan presented the Public Protection annual report, outlining the scope and current challenges faced by a small Public Protection Team consisting of only 3.2 WTE specialist nurses with increasing pressure due to complex caseloads and upcoming retirements. The cover adult support and protection, child protection, violence against women and girls, and MAPA (multi-agency arrangements for offenders).

5.5.2 The key issues and risks were noted as below:

- Rising risk among frail adults and those with complex needs, exacerbated by delayed discharges and inappropriate care settings.
- Concerns around institutional harm, especially where patients are frequently moved between services.
- Data system fragmentation is a significant risk:
- Multiple systems (Emis, Trak, Sky Store, labs) hinder effective safeguarding.
- Difficulty linking adult and child records, especially in kinship care scenarios.

- Manual cross-referencing is time-consuming and error prone.

5.5.3 Sarah noted the team would most likely benefit from stronger integration with Patient Safety Team in relation to learning from reviews to provide better quality assurance. They would also benefit from improved multi-agency working with SBC and Police Scotland, co-located in Langlee.

5.5.4 Committee members acknowledged the complexity and importance of the work, particularly the risks posed by disconnected systems and the need for national-level solutions. Sarah proposed a development session for exec and non-exec members on Public Protection, noting this had not yet been included in board development planning.

5.5.5 ACTION: Development session for executive and non-executive member be noted in Board Development planning. Sarah will liaise with Iris Bishop, Board Secretary

5.5.6 The **CLINICAL GOVERNANCE COMMITTEE** noted contents of the report and confirmed **Moderate Assurance**

5.6 Research Governance Annual Assurance Report

5.6.1 Laura Jones presented the Research and Innovation update noting the portfolio is steadily recovering to pre-pandemic levels, with active recruitment resuming across studies.

5.6.2 Laura reported that despite maintaining study numbers, the team has faced funding reductions with £50,000 cut from the Chief Scientist Office allocation and £20,000 cut from the regional cancer allocation. These reductions will be addressed in future board-level research strategy discussions.

5.6.3 Laboratory accreditation issues have not impacted current studies, thanks to effective mitigations. However, accreditation will be important for opening new studies.

5.6.4 Innovation activity is growing, with five to six active initiatives under the Anya innovation adopter programme.

5.6.5 Sarah Horan highlighted the need to support involvement of clinical staff in research, particularly nurses and AHPs.

5.6.6 The **CLINICAL GOVERNANCE COMMITTEE** noted contents of the report and confirmed **Significant Assurance**

5.7 Medical Education Annual Report and update on General Surgery Training

5.7.1 Lynn McCallum presented the Medical Education report, highlighting both positive developments and significant challenges. There had been positive undergraduate feedback, particularly in orthopaedics and primary care and a continued collaboration with NES to fill trainee allocations, with support from NES Medical Director.

5.7.2 Lynn noted NHS Borders is now involved in the Scott Comm training programme via University of St Andrews which provides a new apprenticeship-style GP training model.

5.7.3 Challenges remain in relation to finding SPA time to deliver against clinical supervision but work continues in relation to job plans to address this.

5.7.4 Major challenges have been identified following FY1 feedback which triggered quality visit and GMC enhanced measures being placed on the General Surgery Department. An action plan with SMART objectives is in place, and NES/GMC will conduct multiple follow-up visits. The department relies heavily on 11 resident doctor posts; losing training accreditation would jeopardise service delivery and cost the board over £1 million. As a result a zero-tolerance approach to poor behaviours is being implemented, with support extended to the wider MDT.

5.7.5 Assurance was sought regarding compliance with whistleblowing standards for trainees and students. Engagement work led by Michelle O'Reilly and Elaine Dickon is underway, including surveys and review of student feedback. Weekly meetings with FY1 doctors have been established to monitor wellbeing and address concerns in real time.

5.7.6 The **CLINICAL GOVERNANCE COMMITTEE** noted contents of the report and confirmed **Significant Assurance** from the medical education report overall but have noted **limited assurance** for General Surgery department due to current risks and ongoing scrutiny.

6 Patient Safety

6.1 Infection Control Report

6.1.1 Samuel Whiting presented the Infection Control update, highlighting several key areas. Hand Hygiene latest audit (August) showed 71% compliance, up from 66% in May. Quality improvement work is ongoing in Ward 9, DME 14, BSU, MKU with the next audit round scheduled for October–November.

6.1.2 Following a round of spot checks, even locations were rated Amber; four have since improved to Green following re-check and three locations were still pending follow-up.

6.1.3 It was noted there is a new section of the report covering infection control in care homes, following increased accountability from Scottish Government. St Andrew's Care Home recorded a red RAG status prompting intensive support, which included training for 22 staff and full room-by-room review. Issue included cleanliness and environmental damage, support was given to the care home managers to prioritise any improvement activity required.

6.1.4 There was some discussion relating to NHS Borders Catheter policy and the work of the CAUTI group. Ongoing concerns remain around catheter documentation and communication. A task and finish group will be formed to review catheter documentation and patient information, reassess the catheter passport approach and update catheter policy. Philip Grieve noted that broader organisational support is needed to progress catheter-related actions, and commented a timeline for implementation should be developed.

6.1.5 The **CLINICAL GOVERNANCE COMMITTEE** noted contents of the report and confirmed **Moderate Assurance**

6.2 Strategic Risks – Environmental Risk

6.2.1 Gavin McLaren provided an update on the outstanding actions relating to Ventilation and HAI Scribe following internal audit.

6.2.2 Ventilation (Environmental Risk)

- The outstanding action regarding annual verification of critical systems has now been completed.
- This process is now embedded into the maintenance schedule, with verifications commencing the following week.
- The Committee was assured that this process is now sustainable and functioning as intended.

6.2.3 HAI Scribe

- Three actions remain outstanding, primarily relating to ratification of local Standard Operating Procedures (SOPs).
- Draft SOPs have been shared, and meetings scheduled in September and October to finalise and ratify.
- Despite the delay, national guidance is being followed, Estates and Infection Control teams are working closely together.
- Completion is expected by end of October 2025.

6.2.4 Laura Jones acknowledged the significant progress made, particularly given the scale of work and small team sizes. She noted ventilation work spanned approximately three years, and both areas have moved to a much stronger position since the original internal audit reports.

6.2.5 Gavin asked the Committee to formally note the actions on ventilation were now completed.

6.2.6 The **CLINICAL GOVERNANCE COMMITTEE** noted contents of the report and confirmed **Moderate Assurance**

6.3 Duty of Candour Annual Assurance Report

6.3.1 Julie Campbell presented the annual Duty of Candour report, noting that 141 significant adverse events were reviewed during the reporting period, with 36 events meeting the statutory Duty of Candour criteria, where different care could have led to a different outcome.

6.3.2 The report included:

- Evaluation of harm using the review outcome gradients from the acute adverse event management framework.
- Ongoing training and learning from other boards to improve reporting.
- Plans to update the adverse event management policy in line with national frameworks and Duty of Candour guidance.
- A new approach to sharing learning summaries with patients and families for higher-graded reviews.
- Active participation in learning forums.

6.3.3 Laura Jones highlighted improved compliance, especially in falls and pressure area care, reflecting better engagement from clinical teams. While pressure injury compliance still needed improvement, progress had been incremental and positive.

6.3.4 The **CLINICAL GOVERNANCE COMMITTEE** noted contents of the report and confirmed **Significant Assurance**

7 Person Centred

7.1 Claims Update

7.1.1 Laura Jones presented the annual claims report, noting that NHS Borders averages around 13 new claims per year, split between clinical and staff-related claims. No consistent trends were identified across categories over time.

7.1.2 Following a request from the previous year, benchmarking data was obtained via a subject access request. Although limited to two years and anonymised, the data showed NHS Borders is comparable to other small boards and within expected range relative to medium-sized boards. Efforts are ongoing to obtain a 10-year dataset for more meaningful analysis.

7.1.3 A key observation was that 88% of new claims were linked to significant adverse events and complaints, indicating a growing trend across boards where transparency and openness may correlate with increased claims.

7.1.4 The Committee welcomed the report finding the benchmarking exercise reassuring, members agreed it was important to understand claims in the context of vulnerable services and workforce pressures and to monitor the value of claims and impact on cost to services.

7.1.5 The **CLINICAL GOVERNANCE COMMITTEE** noted contents of the report and confirmed **Moderate Assurance**

8 Items for Noting

The **CLINICAL GOVERNANCE COMMITTEE** noted the items listed below:

LD Governance Minutes from meetings dated 26.03.25, 21.05.25 & 24.07.2025
PCS Governance Minutes from meetings dated 22.04.25 & 24.06.25
ASBC Governance Minutes from meetings dated 23.04.25
PPC Minutes from meetings dated 05.03.25 & 15.05.25

9 Any other Business

There was no other competent business recorded.

10 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 12 November 2025** at **10am** via Teams Call.

The meeting concluded at 12:17

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**4 December 2025**
Title:	**Quality & Clinical Governance Report – November 2025**
Responsible Executive/Non Executive	**Laura Jones - Director of Quality and Improvement**
Report Author (s):	**Julie Campbell - Lead Nurse for Patient Safety and Care Assurance** **Susan Hogg - Patient Experience Coordinator** **Justin Wilson - Quality Improvement Facilitator Effectiveness** **Susan 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 12 November 2025 and discussed papers from all four clinical boards and corporate clinical support services.

2.3.2 The CGC considered a paper on acute services. It was noted by the committee that the Acute Services team continues to make progress in addressing key challenges, particularly in planned care and outpatient services. The committee acknowledged the identification and management of an adverse event relating to expired allergen testing kits and were pleased to note that a new standard operating procedure is being implemented, alongside a recall of affected patients to ensure safety and accuracy of results. The committee further recognised the ongoing pressures in cardiology due to consultant recruitment challenges and welcomed the rapid quality improvement initiatives being introduced. The committee requested an update on review waiting lists and diagnostics including endoscopy surveillance for the next meeting and an update on planned timescale for laboratory UKAS (United Kingdom Accreditation Service) accreditation. The committee took **limited assurance** from the report, encouraging continued feedback and support for further improvements.

2.3.3 The CGC considered a paper from mental health services. The committee acknowledged the ongoing efforts within mental health services to maintain high-quality care amidst recruitment and workforce challenges. The committee was updated on the work underway through the care assurance delivery programme to scope out how this will be applied in mental health inpatient areas and community teams. The committee discussed work underway to review anti-ligature measures and to review access systems in Huntlyburn ward as part of the teams focus to ensure patient safety. The committee also recognised the positive developments in workforce planning, including the recruitment of newly qualified practitioners and approval for a nurse consultant post. The committee further acknowledged the award received by East Brig ward for inspirational mental healthcare, reflecting the dedication of staff. The committee took **moderate assurance** from the report, with the committee highlighting the importance of continued vigilance and support for staff wellbeing.

2.3.4 The CGC received a paper on psychological services. It was noted by the committee that the psychological services team continues to deliver a high standard of care, despite ongoing workforce and capacity challenges. The committee acknowledged the small increase in waiting list numbers and the slight fluctuation in performance against the 18-week target, which was attributed to the successful recruitment of new staff who are now addressing the longest waits. The committee were pleased to note the completion of a comprehensive service review, which included benchmarking and

stakeholder engagement, and welcomed the positive feedback received from the Scottish Government mental health directorate regarding the improvement plan and trajectory. The committee further recognised the ongoing commitment to training and supervision, including the rollout of eye movement desensitisation and reprocessing and schema therapy training, and the establishment of robust governance frameworks for psychological therapies delivered by both psychologists and other professionals. The committee were also pleased to note the innovative digital strategy developments and the proactive approach to addressing service gaps, particularly in inpatient mental health, cancer, and stroke psychology. The committee took **moderate assurance** from the report, with the committee encouraging continued focus on reducing waiting times and supporting staff development.

2.3.5 The CGC received a paper from learning disability services. It was escalated to the committee that the learning disability service is under significant pressure due to increasing complexity and the demands of the Coming Home Project. The committee acknowledged the innovative approaches being taken to annual health checks, which have received national commendation, and were pleased to note the proactive engagement strategies being implemented. The committee recognised the value of the mortality review programme, which has not only provided learning opportunities but has also received national recognition. The committee were pleased to note that a staffing increase for the Coming Home Team has been agreed in principle, pending funding confirmation, and that efforts are ongoing to address workforce gaps, particularly in transitions support. The committee took **moderate assurance** from the report.

2.3.6 The CGC received a report on primary and community services. The committee acknowledged the multiple examples of high-quality care across primary and community services, while also recognising the significant risks posed by increasing demand and workforce challenges. It was noted by the committee that innovative developments, such as the modern apprenticeship in podiatry and the real-time staffing dashboard for physiotherapy, are enhancing service delivery and staff engagement. The committee were pleased to note improvements in delayed discharges and the positive impact of multidisciplinary discharge planning. The committee were keen to have a wider data set to provide assurance that non nationally reported delays in community services were not growing as a result of reducing in hospital delays. The committee were briefed on some fragility in the sexual health service, respiratory on-call physiotherapy service and in school nursing services extending reflecting the increase in their workload relating to child protection. The committee acknowledged the mitigations in place and were keen to keep a regular focus on these areas and for an update on child protection workload to be provided at the next meeting. The committee also asked for an update on the paediatric speech and language therapy waits and mitigating actions being taken to reduce the waiting list for the next meeting. The committee took **Limited assurance** from the report, with a request for further data and action on highlighted areas.

2.3.7 The CGC considered the report on health inequalities. The committee recognised the importance of embedding prevention and equity into all aspects of service delivery and were encouraged by the case studies demonstrating positive community impact. The committee were pleased to hear of the planned discussions with the Community Planning Partnership (CCP) to form an integrated plan on health inequalities and were keen to see the outcome of this. It was noted that there has been a significant capacity gap due to the public health service review in progressing this area beyond the existing core local work already in place. The committee were advised that the new structure is now in place which will enable the action plan to progress relating to the initial actions

agreed for the strategy approved by the Board in April 2024. The committee highlighted the need for robust data, clear accountability, and ongoing collaboration with partners to ensure sustained progress on this important agenda. The committee took **limited assurance** from the report, with the committee requesting further detail on delivery against the action plan and the development of measurable outcomes.

2.3.8 The CGC received the cancer services annual assurance report. It was noted by the committee that cancer services continue to experience rising demand and increasing complexity, with a projected 11% increase in annual diagnoses by 2027. The committee acknowledged the successful implementation of the oncology workforce plan, the recruitment of additional clinical staff, and the positive impact of initiatives such as the single point of contact and prehabilitation pathways. The committee were pleased to note the strong performance against the 31-day treatment standard and the ongoing public engagement shaping the new cancer strategy. However, the committee recognised ongoing challenges in waiting times, particularly within the urology and lung pathway, and facility pressures due to delayed redevelopment of macmillan unit. The committee took split assurance levels from the report, taking **significant assurance** for the progress made, with **moderate assurance** for outcomes, and the committee encouraged continued focus on addressing pathway delays and capacity.

2.3.9 The CGC considered a paper relating to maternity and neonatal services including the national MBRRACE (Mothers and Babies: Reducing Risk through Adults and Confidential Enquiries across the UK) report. The committee noting that our maternity workforce remains strong with good local recruitment and retention and acknowledged the significant workload pressure in the obstetrics and gynaecology consultant workforce. The committee heard about the work through the Project LEAP initiative to maintain a positive working culture focusing on psychological safety and staff morale. The team described the local improvement work on Maternal Early Warning Scoring (MEWS), handover processes and the fresh eyes system for cardiotocography. It was noted by the committee that stillbirth and neonatal death rates remain below national averages, and that robust processes are in place for investigating and learning from adverse events. A Maternity Safety Oversight Group is in place to oversee this work and ensure actions are concluded. The committee were pleased to note the successful recruitment to consultant posts and the ongoing focus on staff wellbeing and psychological safety. The committee recognised the alignment with national policy and the development of new maternity standards. The committee took taking **significant assurance** from the systems and processes in place and how they were operating and **moderate assurance** for outcomes relating to the ongoing fragility in medical workforce.

2.3.10 The CGC took a report surrounding Hospital Standardises Mortality Ratio (HSMR). The committee noted that the data remains within normal limits on the NHS Scotland funnel plot. It was noted by the committee that the slightly higher crude mortality rate observed locally is well understood and primarily attributable to the presence of the Margaret Kerr palliative care unit within the acute hospital bed base, a factor previously validated by Public Health Scotland. The committee were pleased to note the ongoing commitment to robust mortality review processes and the plans to further enhance morbidity and mortality processes over the coming year to include a team based quality review methodology. The committee recognised that no areas of concern or escalation were identified in the current reporting period and expressed confidence in the quality assurance provided by the regular review programme. The committee took **significant assurance** from the report.

2.3.11 The CGC considered the patient feedback update and annual report. It was noted by the committee that the Patient Experience Team (PET) continues to manage a substantial and increasing volume of complaints, with 474 complaints received in the reporting year. The committee acknowledged the ongoing pressures on clinical staff availability, which have impacted the timeliness of responses on top of the significant increase in demand for both formal and informal patient experience enquiries. The committee recognised the efforts being made to improve both the quality and speed of complaint handling through face-to-face engagement. The committee were pleased to note the innovative approaches being trialled and the commitment to capturing and reporting on early resolution work, which is of a similar scale to formal complaints. The committee further recognised the challenges posed by limited workforce capacity and recognised there has been an ongoing need for additional fixed term staff to respond to the demand. The committee expressed appreciation for the dedication and professionalism of the PE team and encouraged continued focus on both process improvement and supporting staff wellbeing. The committee took **limited assurance** from the report due to the current response times.

2.3.12 Patient Safety and Care Assurance

2.3.13 Care Assurance

2.3.14 In alignment with the national 'Once for Scotland' Excellence in Care (EiC) approach to care assurance, NHS Borders has approved implementation of the Quality of Care (QoC) review guidance locally, which is grounded in the EiC framework. To support the integration of national guidance, NHS Borders has developed a care assurance and delivery programme. In line with Quality Improvement (QI), implementation of the programme will be embedded in phases across adult inpatient areas and community teams spanning primary and community services and mental health and learning disabilities.

2.3.15 Initial phase of implementation was commissioned within Acute Adult Inpatient areas and Women's and Children's services, primarily across our inpatient Maternity and Labour Wards in September 2024.

2.3.16 As part of the care assurance process full QoC reviews have been commissioned since the guidance launch in September 2024 in three wards in acute services including Ward 14, Ward 7, Ward 4 and the Medical Assessment Unit.

2.3.17 Learning and Improvement plans generated from QoC reviews are shared with key stakeholders, who were involved in the QoC review, the Senior Charge Nurse (SCN) is responsible for ensuring that actions are reviewed and discussed at local governance group meetings and approved by the Associate Director of Nursing for Acute Services. Recent work to co-design implementation plans prior to presenting these to the delivery group in October 2025 provided an opportunity to relaunch expectations on roles and responsibilities of team leaders and overall governance of the programme.

2.3.18 The launch of the acute, women's and children's quarterly forum took place on the 29 October 2025. Team leads across acute services were invited to participate, with a strong emphasis on shared learning from Care Assurance Visits (CAV's) and QoC reviews. The forum aims to provide a structured space for peer-to-peer discussion, enabling teams to share lessons learned, identify areas requiring support, and highlight key insights. Active engagement from all participants was expected to ensure the forum

drove meaningful improvement in care assurance across acute, women's and children's services. These are scheduled quarterly for the year ahead.

2.3.19 The next phase for implementation aims to be commissioned across mental health inpatient areas and community hospitals. Further developmental work is required across primary and community services and mental health and learning disabilities to embed the process within community teams and to consider alternative solutions that provides assurance and governance of care delivery.

2.3.20 NHS Borders care assurance delivery programme also highlights the importance of a local leadership programme, aimed at team leads involved in CAV's, and recognition of celebrating excellence amongst teams. An overarching Leadership collaborative is being designed, with an intention to invite clinical teams to meet with the Director of Nursing, Midwives and Allied Health Professionals annually to share their learning, celebrate success and discuss any challenges in progressing improvements.

2.3.21 Patient Safety

2.3.22 Healthcare Improvement Scotland (HIS) have relaunched the Scottish Patient Safety Programme (SPSP) Adults in Hospital programme in November 2025. NHS Borders have submitted an intention to participate in the full programme. The safety priorities identified for 2025-27 include:

- Deteriorating patient: improving the recognition, response, review and reassessment of deteriorating patients
- Falls: reducing falls and falls with harm
- Pressure ulcers: reducing pressure ulcers through prevention and early intervention
- Medicines in hospital: diabetes medicine management at transitions in care settings: this topic has been decided upon following a focused task and finish group of multidisciplinary membership across NHS Boards.

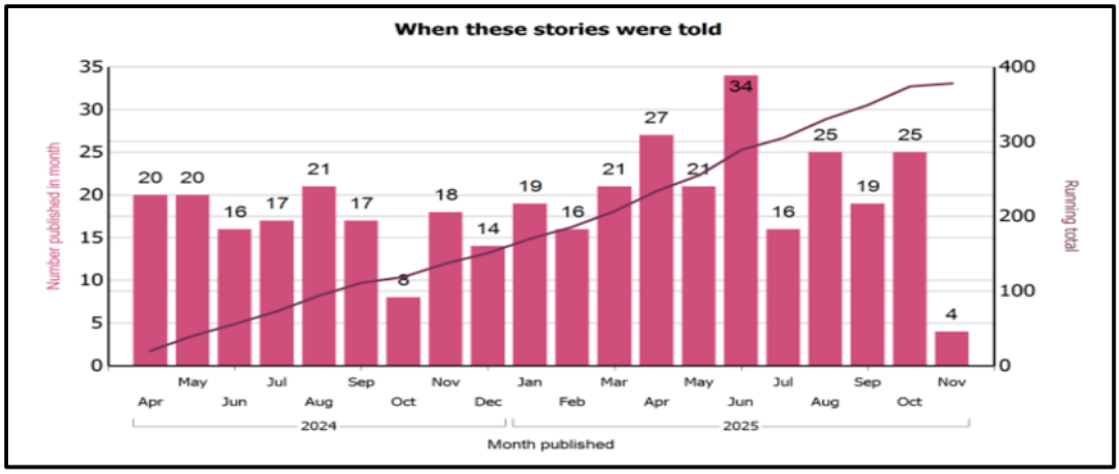
2.3.23 NHS Borders EiC Steering Group continue to meet every six weeks, with strategic leads identified for all safety workstreams. Recent work has been to review workstreams by completing a gap analysis and designing an A3 implementation plan for each workstream. The gap analysis' will be used to review NHS Borders quality ward audit programme across adult inpatient areas and the A3 plans will be used to identify local priorities for 2025/26.

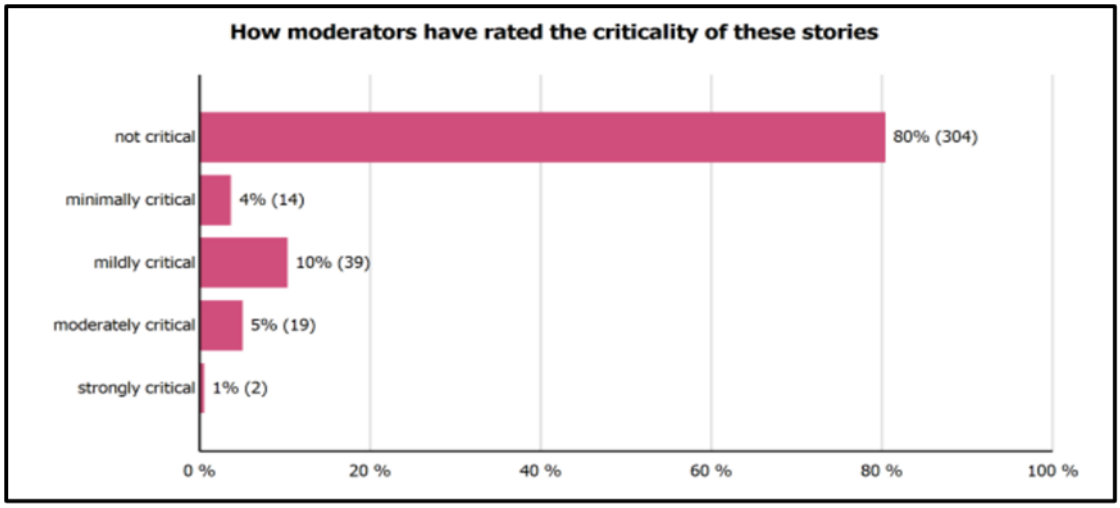
2.3.24 SPSP perinatal and paediatric programme continue to progress locally with an expected refresh to the national priority areas in 2025/26.

2.3.25 Patient Experience

2.3.26 Care Opinion

For the period 1 April 2025 to 7 November 2025 378 new stories were posted about NHS Borders on Care Opinion. Graphs 1 and 2 below show the number of stories told in that period and their criticality. As of 7 November 2025, 378 stories had been viewed 56,696 times:





2.3.27 The three most popular viewed stories are detailed below:

Giving birth - 508 views

Posted by **novembergrace** as a service user 7 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...

The shared joy of music - 429 views

Posted by **Bill1245** as a relative 4 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...

Everyone involved was brilliant - 425 views

Posted by **Allan904** as a parent/guardian about a year and a half 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...

2.3.28 The word cloud displays ‘What Was Good’ as detailed in Care Opinion posts for this period:

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, Amazing, Kindness, Professional, Above & Beyond, Midwives, Level of Care, Nothing Too Much Trouble

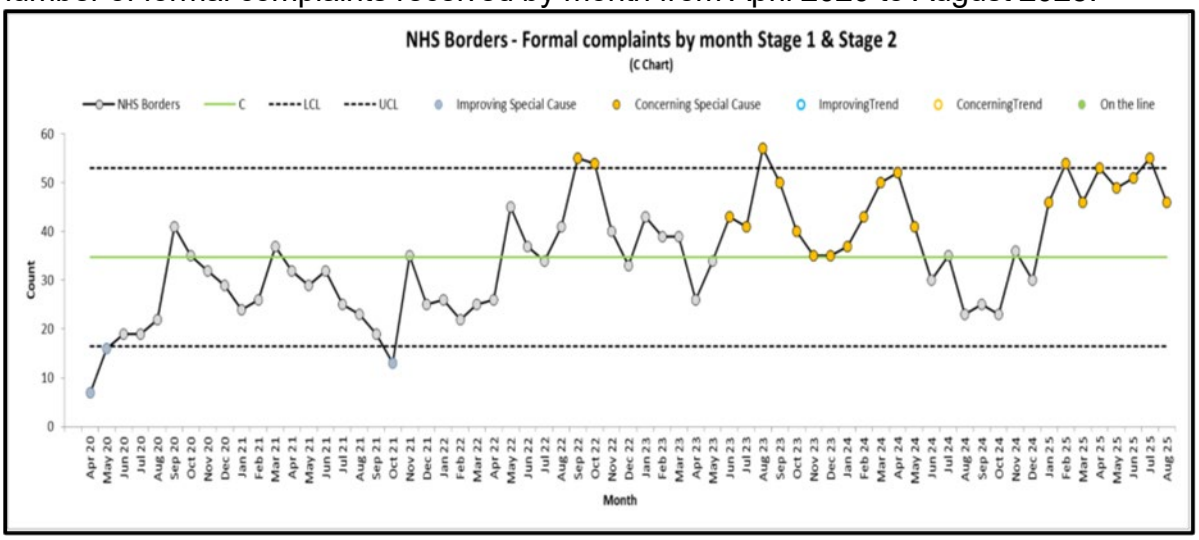
2.3.29 The word cloud displays ‘What Could Be Improved’ as detailed in Care Opinion posts for this period:

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:

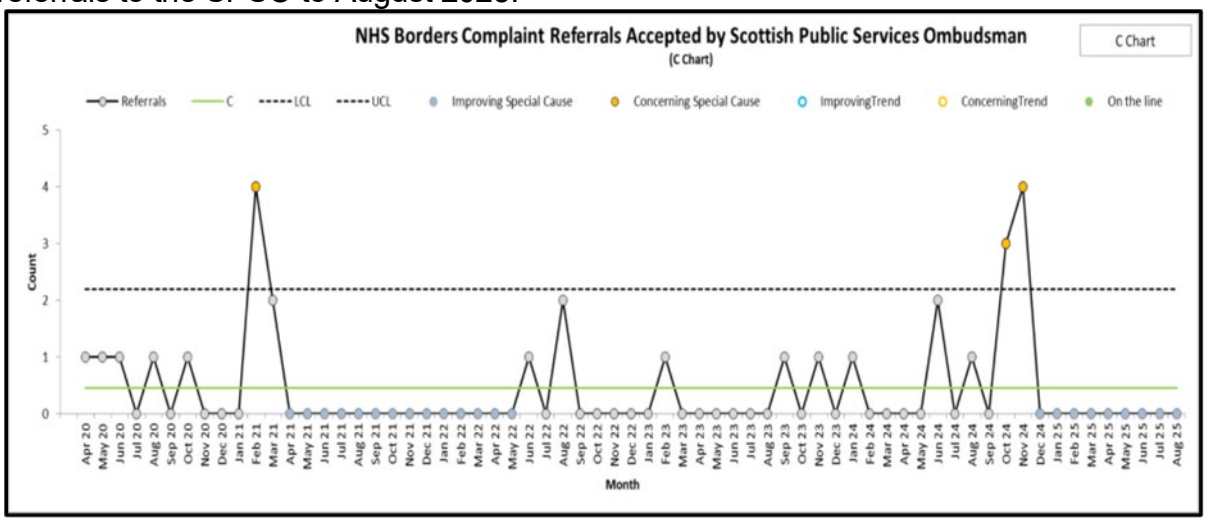
Communication, Discharge Process, Staffing, Information, Waiting Time, More Funding, More Staff

2.3.30 Complaints

The significant increase in demand for patient experience responses either formal or informal has meant that not all responses are delivered within the legislated 20 working day timescale. The average response time is 49 working days. Graph 3 shows the number of formal complaints received by month from April 2020 to August 2025:



2.3.31 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. Graph 4 shows complaint referrals to the SPSO to August 2025:

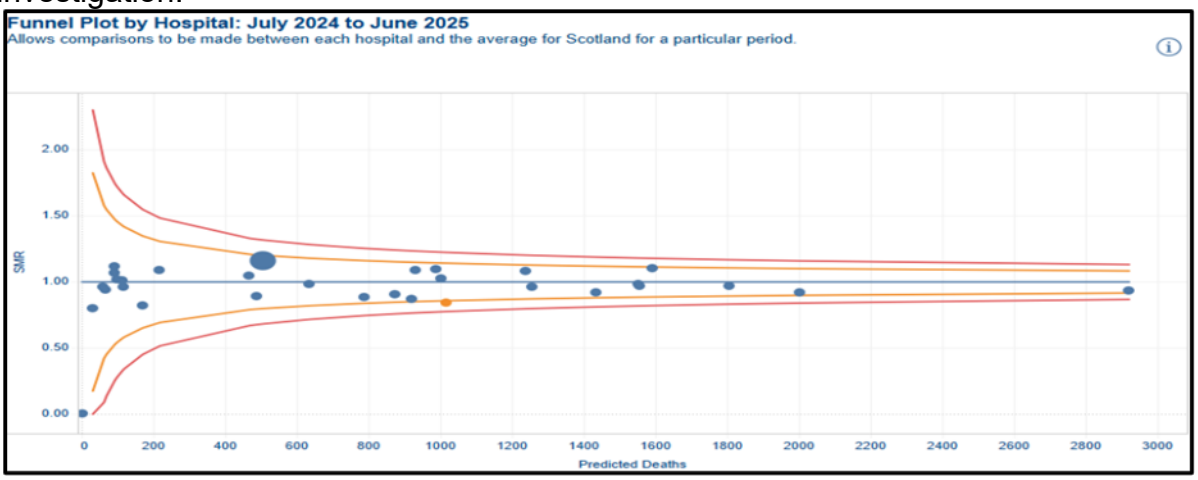


2.3.32 The following decisions and recommendations were received by the SPSO between 1 April 2025 and 31 October 2025 for cases investigated by them in relation to complaints made to NHS Borders:

SPSO Case Reference	Status
SPSO Case Reference 202506887	The Boards response to the complaint was considered reasonable, so no further action. **Case Closed.**
SPSO Case Reference 202501506	The Boards response to the complaint was considered reasonable, so no further action. **Case Closed.**
SPSO Case Reference 202502538	The Boards response to the complaint was considered reasonable, so no further action. **Case Closed.**
SPSO Case Reference 202311156	Review by SPSO ongoing
SPSO Case Reference 202504939	
SPSO Case Reference 202409713	
SPSO Case Reference 202504305	
SPSO Case Reference 202410721	

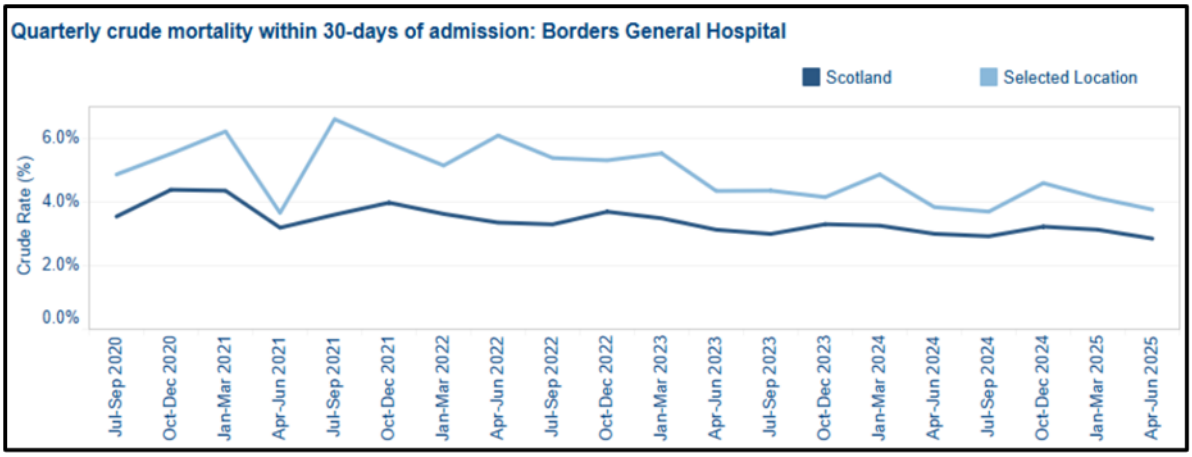
2.3.33 Hospital Mortality

NHS Borders Hospital Standardised Mortality Ratio (HSMR) for the 26th data release under the new methodology is 1.16. This figure covers the period July 2024 to June 2025 and is based on 586 observed deaths divided by 507 predicted deaths. The funnel plot in Figure 8 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:



*Contains deaths in the Margaret Kerr Palliative Care Unit

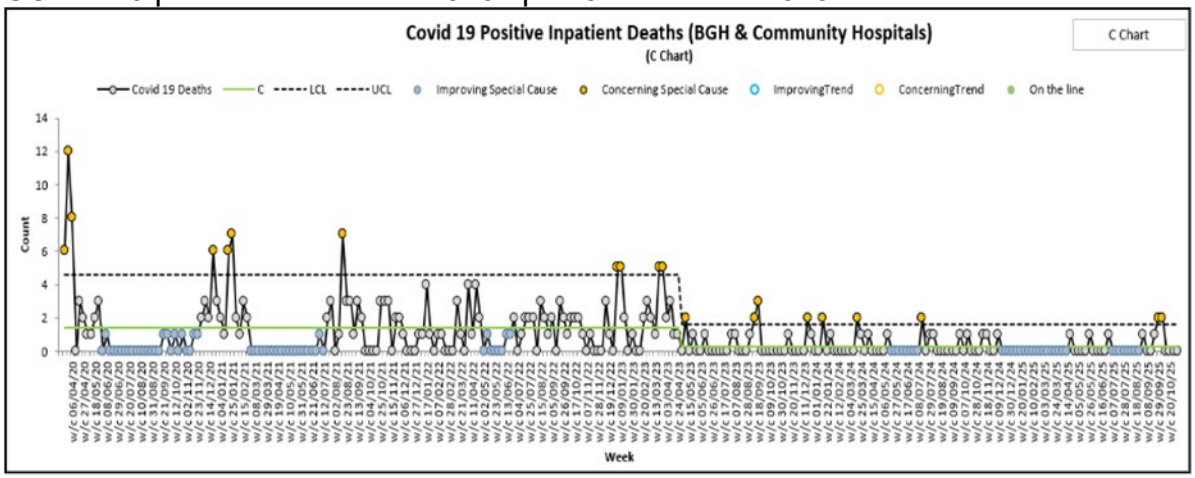
2.3.34 NHS Borders crude mortality rate for quarter April 2025 to June 2025 was **3.8%** and is presented in Figure 9 below:



*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 Borders General Hospital (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 Figure 10 details the COVID 19 deaths which have occurred since the start of the COVID 19 pandemic in March 2020 up to 9 November 2025:



* 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.

2.3.37 COVID Inquiries update

NHS Borders continues to participate in the Scottish Covid-19 Inquiry along with all other Boards in NHS Scotland.

2.3.38 On 22 and 23 September Dr Ashley Croft returned to the Scottish Inquiry to answer questions from core participants following his report and appearance in July 2023. From 24 September to 2 October 2025 the Scottish Inquiry held hearings examining the use of lockdown and other non-pharmaceutical measures, such as social distancing, travel restrictions and self-isolation, as tools available to governments to prevent and control infection in a public health emergency. These hearings were held in a round table format with a range of national and international experts.

Hearings are available on the Scottish Covid-19 Inquiry's YouTube channel: https://www.youtube.com/@covidinquirysco.

2.3.39 The UK Covid-19 Inquiry published its latest Every Story Matters record, documenting the "life-changing" impact of the Covid-19 pandemic on children and young people on 29 September 2015. It features powerful personal accounts drawn from parents, carers and professionals working with and caring for children across the UK, as well as young people aged 18-25, all reflecting on their pandemic experiences. The UK Inquiry's programme for public hearings is as follows:

- Module 8 Children and Young People – 29 September 2025 to 23 October 2025
- Module 9 Economic Response – 24 November 2025 to 18 December 2025
- Module 10 Impact on Society – 16 February 2026 to 5 March 2026

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.

2.3.40 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.

2.3.41 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.

2.3.42 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.

2.3.43 Risk Assessment/Management

Each clinical board is monitoring clinical risk associated with the recovery of elective waiting times and pressure on urgent and unscheduled care services. The NHS Borders risk profile has increased as a result of the extreme pressures across Health and Social Care services.

2.3.44 Equality and Diversity, including health inequalities
An equality impact assessment has not been undertaken for the purposes of this awareness report.

2.3.45 Climate Change
No additional points to note.

2.3.46 Other impacts
No additional points to note.

2.3.47 Communication, involvement, engagement and consultation
This paper is for awareness and assurance purposes and has not followed any consultation or engagement process.

2.3.48 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**

3 Glossary

BGH	Borders General Hospital
CAV	Care Assurance Visits
CCP	Community Planning Partnership
CGC	Clinical Governance Committee
EiC	Excellence in Care
HIS	Healthcare Improvement Scotland
HSMR	Hospital Standardised Mortality Ratio
MBRRACE	Mothers and Babies: Reducing Risk through Adults and Confidential Enquiries across the UK
MEWS	Maternal Early Warning Scoring
PET	Patient Experience Team
QI	Quality Improvement
QoC	Quality of Care
SCN	Senior Charge Nurse
SPSO	Scottish Public Services Ombudsman
SPSP	Scottish Patient Safety Programme
UKAS	United Kingdom Accreditation Service

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**4 December 2025**
Title:	**Infection Prevention and Control**
Responsible Executive/Non-Executive:	**Director of Nursing, Midwifery & AHPs**
Report Author:	**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 Executive Summary

2.0 Outcome Measures. Infection Surveillance

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2.2 CDI – National context
2.3 CDI – Local context
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2.6 ECB – Local context
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2.9 SAB – Local context
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3.3 Audit
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3.6 Mandatory training uptake
3.7 Systems for Controlling the Risk in the Built Environment (SCRIBE)

4.0 Outbreaks and Incidents

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4.3 Outbreaks

5.0 Quality improvement

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5.2 Hand Hygiene

6.0 Horizon scanning

7.0 National Guidance/Learning

7.1 Policy/Guidance updates
7.2 HIS reports

List of appendices

The following appendices are included with this report:

- Appendix A, Background and Explanation
- Appendix B, Graphs and Data Explanation
- Appendix C, Infection Prevention and Control Audit and Spot Check Process RAG

1.0 Executive Summary

This report provides an overview of infection prevention and control performance across NHS Borders, highlighting surveillance outcomes, process measures, incidents, and quality improvement initiatives.

1.2 Key Infection Surveillance Findings

- **Clostridioides difficile (CDI):** NHS Borders rates remain comparable to national levels, with no significant changes in healthcare-associated cases.
- **Escherichia coli bacteraemia (ECB):** Community-associated ECB rates were previously elevated but show signs of improvement.
- **Staphylococcus aureus bacteraemia (SAB):** Community-associated SAB rates were high in 2024 but have since stabilised.
- **Surgical Site Infection (SSI) Surveillance:** Up-to-date data is currently unavailable. Following recent meetings with relevant services, it is anticipated that data will be available for the next report.

1.3 Process Measures

- **Hand Hygiene:** Audits are ongoing; targeted quality improvement support is being provided to specific wards.
- **Cleaning Standards:** All areas achieved over 90% compliance in September, meeting national targets.
- **Audits & Spot Checks:** 10 full audits and 17 spot checks were completed, with most areas achieving ‘green’ status.
- **Care Home Visits:** A RAG-rated audit tool is being used to guide further support and visits.
- **Admission Screening:** MRSA and CPE screening compliance is generally high.
- **Mandatory Training:** Infection Control training compliance is at 87.7%; NES Hand Hygiene training has improved to 35%.

1.4 Outbreaks and Incidents

- One suspected healthcare-associated transmission of *Pseudomonas aeruginosa* was investigated; no further cases were identified.
- Ten closures due to Covid-19 were reported since the last update.

1.5 Quality Improvement

- A Task and Finish Group has been established to improve catheter-associated urinary tract infection (CAUTI) prevention.
- Hand hygiene improvement initiatives include enhanced accessibility, real-time feedback, and targeted education.

2.0 Outcome Measures - Infection Surveillance

2.1 *Clostridioides difficile* infection (CDI) - Key Messages

- NHS Borders CDI rates are not significantly higher than the rest of NHS Scotland (**Figure 1** and **Figure 2**)
- There has not been any statistically significant change in the number of healthcare associated CDI cases since the last report (**Figure 3**)
- NHS Borders is on trajectory to meet the new Scottish Government HAI CDI standard for 2025/26 (**Figure 4**)
- 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, B and C**

2.2 CDI National Context (ARHAI Scotland data)

Figure 1 Funnel plot of healthcare associated CDI rates per 100,000 TOBD for all NHS boards in Scotland in Q2 2025

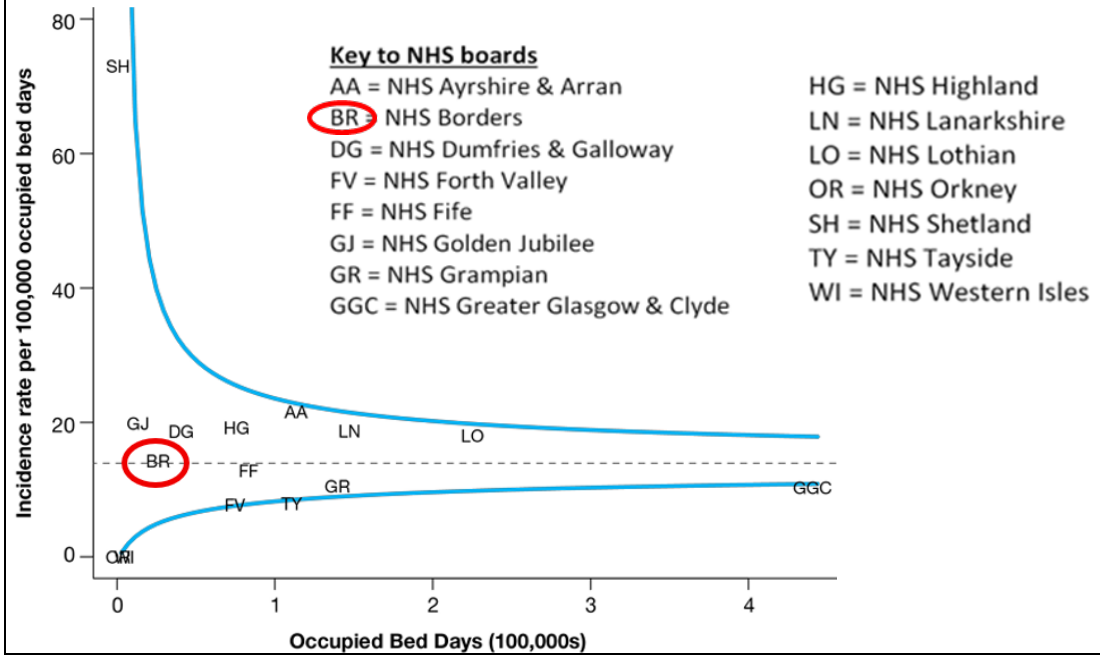
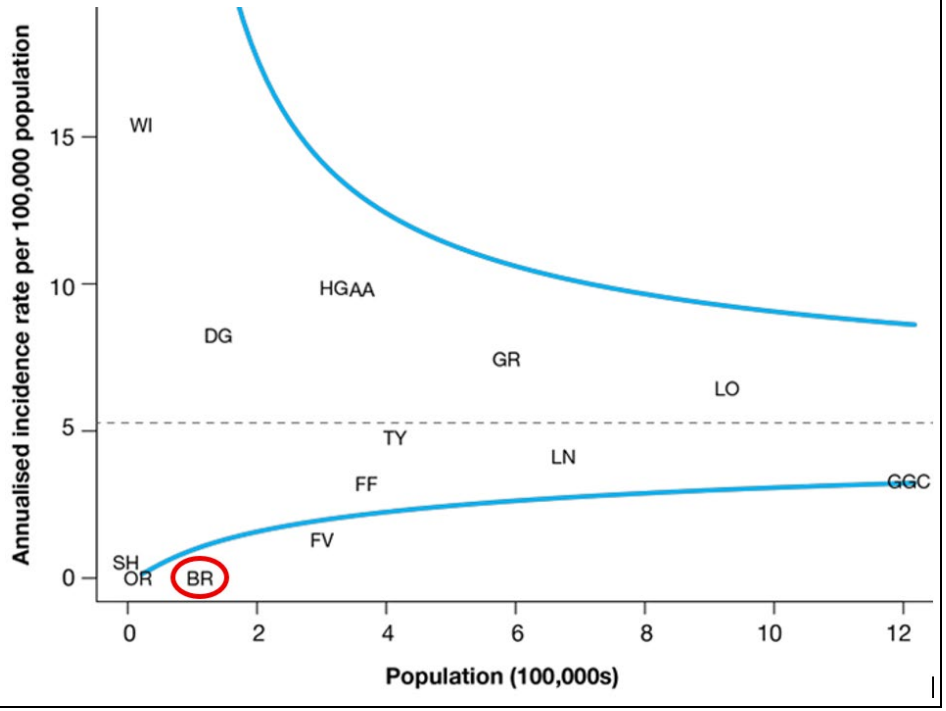


Figure 2 Funnel plot of community associated CDI rates per 100,000 population for all NHS boards in Scotland in Q2 2025



2.3 CDI Local Context

Figure 3

NHS Borders, days between healthcare associated CDI cases (G Chart). May 2023 - September 2025

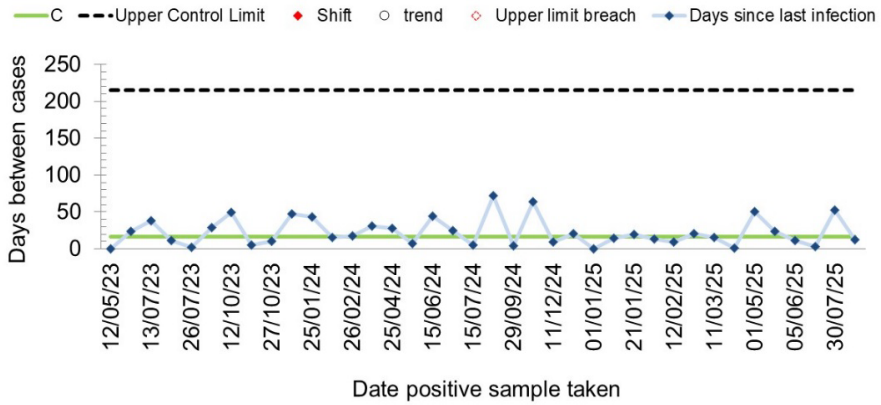
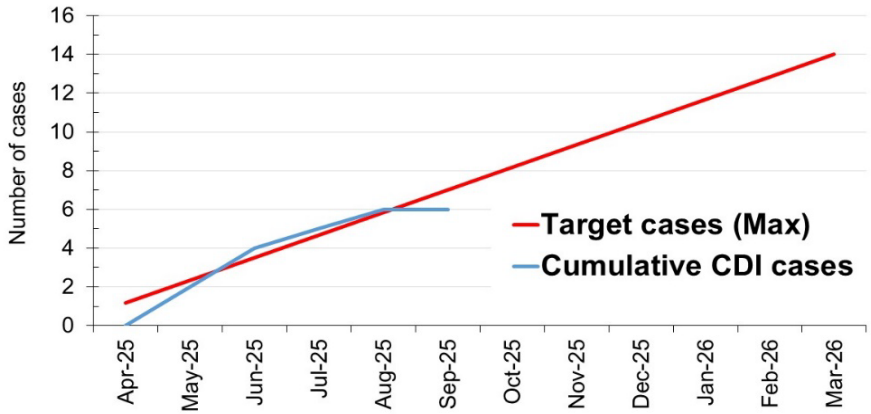


Figure 4

NHS Borders cumulative healthcare associated CDI cases Vs Scottish Government target trajectory (April 2025 - March 2026)



2.4 *Escherichia coli* bacteraemia (ECB) - Key Messages

- ARHAI Scotland reports that NHS Borders had a significantly higher community ECB rate than NHS Scotland in 2024 (**Figure 5)**
- ARHAI Scotland reports that NHS Borders had a significantly higher community ECB rate than NHS Scotland in Quarter 2 2025 (**Figure 7)**
- Early indications are that the high rate has not continued in Quarter 3 2025. The reason for the high rates is not known - community cases had no prior healthcare intervention.
- There has not been any statistically significant change in the number of Healthcare Associated Infection (HAI) ECB cases since the last report (**Figure 8**)
- NHS Borders is not on trajectory to meet the new HAI ECB standard for 2025/26 (**Figure 9**)
- Urinary catheters are the primary cause of HAI ECB infections (**Figure 10**)
- 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)

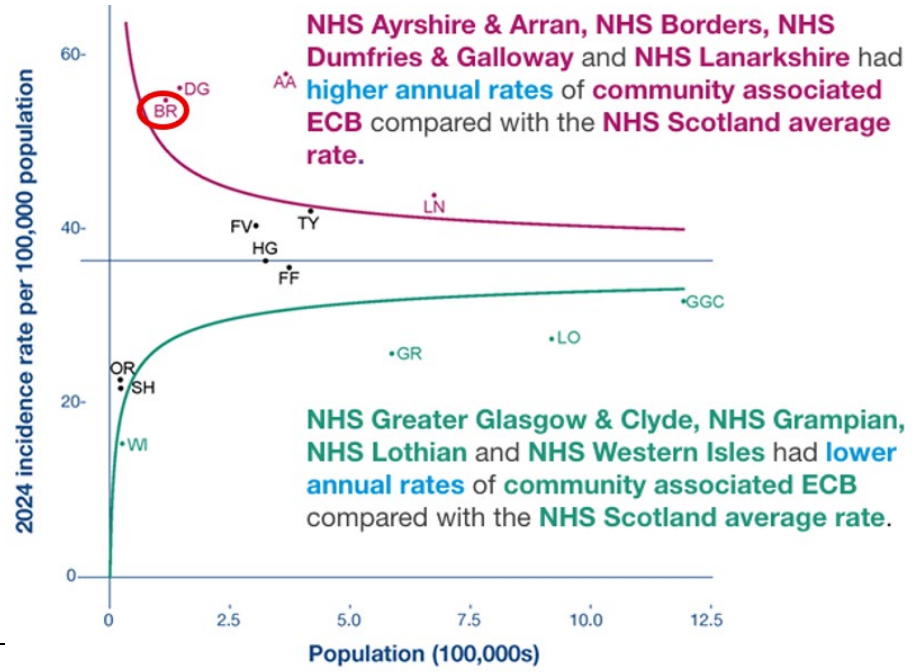


Figure 5 Excerpt from ARHAI Scotland 2024 annual report: Funnel plot of community associated ECB rates per 100,000 population for all NHS boards in Scotland in 2024

Figure 6 Funnel plot of healthcare associated ECB incidence rates per 100,000 TOBD for all NHS boards in Scotland in Q2 2025

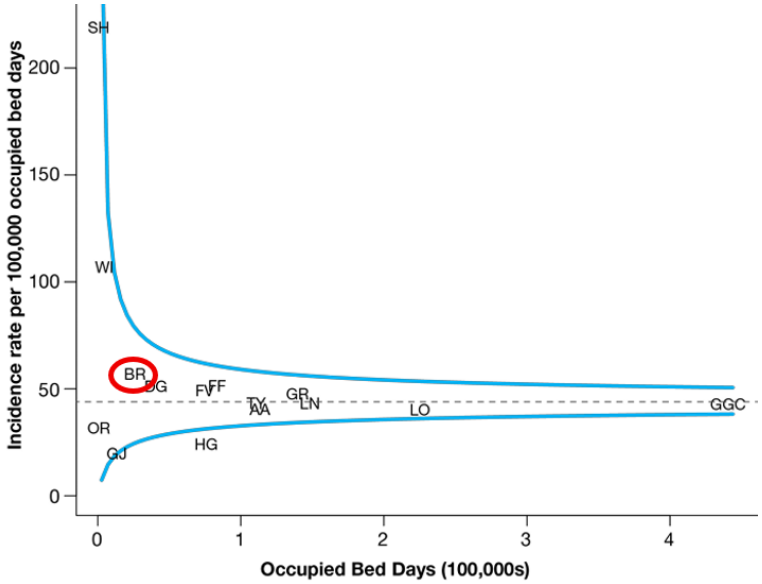
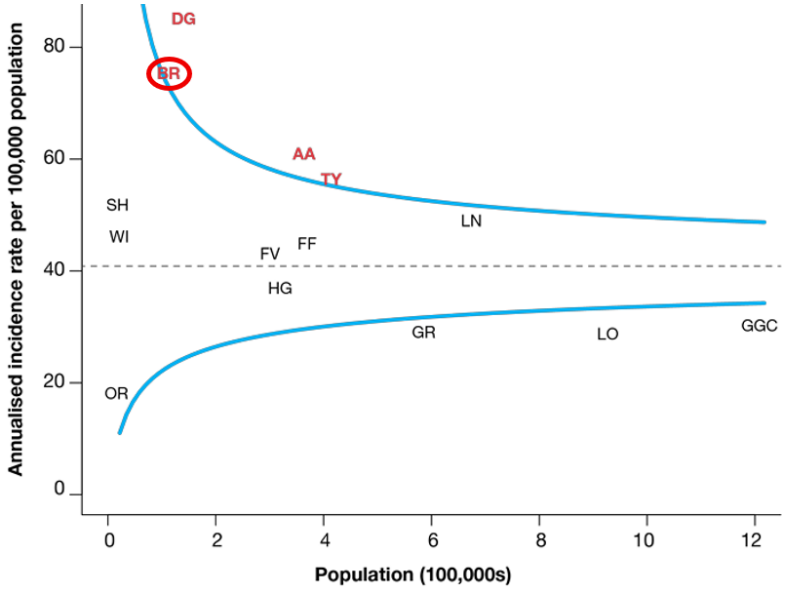


Figure 7 Funnel plot of community associated ECB rates per 100,000 population for all NHS boards in Scotland in Q2 2025



2.6 ECB Local Context

Figure 8

NHS Borders healthcare associated ECB cases per month (C Chart). March 2022 - September 2025

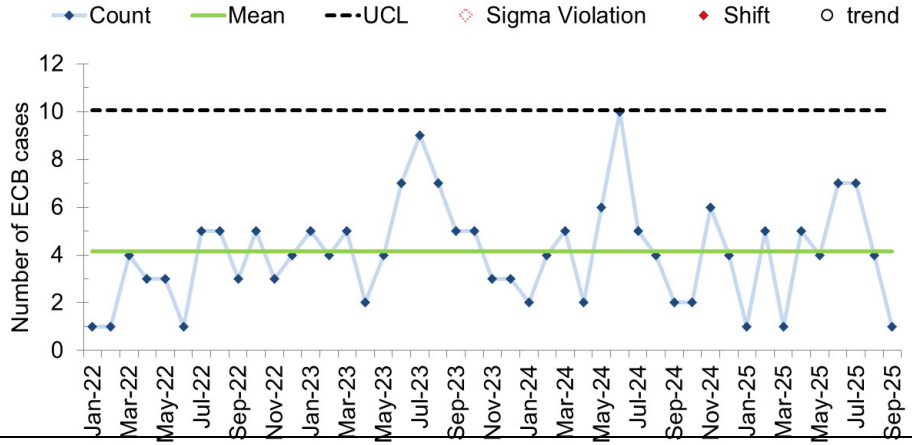


Figure 9

NHS Borders cumulative healthcare associated ECB cases Vs Scottish Government target trajectory (April 2025 - March 2026)

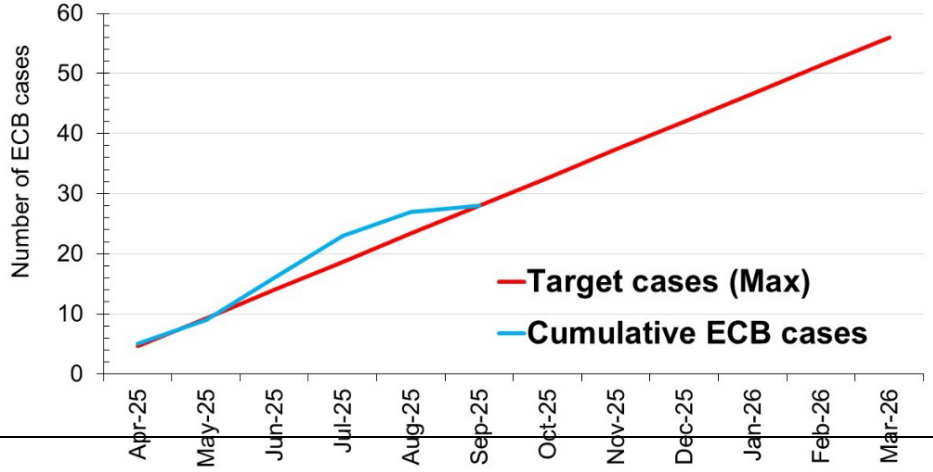
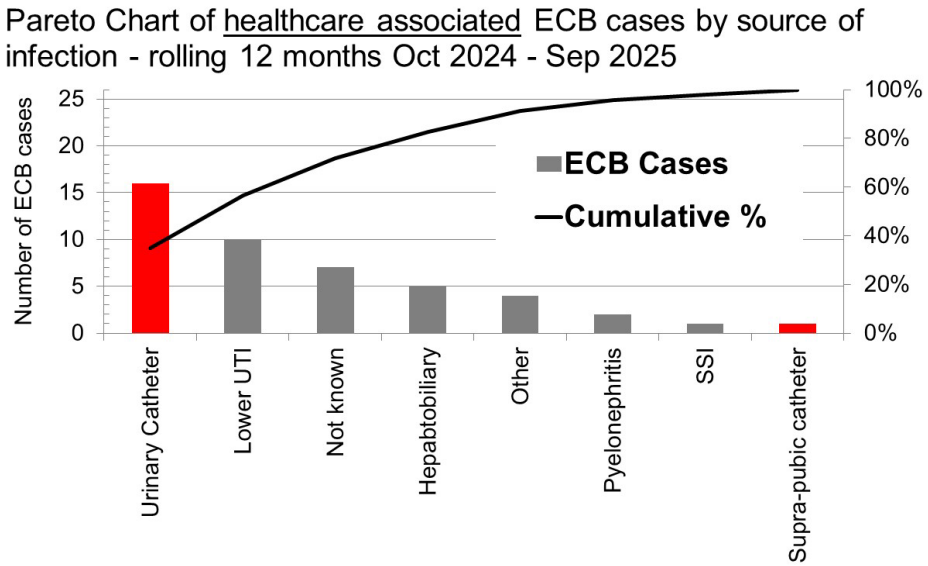


Figure 10


Pareto Chart of healthcare associated ECB cases by source of infection - rolling 12 months Oct 2024 - Sep 2025
Number of ECB cases
25
20
15
10
5
0
100%
80%
60%
40%
20%
0%
ECB Cases
Cumulative %
Urinary Catheter
Lower UTI
Not known
Hepabtobiliary
Other
Pyelonephritis
SSI
Supra-pubic catheter

2.7 *Staphylococcus aureus* Bacteraemia (SAB) - Key Messages

- ARHAI Scotland reports that NHS Borders had a significantly higher community SAB rate than NHS Scotland in 2024 (**Figure 11)**
- The reason for the high rate is not known - community cases had no prior healthcare intervention
- NHS Borders SAB rates were not significantly higher than the rest of NHS Scotland in Quarter 2 2025 (**Figure 12** and **Figure 13**)
- There has not been any statistically significant change in the number of Healthcare Associated Infection (HAI) SAB cases since the last report (**Figure 14**)
- NHS Borders is not on target to achieve the new HAI SAB standard in 2025/26 (**Figure 15**)
- The main known recent causes of healthcare associated SAB cases were urinary catheters and diabetic foot ulcers (**Figure 16**)
- 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 3.4**)
- Background information and explanation is provided in **Appendix A and B**

2.8 SAB National Context (ARHAI Scotland data)

Figure 11 Excerpt from ARHAI Scotland 2024 annual report: Funnel plot of community associated SAB rates per 100,000 population for all NHS boards in Scotland in 2024

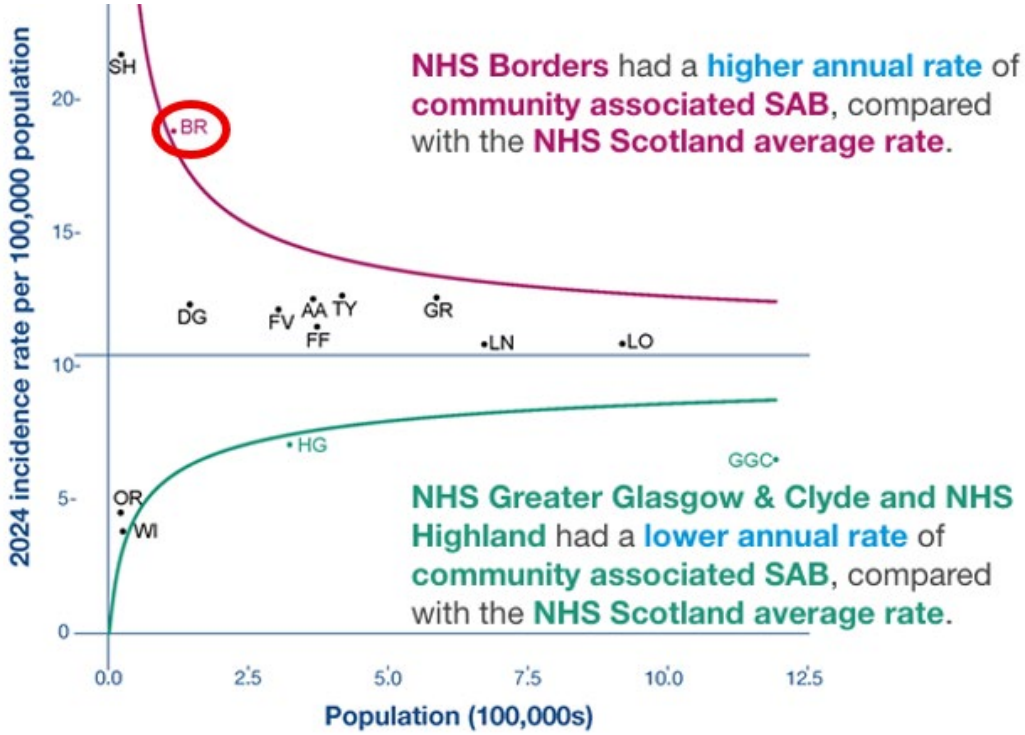


Figure 12 Funnel plot of healthcare associated SAB rates per 100,000 TOBD for all NHS boards in Scotland in Q2 2025

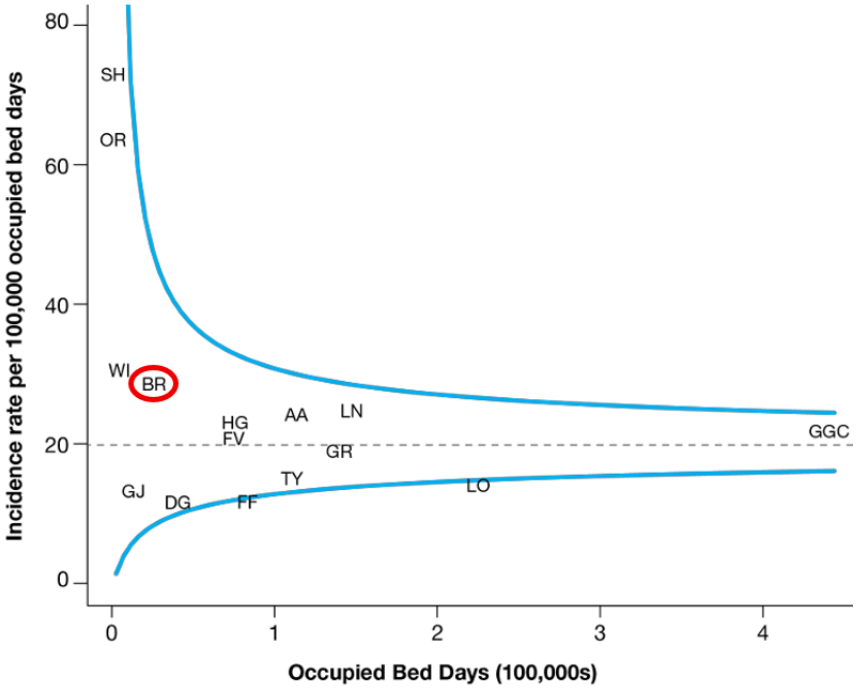
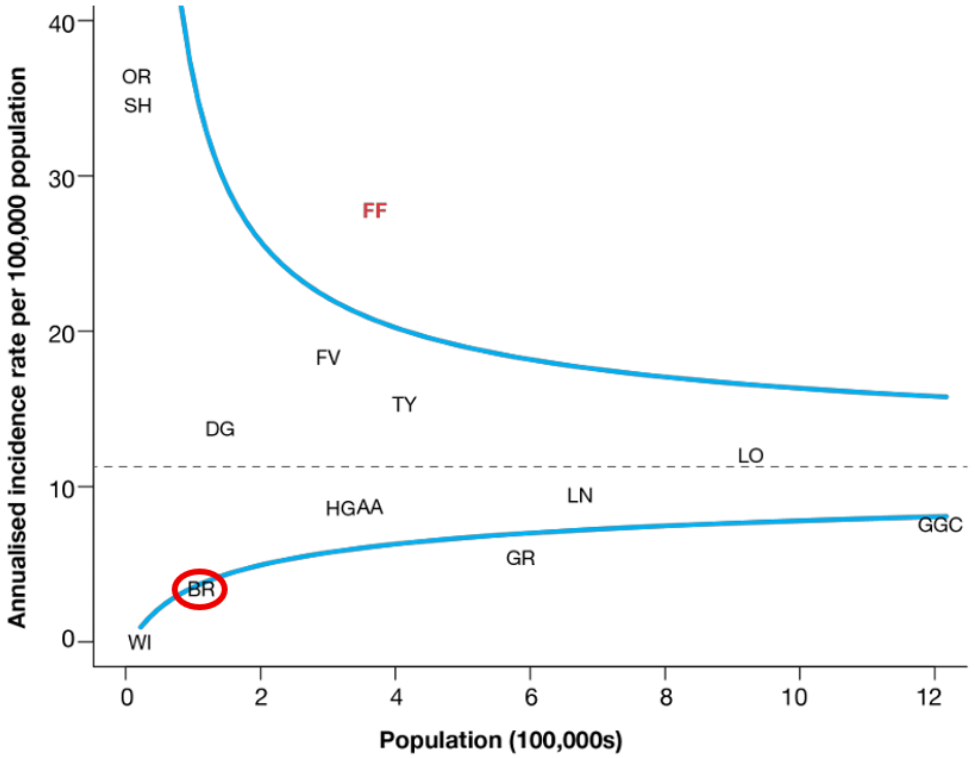


Figure 13 Funnel plot of community associated SAB rates per 100,000 population for all NHS boards in Scotland in Q2 2025



2.9 SAB Local Context

Figure 14

NHS Borders, days between healthcare associated SAB cases (G Chart). January 2023 - September 2025

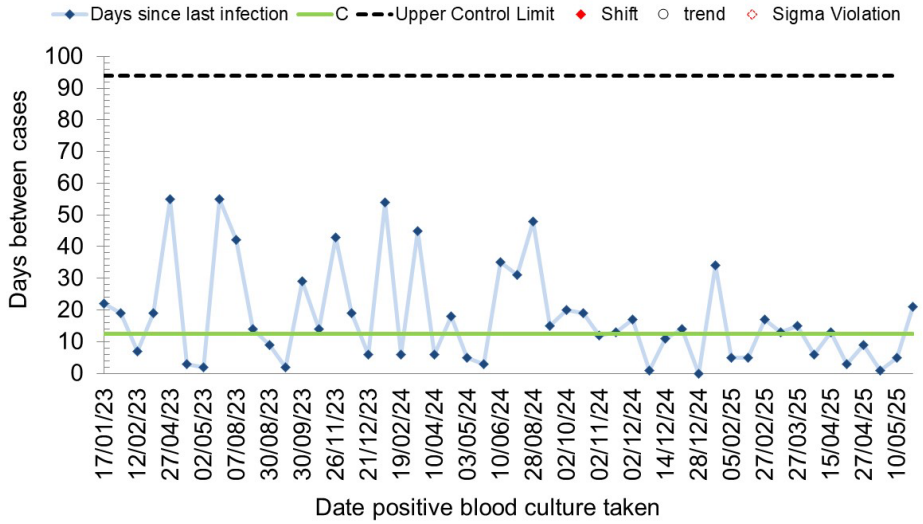


Figure 15

NHS Borders cumulative healthcare associated SAB cases Vs Scottish Government target trajectory (April 2025 - March 2026)

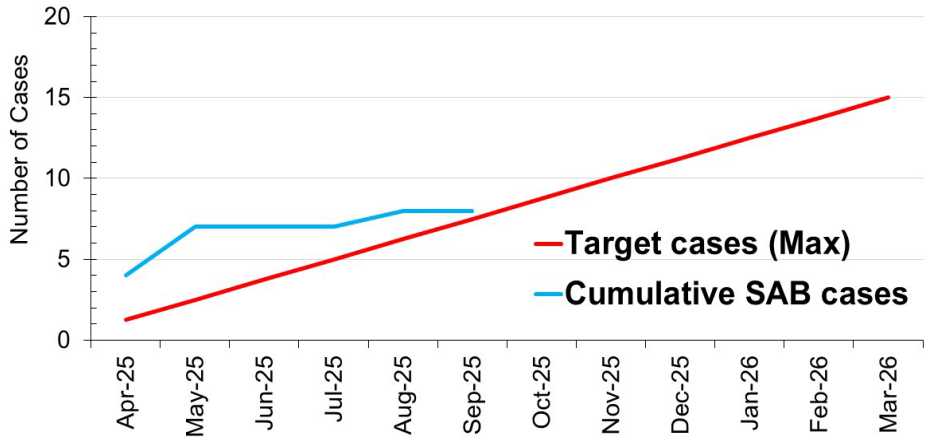
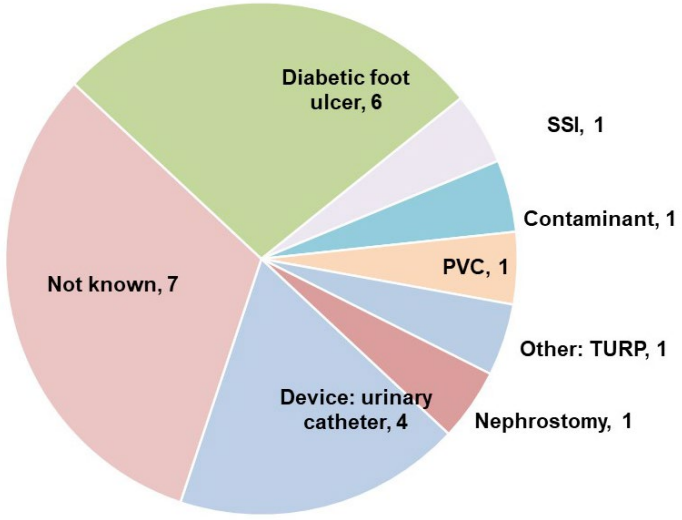


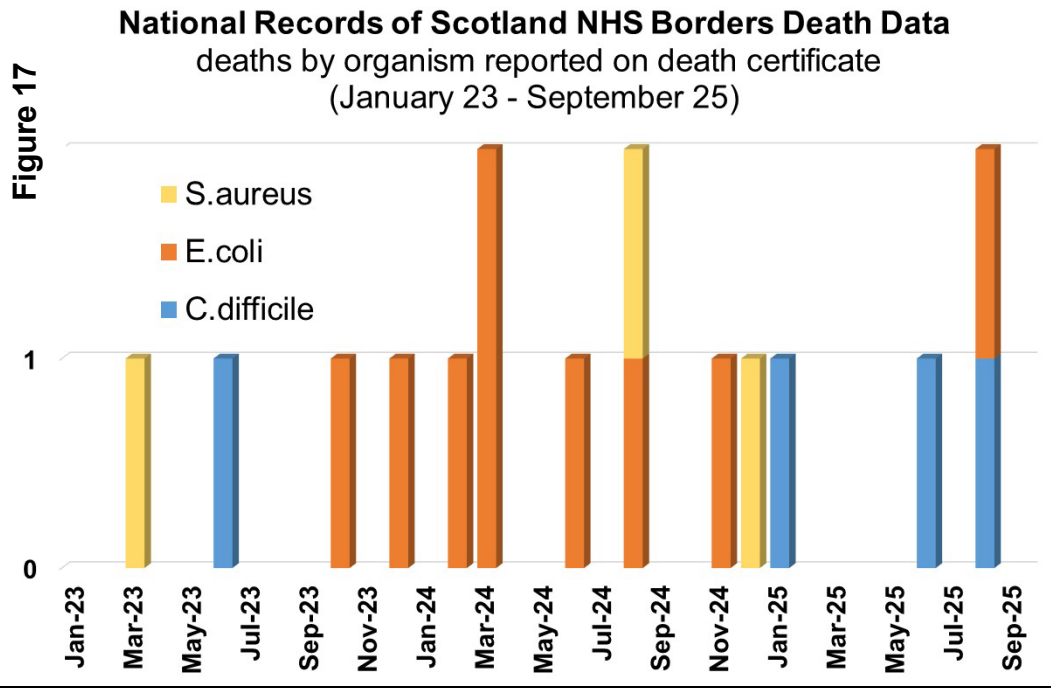
Figure 16

Healthcare Associated SAB cases by source (Oct 2024 - September 2025)



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 17** 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.



3.0 Process Measures

3.1 Hand Hygiene

- Hand hygiene audits are currently progressing, updated compliance data will be included in the next report

3.2 Cleaning Standards – Key Messages

- Cleanliness is monitored in accordance with national standards. 'Domestic' reporting refers to the environmental cleanliness of surfaces cleaned by domestics
- 'Estates' reporting refers to issues with the fabric of the building which impede effective cleaning
- There is a national target to maintain overall compliance with standards above 90%
- **Figure 21** shows all areas achieved above 90% in September
- 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 22**)

Figure 22

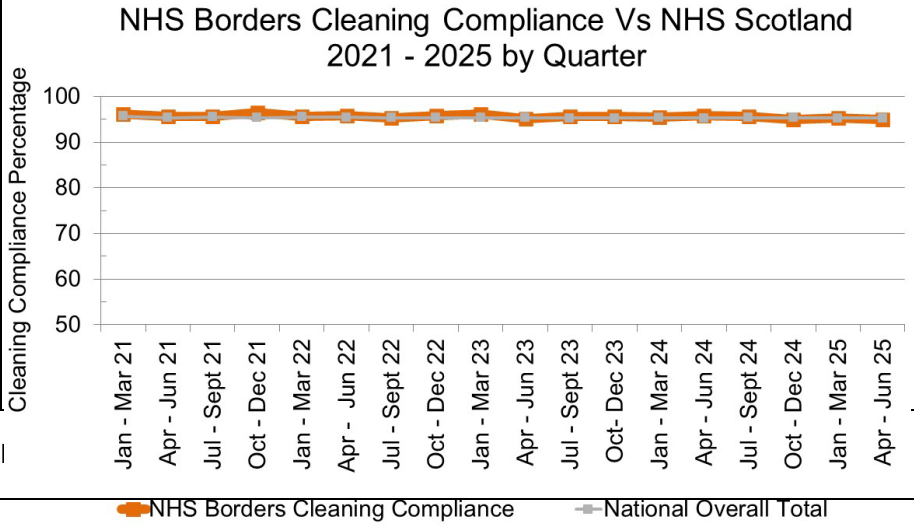


Figure 21

Ward	2025					
	July		Aug		Sep	
	Domestic	Estates	Domestic	Estates	Domestic	Estates
Ward 4	97.2	97.0	94.6	98.6	96.0	96.7
Ward 5	96.4	98.6	98.0	91.9	92.2	93.0
Medical Assessment Unit	96.2	95.9	92.5	94.2	93.0	96.1
DME14	97.9	93.7	90.7	100.0	96.5	99.3
Emergency Department	85.2	100.0	96.9	92.6	93.4	96.6
MKU			94.7	100.0	95.7	98.4
BSU	96.9	98.2	93.9	100.0	97.1	97.5
Renal Dialysis	97.9	100.0	96.2	100.0	97.5	100.0
Ward 7			91.5	94.9	94.7	94.9
Ward 9			94.3	94.2	92.7	100.0
ITU	97.1	97.3	97.8	99.4	96.4	97.1
DPU	97.4	93.9	91.8	100.0	96.7	100.0
Ward 17	86.1	100.0	95.4	99.4	95.4	100.0
Borders Macmillan Centre	96.1	95.6	97.9	99.5	93.6	100.0
Theatre	91.2	100.0	96.0	92.3	95.5	100.0
Endoscopy	96.6	100.0	95.1	94.4	95.0	94.8
Ward 15	95.3	100.0	95.8	97.6	96.9	97.5
Ward 16	94.6	98.0	96.6	98.8	93.0	99.3
Labour/SCBU	96.8	100.0	94.6	88.3	94.9	100.0
	Estates		Domestic		Estates	
Haylodge Hospital (Ward 1)	99.3		99.5		99.4	
Hawick Hospital (Ground Floor Ward Area)	100.0					
Kelso Hospital (Ward 2)	99.4					
Knoll Hospital (Ward Area)						
East Brig (Galavale)	99.2		97.4		97.3	
Huntlyburn Ground Floor Ward	98.3		96.0		95.0	
Borders Specialist Care Dementia Unit	99.5					
Cauldshiels	100.0		94.4		100.0	
	Domestic		Estates			
New OPD	97.7		98.3			
BUCC	97.0		100.0			
OPD First Floor						
Eye Centre	95.4		100.0			
Coldstream Dental Unit	99.1		100.0			
Hawick Dental Unit	99.8		100.0			

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 23**)
- Between August and October 2025, 10 full audits were completed across NHS Borders with all areas achieving a 'green' status of 90% or higher. 17 spot checks were completed resulting in 3 areas achieving an 'Amber' status (80%-89%) with the remaining achieving a 'green' status
- Recurring themes from the audits and spot checks:

Recurring themes of good practice

- Management of patients with precautions in place
- Clean environment
- Clutter removed to ensure ease of cleaning
- Waste managed correctly

Recurring themes of poor practice

- Use and knowledge of cleaning solution
- Dirty equipment
- Linen management
- PPE selection for tasks
-

- 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
- Testing and rollout of cleaning standards is underway in acute inpatient areas. The output from this work will be shared across NHS Borders.
- Themes from spot checks and audits are used to inform content of staff education delivered by the Infection Prevention and Control Team
- Since the last Board update, 3 care homes have been audited by the Infection Prevention and Control Team (IPCT). Two care homes achieved an 'Amber' status and the third achieved a 'Green' status. 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 homes with the 'amber' status will be revisited by the IPCT within 6 months.

Figure 23

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 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)
- In Quarter 2 2025, NHS Borders had a higher level of compliance with MRSA and CPE screening than NHS Scotland (**Figure 24**)
- Monthly compliance reports are fed back to the Senior Charge Nurse and Clinical Nurse Manager for the relevant wards

3.5 HAI Inpatient HAI Risk Screening National Context (ARHAI Scotland data)

Figure 24

MRSA Uptake	2024 Q3	2024 Q4	2025 Q1	2025 Q2
Borders	95.0%	90.0%	95.0%	95.0%
Scotland	80.7%	81.4%	81.3%	83.0%

CPE Uptake	2024 Q3	2024 Q4	2025 Q1	2025 Q2
Borders	95.0%	100.0%	95.0%	**100.0%**
Scotland	82.0%	83.3%	84.4%	85.4%

3.6 Mandatory Training

- On 1st October 2025, NHS Borders overall staff training compliance was:
  - Infection Control – Core Mandatory E-Learning Module (all substantive staff) 87.7%
  - NES Hand Hygiene – Role Mandatory E-Learning Module (all relevant substantive staff) 35%. This is an increase of 11% since the last report

3.7 Healthcare Associated Infection System for Controlling Risk in the Built Environment (HAI-SCRIBE)

- NHS Borders follows national guidance (SHFN 30) to control the risks associated with building works. The process requires a risk assessment to guide proportionate control measures. The risk assessment considers the type of works being undertaken (**Figure 25**) and the risk to patients (**Figure 26**) to determine the class of precautions to be implemented (**Figure 27**).
- HAI-SCRIBE applies to all relevant stages of each project with detailed steps to consider risks associated with the planned location, design and specification along with the infection risks arising from the building works:
  - Stage 1: Initial brief and proposed site for development
  - Stage 2: Design and planning
  - Stage 3: Construction and refurbishment work
  - Stage 4: Review of completed project
- The Infection Prevention and Control Team are currently supporting the following live Estates projects:

Estates Project	Estates Activity	Patient Risk	Classification of Precautions
RAAC assessment / mitigation (Jedburgh)	Type 3	Medium	Class III
RAAC assessment / mitigation (Kelso)	Type 3	High	Class III / IV
RAAC assessment / mitigation (Duns)	Type 3	High	Class III / IV
Laboratories reconfiguration for replacement equipment (BGH)	Type 3	High	Class III / IV
Theatres – establishing QI zone (BGH)	Type 2	Highest	Class III / IV
Flooring replacement (Hawick)	Type 3	High	Class III / IV

Figure 25

Type	Construction/Refurbishment Activity
Type 1	**Inspection and non-invasive activities.** Includes, but is not limited to, removal of ceiling tiles or access hatches for visual inspection, painting which does not include sanding, wall covering, electrical trim work, minor plumbing and activities which do not generate dust or require cutting of walls or access to ceilings other than for visual inspection.
Type 2	**Small scale, short duration activities which create minimal dust.** Includes, but is not limited to, installation of telephone and computer cabling, access to chase spaces, cutting of walls or ceiling where dust migration can be controlled.
Type 3	**Any work which generates a moderate to high level of dust, aerosols and other contaminants or requires demolition or removal of any fixed building components or assemblies.** Includes, but is not limited to, sanding of walls for painting or wall covering, removal of floor coverings, ceiling tiles and casework, new wall construction, minor duct work or electrical work above ceilings, major cabling activities, and any activity which cannot be completed within a single work shift.
Type 4	**Major demolition and construction projects.** Includes, but it not limited to, activities which require consecutive work shifts, requires heavy demolition or removal of a complete cabling system, and new construction.

Figure 27

	Construction Project Type			
Patient Risk Group	TYPE 1	TYPE 2	TYPE 3	TYPE 4
Lowest Risk	Class I	Class II	Class II	Class III/IV
Medium Risk	Class I	Class II	Class III	Class IV
High Risk	Class I	Class II	Class III/IV	Class IV
Highest Risk	Class II	Class III/IV	Class III/IV	Class IV

Figure 26

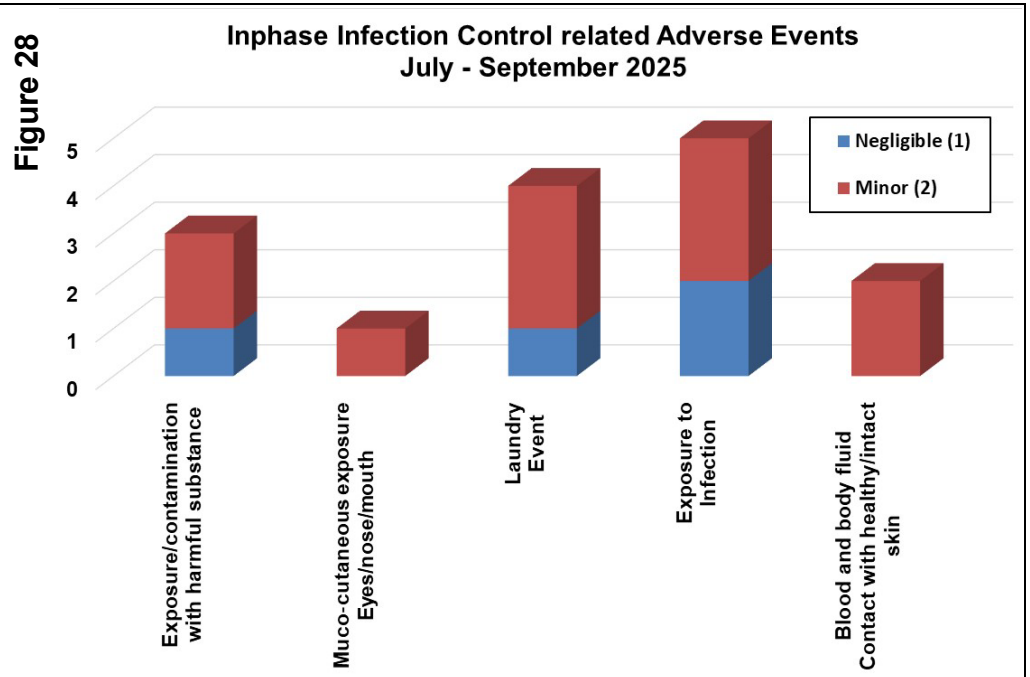
Risk to patients of infection from construction work in healthcare premises, by clinical areas	
Risk rating	**Area**
Group 1 Lowest risk	1. Office areas; 2. Unoccupied wards; 3. Public areas/Reception; 4. Custodial facilities; 5. Mental Health facilities.
Group 2 Medium risk	1. All other patient care areas (unless included in Group 3 or Group 4); 2. Outpatient clinics (unless in Group 3 or Group 4); 3. Admission or discharge units; 4. Community/GP facilities; 5. Social Care or Elderly facilities.
Group 3 High risk	1. A & E (Accident and Emergency); 2. Medical wards; 3. Surgical wards (including Day Surgery) and Surgical outpatients; 4. Obstetric wards and neonatal nurseries; 5. Paediatrics; 6. Acute and long-stay care of the elderly; 7. Patient investigation areas, including; • Cardiac catheterisation; • Invasive radiology; • Nuclear medicine; • Endoscopy. Also (indirect risk) 8. Pharmacy preparation areas; 9. Ultra clean room standard laboratories (risk of pseudo-outbreaks and unnecessary treatment); 10. Pharmacy Aseptic suites.
Group 4 Highest Risk	1. Any area caring for immuno-compromised patients*, including: • Transplant units and outpatient clinics for patients who have received bone marrow or solid organ transplants; • Oncology Units and outpatient clinics for patients with cancer; • Haematology units • Burns Units. 2. All Intensive Care Units; 3. All operating theatres; Also (indirect risk) 4. CSSUs (Central Sterile Supply Units).

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 28** shows Infection Control events during the period July – September 2025

Figure 28



4.2 Incidents

- Two patients have been identified with the same strain of *Pseudomonas aeruginosa* whilst in the same ward (background information is provided in **Appendix A**). The most likely hypothesis is healthcare associated transmission from a community associated case. Nearby water outlets in the ward were tested for the organism and found to be negative. The patients were in adjacent beds and the proximity of the patients to each other is thought to have been a significant risk factor for transmission. An estates project to improve bed spacing in the ward is being added to a list of projects with relative risk informing prioritisation. No further cases have been identified.

4.3 Outbreaks

- Since the last update, there have been 10 closures in NHS Borders. Detail of each closure is reported under **Figure 29**

Figure 29 – Infection Prevention & Control Daily Outbreak Summary

NHS Borders Clusters as at 22/10/2025									
Outbreak start date	**Outbreak end date**	**Outbreak location(s)**	**Ward Closure Status**	**Organism**	**Positive patient cases**	**Patient deaths**	**Suspected staff cases**	**Challenges**	**Learning**
15/08/2025	19/08/2025	Ward 4	1 bay	COVID	1	0	0		
12/08/2025	14/08/2025	Ward 9	1 bay	COVID	2	0	0		Education provided to ward staff on the importance of hand hygiene and PPE use. As part of closure management, IPC now inform Stores of closures to prompt PPE stock increase
08/09/2025	12/09/2025	Ward 4	2 bay	COVID	7	0	1		
11/09/2025	15/09/2025	BSDU	-	COVID	5	0	1	Patients walk with purpose posing increased risk of transmission	Early testing of symptomatic patients would have prompted earlier implementation of control measures
22/09/2025	14/10/2025	Ward 4	2 bays	COVID	8	0	3	Patients walk with purpose posing increased risk of transmission	Education of use of eye protection provided to medical staff with supporting communication circulated
15/09/2025	23/09/2025	Ward 5	1 bay	COVID	3	0	0		
15/09/2025	15/09/2025	MAU	1 bay	COVID	1	0	0		
23/09/2025	23/09/2025	MAU	1 bay	COVID	2	0	0		Education of use of eye protection provided to medical staff with supporting communication circulated
24/09/2025	24/09/2025	Ward 7	1 bay	COVID	1	0	0		
23/09/2025	10/10/2025	DME 14	Ward closed	COVID	9	1	2	Patients walk with purpose posing increased risk of transmission	
					39	**1**	**7**		

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. The first meeting of a Task and Finish Group has been scheduled for November 2025 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

5.2 Hand Hygiene

- 3 wards are currently receiving Quality Improvement support with hand hygiene practice and have implemented a range of change ideas
- Hand hygiene audits are currently progressing, and updated compliance data will be included in the next Board update

6.0 Horizon Scanning

- On 10th November 2025 the Scottish Government published CMO(2025)20 reporting early and unusually high influenza activity
- On 13th November 2025 Public Health Scotland (PHS) published alert 2025/27 about seasonal influenza

Both alerts highlighted the following key messages:

- Importance of eligible people being vaccinated against influenza
- Clinicians to consider testing patients with influenza symptoms
- Prompt treatment and post exposure prophylaxis for eligible groups

The alerts included a cascade to relevant staff

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

Queen Margaret hospital – mental health safe delivery of care inspection: June 2025 – Healthcare Improvement Scotland

Dumfries & Galloway Royal Infirmary – safe delivery of care inspection August 2025 – Healthcare Improvement Scotland

Borders General Hospital – safe delivery of care inspection report September 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 resource 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 although much of the data is included in the monthly infection control reports which are 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/Committee will be asked to confirm the level of assurance it has received from this report:

- **Moderate Assurance**

3 List of appendices

The following appendices are included with this report:

- 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 *Pseudomonas aeruginosa*

Pseudomonas aeruginosa can cause severe infections in people who are immunocompromised or whose defences have been breached, such as oncology patients, neonates, severe burn patients, those with invasive medical devices, and people with cystic fibrosis.

Pseudomonas aeruginosa is commonly found in wet or moist environments and can thrive in water systems. There have been serious outbreaks in adult and neonatal intensive care units, where the cause was thought to have been contamination of the tap water supply.

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:	**NHS Borders Board**
Meeting date:	**4 December 2025**
Title:	**NHS Borders Integrated Performance Report (IPR) - October 2025**
Responsible Executive/Non-Executive:	**June Smyth, Director of Planning & Performance**
Report Authors:	**Carol Graham, P&P Officer** **Matthew 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

An 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 Indicators (KPIs). Whilst this version of the IPR does not yet include all measures which we have identified for inclusion, it is an evolving iteration and will be continually developed over the coming months.

2.2 Background

A performance report is presented bimonthly to alternating Board and R&PC meetings so that performance against the key standards (national targets and locally agreed

standards) can be scrutinised, and corrective action can be reviewed. **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 give 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

Please note that we cannot provide assurance statuses for all measures without an alternative target line. These may be developed in the future if targets are set.

Figure 2: Astronomical Points – Sigma Violation

Astronomical Points – Sigma Violation

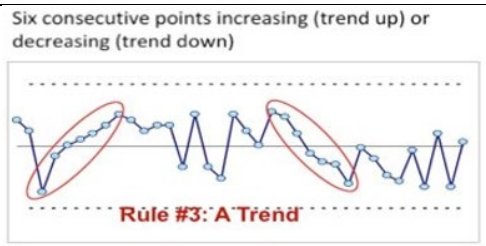
These are points outside the Control Limits, either improving or deteriorating performance depending on colour:

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	

2.3 Assessment

The 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.

There are no new measures added to this month's report.

Lead Directors will be accountable for reviewing and formally approving the measures within their portfolios prior to submission which they will present during the meeting.

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 will be asked to confirm the level of assurance it has received from this report.

3 List of appendices

The following appendices are included with this report:

- **Appendix 1:** NHS Borders Integrated Performance Report October 2025
- **Appendix 2:** Development of Additional Measures

NHS Borders

Integrated Performance Dashboard

October 2025

Last Refresh Date: 25/11/2025

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		
	H L	H L	?	P	F
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	Previous Position	Latest Position	Assurance Status	Variation Status
Emergency Access Standard	Percentage of patients seen within 4 hours of attendance	62.3%	60.8%		
8 Hour Breaches	Percentage of patients who waited greater than 8 hours	13.8%	15.7%		
12 Hour Breaches	Percentage of patients who waited greater than 12 hours	9.2%	10.3%		
Length of Stay	Average Length of stay. Non-elective only. Excludes paediatric and obstetirc specialties and ITU wards	9.6	10.5		
Bed Occupancy	Number of acute occupied beds at end of month	95.54%	92.57%		
Delayed Discharges	Number of delayed discharges at end of month	49	41		
Ambulance Handover Time	Average ambulance handover time in minutes per month	33.87	32.00		
AAU Admissions	Number of patients admitted to AAU	365	391		
Outpatient Waiting List	Number of outpatients waiting over 52 weeks	873	804		
Inpatient Waiting List	Number of inpatients waiting over 52 weeks	296	243		

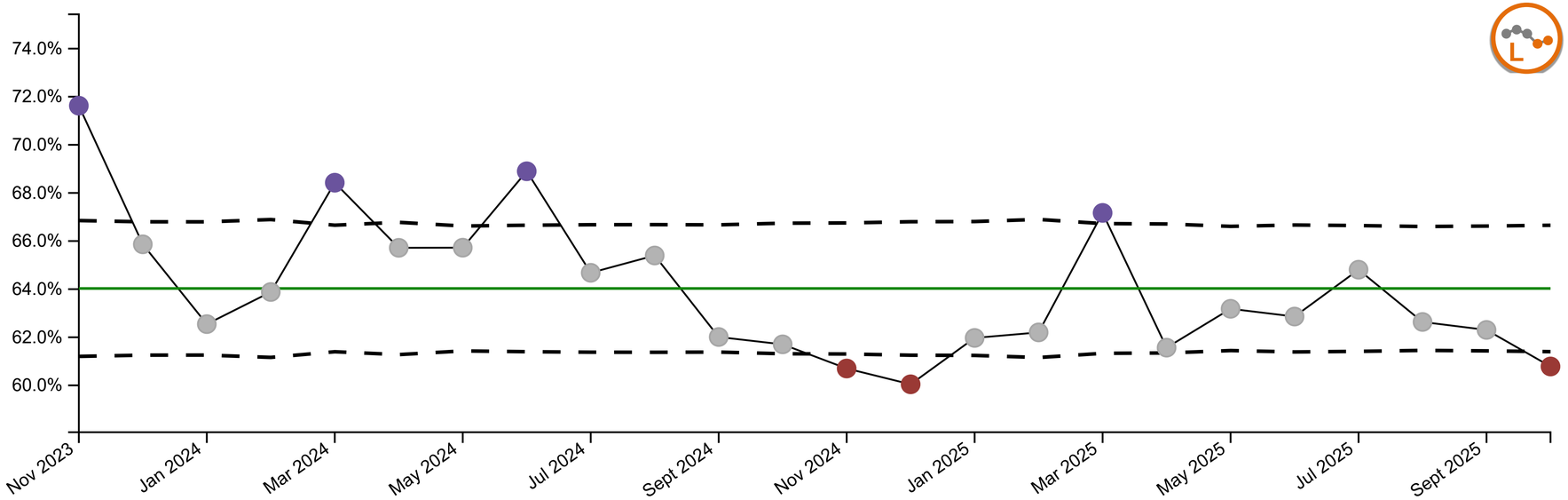
Measure Name	Measure Description	Previous Position	Latest Position	Assurance Status	Variation Status
Theatre Utilisation	Theatre utilisation per month. Elective only, excludes theatre 5	66.4%	65.2%		
Theatres - Cataracts	Average number of cataract cases per session	6.1	7.1		
Diagnostics Over 6 Weeks	Number of patients waiting over 6 weeks	397	340		
Cancer 62 Days	Percentage of patients treated within 62 days of referral	71.1%	80.0%	F	
Cancer 31 Days	Percentage of patients treated within 31 days of referral	95.6%	100.0%	P	
Cancer Backlog	Number of patients waiting over 62 days for treatment	12	12		
CAMHS RTT	Percentage of patients received treatment within 18 weeks of referral	100.0%	92.0%	?	H
CAMHS CAT 1	Percentage of Neurodevelopmental Waits seen within 52 weeks	30.30%	42.42%		L
Psychological Therapy	Percentage of patients received treatment within 18 weeks of referral	75.7%	72.4%	?	
BAS 3 Week Target	Percentage of Patients treated within 3 weeks of referral	99.0%	98.0%	P	
Workforce Absence	% of hours lost for all departments per month	6.31%	6.50%	F	H

Integrated Performance Dashboard - Urgent & Unscheduled Care

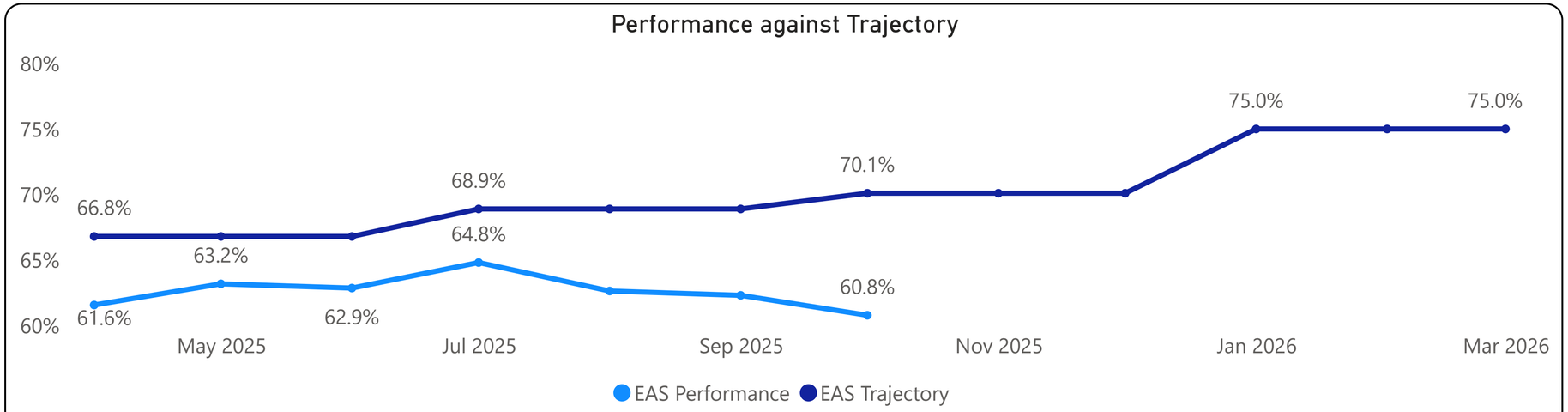
Lead Director: Gareth Clinkscale

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



Month

October 2025

The data shows special cause of a deteriorating nature and performance remains off trajectory.

Performance for October was 60.8% against a trajectory of 70.1%, representing a variance of -9.3%. This continues the declining trend seen in the previous two months. Improvement actions continue to be progressed through Workstream 1 of the UUC, with the reintroduction of weekly robust breach validation. Additionally, the ED workforce modelling, supported by CfSD, will assess demand and capacity to ensure staffing resources are appropriately aligned.

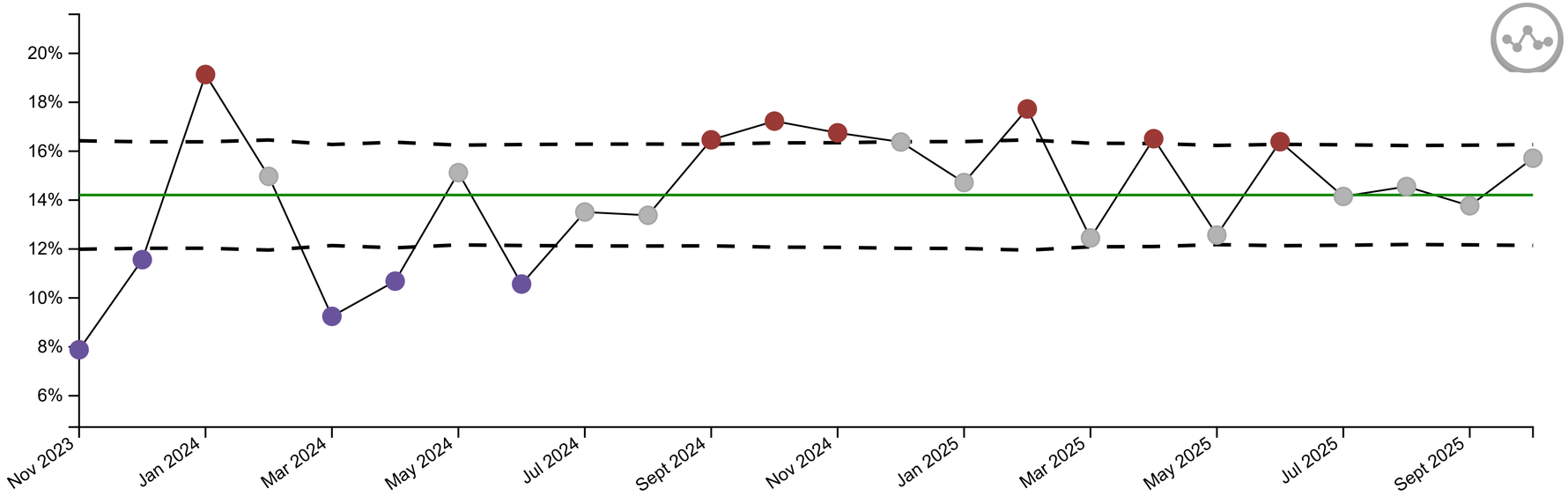
MonthEndDate	Attendances	Breaches	EAS
31/10/2025	3004	1826	60.8%
30/09/2025	3080	1919	62.3%
31/08/2025	3126	1958	62.6%
31/07/2025	3032	1965	64.8%
30/06/2025	2978	1872	62.9%
31/05/2025	3110	1965	63.2%
30/04/2025	2883	1775	61.6%
31/03/2025	2851	1915	67.2%

Integrated Performance Dashboard - Urgent & Unscheduled Care

Lead Director: Gareth Clinkscale

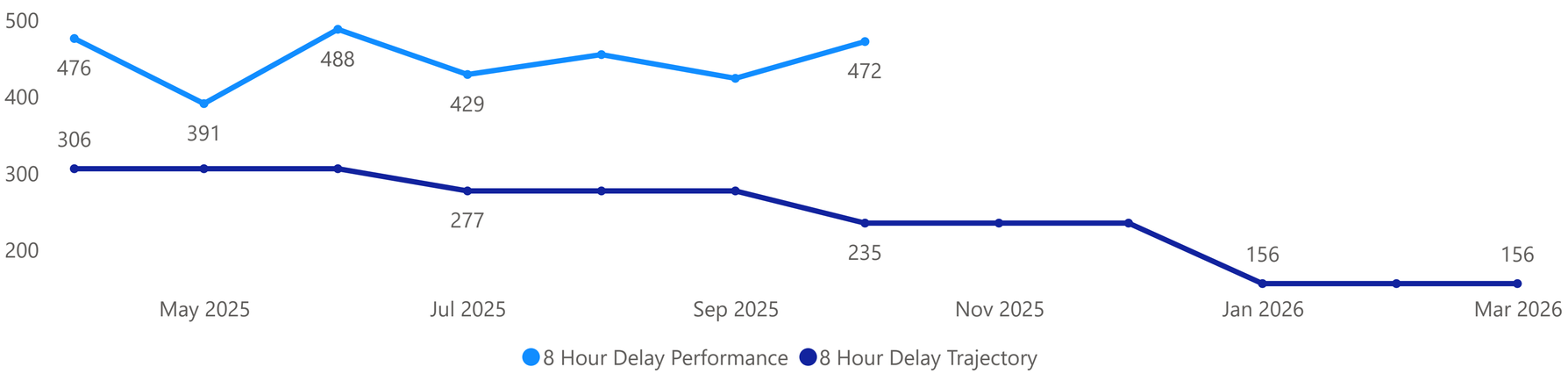
8 Hour Delays

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

Performance against Trajectory



Month

October 2025

The data shows normal variation however performance is significantly off trajectory.

In October, there was an average of 472 8 hr delays, compared to the trajectory of 235, which represents 16% of all attendances. Actions to improve patient flow are being managed through Workstream 1 of the UUC and include scoping the development of an SDEC and a reset of MAU once the Frailty Unit opens.

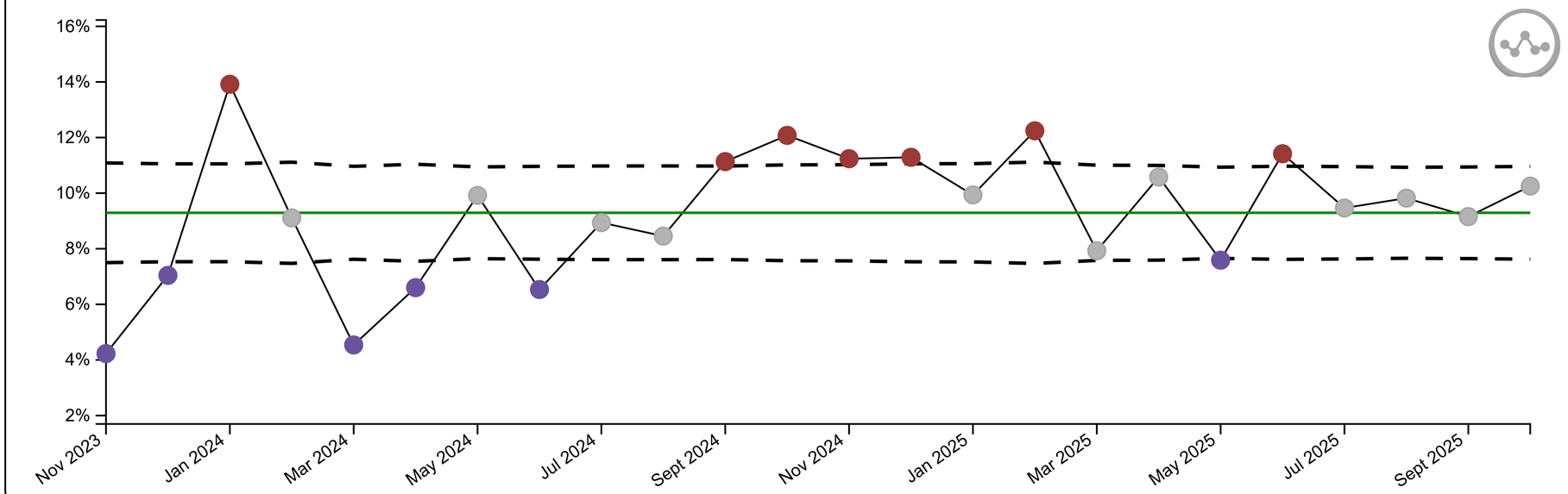
MonthEndDate	Attendances	8 Hour Delays
31/10/2025	3004	472
30/09/2025	3080	424
31/08/2025	3126	455
31/07/2025	3032	429
30/06/2025	2978	488
31/05/2025	3110	391
30/04/2025	2883	476
31/03/2025	2851	355

Integrated Performance Dashboard - Urgent & Unscheduled Care

Lead Director: Gareth Clinkscale

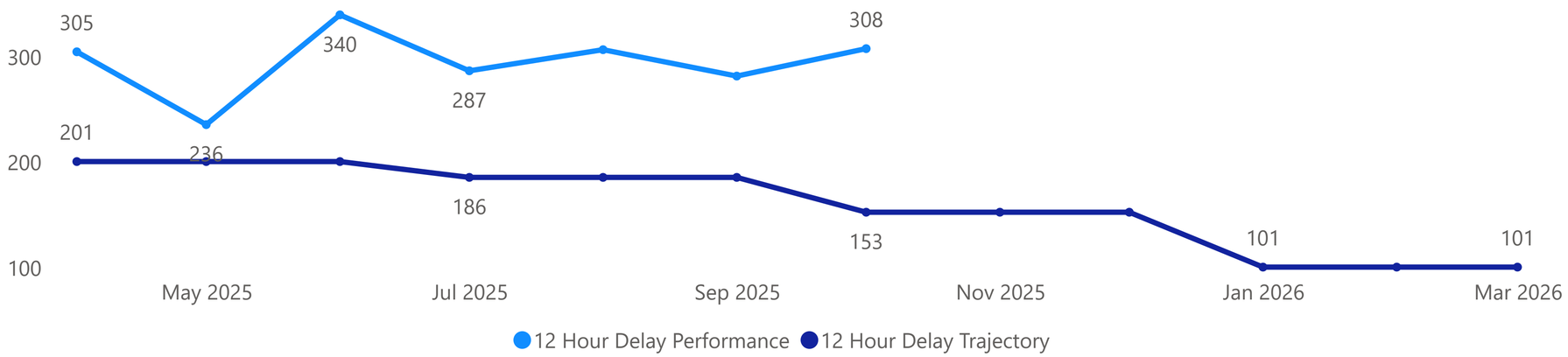
12 Hour Delays

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

October 2025

The data shows normal variation however performance is significantly off trajectory.

BGH are significantly off trajectory with 308 12hr delays in the month of October against a trajectory of 153, representing 10% of attendances. Delivery of the priority projects in the new urgent care improvement plan will significantly improve flow (frailty assessment unit, Home First, Hospital at Home, IDT, QI processes).

MonthEndDate	Attendances	12 Hour Delays
31/10/2025	3004	308
30/09/2025	3080	282
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

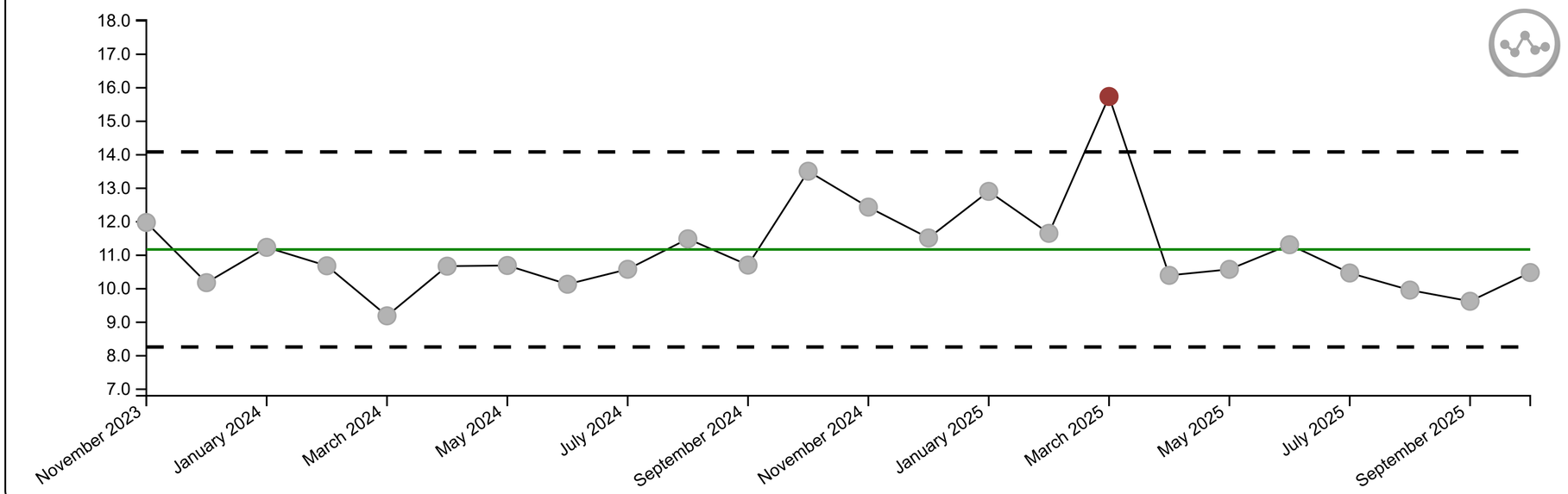
Integrated Performance Dashboard - Urgent & Unscheduled Care

NHS Borders

Lead Director: Gareth Clinkscale

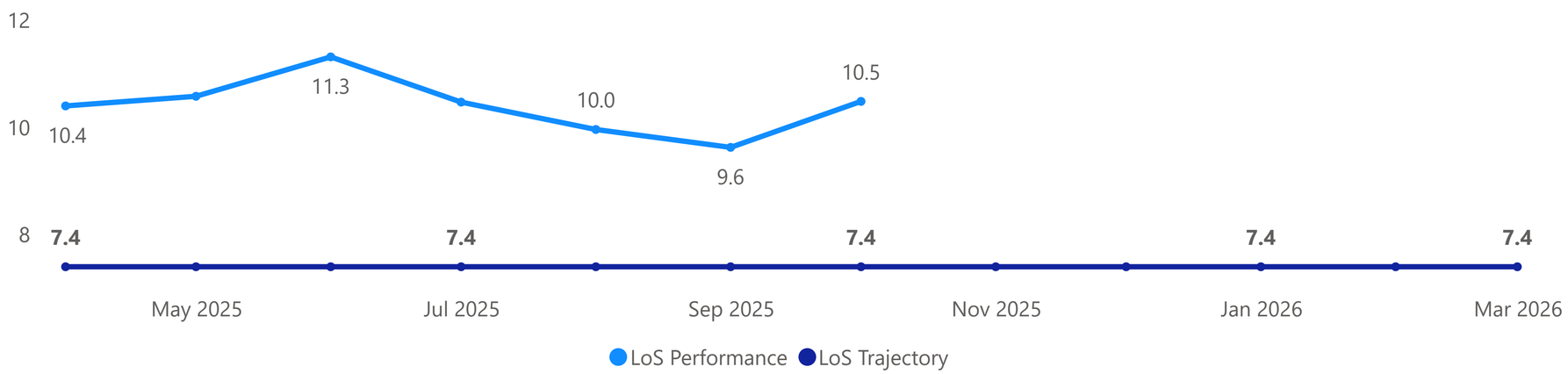
Length of Stay

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

October 2025

The data shows normal variation however performance is significantly off trajectory.

LoS performance has slightly deteriorated but continues within normal variation with average LoS for October was 10.5 days against a trajectory of 7.4. Improvement is being supported through the development of an Integrated Discharge Team, Additional capacity in Home First and Hospital at Home and the opening of a standalone Frailty Unit.

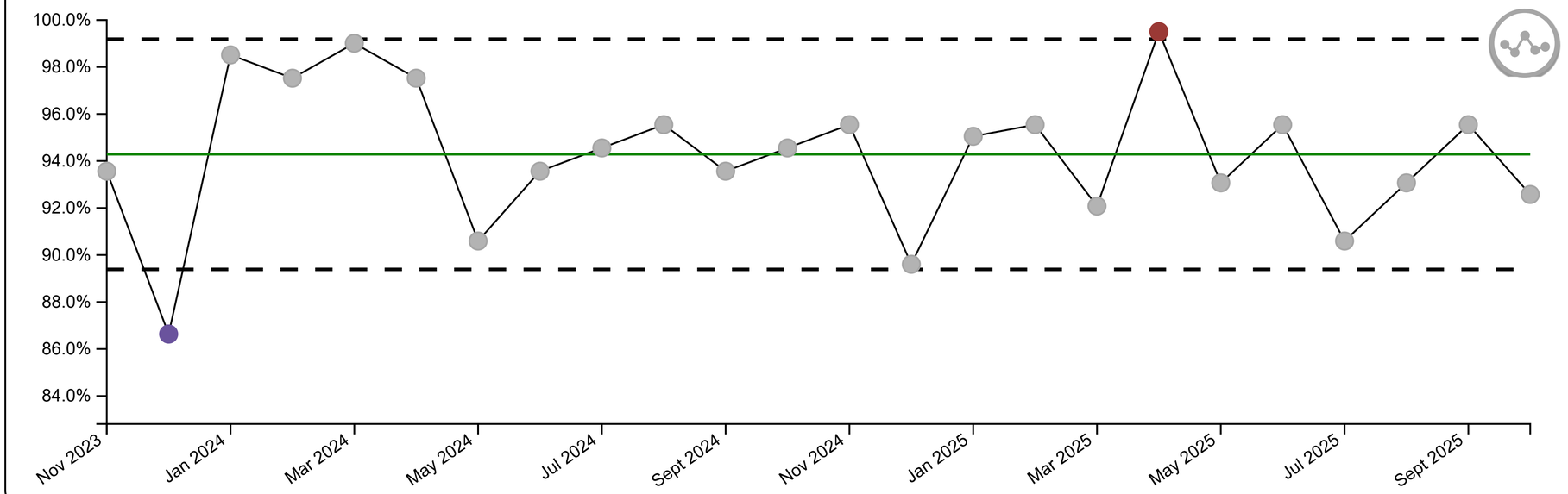
MonthEndDate	Average Length of Stay
October 2025	10.5
September 2025	9.6
August 2025	10.0
July 2025	10.5
June 2025	11.3
May 2025	10.6
April 2025	10.4
March 2025	15.7

Integrated Performance Dashboard - Urgent & Unscheduled Care

Lead Director: Gareth Clinkscale

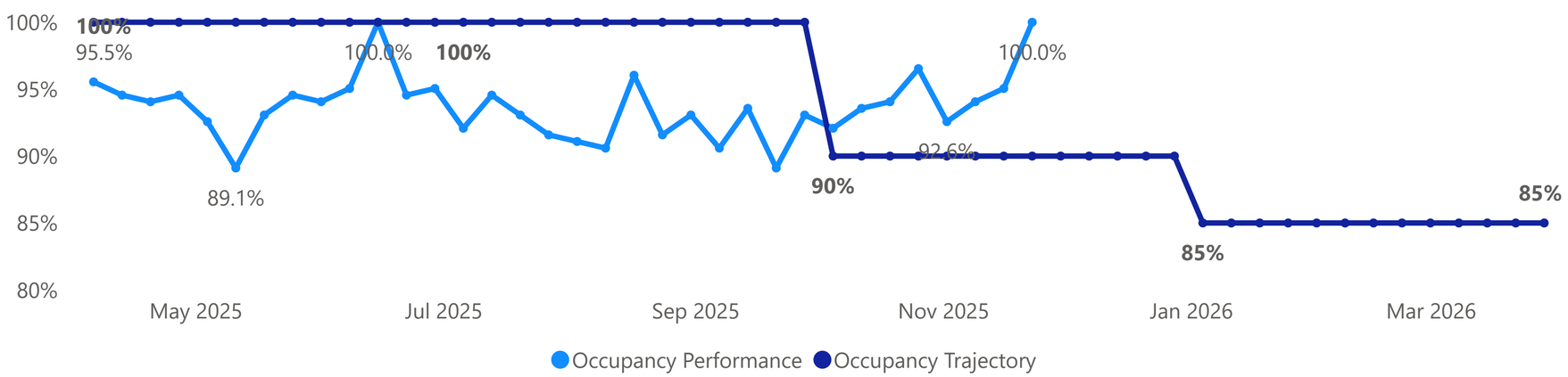
Average Acute Occupancy

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

Performance against Trajectory



Month

October 2025

The data shows normal variation but remains off trajectory.

Av occupancy has reduced in October to 92.6% however still remains above trajectory of 90%. Additional capacity within Home First and Hospital at Home will support reducing occupancy along with the refresh of MAU .

EndOfMonth	Occupied Beds	%
31/10/2025	187	92.6%
30/09/2025	193	95.5%
31/08/2025	188	93.1%
31/07/2025	183	90.6%
30/06/2025	193	95.5%
31/05/2025	188	93.1%
30/04/2025	201	99.5%
31/03/2025	186	92.1%

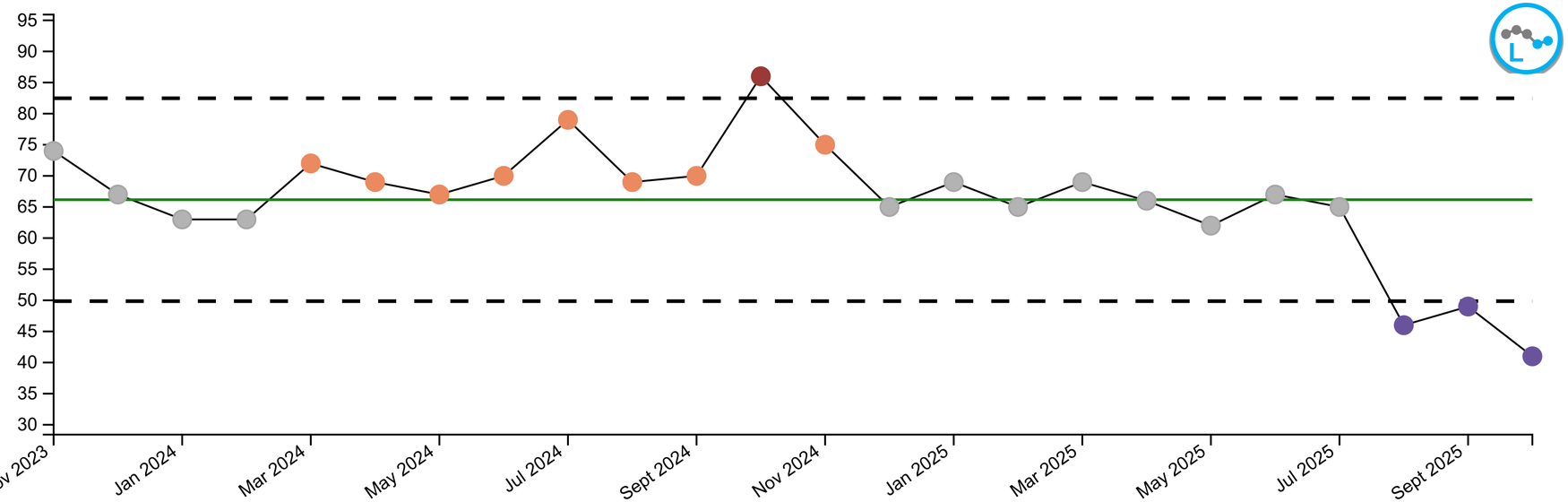
Integrated Performance Dashboard - Urgent & Unscheduled Care

NHS Borders

Lead Director: Gareth Clinkscale

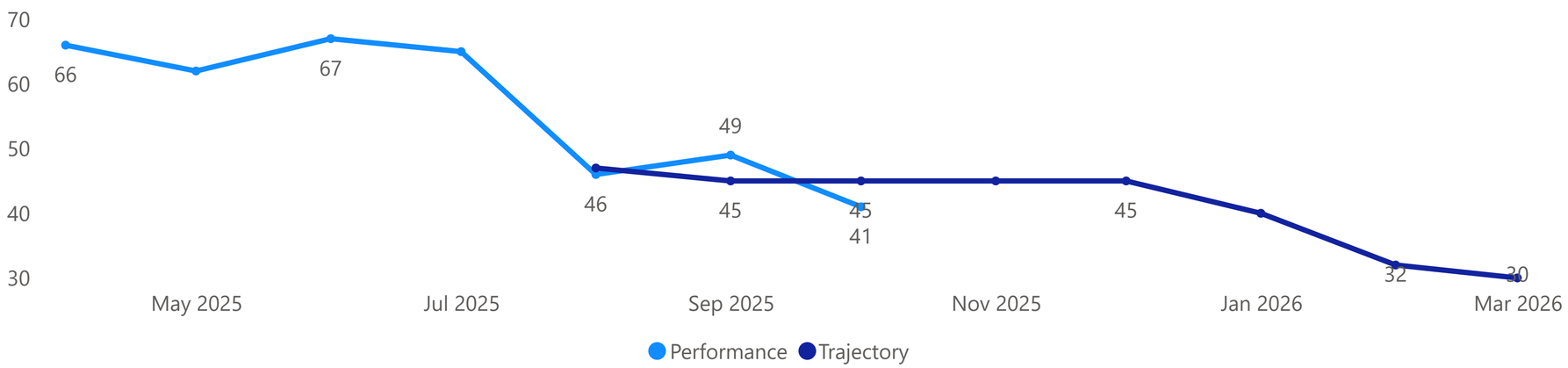
Delayed Discharges

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

Performance against Trajectory



Month

October 2025

The data shows special cause of an improving shift in performance and is above trajectory.

The improving trend in delayed discharges continued in October, with 41 reported against a trajectory of 45. This is the best position since before 2023. Significant collaborative work across Acute and Community services is ongoing to build on this progress, with additional funding from the Scottish Government expected to further support improvement.

EndOfMonth	Delayed Discharges
31/10/2025	41
30/09/2025	49
31/08/2025	46
31/07/2025	65
30/06/2025	67
31/05/2025	62
30/04/2025	66
31/03/2025	69

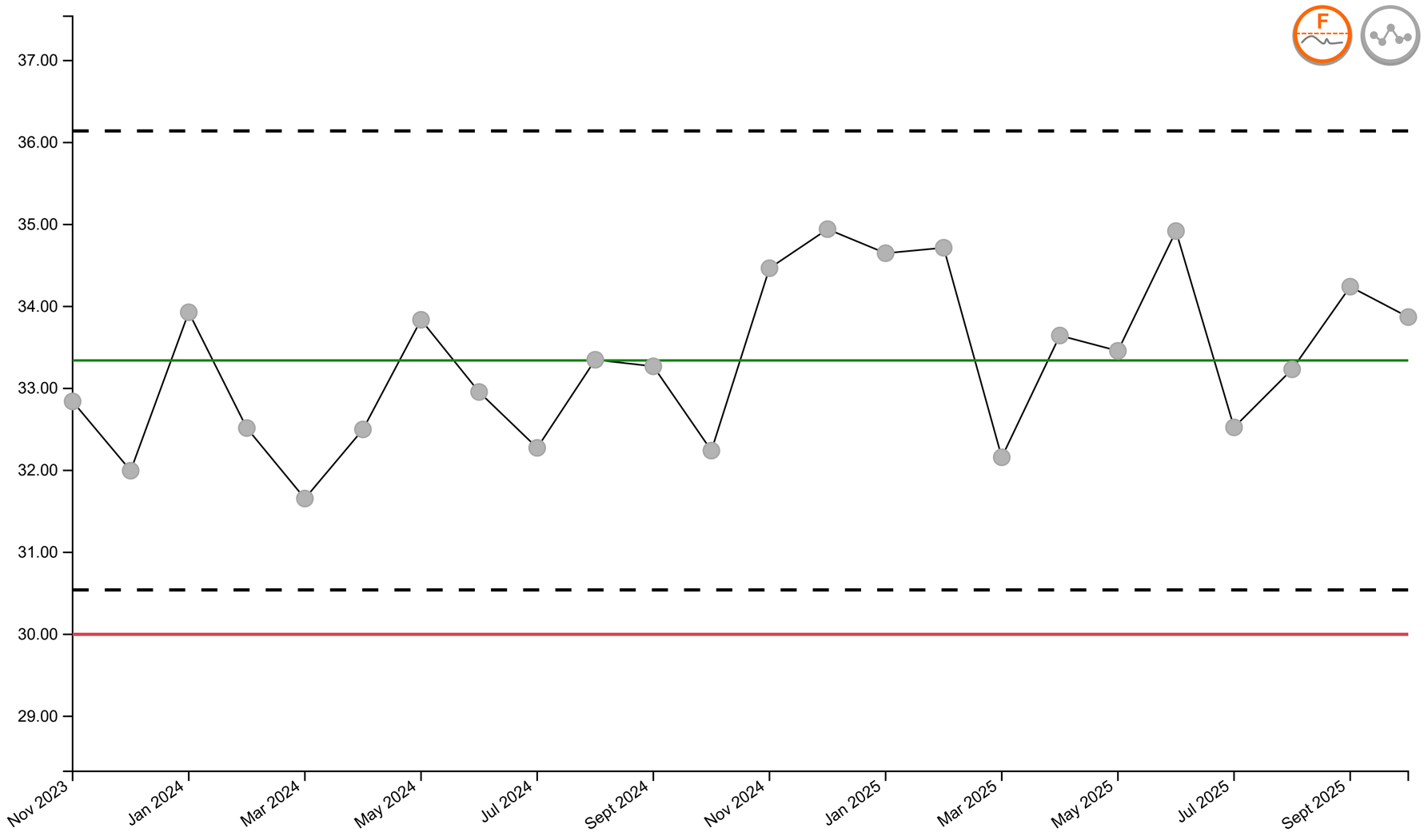
Integrated Performance Dashboard - Urgent & Unscheduled Care

NHS Borders

Lead Director: Gareth Clinkscale

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

October 2025

The data shows normal variation.

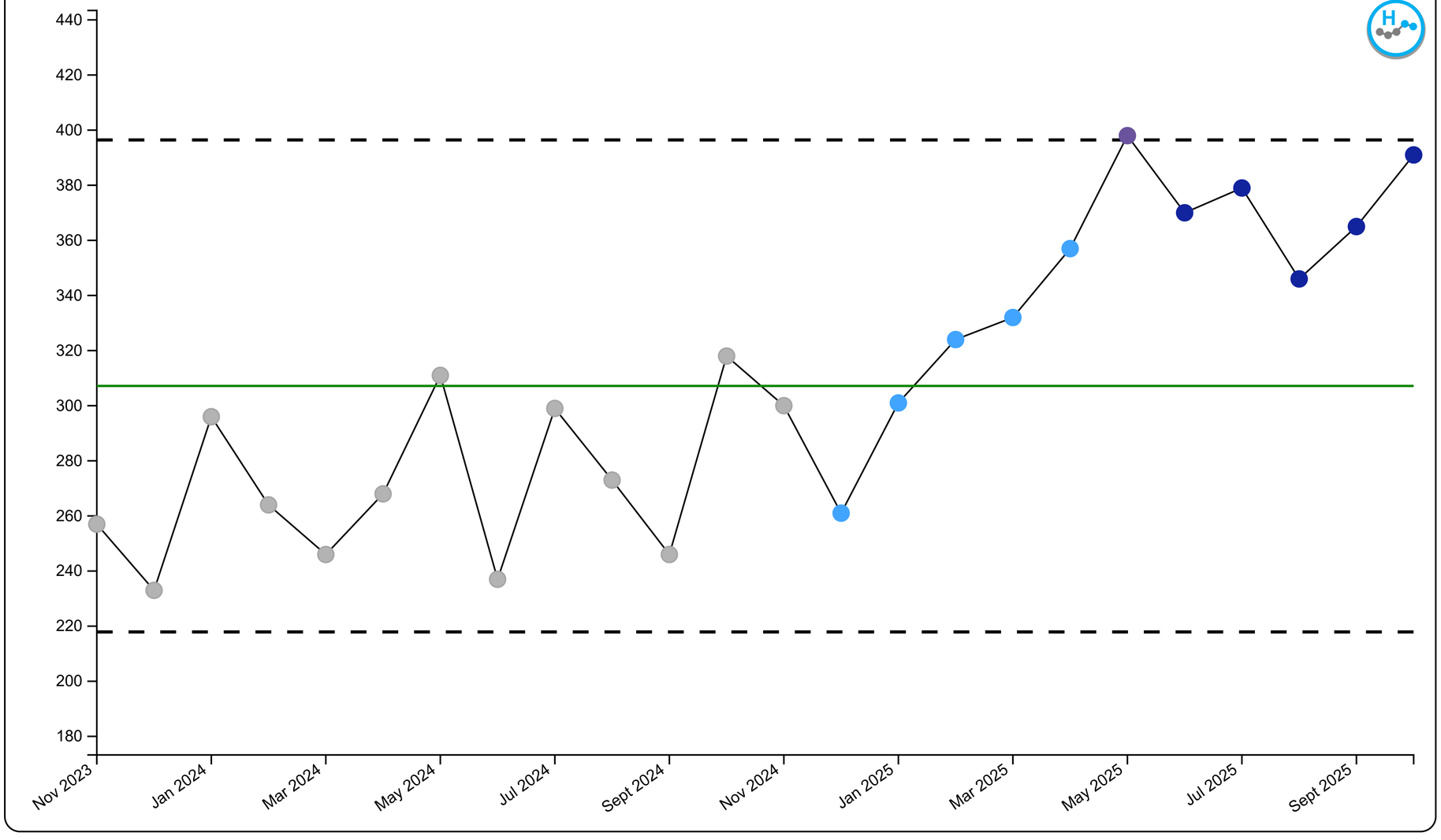
EndOfMonth	Handover Times (Minutes)
31/10/2025	33.87
30/09/2025	34.24
31/08/2025	33.23
31/07/2025	32.53
30/06/2025	34.92
31/05/2025	33.46

Integrated Performance Dashboard - Urgent & Unscheduled Care

Lead Director: Gareth Clinkscale

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

October 2025

The data shows an improving shift in performance.

AAU Admissions for October were 391, and represent an increase when compared to 365 in September. There is ongoing work to scope and progress a higher percentage of the medical take being managed directly in AAU.

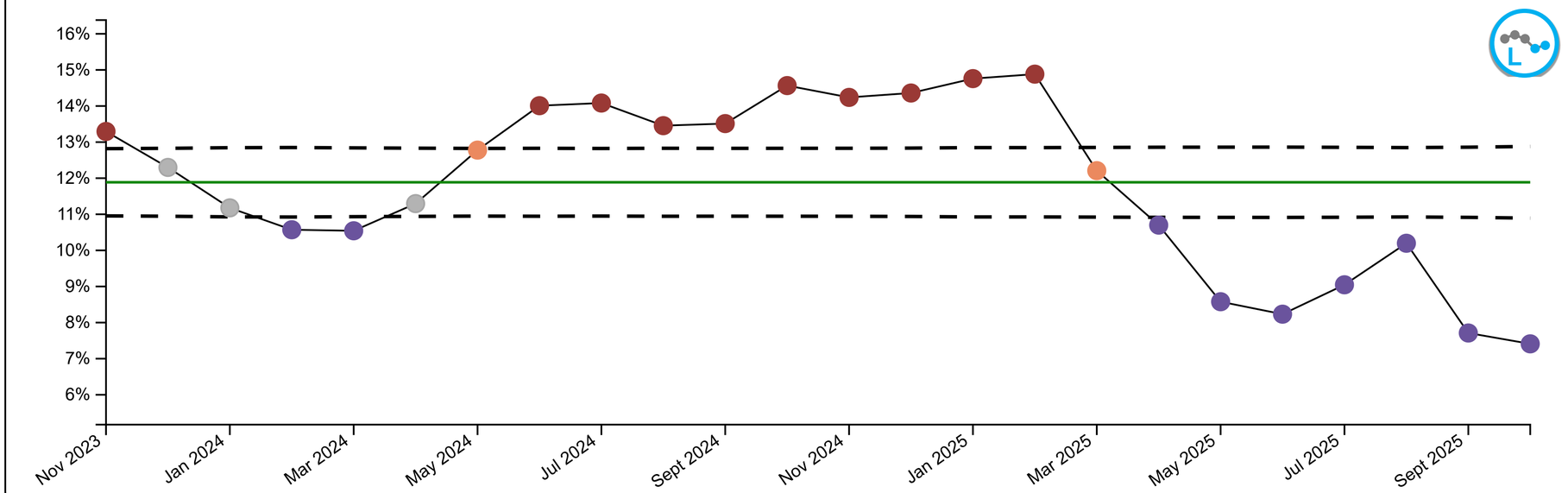
MonthEndDate	Admissions
31/10/2025	391
30/09/2025	365
31/08/2025	346
31/07/2025	379
30/06/2025	370
31/05/2025	398
30/04/2025	357
31/03/2025	332

Integrated Performance Dashboard - Planned Care

Lead Director: Oliver Bennett

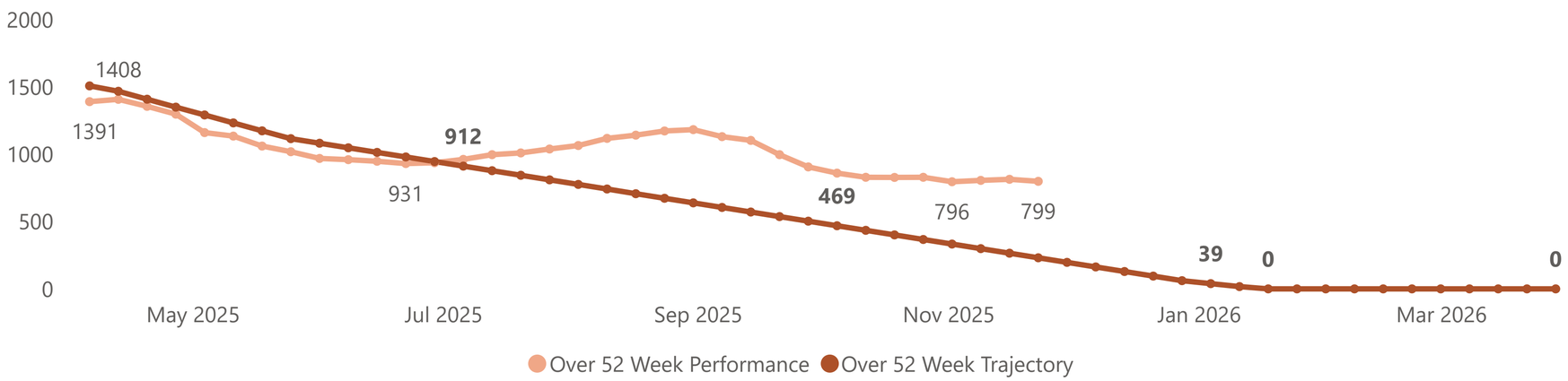
NOP - Over 52 Weeks

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

October 2025

The data shows an improving shift in performance however is significantly off target.

The outpatient total list size is on a downward trend. Over 52 weeks is also been on a downward trend where it has plateaued. The majority of these patients are waiting on Dermatology, Oral Surgery or Orthopaedics. Plans are in place to bring additional capacity on line to address these.

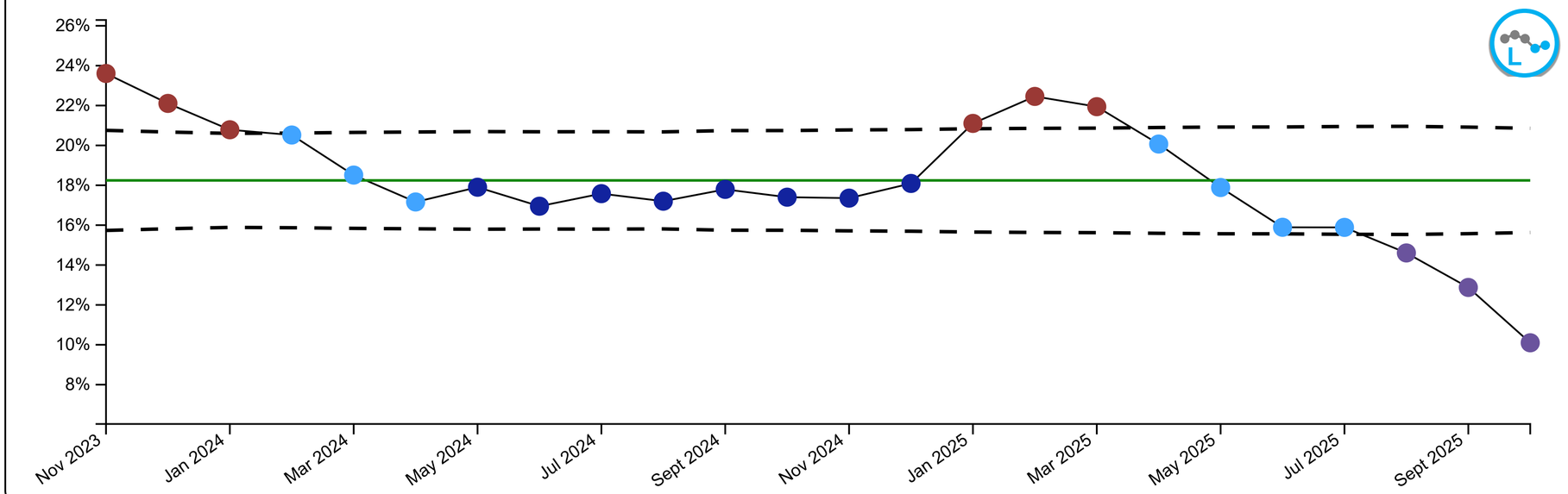
EndOfMonth	Waiting Over 52 Weeks
31/10/2025	804
30/09/2025	873
31/08/2025	1183
31/07/2025	1032
30/06/2025	928
31/05/2025	970
30/04/2025	1214
31/03/2025	1403

Integrated Performance Dashboard - Planned Care

Lead Director: Oliver Bennett

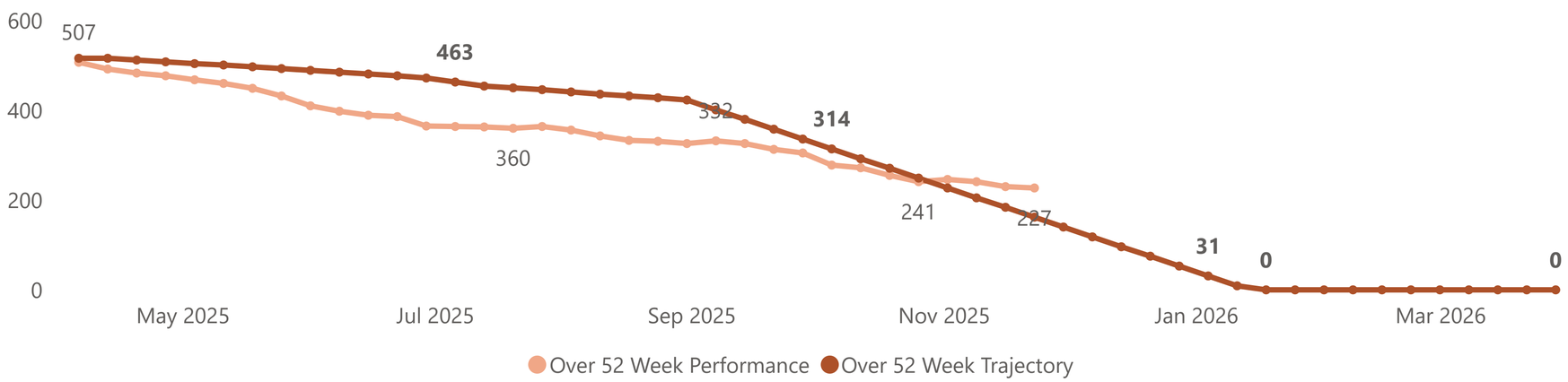
TTG - Over 52 Weeks

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

Performance against Trajectory



Month

October 2025

The data shows an improving shift in performance.
Performance has improved since September, with waits over 104 and 78 weeks reduced by 52% and 38%. We aim to eliminate waits over 78 weeks for available patients by December (currently 57). Overall, waits over one year improved by 21%. While still below trajectory, progress has slowed, and we may exceed trajectory in November. Orthopaedic capacity should improve in January with a locum consultant.

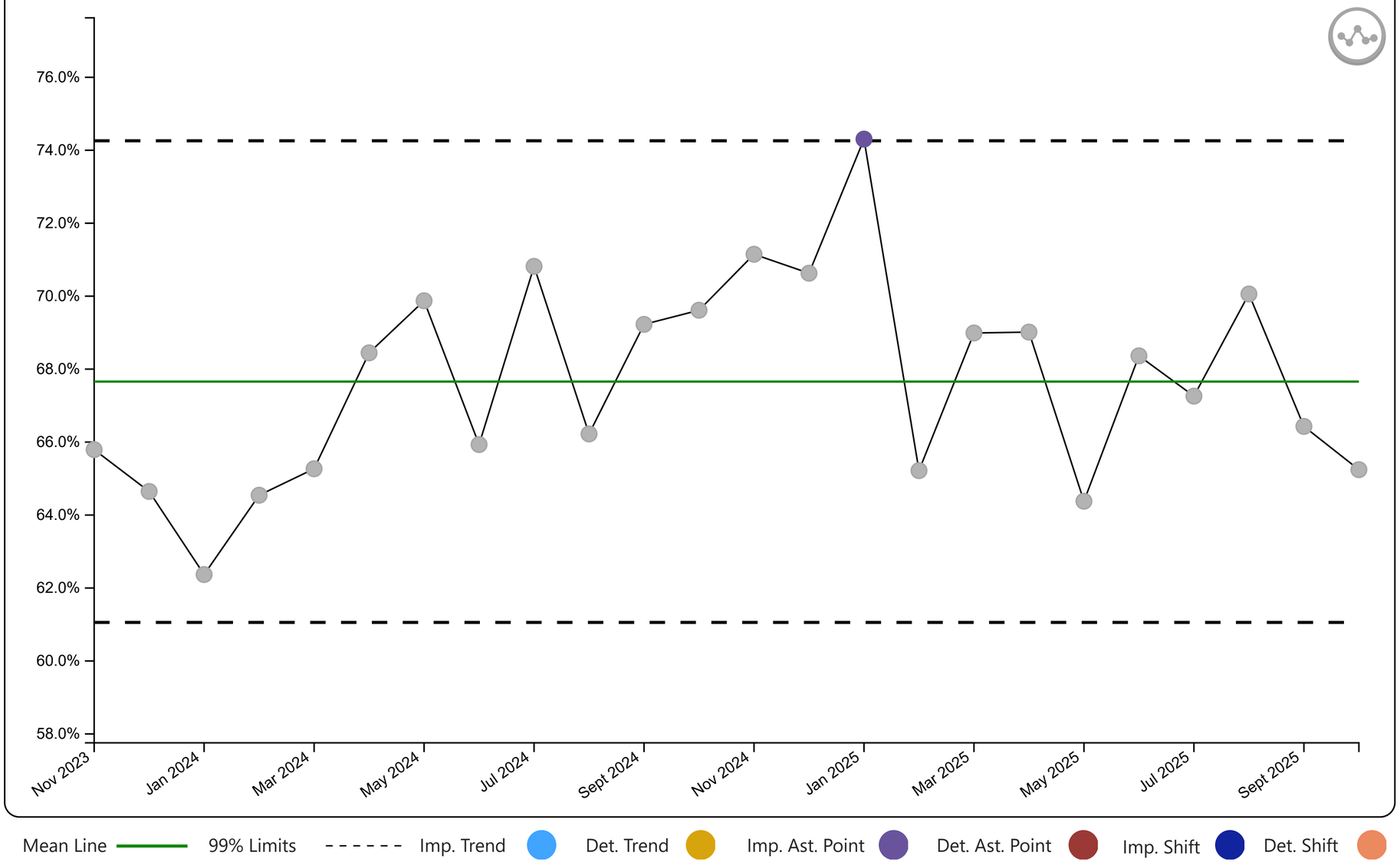
EndOfMonth	Waiting Over 52 Weeks
31/10/2025	243
30/09/2025	296
31/08/2025	326
31/07/2025	357
30/06/2025	363
31/05/2025	410
30/04/2025	468
31/03/2025	524

Integrated Performance Dashboard - Planned Care

Lead Director: Oliver Bennett

Theatre Utilisation

i-Chart: Theatre Utilisation per month. Elective only, excludes theatre 5



Month

October 2025

The data shows normal variation.

Theatre Improvement work continues in key targeted areas and being overseen by the newly established Planned Care Improvement Board.

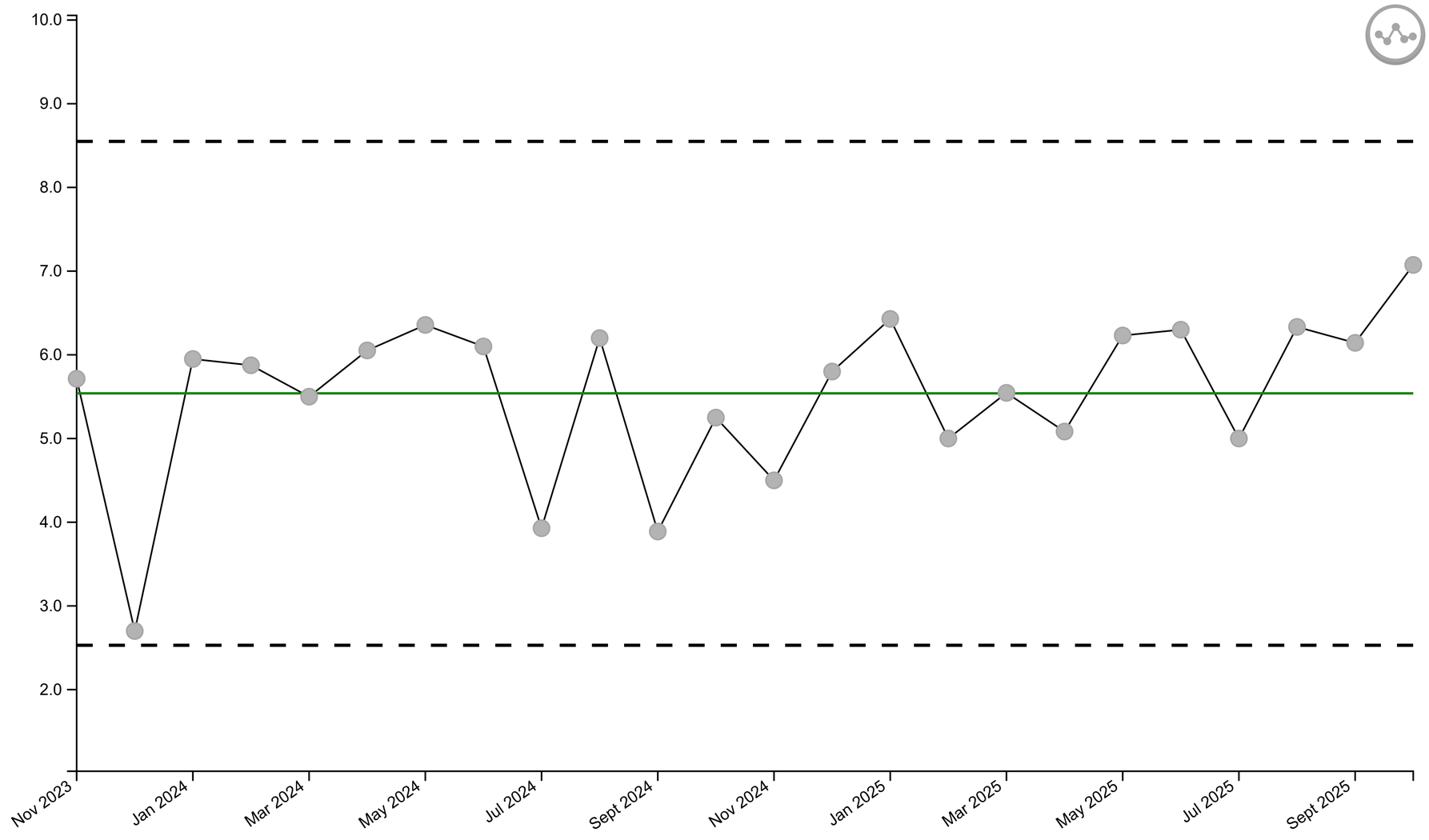
MonthEnding	Utilisation %
31/10/2025	65.2%
30/09/2025	66.4%
31/08/2025	70.1%
31/07/2025	67.3%
30/06/2025	68.4%
31/05/2025	64.4%
30/04/2025	69.0%
31/03/2025	69.0%

Integrated Performance Dashboard - Planned Care

Lead Director: Oliver Bennett

Theatre - Cataract Cases

i-Chart: Average number of cataract cases per session



Mean Line | 99% Limits | Imp. Trend | Det. Trend | Imp. Ast. Point | Det. Ast. Point | Imp. Shift | Det. Shift

Month

October 2025

The data shows normal variation.

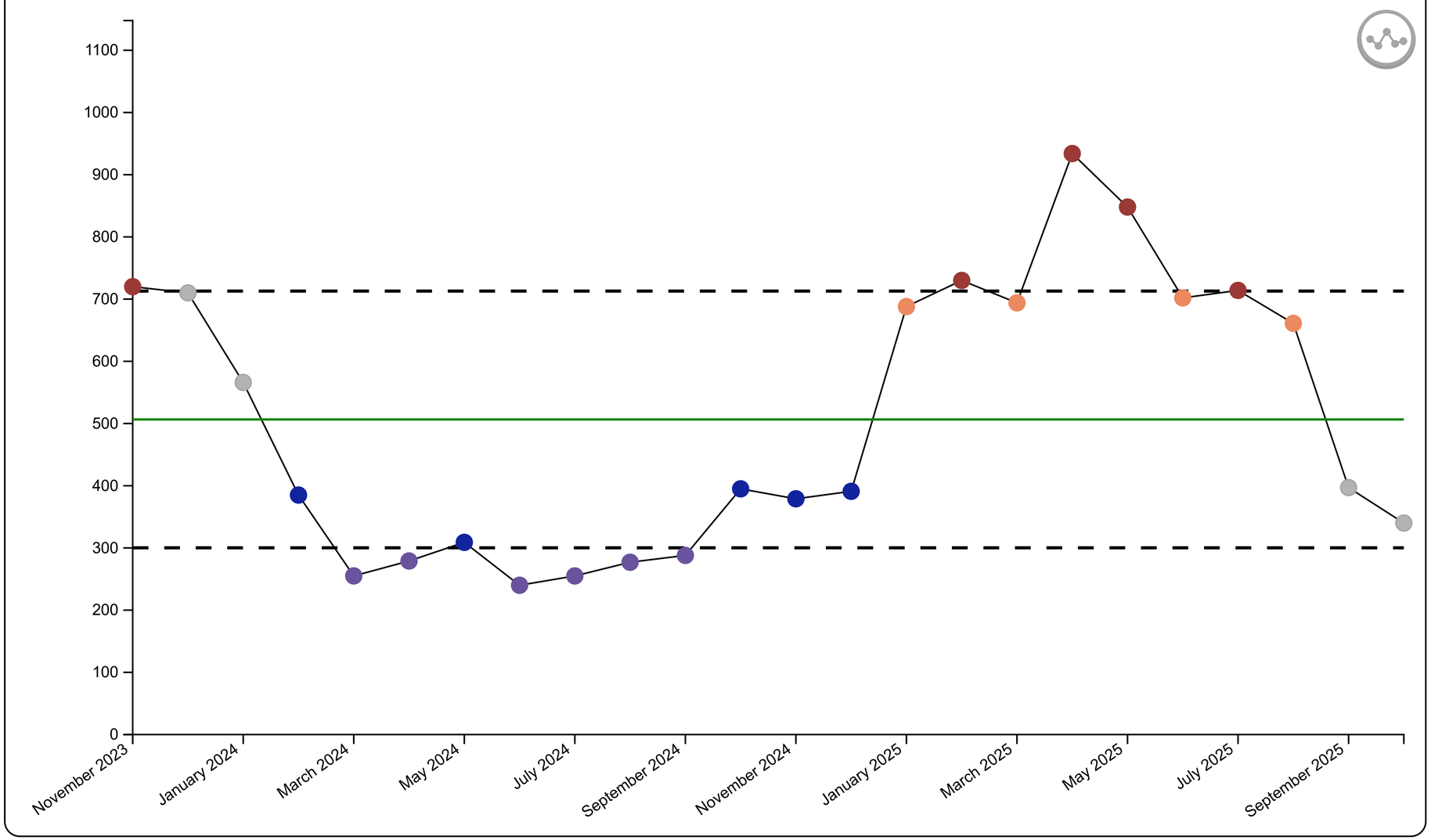
MonthEnding	Sessions	Cataract Cases	Average per Session
31/10/2025	27	191	7.1
30/09/2025	14	86	6.1
31/08/2025	12	76	6.3
31/07/2025	12	60	5.0
30/06/2025	10	63	6.3
31/05/2025	13	81	6.2
30/04/2025	12	61	5.1

Integrated Performance Dashboard - Planned Care

Lead Director: Oliver Bennett

Diagnostic Waits Over 6 Weeks

i-Chart: Patients waiting over 6 weeks for diagnostic services



Month

October 2025

The data shows normal variation.

Performance continues to improve. CT and MRI are performing well. Ultrasound is the main challenge with some recent absence in sonographer workforce and gaps in radiologist workforce. The commencement of a new Radiologist in January 2026 will drive ongoing improvements for the longest waiting patients.

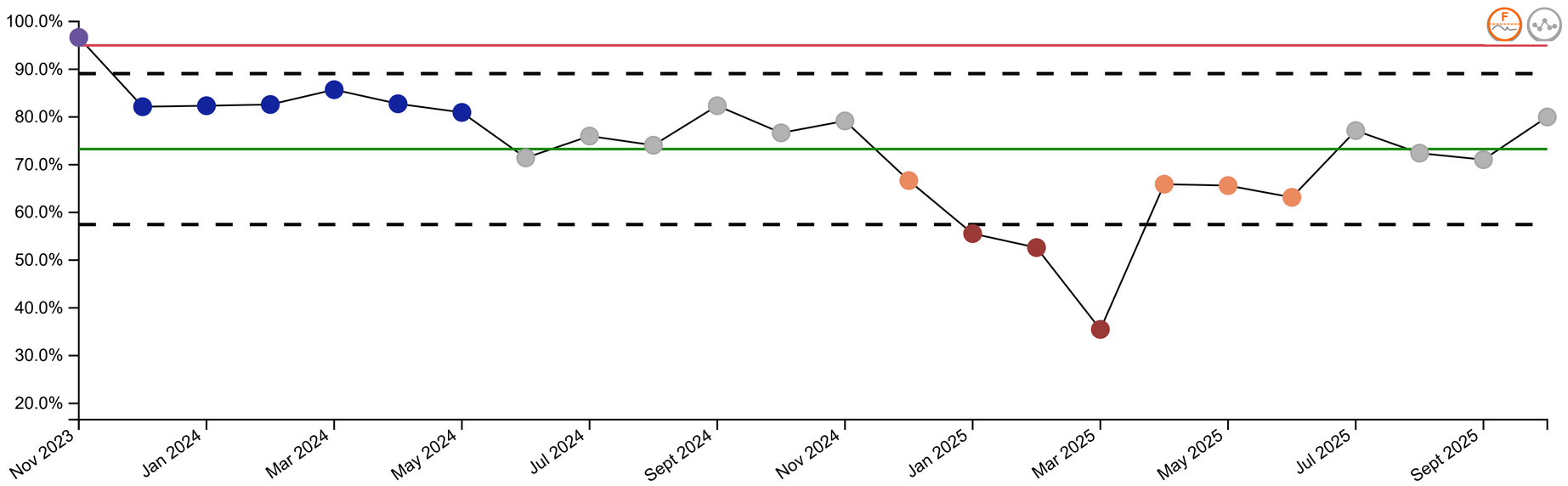
Month/Year	Patients Waiting
October 2025	340
September 2025	397
August 2025	661
July 2025	714
June 2025	702
May 2025	848
April 2025	934
March 2025	694

Integrated Performance Dashboard - Cancer Care

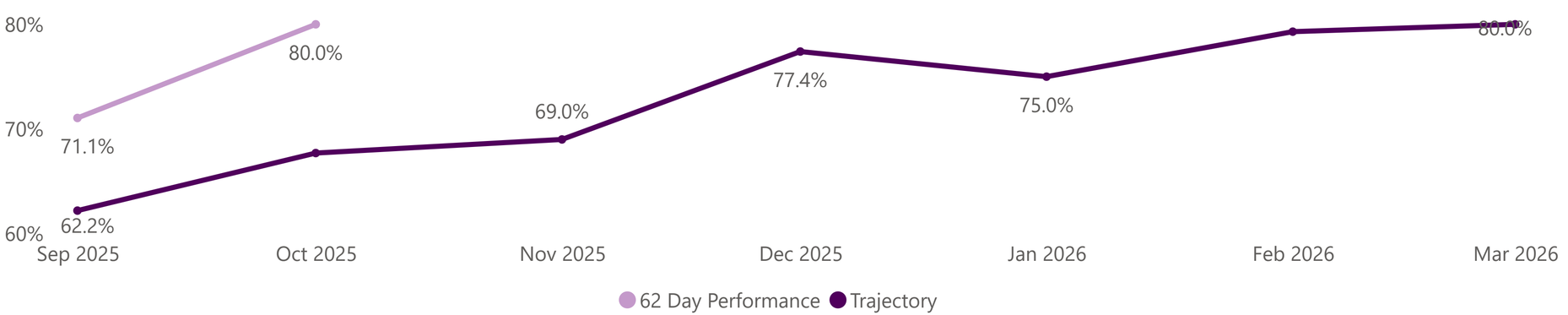
Lead Director: Oliver Bennett

Cancer - Treated within 62 Days

i-Chart: Percentage of patients treated within 62 days of referral



Performance against Trajectory



95% Target | Mean Line | 99% Limits | Imp. Trend | Det. Trend | Imp. Ast. Point | Det. Ast. Point | Imp. Shift | Det. Shift

Month

October 2025

The data shows normal variation but remains off trajectory.

New trajectories have been submitted to Scottish Government through to March 2026. In October, reported performance was 80.0%, compared to trajectory of 68%. This improvement is due to a reduction in the number of breaches reported against the Lung cancer pathway as a consequence of improvement work undertaken.

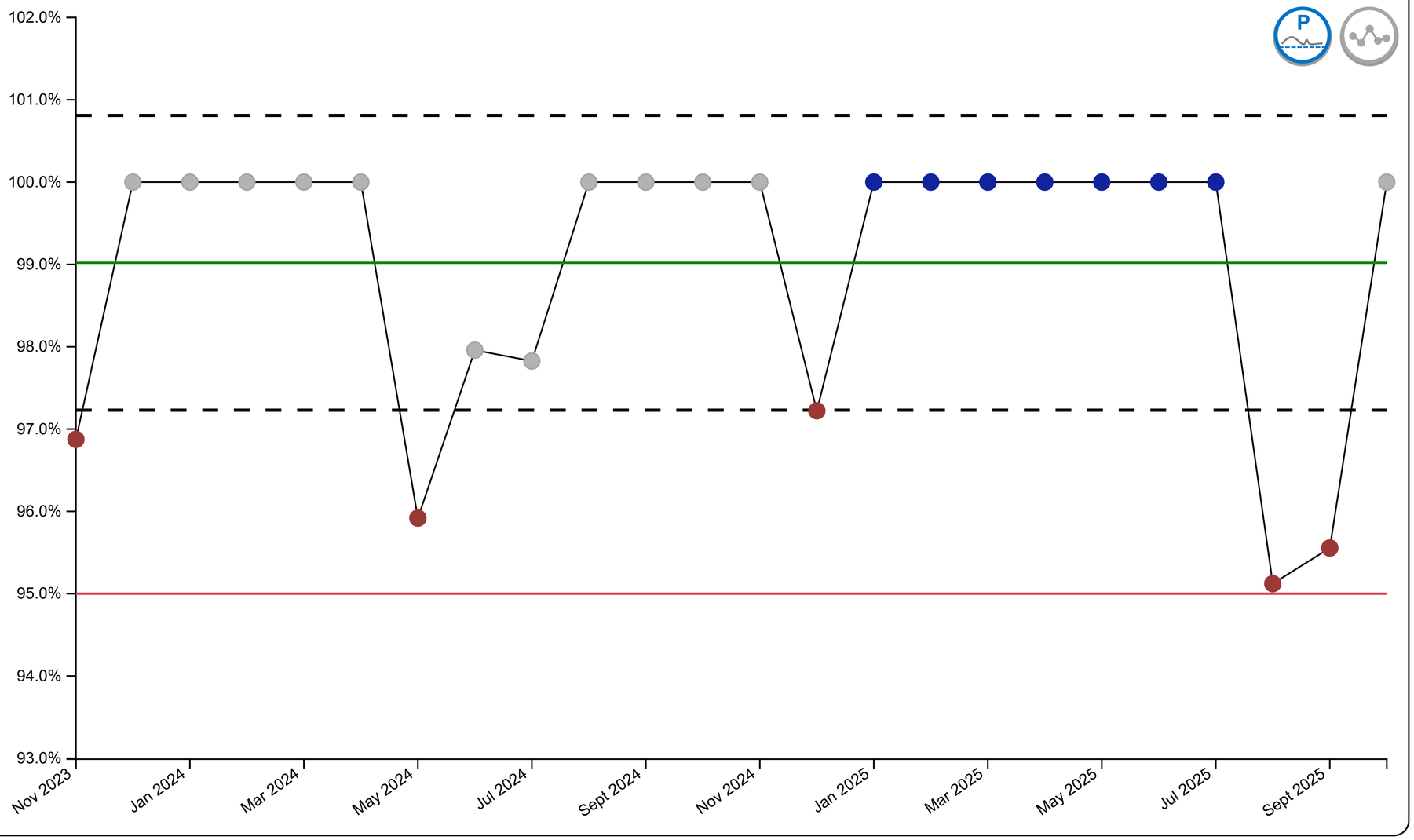
Treat Month	62Day%
October 2025	80.0%
September 2025	71.1%
August 2025	72.4%
July 2025	77.1%
June 2025	63.2%
May 2025	65.6%
April 2025	65.9%

Integrated Performance Dashboard - Cancer Care

Lead Director: Oliver Bennett

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

October 2025

The data shows normal variation and remains above trajectory.

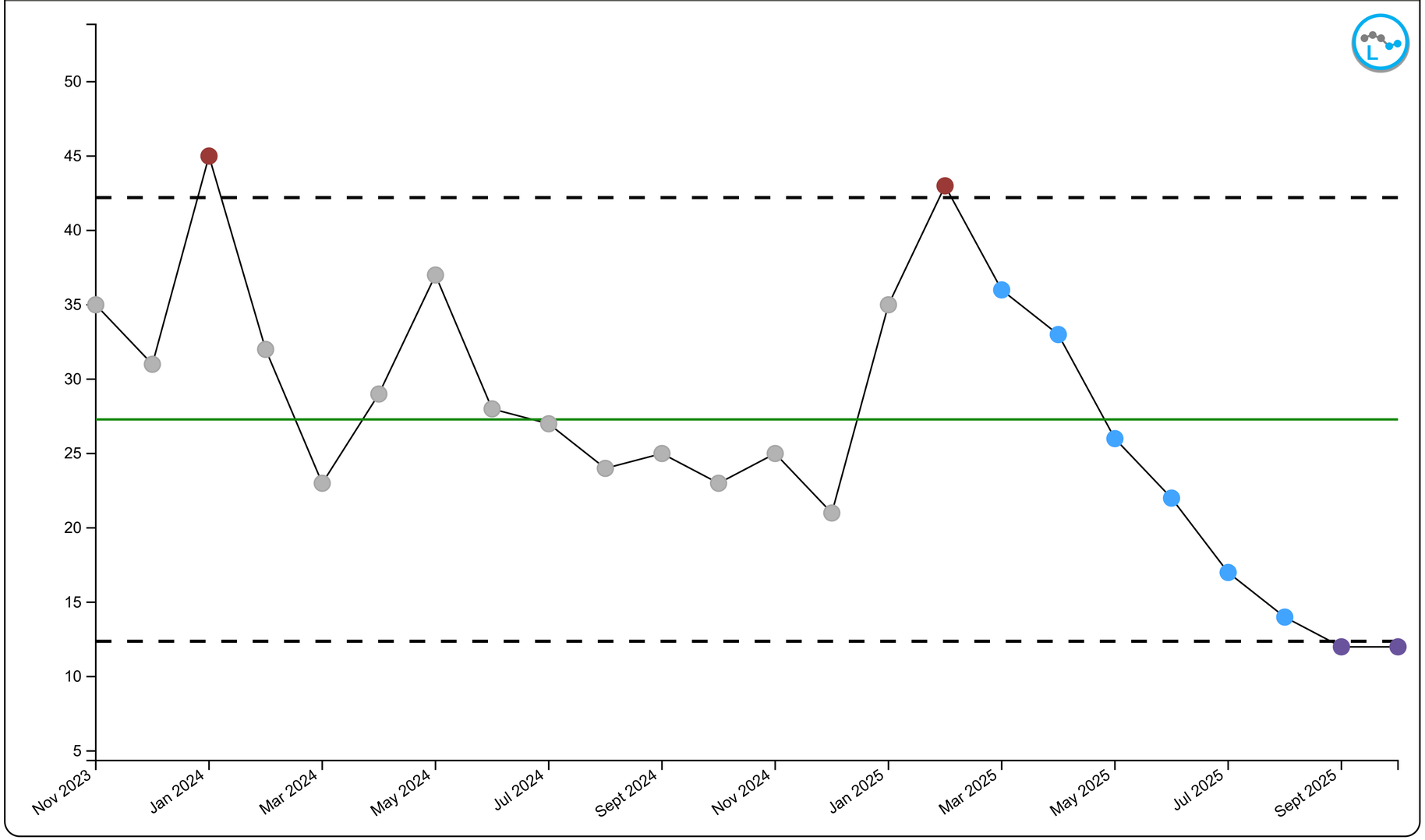
Treat Month	31Day%
October 2025	100.0%
September 2025	95.6%
August 2025	95.1%
July 2025	100.0%
June 2025	100.0%
May 2025	100.0%
April 2025	100.0%

Integrated Performance Dashboard - Cancer Care

Lead Director: Oliver Bennett

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

October 2025

The data shows special cause of an improving shift in performance.

There has been a significant reduction in the number of patients waiting longer than 62-days; the majority of patients in this group are on the Prostate cancer pathway, and this reflects improved performance in the diagnostic pathway locally, and reduced waiting times for surgery in NHS Lothian.

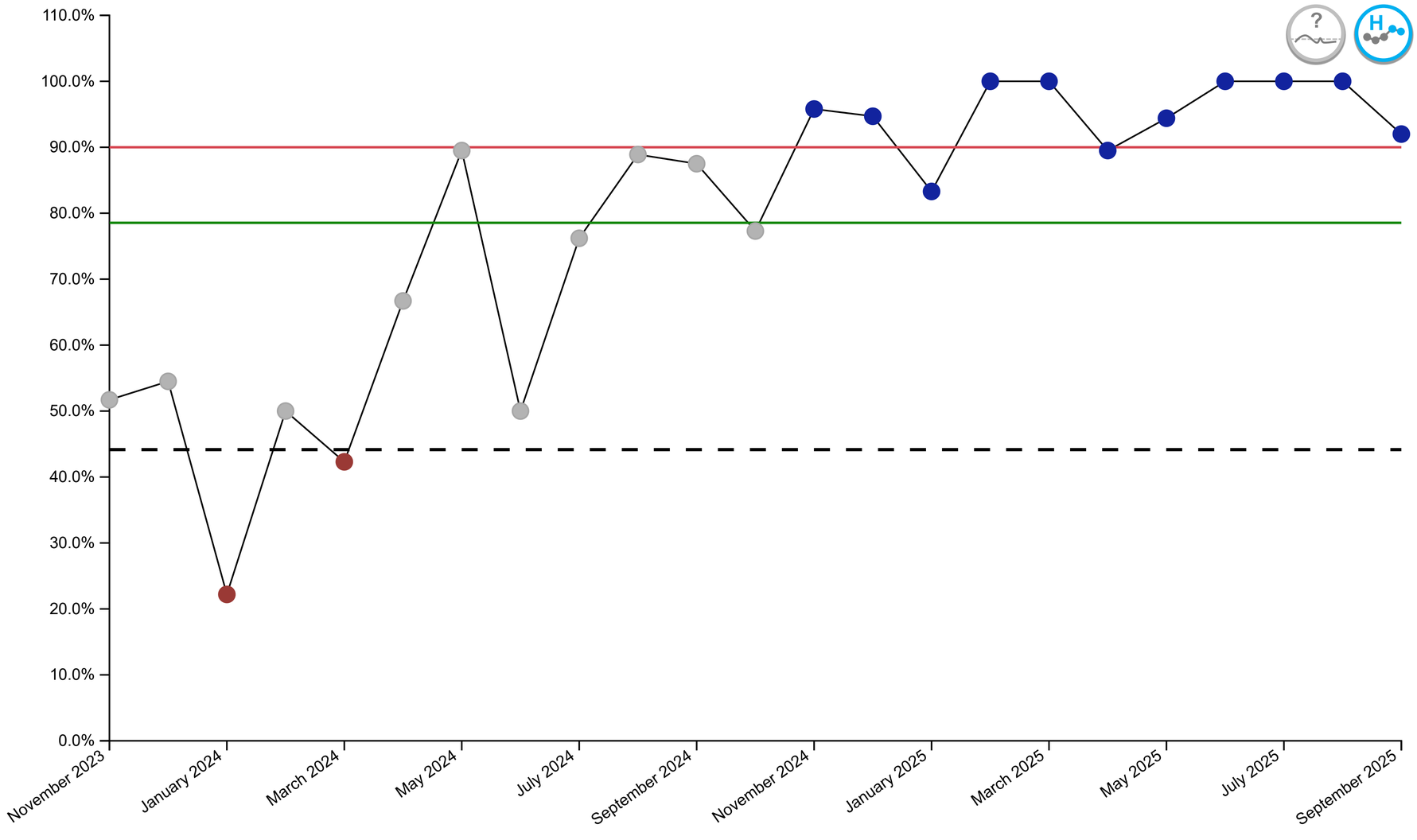
MonthEndDate	Total Backlog
31/10/2025	12
30/09/2025	12
31/08/2025	14
31/07/2025	17
30/06/2025	22
31/05/2025	26
30/04/2025	33
31/03/2025	36

Integrated Performance Dashboard - Mental Health

Lead Director: Gareth Clinkscale

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

October 2025

The data shows normal variation and meeting target.

Please Note: Data has a 1 month lag time.

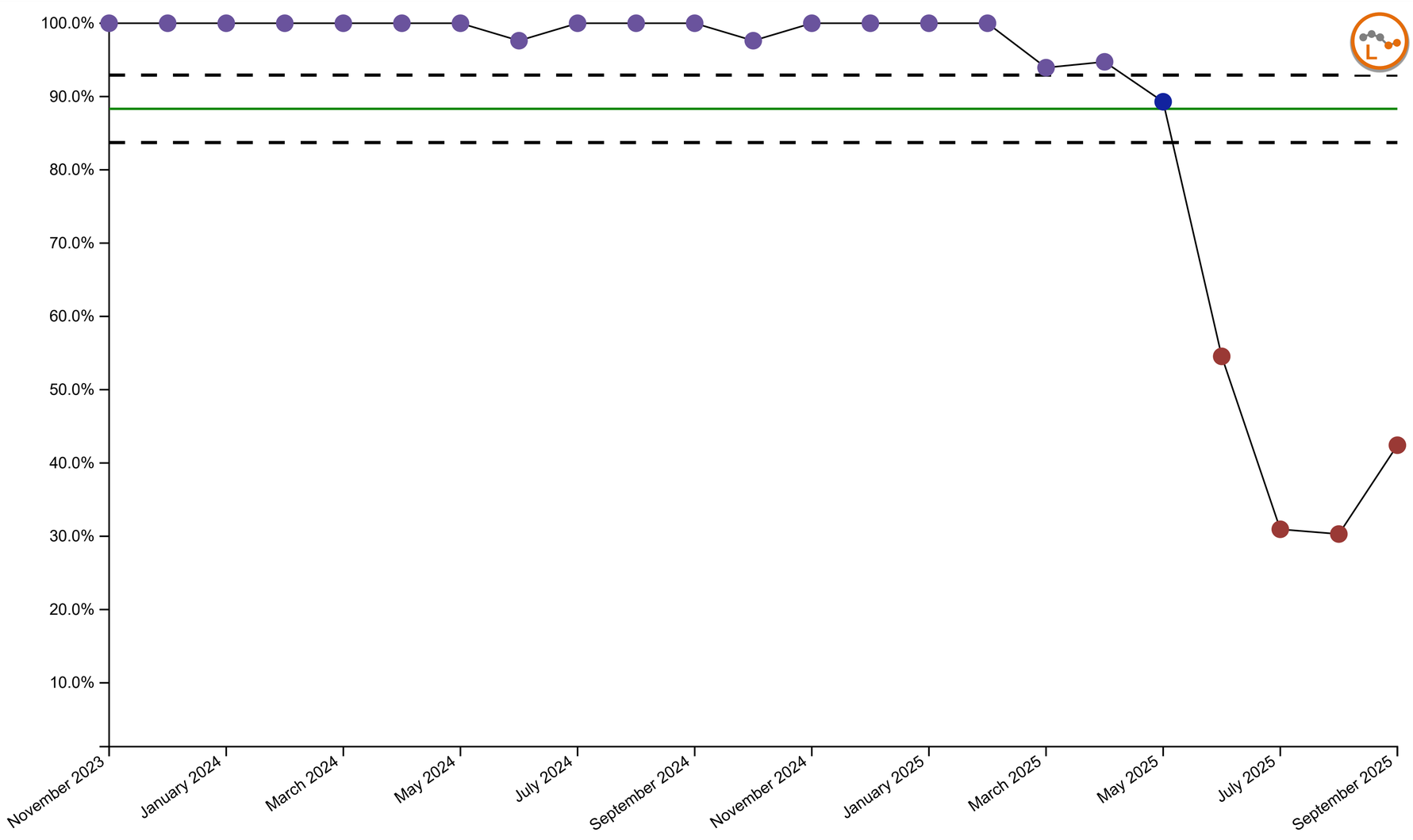
Month	Treatment %
September 2025	92.00%
August 2025	100.00%
July 2025	100.00%
June 2025	100.00%
May 2025	94.40%
April 2025	89.50%
March 2025	100.00%

Integrated Performance Dashboard - Mental Health

Lead Director: Gareth Clinkscale

CAMHS CAT 1

i-Chart: Percentage of Neurodevelopmental Waits seen within 52 weeks



90% Target — Mean Line — 99% Limits - - - - - - Imp. Trend — Det. Trend — Imp. Ast. Point — Det. Ast. Point — Imp. Shift — Det. Shift

Month

October 2025

The data shows special cause of a deteriorating nature.
CAMHS continues to achieve over 90% compliance with the 0–18 week RTT target. In September (October data still to be ratified) Performance (0-18 weeks) for Q/E September 2025 has increased to 96.4% compared to data for last quarter (93.9%). We had 1 DNA at First Assessment New patient appointment.
Please Note: Data has a 1 month lag time.

Month	Treatment %
September 2025	42.42%
August 2025	30.30%
July 2025	30.95%
June 2025	54.55%
May 2025	89.29%
April 2025	94.74%
March 2025	93.94%

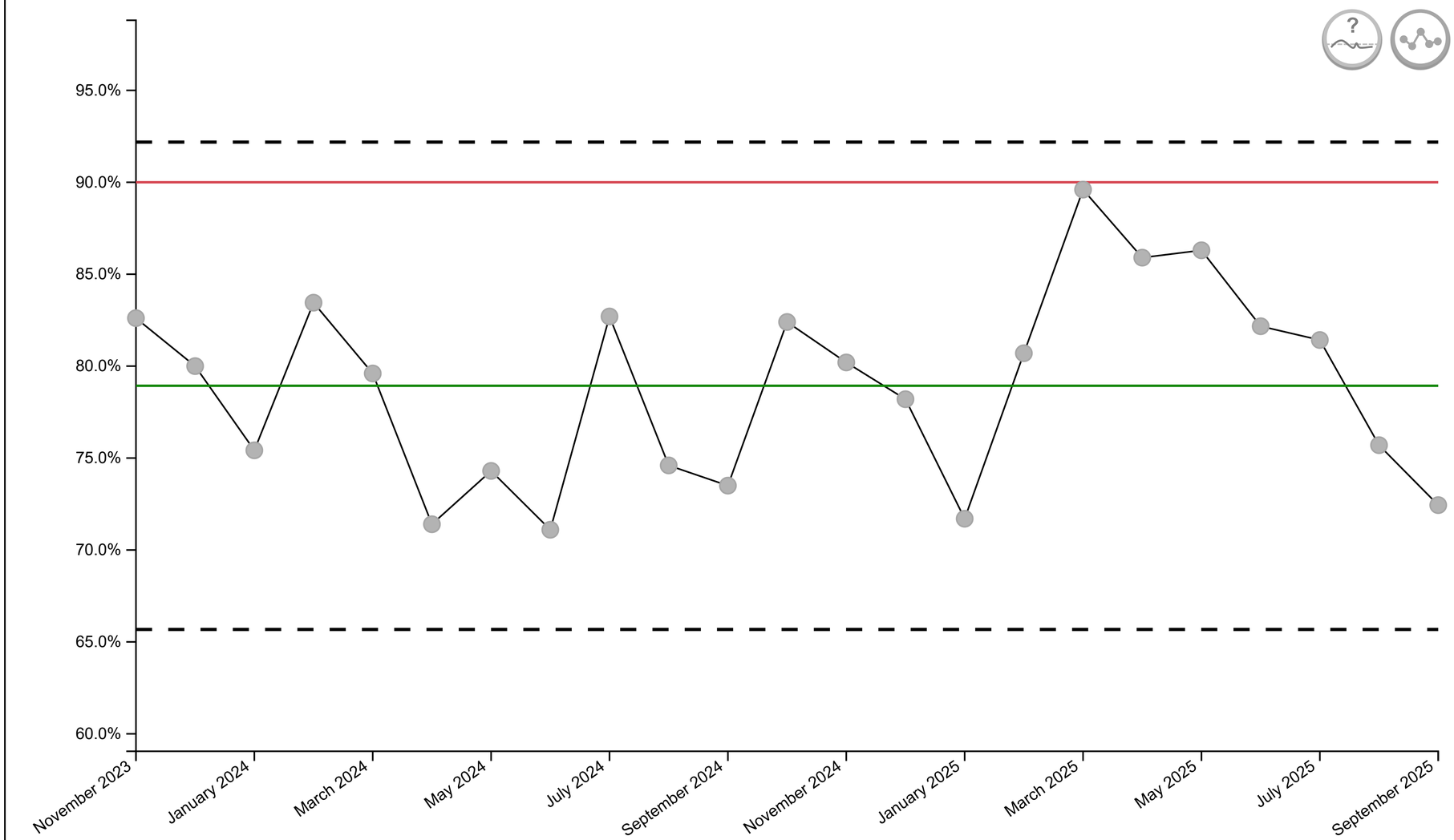
Integrated Performance Dashboard - Mental Health

NHS Borders

Lead Director: Gareth Clinkscale

Psychological Therapy

i-Chart: Percentage of Patients Received Treatment within 18 weeks of Referral



Month

October 2025

The data shows normal variation but outwith trajectory.
Performance in October has very slightly improved but still doesn't meet the Access target. A waiting list initiative has started and will be increased in December to address the longest waits and improve performance. Delays to this starting have related to recruitment and finance which are being resolved.
Please Note: Data has a 1 month lag time.

Month	Treatment %
September 2025	72.4%
August 2025	75.7%
July 2025	81.4%
June 2025	82.2%
May 2025	86.3%
April 2025	85.9%
March 2025	89.6%

90% Target — Mean Line — 99% Limits - - - - - - Imp. Trend — Det. Trend — Imp. Ast. Point — Det. Ast. Point — Imp. Shift — Det. Shift

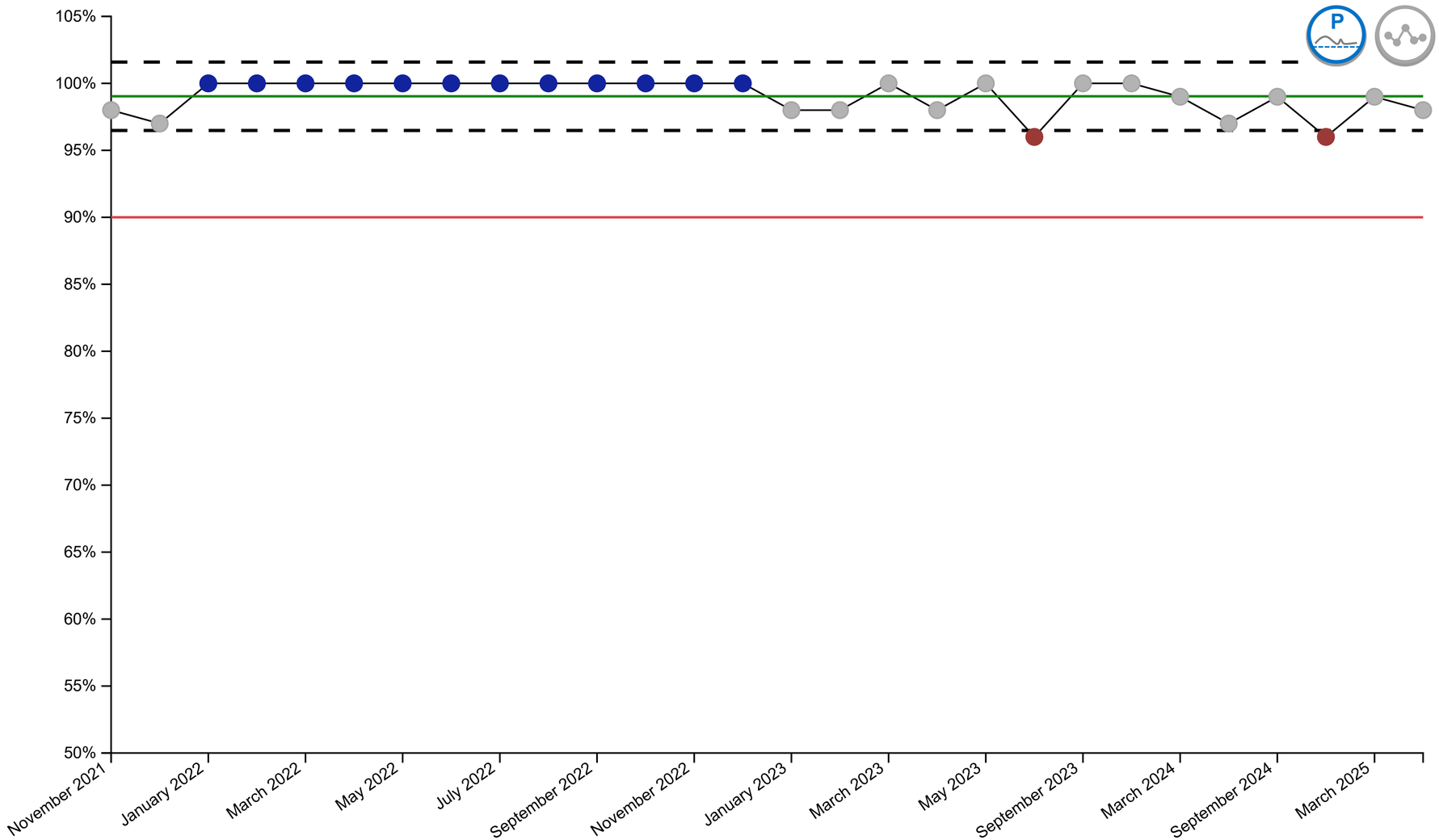
Integrated Performance Dashboard - Mental Health

NHS Borders

Lead Director: Gareth Clinkscale

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

October 2025

The data shows normal variation with performance consistently meeting the 3 week referral to treatment target.

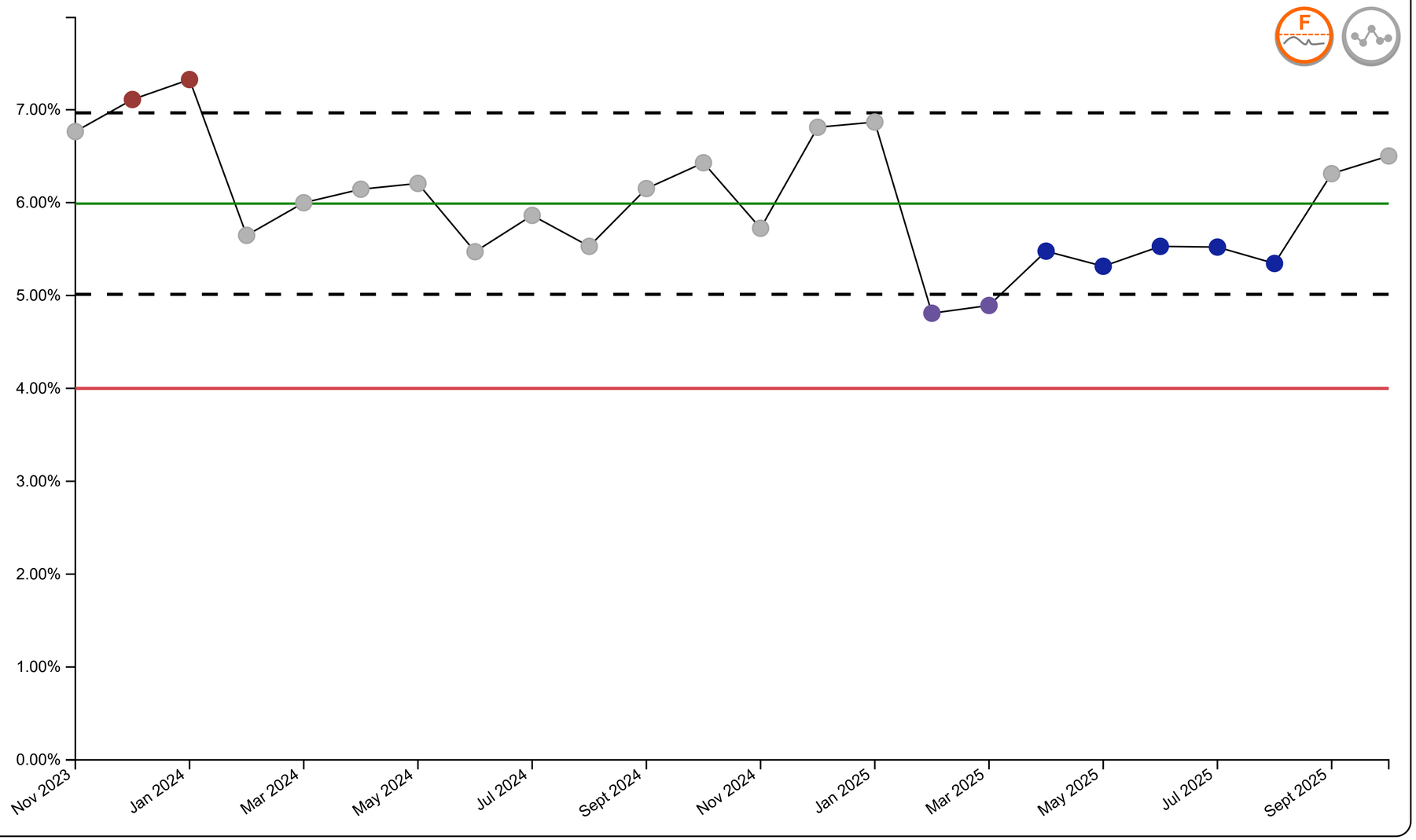
Date	Treatment %
June 2025	98%
March 2025	99%
December 2024	96%
September 2024	99%
June 2024	97%
March 2024	99%
December 2023	100%

Integrated Performance Dashboard - Workforce

Lead Director: Vacant

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

October 2025

Performance within normal variation, but outwith trajectory. Actions taken to improve 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. HR 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
October 2025	6.50%
September 2025	6.31%
August 2025	5.34%
July 2025	5.52%
June 2025	5.53%
May 2025	5.31%
April 2025	5.48%

Integrated Performance Dashboard - Methods & Sources

NHS Borders

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 - Diagnostics	Chart: Diagnostic Waits	Daignostic waits over 6 weeks	Patients waiting over 6 weeks for diagnostic services	Diagnostics Return	Manually calculated figure	Monthly
12	Page: Cancer Care - 31 Days	Chart: Cancer - 31 Days	Cancer 31 Day Target	Percentage of patients treated within	Cancer WT Database (Excel)	Data subject to	Weekly

Integrated Performance Dashboard - Methods & Sources

Number	Topic or Page	Report Element	Indicator Name	Indicator Description	Data Source or Calculation	Known Issues	Refresh Schedule
13	Page: Cancer Care - 62 Days	Chart: Cancer - 62 Days	Cancer 62 Day Target	Percentage of patients treated within 62 days of referral	Cancer WT Database (Excel)	Data subject to updates	Weekly
14	Page: Cancer Care - Treaments	Chart: Cancer - Treated within 62 Days	Cancer Treated within 62 Days	Percentage of patients treated within 62 days of referral	Cancer WT Database (Excel)	Data subject to updates	Weekly
15	Page: Mental Health - CAMHS RTT	Chart: CAMHS RTT	CAMHS RTT	Percentage of patients received treatment within 18 weeks of referral	CAMHS Return	Manually calculated figure	Monthly
16	Page: Mental Health - Psychological Therapy	Chart: Psychological Therapy	Psychological Therapy	Percentage of patients received treatment within 18 weeks of referral	PT Return	Manually calculated figure	Monthly
17	Page: Mental Health - BAS	Chart: BAS	BAS 3 Week Target	Percentage of patients received treatment within 3 weeks of referral	BAS Return	Manually calculated figure	Quarterly
18	Page: Workforce - Total Absence	Chart: Workforce Absence	Total Workforce Absence	% of hours lost for all departments per month	HR Dataset		Monthly

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 in the November 2025 IPR.
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	Will be reported via narrative in the IPR
P10: Increasing capacity for endoscopy and other diagnostic services	ADP	Monitor in 6 week Diagnostic waits
Urgent & Unscheduled Care		
W&CS		
Women & Children's Improvement Measures		To be developed by the service.
MH&LD		
P11: CAMHS Cat 1	ADP	Included in September report for the first month

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	Aim for 2026/27 when the service are confident they are accurately recording
Primary & Community Services		
Primary & Community Services Improvement Measures **Vaccination & Immunisation** • Flu Vaccination Delivery		To be developed by the service. To be included in November report
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:	**4 December 2025**
Title:	**Blueprint for Good Governance Update**
Responsible Executive/Non-Executive:	**Karen Hamilton, Chair**
Report Author:	**Iris Bishop, Board Secretary**

1 Purpose

This is presented to the Board for:

- Awareness

This report relates to a:

- Government policy/directive
- Local policy

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

- Effective

2 Report summary

2.1 Situation

This paper has been developed to provide NHS Board members with an update on the second action plan from the Blueprint for Good Governance.

2.2 Background

The first edition of the Blueprint for Good Governance was published in January 2019 and set out a formal governance model to allow a consistent approach to governance to be developed within each Board. The Board undertook a self assessment against the blueprint in 2020 and concluded its improvement plan against that assessment during 2020-2023.

The second edition of the Blueprint was approved by Ministers and issued to NHS Boards on 23 December 2022. The second edition was formulated to look at the lessons learnt and revised methods of governance following the pandemic, to define what was meant by good governance.

The Board undertook a self assessment survey at its Board Development session held in February 2024 which was facilitated by Scottish Government colleagues and produced an improvement plan (Appendix 1). The improvement plan has been kept under review and is attached as a reminder of the outcomes from that self assessment and the 2 outstanding matters to be concluded by March 2026.

2.3 Assessment

The second edition of the Blueprint built on the ethos of active governance that was introduced to NHS Boards in 2019 and covered a number of areas including governance of healthcare, performance frameworks, risk management and collaborative governance.

It had a greater emphasis on the delivery mechanisms that support governance and the continuous improvement approach needed to ensure governance remains responsive to the challenges facing the NHS.

The Board will be required to undertake an annual structured self assessment to review its effectiveness, and identify any new and emerging issues or concerns. The self assessment will be issued by the Scottish Government and take the form of an online survey. A date for the release of the self assessment has not yet been determined.

The Scottish Government requested sight of all Health Board Self Assessment Improvement Plans in September 2025 and we submitted out action plan as attached.

Board Secretaries are awaiting confirmation of the next self assessment cycle from the Scottish Government.

2.3.1 Quality/ Patient Care

No quality or patient care issues have been identified.

2.3.2 Workforce

No workforce related issues have been identified.

2.3.3 Financial

No financial issues have been identified.

2.3.4 Risk Assessment/Management

Risk management is an integral part of the active and collaborative approaches to delivering good governance.

2.3.5 Equality and Diversity, including health inequalities

An impact assessment is not required.

2.3.6 Climate Change

No impacts have been identified.

2.3.7 Other impacts

No other impacts have been identified.

2.3.8 Communication, involvement, engagement and consultation

This paper has been prepared specifically for the Board and does not require external consultation.

2.3.9 Route to the Meeting

This has been developed directly for the Board.

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:

- **Moderate Assurance**

3 List of appendices

The following appendices are included with this report:

- Appendix No, 2025 Blueprint for Good Governance Action Plan Update

Priority Area	Blueprint Function	High level Action	Lead	Timeline	Status	intended good governance outcome	What we are doing
Functions	Setting the Direction	Refresh approach to oversight of major priorities to enhance visibility and assessment of impact.	Chief Executive	Mar-25	Complete	Ensure the Board owns the plans for major priorities and the key drivers are well understood	Creation of an Organisational Strategy, underpinned by a Clinical Strategy. Organisational Strategy to be approved by Borders NHS Board in April 2025
Functions	Managing Risk	Revisit risk appetite in light of current operating context and use this as part of empowering teams to be innovative and ensure best value.	Director of Quality & Improvement	Mar-25	Complete	Enhanced scrutiny of risk at Board and Governance Committee level and its link to best value	Strategic Risks are allocated to each Governance Committee.
Delivery	The Assurance Framework	Given current challenging operating context, ensure that the Board is looking to others outwith the NHS for innovation, including bodies such as The Kings Fund.	Chief Executive, Board Secretary	Mar-26	In Progress	Improved visibility of assurance pathways across the Board and the Governance Committees. Provide a clear triangulation of assurance information.	Formulate a clear process for the triangulation of assurance (Data & Information/Observing/People)
Delivery	The Integrated Governance System and The Operating System	To ensure that the Board is operating as effectively and efficiently as possible, and that the Board are sighted on improvement and transformation programmes, embed a focus on Best Value across the organisation and regular reporting to the Board on timescales and progress with major transformational programmes.	Director of Planning & Performance / Director of Quality & Improvement	Mar-26	In Progress	Clearer oversight of how success is achieved and monitored on improvement and transformational programmes.	Quality Improvement to be embedded through the organisation as an enabler to support the Organisational Strategy and Decision Making processes.

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**4 December 2025**
Title:	**Consultant Appointments**
Responsible Executive/Non-Executive:	**P Moore, Chief Executive**
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, 2 new consultants have been interviewed, offered and accepted a consultant post.

New Consultant	Post	Start Date
Dr Alasdair Turnbull	Consultant Anaesthetist	February 2026
Dr Elizabeth Layden	Consultant Obstetrician & Gynaecologist	TBC – likely Summer 2026

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.