NHS Borders

Our Future Selves

Improving the Health and Wellbeing of Children and Young People in the Scottish Borders

The Director of Public Health Annual Report

Dr Sohail Bhatti | Director of Public Health

2025

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FOREWORD AND ACKNOWLEDGEMENTS

This Director of Public Health (DPH) Report is my independent professional assessment, intended to support strategic decision-making across NHS Borders and our partner organisations. It provides an evidence-informed overview of the health and wellbeing of children and young people in the Scottish Borders, highlighting challenges and opportunities and setting out recommendations for action.

Against the backdrop of an ageing population and growing demand on services, we must ensure that the needs of children and young people in the Borders are not overlooked. The foundations for lifelong health are laid early, and investing in upstream prevention offers one of the most effective ways to improve outcomes and reduce avoidable future harm.

I would like to thank colleagues across the Public Health Department who contributed to the development of this report. I am also grateful to colleagues in the Education Department of Scottish Borders Council, teaching staff across the authority, and frontline NHS professionals, including health visitors and school nurses, who took the time to share their insights and reflections.

Following the publication of this report, I would like to hear more from children and young people directly to consider how we tackle some of the issues identified and support them to live happier and healthier lives.

Dr Sohail Bhatti | Director of Public Health | NHS Borders

INTRODUCTION

Children and young people in the Scottish Borders deserve to grow up in environments that allow them not only to be healthy, but to thrive. Yet for too many, this is not the reality. This year's DPH Report focuses on the health and wellbeing of the youngest people in our communities, recognising both the unique opportunities of early life and the persistent challenges that shape outcomes long before adulthood.

Many of the issues highlighted in this report are not new. Hidden deprivation continues to affect families across the Borders, often masked by rurality and dispersed communities. We know that substantial health inequalities are evident even before a child starts school, and that these gaps widen over time. The early years remain a critical window for prevention, yet longstanding social and economic disadvantage continues to drive markedly different life chances for children growing up only a few miles apart.

Alongside these entrenched problems are the stubborn challenges that we, as a system, have struggled to shift. Rates of smoking in pregnancy remain disproportionately high in our more deprived communities; child poverty continues to shape daily life for many families; and parental stress, financial strain and poor mental health affect the foundations on which children build their development. These issues demand ongoing, coordinated attention, drawing on the strengths of health, education, social care, the third sector and communities themselves.

We must also address the emerging pressures that are reshaping childhood. Rising screen time, exposure to online harms and the normalisation of ultra processed diets present new and complex risks to physical and mental wellbeing. These trends affect all families, but the impacts are greatest where resources, stability and choices are most constrained.

There is no doubt that childhood is the setting on which whole of life experience is based. Childhood obesity leads on to obesity in adulthood in many, if not most cases. Habits and the response to childhood trauma (self-medication) results in diseases later in life such as mental ill-health, circulatory and respiratory diseases which lead to

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expensive interventions and complex care packages. Primary prevention means we must tackle these root cause issues at source: in childhood. A whole systems approach to childhood for children and young people benefits the entire system. With approximately 30 to 40% of grandparents providing regular childcare to their grandchildren in Scotland, I estimate that approximately 60% of adults in the population partake in formal caring roles for children. Not only can we save future costs by promoting healthy childhoods, but we can also see children as agents of change who can influence their parents and grandparents, becoming "healthy heroes" for everyone around them. We need to do this explicitly and at scale, if we are to prevent future ill-health, which is otherwise at risk of creating demands for healthcare that we cannot afford nor manage.

This report calls for us to strengthen our collective response, ensuring that children and young people become a shared priority across the whole system. In a region where demographic pressures mean that older adults have rightly received significant strategic focus, it is essential that the needs of children are not overshadowed. A truly preventative approach requires us to invest earlier, act on the determinants of health, and design services and systems that work seamlessly around families, not the other way around. Indeed, the health inequalities that we see throughout life start early and widen with time. The Tackling Health Inequalities in the Scottish Borders Strategy (THIS Borders), produced in 2024, provides the evidence base for us to work from in improving fairness of opportunity and outcome for our young people.

Supporting children to thrive means focusing on what matters most: secure and nurturing relationships, safe and healthy environments, access to nutritious food, opportunities for play and learning, and communities that enable families to flourish. While the greatest need lies in areas of multiple deprivation, we must remain attentive to the experiences of families across all of the Borders, recognising that vulnerability exists everywhere, and that prevention must be proportionate and equitable.

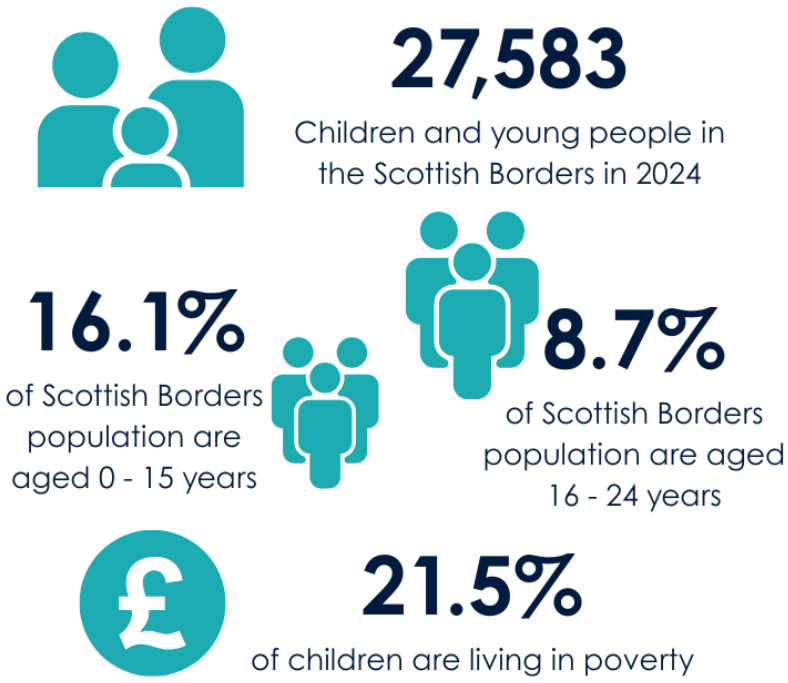
By bringing together evidence, lived experience and the perspectives of partners across sectors, this report invites us to recommit to a shared ambition: that every child in the Scottish Borders grows up with strong foundations for lifelong health and wellbeing.

CHAPTER 1
THE DEMOGRAPHICS OF THE BORDERS

- **There are proportionally fewer children and young people living in the Scottish Borders compared to the rest of Scotland**
- **A low birth rate is driving natural decline in the population which has implications for service planning**
- **21.5% of children growing up in the Borders are experiencing poverty**

The Scottish Borders has a comparatively smaller proportion of children and young people than Scotland overall. In 2022, the largest age group locally was those aged 45 to 64 (35,278 people), while young adults aged 16 to 24 formed the smallest group (9,456 people). More females than males lived in the area in four out of six age groups.

In 2021, the region had proportionally fewer children aged 0 to 15 (16.1%) and young people aged 16 to 24 (8.7%) compared with the Scottish averages of 16.6% and 10.2% respectively. Within the Scottish Borders, demographic patterns vary by locality: Tweeddale had the highest proportion of children aged 0 to 15 (17.5%) and Cheviot has the lowest at 14.7%. The proportion of young people aged 16 to 24 ranged from 8.1% in Berwickshire and Cheviot to 9.3% in Eildon, as below.



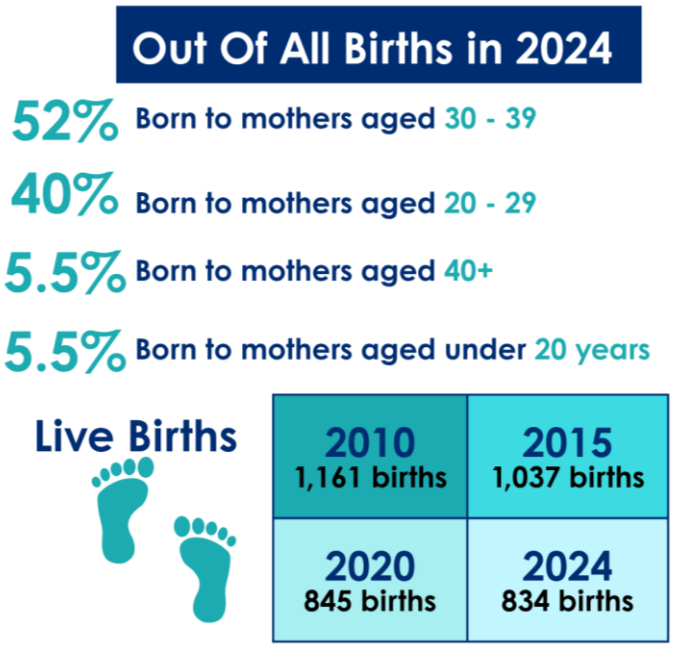
CHAPTER 1
THE DEMOGRAPHICS OF THE BORDERS

Table 1:The population of children and young people in the Scottish Borders by area.

Area	% of population aged 0 - 15	% of population aged 16 -24
Berwickshire	15.7%	8.1%
Cheviot	14.7%	8.1%
Eildon	16.4%	9.3%
Teviot and Liddesdale	15.9%	8.7%
Tweeddale	17.5%	8.7%
Scottish Borders	16.1%	8.7%
Scotland	16.6%	10.2%

The Scottish Borders continues to experience a notably low birth rate, now well below the Scottish average, contributing to a widening demographic imbalance. With fewer children and young people and a shrinking population of people of reproductive age, the area faces ongoing natural population decline, driven by sustained low fertility and an ageing population structure. Although inward migration provides some short-term offset, it is insufficient to counteract long-term demographic pressures. These trends have significant implications for future service planning, workforce sustainability and the wider social and economic resilience of the region.

To better understand the demographic and outcome data for children and young people in the Borders, the public health team are compiling a joint strategic needs assessment that will be published later in the year.



CHAPTER 2
OVERARCHING ISSUES

- **It is hard to measure deprivation in rural areas such as the Scottish Borders because of pockets of deprivation can be hidden.**
- **Parents play an essential role in supporting children's learning, wellbeing, and behaviour at school as well as at home.**
- **We need to ensure that care-experienced children and children with additional needs are given specific consideration in service planning.**

Measuring Deprivation

Measuring deprivation in a rural area such as the Scottish Borders presents unique challenges that are often overlooked by traditional indices like the Scottish Index of Multiple Deprivation (SIMD). Households experiencing hardship may be scattered across large geographic areas, making it difficult for standard measures to accurately capture their circumstances. In dispersed rural communities, poverty can be exacerbated by factors such as:

- distance from services
- limited public transport
- the absence of visible concentrations of disadvantage
- a higher cost of living and food insecurity
- social isolation.

As a result, significant pockets of deprivation can remain hidden, leading to underestimation of need and gaps in support. To ensure that resources are targeted effectively and all children and families receive the help they require, it is essential to develop more nuanced approaches that combine quantitative data with local insight and lived experience. By better understanding hidden deprivation, we can design interventions that are truly responsive to the realities of rural life and address inequalities wherever they exist.

Tackling Child Poverty

Child poverty remains a significant issue in the Scottish Borders, though the proportion of children living in low-income families (before housing costs) has seen a slight improvement, falling from 16.2% in 2022/23 to 15.9% in 2023/24. After housing costs, however, 21.5% of children continue to live in poverty, highlighting the pressure that

housing affordability places on family finances. Ward-level variation is marked, with Hawick and Denholm experiencing the highest rate of child poverty at 25.6%, compared with 11.3% in Tweeddale West, the lowest. Overall, 15.8% of households in the Scottish Borders receive Universal Credit, indicating widespread reliance on social security. These challenges sit within the Children & Young People's Services Plan 2023–26, where child poverty is a core priority delivered through a whole family support approach and overseen locally by the CPP and the Child Poverty Group.

Scottish Government has identified a list of families most at risk of living in poverty, as set out here.[1] More needs to be done across services to support these families.

Families at Greatest Risk of Poverty

	**1 - Lone parents**
	**2 - Families where a member of the household is disabled**
	**3 - Families with 3 or more children**
	**4 - Minority ethnic families**
	**5 - Families where the youngest child is under 1**
	**6 - Mothers aged under 25**

The new child poverty dashboard being developed by Public Health Scotland will provide a single, trusted and regularly updated source of intelligence, enabling NHS Borders and partners to build a clear and current picture of poverty and child poverty locally. By bringing together rich, nationally published data and presenting both primary and secondary indicators, the dashboard supports a deeper understanding of needs, trends and patterns, including comparisons with similar local authority areas.

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The Vital Role of Parenting

Modern-day parenting is increasingly shaped by a complex mix of social, economic and environmental pressures. Parents describe rising living costs, transport barriers, rural isolation, and high expectations around child development as persistent stressors, all of which can heighten daily strain.[2] Digital pressures, including social media comparison, managing screen time and online safety, add another layer of challenge for families already navigating reduced informal support networks. These pressures contribute to parental stress and anxiety, which Public Health Scotland notes can significantly influence children's early development, affecting attachment, emotional security and behavioural regulation[3]. Financial strain, housing insecurity, loneliness and perinatal mental health concerns often compound these challenges, shaping family wellbeing from infancy onwards.

In response, national policy and practice across Scotland highlight the importance of early, accessible and non-stigmatising parenting support.[4] Evidence-based programmes such as Mellow Parenting, Play, Talk, Read, and the Universal Health Visiting Pathway aim to strengthen parent–child relationships and build emotional resilience, particularly for families facing adversity.[5]

Parents also play an essential role in supporting children's learning, wellbeing, and behaviour at school. National guidance is clear that while schools provide structure, teaching and pastoral support, they cannot resolve every difficulty children face; positive outcomes rely on a strong partnership between home and school. Research commissioned by the Scottish Government and Education Scotland shows that when parents reinforce expectations at home, such as attendance, routines, respect, and engagement with learning, children are more settled, more resilient, and better able to thrive in the classroom.[6]

Vulnerable Children

Our children deserve our support, but most of all are those children who fall into vulnerable groups. These include children outside of mainstream education, those with learning and physical disabilities, those living in poverty or in care, and those who belong to excluded groups such as gypsy, traveller communities. Protecting vulnerable

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OVERARCHING ISSUES

children is a core public health responsibility in Scotland. This is underpinned by national frameworks such as Getting It Right for Every Child (GIRFEC), the Children and Young People (Scotland) Act 2014, and the UNCRC approach to safeguarding rights and wellbeing. Children in care, and those with care-experienced backgrounds, require particular attention through robust corporate parenting duties placed on public bodies to ensure they are safe, nurtured and enabled to thrive. Public health guidance highlights the heightened risks faced by these children. This includes disrupted relationships, poorer health outcomes and structural disadvantage, hence reinforcing the need for trauma-informed, rights-based practice. As a system we must ensure that we have a properly resourced and accountable approach to corporate parenting, with clear roles and responsibilities between organisations.

Children and young people with learning disabilities experience significant health and social inequalities. Public Health Scotland emphasises the importance of coordinated support and inclusive education in addressing these gaps.[7] Indeed, trusted relationships, early recognition of needs and accessible support services contribute positively to wellbeing and long-term outcomes. We must improve understanding of the needs of children with learning disabilities. I believe we have incomplete data and evidence in relation to planning services that provide this support.

CHAPTER 3
WHAT WE HAVE BEEN TOLD

We have spoken to colleagues across the Scottish Borders who are working closely with children and families. We have heard from teachers, health visitors, and school nurses. They have given us a rich insight, and we must do more to involve these perspectives as part of routine practice.

What health visitors have told us:

- Although there is a lot of willingness across professionals and organisations, strategic planning and oversight is fragmented and there is a risk of duplication.
- There is a risk of defaulting to "throwing interventions" at communities to see what works. A joined-up approach at every level is needed for change to work and be sustained.
- There is a perceived gap in Infant/Parent Mental Health (IPMH) support and need to develop different approaches to family support.
- There are challenges around autism/neurodevelopmental pathways as well as delays in Speech and Language Therapy (SLT) appointments.
- Complex needs of many families, including the impacts of poverty and poor parental mental health, means that services are stretched.

What teachers have told us:

- Pupils arriving hungry (and some consuming energy drinks) are struggling to concentrate; some families are not accessing free school meals, and there is no provision for breaktime snacks.
- Increasing concerns around basic hygiene (e.g., unclean clothing/body odour), with occasional indicators of exposure to substance use at home (e.g., smell of cannabis on clothing).
- Stigma prevents some families from seeking help early, meaning schools often identify needs indirectly and later, reducing opportunities for early intervention.
- A widening poverty gap is limiting access to enrichment opportunities, such as swimming lessons, affecting pupils' physical health and social development.
- Rising additional support and mental health needs, delays and capacity in services, and challenges, such as mobile phone impacts, parental capacity, and short-term social work involvement, are increasing pressure on schools.

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WHAT WE HAVE BEEN TOLD

What school nurses have told us:

- We need to better consider our care experienced population (links to UNCRC and The Promise) and our corporate parenting responsibilities.
- There are rising emotional health and wellbeing needs for pre-adolescents and adolescents causing school non-attendance due to anxiety/low mood.
- There is an increase in neurodevelopmental diagnoses which has an impact across health and education.
- We need to address the lack of parenting support for parents of older children and young people, when challenges often increase as independence grows.
- Some children experience a poverty of opportunity made worse by transport barriers for young people.

CHAPTER 4

SUPPORTING CHILDREN TO HAVE THE BEST START

- **Health inequalities are persistent and enduring and are already evident by the time a child starts school**
- **Giving children the best start in life begins with the pre-conception health of the mother and continues through the early years**
- **We see particular challenges in more deprived areas of the Borders in smoking in pregnancy and sustaining breastfeeding**
- **Poor parental mental health is a worsening problem experienced disproportionately in families in more deprived areas.**

Health inequalities start before birth, are already evident by the time children begin school, and can persist throughout life. Preconception health plays a crucial role in shaping outcomes for parents, babies and families across Scotland.[8]

Factors, such as those below, are linked to risks including premature birth, low birth weight and complications for both mother and baby:

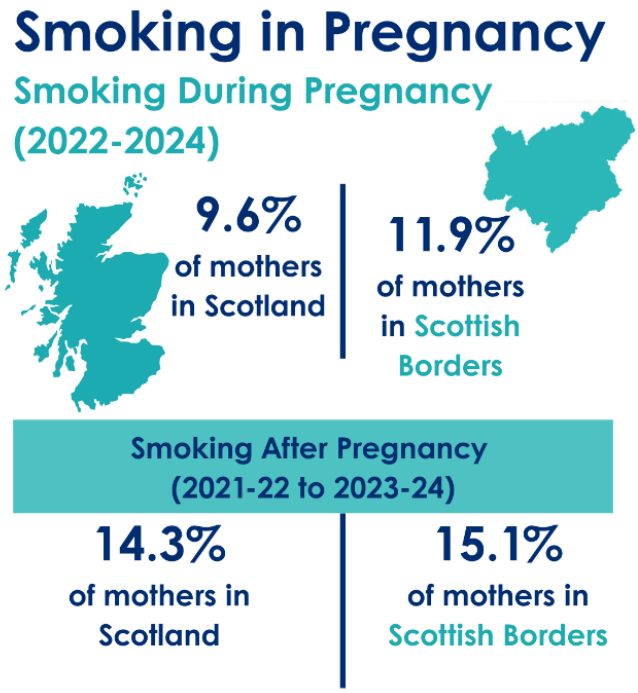
- nutrition,
- mental wellbeing,
- smoking,
- alcohol use, and
- long-term conditions before pregnancy.

Because pre-conception health is shaped by the wider social determinants of health, and many risks are patterned by deprivation, it is essential that services take a non-judgemental approach that recognises the structural barriers people face.

Smoking in Pregnancy

As highlighted in the 2024 NHS Borders Health Inequalities Strategy, THIS Borders, local data demonstrates a stark and persistent gap in smoking rates during pregnancy, with clear inequalities across the deprivation spectrum. Although overall smoking among expectant mothers has declined, women living in the most deprived areas remain more

than four times as likely to smoke during pregnancy compared with those in the least deprived communities (SCOTPHO data).



This pattern mirrors wider socioeconomic differences seen in early years health. Smoking in pregnancy carries significant and lifelong risks for the developing baby and helping mothers to stop smoking remains one of the most cost-effective preventative interventions available. Community midwives have also reported a noticeable rise in vaping during pregnancy, particularly in more deprived areas. While vaping may play a role in smoking cessation, the longer-term implications of vape use in pregnancy are not yet well understood, underscoring the need for clear guidance and continued support. We want to explore how we can do more work to ensure women are well supported to quit smoking and vaping in pregnancy, particularly in locality areas of multiple deprivation, with the insight and experiences of the midwifery team.

Pregnancy and Newborn Screening

Pregnancy and newborn screening in Scotland is a universal public health programme designed to identify conditions in the mother or baby as early as possible. This enables timely clinical care, treatment, surveillance and informed family decision-making. A child can develop life-long chronic conditions that harm future health and life expectancy. Screening is therefore offered at defined points throughout pregnancy and the early postnatal period and forms a core component of routine maternity and neonatal care. Within NHS Borders, these programmes are delivered through integrated midwifery, maternity, laboratory, sonography and public health services. Quality assurance is provided through local and national governance arrangements.

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During pregnancy, screening includes tests for

- infectious diseases (HIV, hepatitis B and syphilis),
- blood group and red cell antibodies,
- haemoglobinopathies (sickle cell disease and thalassaemia),
- chromosomal conditions such as Down's, Edwards' and Patau's syndromes,
- alongside ultrasound-based screening including the mid-pregnancy screening ultrasound scan.

These tests aim to identify conditions where early detection can significantly improve maternal and infant outcomes, reduce morbidity, and support safe pregnancy and birth planning. In NHS Borders, pregnancy screening is embedded within routine antenatal care delivered by community and hospital-based midwifery services, with ultrasound examinations undertaken by sonographers at the Borders General Hospital.

Following birth, all newborns are offered universal newborn hearing screening and the newborn blood spot screening programme, which tests for a range of rare but serious inherited, metabolic and endocrine conditions. Hearing loss, if not detected early can result in lifelong speech impediments and poorer educational attainment. Blood spot samples are usually taken by community midwives in the home setting, with arrangements in place to ensure babies who move into the area without a screening history are offered testing. The overarching aim, as outlined by Public Health Scotland, is to ensure that affected babies are identified as early as possible so that treatment and follow-up can begin promptly, improving long-term health and life-course outcomes.

Local quality assurance overviews across NHS Borders Pregnancy and Newborn Screening groups over the past two years have consistently highlighted the complexity of data flows, with its reliance on multiple IT systems, and the need for robust processes to ensure screening results are received, recorded and acted upon in a timely manner.

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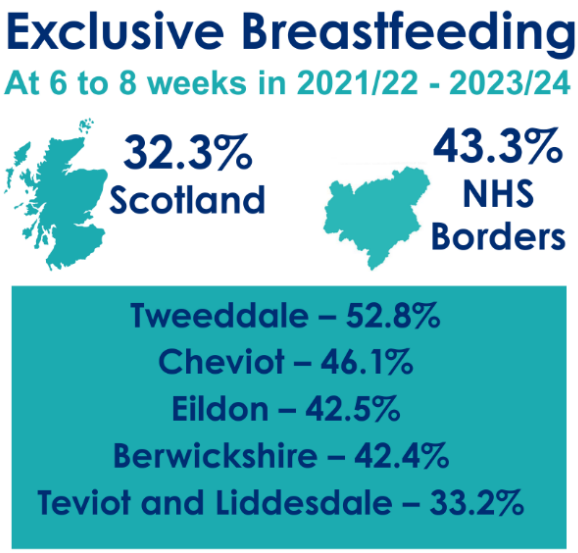
Focus has been placed on:

- haemoglobinopathy screening data quality,
- newborn blood spot timeliness
- avoidable repeat samples, and
- the management of vertical transmission of infectious diseases, with shared learning and improvement actions progressing through established governance routes. We must continue to improve our access to data so we can respond in a timely and appropriate way to any identified issues.

Scotland continues to evolve and expand its screening offer in response to emerging evidence. Spinal Muscular Atrophy (SMA) from 2026 is being added to the programme. This is a sign of a system keen to support the prevention of diseases that affect our youngest members of our community.

Breastfeeding

Breastfeeding is a major public health priority locally and nationally, given its well-established benefits for infant and maternal health, including nutrition, protection against illness and, importantly, connection and attachment. Public Health Scotland's Infant Feeding Statistics 2024/25 report shows breastfeeding rates at their highest levels since records began, with 69% of babies breastfed at birth and, critically, 51% being breastfed at the 6–8 week review, the first time the national target has been surpassed.



Rates have risen in the most deprived areas, helping narrow the socioeconomic gap, although substantial disparities remain. In 2021/22 to 2023/24, the rates of breastfeeding at the 6 to 8 week check were only 18.6% in Burnfoot and 21.3% in Langlee in the Borders specifically (SCOTPHO). Through locality planning activities, in conjunction with Scottish Borders Council, we will seek to explore how to support breastfeeding and increase rates in areas where the rates are lowest.

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We want to seek to implement The Breastfeeding Friendly Scotland Early Learning scheme across nurseries in the Scottish Borders, particularly those in more deprived areas. The scheme offers a structured approach for nurseries to become breastfeeding-friendly through staff training, visible signage, and alignment with national standards. Embedding this scheme within nurseries helps normalise breastfeeding, enhance the support available to families, and contribute to reducing the persistent inequalities in infant feeding outcomes across the region.

It is important to recognise that secure attachment can be achieved through bottle feeding, but it is important that this is done in a responsive, paced, and relationship-focused way. Holding the baby close during feeding, watching for cues, and limiting the number of feeders to maintain consistency and connection, reinforce emotional security. Supporting parents to develop strong bonds of attachment in the early days has lifelong benefits for mental and physical health.

Adverse Childhood Experiences

Adverse Childhood Experiences (ACEs) are potentially traumatic events such as abuse, neglect, or household adversity that can disrupt children's development and increase the risk of poorer physical, mental and social outcomes across the life course. Evidence from the Welsh ACE studies shows that at a population level approximately 47% of adults had at least one ACE and 14% had four or more, with high ACE exposure linked to increased risk of poor mental health, harmful behaviours, and long-term conditions.

This structured collection is valuable because it provides a clearer picture of population level need, highlights inequalities, particularly the higher ACE burden in more deprived communities, and helps services design proportionate, targeted interventions to break intergenerational cycles of harm. Embedding ACE awareness and trauma-informed principles into health, education and social care ensures that practitioners understand how adversity shapes behaviour and health and can respond safely and compassionately.

Our health visiting colleagues have begun collecting data on ACEs over recent years.

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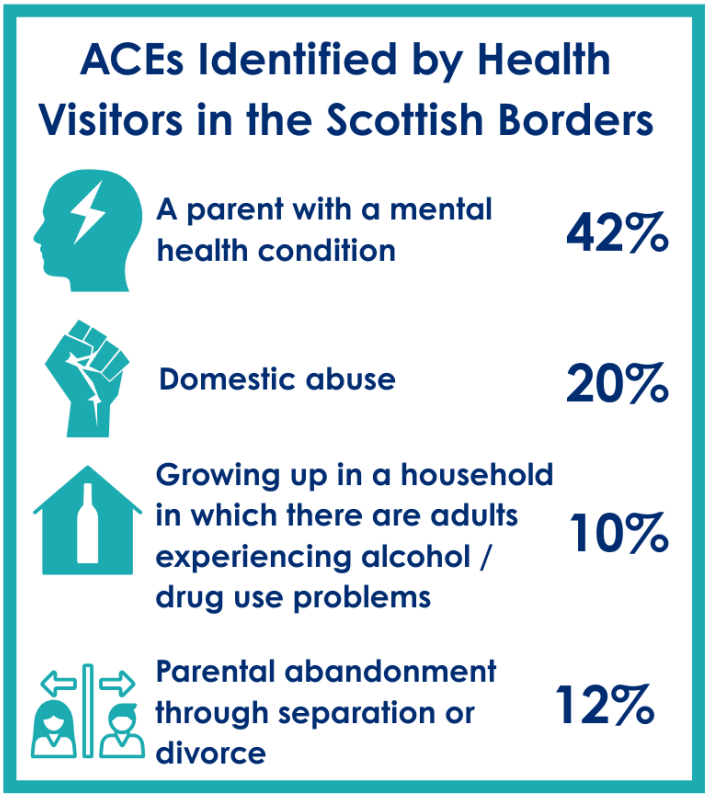
SUPPORTING CHILDREN TO HAVE THE BEST START

We want to better understand how we can reduce issues in data collection and also consider how we can use the data to understand where there is greatest need for early intervention and support is.

The data collected consistently identifies parental mental health as the most prevalent ACE. The current data, however, only captures information about one parent and does not reflect the mental health of other adults in the household, so the figure may be under-reporting.



Evidence indicates that adversity in childhood contributes to approximately 30% of adult mental health problems (Mental Health Foundation, 2020). Strengthening support for parental mental health is therefore essential to preventing future mental ill health and reducing long-term emotional, cognitive and social development inequalities.

To strengthen the collection and use of ACEs data in the Scottish Borders, there is a need for a consistent and trauma-informed approach across all services working with children, young people and families. Current activity, including early work within Health Visiting, highlights the value of gathering high quality ACE information to understand the distribution of childhood adversity locally and its relationship with health inequalities.

However, further development is required to ensure that ACEs are collected sensitively and ethically, with clear guidance on when and how information should be recorded, how it is stored, and how it informs decision-making. A Borders-wide framework would support consistency, enhance confidence among practitioners, and ensure that the collection of ACEs is purposeful and linked to timely and proportionate support.

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Embedding this approach also requires strengthening trauma-informed practice across the system. This includes developing shared training, ensuring alignment between health, education, social care and community partners, and establishing mechanisms for translating ACEs data into earlier intervention and prevention activity.

Expanding routine use of ACEs will help us identify children who would benefit from wrap-around support. This would build future resilience and hence improve educational attainment with all the positive impacts on future life chances that this brings. This informed insight, particularly through close collaboration with education services, will improve understanding of the pressures facing families and support more effective, compassionate responses. In an area where multiple deprivation is difficult to identify at an individual level, this provides another tool to help target support more accurately. Collectively, these steps would enable the Scottish Borders to make better use of ACE data to inform planning, reduce inequalities and ensure services respond in ways that recognise the impact of trauma on children's development, behaviour and long-term health.

CHAPTER 5
THRIVING THROUGH THE SCHOOL YEARS

The school years play a crucial role in shaping lifelong health. During this period, children develop the habits, confidence and social connections that influence their wellbeing well into adulthood. Schools provide far more than education, they offer:

- stability,
- routine,
- opportunities for play and physical activity,
- nutritious meals,
- trusted relationships, and
- early identification of additional needs.

These experiences help protect long-term health and can buffer the effects of disadvantage. When school environments are nurturing, they support children to thrive, strengthen resilience, and reduce the risk of future health inequalities. However, schools report increasing challenges in supporting learning and behaviour as needs become more complex. Earlier, practical support for families to strengthen routines, boundaries and behaviour at home is vital to support and promote inclusive education.

Taking a Rights-Based Approach

Listening to children and young people is central to the UNCRC (Scotland) Act 2024 and aligns with the aim of amplifying young people's voices, addressing inequalities, and informing local action. To support this, the CYPPP undertook focused engagement work to explore which rights matter most to children, how these rights play out in daily life, and what barriers they face. Twenty-four focus groups across the Borders were carried out. These were facilitated by trusted adults already known to the children, helping ensure a safe and supportive environment where participants could speak openly and honestly. The focus groups included a range of age groups across primary and secondary schools as well as specific groups with care-experienced children and young people

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THRIVING THROUGH THE SCHOOL YEARS

These sessions aimed to:

- Understand how children interpret their own rights in the context of home, school and community life.
- Identify the rights they feel are most important to their wellbeing.
- Explore barriers to realising these rights.
- Support a participatory approach to embedding UNCRC principles locally.

Care-experienced children and young people consistently spoke about the importance of having their voices heard. They emphasised their right to express their views and to be genuinely included in decisions that shape their lives. Many explained that simply being invited to take part was not enough: opportunities needed to be real, meaningful and accessible. A number of practical barriers were highlighted, particularly in rural areas. Transport difficulties often prevented children from joining activities or contributing to decision-making spaces. For those with disabilities, these barriers were felt even more acutely, because challenges around accessibility and transport often overlapped.

Among children and young people who were not care-experienced, concerns centred strongly on safety and protection. Many talked about witnessing or hearing about violence in and around school, alongside exposure to violent or frightening stories in the media, all of which contributed to a heightened sense of worry about personal safety. They also raised experiences of misogynistic or racist behaviour that affected their daily lives and shaped their understanding of fairness and respect. Beyond personal safety, some children expressed worries about instability within their families and the pressures many households face in meeting basic needs. They spoke about the importance of having access to clothing, warmth and a safe home environment, and voiced real concern about the wider impact of poverty on children's wellbeing across the region. Across all groups, children and young people were clear that rights genuinely matter to them. As highlighted previously in the report, it is important that we continue to find opportunities to hear the voices of children and professionals who work closely with children. These rights are there to protect everyone, and they work best when people understand the responsibilities that accompany them.

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Children spoke about the importance of recognising that you cannot claim your own rights while ignoring the rights of those around you. Educational professionals tell us how crucial clear boundaries, fair rules and consistent consequences are in creating environments where everyone can feel safe respected and able to learn. A rights-based approach is about creating a framework built on participation, mutual respect, fairness and accountability, principles that help ensure rights are meaningful and protective for all children and young people. This includes at school and at home.

Strengthening the voice and lived experience of children and young people is essential to shaping effective policy, services and decision-making. Their insights must have a more systematic and influential role, with participation that genuinely shapes local priorities and actions. Embedding meaningful participation requires shifting power, which is demonstrated not through consultation alone but through tangible evidence of influence, including how resources flow and how budgets are allocated. Ensuring that young people's experiences directly guide investment decisions is a critical step towards creating a system that responds to what matters most to them and delivers more equitable outcomes.

Child Healthy Weight

Early childhood is a critical period: growth patterns established in the first years strongly predict later health[9]. Child healthy weight remains a key public health priority nationally and locally, with persistent inequalities shaping risk and outcomes. Public Health Scotland data indicates that children living in Scotland's most deprived communities continue to experience significantly higher rates of overweight and obesity compared with those in least deprived areas. In the Borders, overall healthy weight patterns are broadly aligned with national averages, but variation exists between communities, mirroring deprivation, access to healthy food and opportunities for physical activity.

Childhood Obesity and Overweight

Primary 1 aged children are a healthy weight

58.3%		81.6%
Most deprived areas		Least deprived areas

CHAPTER 5
THRIVING THROUGH THE SCHOOL YEARS

Universal early years programmes offer key opportunities for early identification and support, while specialist dietetic services provide targeted interventions. A whole-systems approach remains essential, engaging the Good Food Nation agenda, Community Planning and school-based nutrition. However, cost-of-living pressures, limited affordable leisure options and the marketing of unhealthy foods continue to create significant barriers.

Engagement with colleagues in the Dietetics Service have highlighted challenges in engaging families from the most socioeconomically deprived communities and we are aware that some families feel judged. Once a family is engaged and realises this is not the case, there is usually improved ongoing engagement. A recent audit of service level data found that people not attending appointments in the dietetics service were more commonly living in lower SIMD areas. We need to do more to tackle perceived stigma and judgement for people who need our services.

Oral Health

Good oral health is fundamental to children's overall health, wellbeing and future life chances. Childsmile is Scotland's national child oral-health improvement programme. It is a long-established, evidence-based initiative designed to reduce dental decay, improve oral-health behaviours, and tackle inequalities, particularly for children in more deprived communities. Evidence from the Childsmile programme shows that early preventative interventions, particularly supervised toothbrushing in nursery and school settings, significantly reduce dental caries, with the greatest benefits seen among children living in the most socioeconomically deprived areas.

Poor oral health can lead to pain, infection and disrupted sleep, but it also has wider consequences: children with dental decay experience substantially higher levels of school absence, which is known to affect attainment and long-term outcomes.

Ensuring that every child has a healthy mouth is therefore both a core public health priority and a vital component of reducing inequalities and supporting children to

thrive. Economic analyses demonstrate that the programme not only improves health outcomes but also delivers substantial cost savings: within three years the NHS savings exceeded implementation costs, and by eight years the savings were more than 2.5 times greater. This work is now regarded as a national exemplar of preventive spending and sustainable public health investment. Environmental sustainability assessments also show that the supervised toothbrushing programme results in substantial reductions in carbon emissions compared with treatment-based dental care and is highlighted nationally as a case study in sustainable health service delivery.

The Childsmile programme is underpinned by proportionate universalism: offering universal support to all children while providing enhanced interventions for those at greatest risk. This approach is essential for reducing oral health inequalities, which remain strongly patterned by socioeconomic status. Evidence shows that vulnerable groups, including children with additional support needs, care-experienced children, and children experiencing poverty, continue to experience disproportionately high levels of dental caries and dental general anaesthetic. Childsmile reaches many of these groups, but further work is required to reduce persistent inequalities (as shown below) and support equitable access.

We will continue to work with the Childsmile Team in areas of deprivation to explore what actions we can take to reduce these persistent and enduring inequalities.

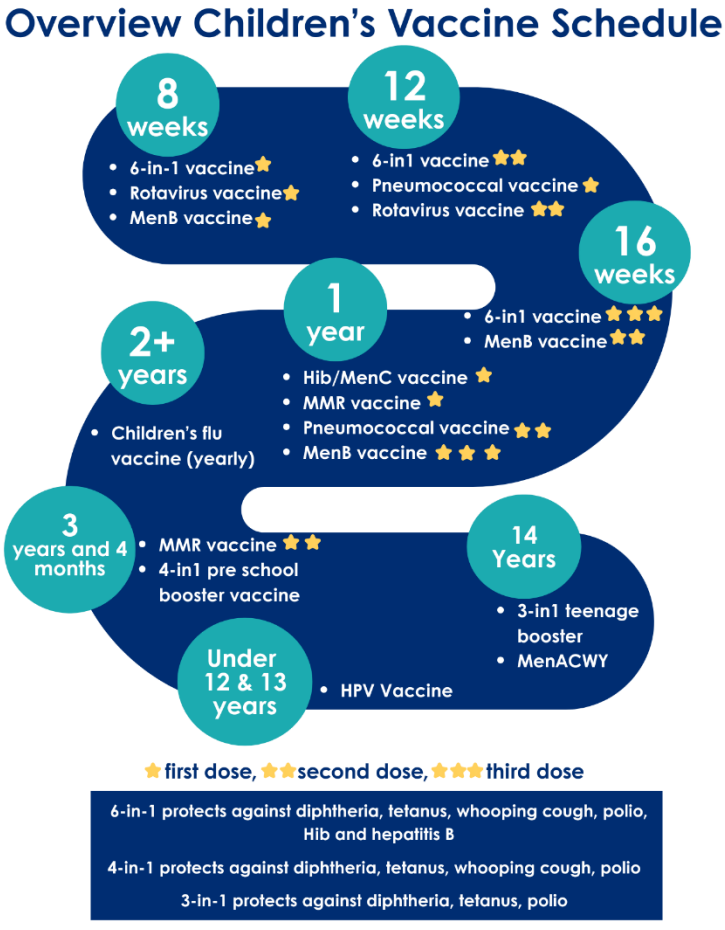
CHAPTER 5
THRIVING THROUGH THE SCHOOL YEARS

Vaccination

Childhood vaccination is fundamental to protecting population health. The Scottish Borders generally maintains high uptake rates although variation across localities and small pockets of lower coverage pose risks. Challenges include rural access, transport, competing family commitments, and vaccine hesitancy linked to misinformation.

Maintaining high uptake for measles, mumps, and rubella (MMR), pertussis and human papilloma virus (HPV) is especially important. Strengthened community engagement, flexible delivery models and trusted communication are key. School nursing teams, health visiting and primary care remain essential partners in sustaining equitable access.

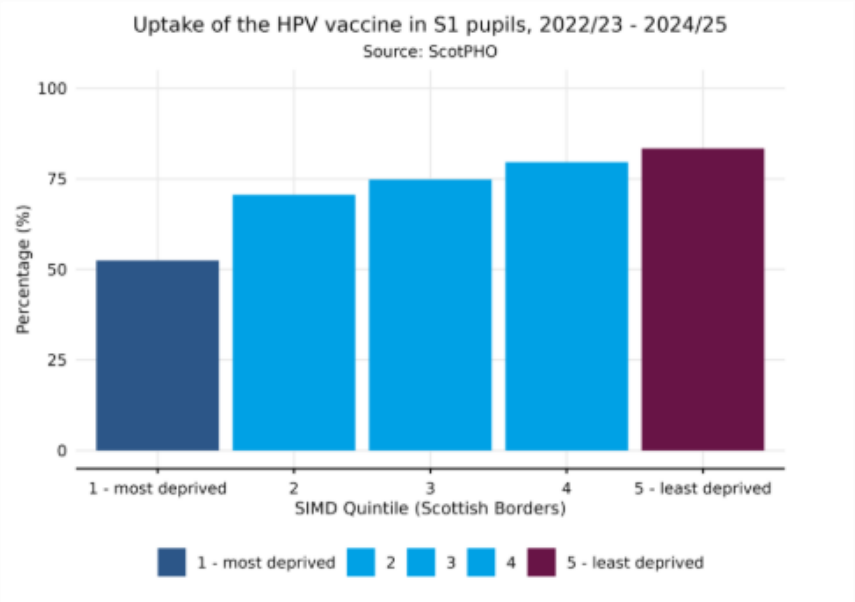
This infographic sets out the routine childhood vaccination schedule, showing the vaccines offered in early childhood and the ages at which they are given. Timely uptake is vitally important and, whilst we perform well compared to national averages across most of our vaccination programmes, there are some areas where we need additional focus to protect children and communities from serious infectious diseases.



There is a significant and notable variation in the HPV vaccination programme according to SIMD. There is almost 25% difference in uptake between SIMD1 and 5 and evidence of a socio-economic gradient, as per the graph on next page.

CHAPTER 5
THRIVING THROUGH THE SCHOOL YEARS

The HPV vaccine is transforming the landscape of cervical cancer prevention by targeting the virus responsible for most cervical cancer cases. Routine HPV immunisation, now offered from S1 onwards, protects against the high-risk HPV types that cause cervical, anogenital, and head and neck cancers, with cervical cancer remaining the most common HPV-related cancer. By preventing infection at its source, the vaccine significantly reduces the likelihood that individuals will develop the persistent HPV infection that leads to precancerous change and, ultimately, cervical cancer. Those who are unvaccinated remain at higher risk of HPV infection and subsequent cervical cancer, and that increased vaccine uptake, alongside screening, will drive long-term reductions in incidence and mortality. Through the locality planning approach with Scottish Borders Council, we will consider how we can better inform those who are least likely to accept the vaccine of the potential benefits.



Additionally, improving uptake of the RSV vaccine in pregnancy is a preventative measure that can significantly reduce harm in early infancy. Evidence from a Public Health Scotland study shows that babies under three months old whose mothers received the respiratory syncytial virus (RSV) vaccine during pregnancy had around an 80% lower risk of hospitalisation due to RSV infection compared with infants of unvaccinated mothers.[10] Given that RSV is a leading cause of severe respiratory illness in young infants, increasing maternal vaccination provides strong early protection at a critical developmental stage. Strengthening uptake will ensure more newborns benefit from this early immunity, reduce winter pressures on paediatric services, and support a more equitable start for babies across the Scottish Borders.

CHAPTER 5
THRIVING THROUGH THE SCHOOL YEARS

Smoking and Vaping

Smoking among young people has decreased markedly over the last decade, but vaping has risen rapidly. Public Health Scotland reports increasing experimentation and regular use of disposable vapes, driven by targeted marketing, flavours and easy availability.[11] In the Borders, youth surveys show similar trends, with vaping becoming normalised in some groups. While vaping is less harmful than tobacco for adults who smoke, it poses risks for young people, including nicotine addiction, respiratory symptoms and potential cognitive impacts. Schools, youth services and trading standards are working to reduce access and challenge normalisation. National legislative changes, including restrictions on disposable vapes, aim to strengthen prevention. Continued local action and school-based prevention programmes are essential.

Vaping is not only a problem because of the health harms it poses directly but because:

- Young people who vape are **2.7–6 times more likely to go on to use cannabis**, compared with non-vapers.
- They are also **4.5–6.7 times more likely to engage in alcohol use or binge drinking**.[12]

Children at schools in the Borders have told us that vaping negatively affects their experiences of school. However, schools have played a vital role in introducing measures to reduce their prevalence and impact. The case study (Youth Nicotine Prevention Toolkit) on the next page 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 coproduction, partnership working, and targeted intervention in creating healthier futures for young people in the Scottish Borders. We would like to support this work developing further and build on the lessons learned for future collaborative work.

CHAPTER 5
THRIVING THROUGH THE SCHOOL YEARS

Case Study: Youth Nicotine Prevention Toolkit

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 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 and the Scottish Government.

Mental Health

Mental health is one of the most significant issues facing young people. National data shows rising anxiety, low mood and distress, driven by social pressures, academic expectations, online influences and financial insecurity. Impacts are greatest among young people experiencing disadvantage, trauma, neurodiversity or chronic health conditions. In the Borders, demand is rising across universal and specialist services. Schools and youth services often provide initial support but face capacity pressures.

CHAPTER 5
THRIVING THROUGH THE SCHOOL YEARS

A whole-system, trauma-informed approach is essential, with strengthened early intervention, increased school-based support and improved coordination across services to ensure timely and compassionate care. We know that Child and Adolescent Mental Health Services (CAMHS) faces rising demand and it is important that we try to get upstream of some of the causes of poor mental health in childhood and also support developing protective influences.

The Planet Youth model closely aligns with what we know about Benevolent Childhood Experiences (BCEs). Both focus on creating the conditions that help young people thrive – supportive families, positive relationships at school, healthy peer connections, and good opportunities to take part in community and leisure activities. Although they come from different evidence bases, the protective factors they emphasise strongly overlap.

Planet Youth works at a population level. It uses anonymous school surveys to help communities make changes that strengthen protective factors – for example improving structured leisure options, supporting parental monitoring, and building stronger links between young people and their schools. BCEs research, on the other hand, focuses on individual experiences and shows that positive relationships and routine can buffer the impacts of adversity and support better mental health.

Where the two approaches align most clearly is in preventing substance use. Planet Youth consistently shows that stronger family, school, and community connections reduce risky behaviours. BCE studies show the same protective factors help young people remain resilient even when they face adversity. Planet Youth essentially puts this evidence into practice by creating environments that offer more positive experiences for children and young people.

Behaviour, Development and Neurodiversity Diagnoses

In the Scottish Borders, services are experiencing a steady rise in the number of children and young people being referred for assessment of neurodivergence, including autism, ADHD, and other developmental differences. While early identification is important,

there is concern that we must avoid unintentionally medicalising typical developmental variation or interpreting all behavioural challenges through a diagnostic lens. A clinical diagnosis should not be seen as replacing the vital role of parents and carers in providing consistent boundaries, guidance, and support.

Within the Borders system, there is a need to strengthen universal and targeted approaches that build parental confidence and accessible self-help strategies, particularly for managing common behavioural issues without immediate escalation to specialist pathways. For those awaiting CAMHS assessment, the development of local self-management resources and early support offers is essential to reduce distress, maintain family resilience, and ensure that clinical pathways remain focused on children with the highest level of need.

The Important Role of School Nurses

We target children in the 0-4 age range because we recognise that young minds are being formed and neurones and their pathways are being established, which leads onto good behaviours. We have invested in this area of childhood through health visiting.

There is a second period of neuroplasticity: puberty. This has received much less targeted support, and yet numerous life histories relate how children have reformed their character and life chances at this age, often attaching to a significant adult, such as a teacher.

School nurses could also fulfil that role and are vital to children's health and wellbeing, acting as a link between education, health and families. They deliver immunisations, mental health support, safeguarding, chronic condition management and health promotion. In the Borders, they are essential early-intervention partners but face increasing pressures due to rising complexity and demand. Strengthening integration with primary care, CAMHS, community mental health teams, youth services and family support can improve coordination. Ensuring school nurses are strategically involved, well supported and adequately resourced is crucial. Indeed, by targeting young pubescent people, there may be an opportunity to help "rescue" them from a pathway that is more troubled. We should actively look at how we can support this period of neuroplasticity to help improve children's life chances.

CHAPTER 5
THRIVING THROUGH THE SCHOOL YEARS

Young People's Access to Sexual Health Services

Equitable access to youth-friendly sexual health services is essential for improving sexual wellbeing, reducing unintended pregnancies and preventing sexually transmitted infections (STIs), such as chlamydia, which can lead to future infertility if not treated. Young people value confidentiality, flexible appointments, non-judgemental staff and accessible locations. Rural regions face additional barriers including distance, transport, privacy and limited service hours. In the Borders, young people report concerns about being seen, limited drop-ins and difficulty navigating online information. Ensuring staff are trained in youth-friendly practice is important. Education settings, youth workers and the third sector are also important partners in informing and supporting young people to meet the needs of diverse groups, including LGBTQ+ young people.

In 2026, we will look to undertake a full needs assessment of access to sexual health services for young people in the Borders, with a view to reviewing whether the current service design meets the needs identified. This will need to consider transport and accessibility as well as timing of clinics that best support young people to access support that they need.

CHAPTER 6

DEVELOPING HEALHTY COMMUNITIES FOR CHILDREN AND YOUNG PEOPLE

- **It is important that screens and time online does not displace the vital components of childhood: play, learning with adults, and time outdoors.**
- **Access to good and nutritious food is important and we continue to learn about the effects of diets high in ultra-processed foods.**
- **Planning around schools to ensure that children have access to good food during the school day is a long-term investment in the health of the Borders.**

Developing healthy communities for children and young people requires coordinated action across systems, environments and services. A healthy community is one where children have safe spaces to play and learn, families can access the support they need, and local systems work together to remove barriers to wellbeing. In the Scottish Borders, rurality, cost-of-living pressures and service accessibility all shape the conditions in which children grow. Strengthening community assets, designing health-promoting environments and embedding children's needs in planning decisions are essential to ensuring every young person has the opportunity to thrive.

School buildings are community assets, often located within the heart of local communities. It is perhaps a community asset that is often overlooked as a safe place for community activities, that include children. Whilst we deal with assets through the lens of a particular service, e.g. education, we will face challenges that limit flexibilities. Finding a way to release these community assets for the community, out of school hours seems like a potentially easy win for children, young people and their families for environments they can collaborate on collective activities.

The Digital Determinants

Digital determinants of health are the ways that digital access, online environments, and technology shape people's wellbeing. They include whether families can get online reliably, how children are exposed to digital harms, the impact of screen use on sleep and behaviour, and whether public services use digital tools in ways that are accessible and fair. These factors increasingly influence health outcomes and can widen inequalities if not addressed.

CHAPTER 6

DEVELOPING HEALHTY COMMUNITIES FOR CHILDREN AND YOUNG PEOPLE

Digital technology is now a central part of childhood, bringing both opportunities and challenges. Increased screen time has been associated with:

- reduced physical activity,
- sleep disruption,
- impact on attention,
- reduced mental wellbeing, and
- exposure to online harms, including cyberbullying and inappropriate content.

As screen time increases, it pushes out other activities that can helpfully regulate emotional and physical health. More than ever, many young people spend less and less time outdoors with a recent study highlighting that UK children average over 6 hours of screen time daily.[13] Excessive screen time can also cause eye strain, headaches, and blurred vision; it is strongly linked to the rising prevalence of myopia in children and young people.

We know that supporting parents to manage and limit screen time is increasingly important for children's health and wellbeing. UK public health guidance is becoming clearer: for children under two, screen time is not recommended, and for children aged two to four, sedentary screen time should be limited to around one hour per day (NHS and World Health Organisation (WHO) recommendations). Recent UK Government and parliamentary reviews have also stressed that screen time for older children should be carefully balanced with physical activity, social interaction and sleep, and that parents need straightforward advice on how to create healthy digital routines.

At the same time, there are wider questions for schools about how to navigate education in a world where digital skills are essential, but where opportunities for pupils to think independently, problem solve, interact socially and engage hands on with the world must be protected. Schools, therefore, have a vital role in modelling balanced digital use, embracing the benefits of technology for learning while also safeguarding space for play, creativity, critical thinking and physical activity. The introduction of iPads for all pupils in the Borders from Primary 4 is an area for concern. The provision of iPads allows children to access the internet and online games, not just homework tools. This policy has the potential to increase the screen time use of children and we must consider if there are alternatives.

Access to Healthy Food and Community Planning

Access to healthy, affordable food is fundamental to child health and is strongly influenced by local environments, income and food systems. The Good Food Nation (GFN) agenda provides a national framework for promoting sustainable, equitable and health-enhancing food environments. In the Borders, challenges include cost, transport, rural access to fresh produce and the dominance of calorie-dense, low-cost foods. Schools play a pivotal role through universal free school meals, school nutrition standards and whole-school approaches to food and wellbeing. Community-led food initiatives, local growing projects and partnership with the third sector also contribute to improving access. Ensuring food provision is culturally appropriate, dignified and proportionate to need is essential to reducing inequalities.

To drive this work forward locally, we have established a dedicated GFN working group to bring ambition, coordination and momentum to our plans. This group brings together expertise from across the third sector, academia, the public sector and voluntary organisations, creating a shared space to consider how we can develop innovative, practical and community-led solutions that reflect the realities of life in the Borders. By combining local knowledge with national learning, the group aims to strengthen our food system, support dignified access to healthy food, and ensure that our GFN commitments translate into meaningful change for children, families and communities.

CHAPTER 6

DEVELOPING HEALHTY COMMUNITIES FOR CHILDREN AND YOUNG PEOPLE

Alongside this, we recognise the growing evidence on the impacts of ultra-processed foods (UPFs) on children's health, including their link with obesity, poorer metabolic outcomes and increased exposure to aggressive marketing strategies.[14] Given the dominance of low-cost, calorie-dense foods in many local high streets and the limited availability of fresh produce in parts of the Borders, there is a clear need to consider how local planning approaches can help create healthier environments.

CPPs play a crucial role in shaping the environments in which children live, learn and grow, including in relation to food and diet but more widely as well. Decisions about housing, transport, greenspace, early years provision, youth services and community safety all directly influence health outcomes. Embedding children's rights and wellbeing within the Scottish Borders CPP ensures that strategic priorities reflect the needs of local families, particularly those facing disadvantage. Collaborative action between health, education, local government, third sector organisations and communities enables more coherent and preventative approaches. Strengthening the voice of children and young people within local planning processes can further ensure that services and environments are designed with and for them. As the CPP continues to develop, we must make sure that the governance around children and young people's health is clearly articulated at every level.

It is important that we consider how we can make the environments near schools healthier and make it easier for young people and families to make the healthy choice the default option. Granting permission for fast food restaurants and outlets selling high fat, sugar and highly processed foods near schools represents short term policy making and we must strive to do better. In the Scottish Borders, where our secondary school children often leave the premises for their lunch, it is even more important that we consider the options we provide for them in our town centres. Fast food outlets should not be propped up by the teenage pound at lunch time and, if we cannot create a supportive built environment, we should consider whether more children should stay on the school site during the school day.

CHAPTER 6

DEVELOPING HEALHTY COMMUNITIES FOR CHILDREN AND YOUNG PEOPLE

Intergenerational connections

Creating inclusive, intergenerational spaces in communities where children, young people, adults and older people can safely meet, learn and take part in shared activities can deliver tangible health benefits across the life course. These settings help reduce loneliness and social isolation, strengthen protective relationships for children and young people, and provide older adults with meaningful connection and purpose.

Regular, positive contact between generations can also build understanding and trust, reduce stigma and fear, and increase social cohesion, creating communities that feel

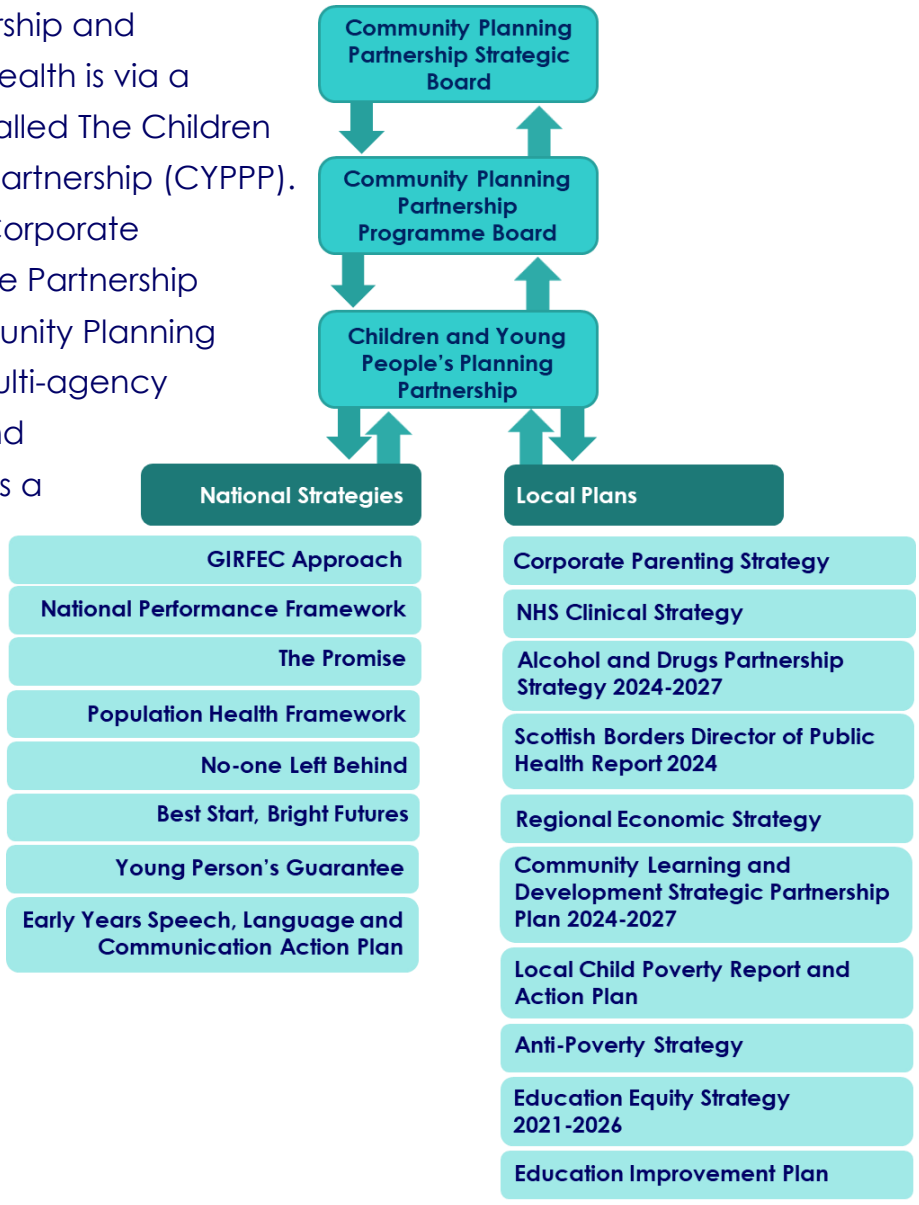
safer and more supportive. In practice, this means designing and investing in welcoming, accessible places and programmes that are affordable and inclusive for people of different ages and abilities.

CHAPTER 7
GOVERNANCE

- **A more unified strategic approach to the oversight and delivery of children's services is required.**
- **Clarity of roles and responsibilities across organisational boundaries will promote consistent planning, delivery and evaluation.**
- **We need to take a wider view of children and young people's health and wellbeing and not simply consider them as service users.**

Strategic Planning and Governance

The current system of partnership and engagement on children's health is via a strategic leadership group called The Children & Young People's Planning Partnership (CYPPP). It also acts as the Strategic Corporate Parenting Steering Group. The Partnership reports directly to the Community Planning Partnership (CPP) and is a multi-agency group of senior managers and executives that meets 4 times a year.



CHAPTER 7
GOVERNANCE

Across the Scottish Borders, the Child Health Commissioner (CHC) role provided a clear, strategic anchor for children's health. A single postholder previously led on commissioning, partnership working, and the wider public-health agenda for children and young people. Since NHS Borders divided this function, its impact has become diluted, with responsibilities, including corporate parenting, The Promise, and UN Convention on Rights of a Child (UNCRC) implementation, being dispersed. A more effective model, used in several Scottish boards, positions the CHC function within a Public Health Consultant remit, ensuring a unified focus on the full breadth of children's health improvement, rights, and wellbeing. Re-establishing this integrated approach would strengthen strategic leadership, restore coherence across partnerships, and ensure that all duties relating to The Promise and UNCRC sit within a single accountable role. To maximise governance and system impact, the CHC and corporate parenting functions should report through the recommended governance structure in which children's services are formally owned by the Integrated Joint Board (IJB), enabling clearer oversight, stronger collaboration, and a more consistent delivery of outcomes for children and young people across the Scottish Borders.

Over recent years, the NHS Borders Children's Service Network has faced challenges in maintaining quoracy and effective governance, reflecting wider system pressures, competing operational demands and workforce absence. While regular communication and accountability have remained central to the Network's approach, weakened governance links and reduced attendance have limited its ability to provide consistent strategic oversight.

A workshop held in November 2025 with the Children's Services Network reviewed current engagement and governance arrangements, resulting in a number of actions to strengthen participation, improve transparency and support more effective decision-making. The Network remains committed to aligning its work with the NHS Borders Clinical Strategy and will review its key performance indicators to ensure they reflect this strategic direction and support improved outcomes for children and young people.

CHAPTER 7
GOVERNANCE

However, these challenges also highlight a broader system issue: children and young people's health and wellbeing do not yet have a sufficiently clear or sustained strategic focus across NHS Borders and partner organisations. The IJB does not hold responsibility for children's services, meaning that the CYPPP is currently the primary forum in which children's issues are formally considered. There is a risk that this focus is overly centred on children as service users. We should recognise children and young people as a distinct population group whose health, wellbeing and development warrant the same level of strategic attention routinely afforded to adult populations. Proposals being consulted on by Scottish Government suggest that extending IJB responsibilities to incorporate children and young people will likely become a requirement in 2027/28.

The CPP also has a critical role in shaping the wider determinants of children and young people's health, including housing, transport, access to green space, early years provision, youth services and community safety. Embedding children's rights and wellbeing more explicitly within CPP priorities would help ensure that strategic decisions across sectors better reflect the needs of local families, particularly those experiencing disadvantage. Closer collaboration between health, education, local government, third sector organisations and communities provide opportunities for more coherent, preventative and place-based approaches, while strengthening the voice of children and young people within local planning processes can help ensure that services and environments are designed with and for them.

Feedback from Health Visitors and other frontline practitioners further highlights that, while there are several established groups addressing specific issues such as child poverty, governance and strategic oversight for children and young people remain fragmented. Greater alignment is needed to reduce duplication, clarify accountability and ensure that frontline insights about emerging pressures and service gaps are systematically incorporated into decision-making. Taken together, this points to the need for a more coherent, systemwide approach that builds on what we know needs to change, strengthens governance and partnership working, and ensures that children and young people are given sustained, considered and visible strategic attention across all levels of the system.

CHAPTER 8
RECOMENDATIONS

1 Strengthen Governance for Children and Young People

- NHS Borders and Scottish Borders Council should embed the needs, rights and priorities of children and young people more explicitly within strategic decision-making structures and delegate funding to the correct joint leadership space, as a core element
- Revise the scope of the IJB to include children and young people. This would enable a unified direction and more effective use of finite resources. Clarity of roles and responsibilities will promote consistent planning, delivery & evaluation of services.
- Management of services should be overseen jointly rather than in organisational silos so whole systems thinking informs best outcomes rather than individual service priorities.
- Avoiding harm at this stage delays/prevents harm that we all pay for in older age.

2 Adopt a Whole System Approach to Children's Wellbeing

- Integration should move beyond siloed models of services; children's outcomes are shaped as much by their home, community and out of school environments as by formal services.
- Strengthening support for parents and carers must be a core priority, ensuring families are equipped to manage expectations, nurture wellbeing, and address emerging concerns collaboratively with schools and other services. We must work beyond schools into places.

3 Amplify The Voice of children and Young People

- The voice and lived experience of children and young people should have a stronger and more systematic role in shaping decisions, policy and service design. This includes embedding participation structures that influence, rather than simply inform, local decision-making.
- Real power is represented by the evidence of flow of funds, and budgets

CHAPTER 8
RECOMENDATIONS

4 Improve Understanding and Prevention for Excluded Groups

- Further work is required to understand the specific needs and risks experienced by learning disabled, care experienced children and other excluded groups. These small groups are at risk of being overlooked.
- Strengthening inclusive practice, safeguarding approaches and early intervention pathways is essential to preventing harm and reducing inequalities.

5 Identify and Support Young Carers More Effectively

- The local system should strengthen mechanisms to understand the scale and nature of caring responsibilities undertaken by children and young people.
- Improved identification, assessment and support are required to mitigate the hidden burden and its impact on education, wellbeing and future outcomes.

6 Embed ACEs Informed Practice and Strengthen Prevention

- The Borders should adopt a consistent, trauma-informed approach to the collection and use of ACEs data. This will support earlier identification of vulnerability, enable more proportionate allocation of limited resources, and strengthen prevention in the early years, where inequalities become deeply entrenched without timely action. This is primary prevention and needs coordinated action.
- We need to develop a means of collecting this data in a way that is sensitive to the needs and rights of children and provides appropriate support as required.

7 Deliver a Comprehensive Whole Family Support Offer

- The Scottish Borders should ensure a robust Whole Family Support system that provides emotional, practical and financial assistance. This includes ensuring consistent access to the Bairns' Hoose model, embedding trauma informed justice pathways, and delivering a clear local approach to preventing and addressing online harm.

CHAPTER 8
RECOMENDATIONS

8 Build Vaccine Confidence

- A coordinated, evidence-based response to rising vaccine hesitancy is needed, with clear public facing communication, trusted professional voices, and targeted support for communities where uptake is lowest.
- Misinformation around specific programmes, such as HPV, should be addressed.

9 Reduce the Pathologising of Childhood Variation

- Services should ensure clinical pathways do not unintentionally medicalise typical developmental variation. This includes careful response to rising identification of neurodivergence and evolving diagnostic thresholds for ADHD and autism, with a focus on supportive environments rather than default clinical labelling.
- Build capacity for parental self-help to address challenging behaviours
- Build self-management capability for those waiting to be seen by CAMHS

10 Create Health Promoting Local Environments

- Planning, licensing and regulatory systems should be more responsive to children's health needs. This includes managing the proliferation of fast-food outlets, addressing obesogenic environments, and tackling the easy availability of harmful substances. A more preventative spatial planning approach is essential to safeguard children's long-term health.

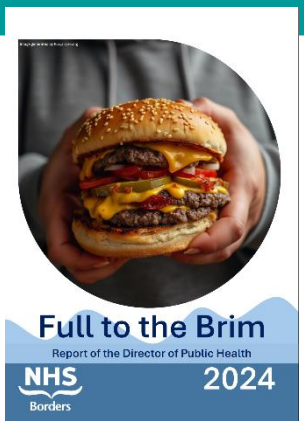
11 Reducing Screen-Time and Promoting Healthy Routines

- Strengthen support for parents and carers to establish healthy screen-use routines for children and young people.
- Consider whether it is appropriate for iPads to be given to all primary school aged children from primary 4.

12 Build Intergenerational Initiatives to Support Better Community Outcomes

- More atomised families leads to greater isolation and misunderstanding; by working across the generations everyone can benefit in better community outcomes.

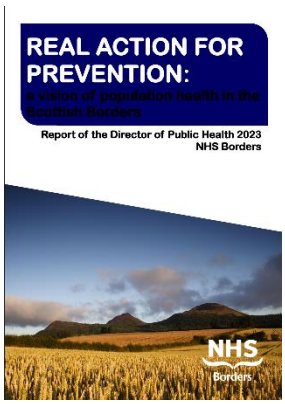
ANNEX 1
REVIEW OF PREVIOUS DPH REPORTS



My last report focussed on the issue of obesity and the potential for it becoming a medicalised condition. I am heartened to report that the issue of obesity was raised on numerous occasions in the clinical strategy discussions within Borders General Hospital and we have therefore begun to address the issue, but from a non-medical perspective initially. GLP-1 medication continues to be scarce and expensive, and whilst this has numerous metabolically beneficial effects and can be used on clinical advice for those with Type 2 diabetes, there is less access for addressing obesity alone.

The Population Health Framework was released in late summer 2025 – a ten year strategy to address demand for healthcare which identified two overarching priorities: prevention and obesity. This again reinforces the importance of the topic of managing being overweight, and the wider concerns of adverse impacts on health, in which I played my part in highlighting during policy development and consultation. The Scottish Government, COSLA and Directors of Public Health recognise the impact that obesity has on health outcomes. It is our view that this is a complex area which will require concerted action in similar ways to how we tackled tobacco addiction: a long-term approach with multiple alliances working under changes to legislation that influence our purchasing decisions.

However, my team has been active in reaching out to occupational health and explore ways that those who are on waiting lists might be supported to improve and maintain good health, including their weight. We have linked up with the weight management service and LiveBorders to pilot a programme of such support. We are also exploring the possibility of a weight management strategy for the staff in NHS Borders, and an internal reference group has been setup to help support this.



Progress from my first report which focussed on prevention has been more patchy. Our aim to set up a social prescribing service is being limited by lack of dedicated funding, and general lack of an agreed service model. I have now managed to reorganise my team so we can get a focussed set of actions on progressing this. LiveBorders is very keen to be a provider of social prescribing activities and we have partnered with them in a limited pilot to help support those on waiting lists to help them improve and maintain their health. After the Public Health service review, we have

managed to protect a dedicated resource in our Wellbeing Service, and we are now working with them to help redesign the shape and delivery of social prescribing within the Scottish Borders. I was also able to influence, in the development process, the Population Health Framework so that both Social Prescribing and Adverse Childhood Experiences were incorporated within it both mentioned in my first report. The Directors of Finance, as part of the sub-National planning process have embarked on a tagging of prevention spend, and our Board is one of the ones piloting this. This will help identify which elements of the Board's expenditure is invested in prevention.

As part of the service review outcomes, we have been able to recruit an Epidemiologist who will allow us to explore and provide health intelligence to support our work. An evidence-based approach to improving health outcomes will help us identify the most effective and efficient way that we can improve the health of our population.

A Wellbeing Board was established after my first DPH report. Unfortunately, this has now been wound down, but the workplan has been handed over to the Community Planning Partnership (theme 3), so I am comfortable that the progress that has been made will not be lost. Within NHS Borders, we have lost governance of population health programmes and activities, but I remain optimistic that we can establish a population health governance committee chaired by a non-executive director which will support our aspiration to become a population health organisation.

ANNEX 2
SCREENING SCHEDULE SCOTLAND

A table is included in the annex of this report which summarises the current pregnancy and newborn national screening tests offered in Scotland, consistent with NHS inform Scotland and reflected in local NHS Borders delivery arrangements.

Screening stage	Screening test	What it screens for	When offered
Pregnancy	Infectious diseases screening	HIV, hepatitis B, syphilis	Ideally between 8–12 weeks of pregnancy
	Haemoglobinopathies screening	Sickle cell disease, thalassaemia	Ideally before 10 weeks
	Combined / quadruple test	Down's syndrome, Edwards' syndrome, Patau's syndrome	First trimester (with second-trimester option if required)
	Mid-pregnancy screening ultrasound scan	Structural abnormalities	Between 18–21 weeks
Newborn	Newborn hearing screening	Permanent childhood hearing impairment	From birth to around 4 weeks
	Newborn blood spot screening	Conditions including PKU, congenital hypothyroidism, cystic fibrosis, MCADD, maple syrup urine disease, isovaleric acidaemia, glutaric aciduria type 1 and homocystinuria, hereditary tyrosinemia 1	Around day 5 of life

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OTHER REFERENCES AND ABREVIATIONS

Other References

1.	Front Cover Image Image by Md Ishak Rahman from Pixabay

Abbreviations

ACEs	Adverse Childhood Experiences
BCE's	Benevolent Childhood Experiences
CAMHS	Child and Adolescent Mental Health Services
CHC	Child Health Commissioner
CPP	Community Planning Partnership
CYPPP	Children and Young People's Planning Partnership
DPH	Director of Public Health
GFN	Good Food Nation
GIRFEC	Getting It Right For Every Child
HPV	Human Papilloma Virus
IJB	Integrated Joint Board
ISE	In Service Evaluation
MMR	Measles, Mumps and Rubella
SIMD	Scottish Index of Multiple Deprivation
SMA	Spinal Muscular Atrophy
STI's	Sexually Transmitted Infections
UK NSC	UK National Screening Committee
UNCRC	United Nations Convention on the Rights of the Child
UPFs	Ultra-processed Foods
WHO	World Health Organisation

CONTACTS

@	public.health@borders.scot.nhs.uk
	Public Health, NHS Borders, Education Centre, Borders General Hospital, Melrose, TD6 9BS
☎	01896 825560